State and School Employees' Health Insurance Plan

Strategic Plan

2019 - 2023

MISSISSIPPI STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
STRATEGIC PLAN FOR 2019 TO 2023

EXECUTIVE SUMMARY

To support the mission of the State and School Employees' Health Insurance Plan (Plan), the Health Insurance Management Board (Board) has developed a five year Strategic Plan which outlines key goals, challenges and strategies that will enable the Board to effectively manage the Plan for 2019-2023 and beyond. The Strategic Plan also fulfills legislative requirements set forth in Mississippi Code Ann. § 25-15-5, which requires the Board to develop a document to address, but not be limited to:

a. Changing trends in the healthcare industry, and how they affect delivery of services to participants of the Plan.

b. Alternative service delivery systems.

c. Any foreseeable problems with the present system of delivering and administering healthcare benefits in Mississippi.

d. The development of options and recommendations for changes in the Plan.

In developing the Strategic Plan, the Board has sought to build upon successful initiatives already implemented for the State and School Employees' Health Insurance Plan, recognize unique characteristics of the health care market in Mississippi and be responsive to the needs of Plan participants and other stakeholders. Additionally, the Board has endeavored to leverage strategies and tactics utilized by other state health plans and innovative employers around the country.

The Strategic Plan is focused on achieving three overarching goals which support the mission of the State and School Employees' Health Insurance Plan. While each goal is unique and measurable, they are somewhat overlapping, meaning success in each one will likely spill over to the other two. Moreover, achieving each goal is paramount to the short and long-term success of the Plan. The goals are:

- Improve the overall health and wellbeing of Plan participants
- Promote more efficiency in health care delivery
- Ensure participant satisfaction with health insurance benefits

Within the Strategic Plan, details are provided on specific objectives under each goal, challenges which will need to be overcome and specific examples of strategies the Board, will evaluate and potentially implement in the coming five years.

The Board intends for this Strategic Plan to be a living document which is referenced often in the coming years as we continually evaluate Plan performance, consider potential changes, communicate/engage with participants and interact with vendors, healthcare providers, governmental agencies and other stakeholders.

BACKGROUND

The State and School Employees' Health Insurance Plan (Plan) is a self-insured program providing health insurance coverage to nearly 190,000 participants. When an organization manages a self-insured plan, it means that the organization (in this case, the State) bears the financial responsibility for its own employee benefit plan. The State is responsible for paying claims and other expenses associated with providing Plan participants with healthcare coverage. The State, through the Board, determines the benefits and sets the premiums. All costs are paid from the money collected in premiums. There is no direct State appropriation of funds to the Plan.

Eligible participants include active, retired (early and Medicare eligible), and COBRA employees (and their enrolled dependents) of the State's agencies, universities, community/junior colleges, school districts, and public library systems. The 330 employer units are located in every county throughout the state, with each exercising a high degree of independence in managing its affairs. Plan participants are primarily located within the State of Mississippi, although a small number of participants reside in other states.

The Plan provides two types of health insurance coverage from which most participants may choose: Base Coverage or Select Coverage. The Base Coverage option meets the federal government's criteria as a qualifying high deductible health plan, for the purpose of establishing a Health Savings Account (HSA). The Plan also provides a separate coverage level for Medicare-eligible retirees and their Medicare-eligible dependents. The State contributes 100% of the premium for employee-only health insurance for all enrolled active employees hired prior to January 1, 2006, who select the Base coverage option. Active employees hired on or after January 1, 2006, may choose the 100% employer-paid Base Coverage option, or choose Select Coverage, for which they must pay a small percentage of the premium. The employee is responsible for 100% of the premium for any eligible dependents he chooses to enroll for coverage in the Plan. Retirees and COBRA participants pay 100% of their premium and their covered dependents' premium.

The Board is the Plan Sponsor of the State and School Employees' Health Insurance Plan and has the sole legal authority to promulgate rules and regulations governing the operations of the Plan within the confines of the law governing the Plan. The Department of Finance and Administration (DFA) provides the day-to-day management of the Plan through the Office of Insurance.

The Board selects, through a competitive bid process, all vendors who provide services under the Plan. These services include claims administration, pharmacy benefits management, provider network administration, utilization management, wellness and health promotion data management, and actuarial and consulting services.

OUR PHILOSOPHY

The State and School Employees Health Insurance Management Board (Board) is committed to providing access to quality care services to our participants and conducting the business of the State and School Employees' Health Insurance Plan (Plan) in a financially responsible manner that fully complies with all applicable laws, regulations and ordinances.

OUR VISION

To positively influence the health of all Plan participants.

OUR MISSION

To improve the health and quality of life of Plan participants, retirees and their family members by providing affordable, quality, coordinated, healthcare coverage.

OUR VALUES

Core values support the mission of the Board and are essential to the success of the Plan. Guiding principles that embody the core values are practiced in performing the Plan's daily functions, and are utilized to fulfill the Board's mission and vision.

INTEGRITY - We conduct our operations with the highest degree of integrity, honesty and fairness all in a professional manner.

RESPECT – We are responsive to the needs of Plan participants and believe each person should be treated with dignity and respect.

COLLABORATION - We believe in building and maintaining collaborative, long-term relationships with our vendors, providers, and the participants we serve.

INNOVATION – The Board looks for new ways to meet the needs of Plan participants by continuously monitoring and researching changes in the health insurance market. We keep Plan participants central in our healthcare decision-making.

STEWARDSHIP - We strive to safeguard the interests and improve the quality of life of current health Plan participants.

CHANGING TRENDS IN THE HEALTHCARE INDUSTRY

Despite the concerted efforts of employers, health plan vendors, provider groups and governmental bodies, healthcare costs have continued to exceed the rate of general inflation in recent years. In particular, the increasing costs of treating patients with chronic conditions and the significant growth in specialty drug costs – combined with a lack of meaningful improvements in participant health – have left private employers, state health plans and other health plan sponsors frustrated with existing approaches to health plan management. In response, innovative plan sponsors have partnered with health plan vendors and provider groups to launch new approaches to transform the healthcare system. These new approaches place much more emphasis on collaboration, shared accountability and measurable outcomes (costs and quality). Key emerging trends are contrasted with traditional health management approaches in the table below.

Traditional Approaches	Emerging Approaches
Limited impact, event-based wellness programs	Evidence-based programs to drive sustained behavior change in participants
Broad networks with emphasis on more participant choice	Narrow or custom networks designed to promote quality and value in care delivery
Provider reimbursement strategies focused on achieving deeper discounts	Shared savings models that put providers at risk for controlling total costs and improving quality
Aggregate cost-shifting through plan design (e.g., increased copays for all services)	Value-based plan designs featuring reduced cost sharing for high value services
Strategies to coerce participants to be better healthcare consumers	Increased transparency and resources to help participants be better health consumers
Vendor performance metrics tied to administrative efficiencies (e.g., claims payment)	Outcomes-based performance guarantees with vendors (e.g., member health improvement)

ALTERNATIVE SERVICE DELIVERY SYSTEMS AND PAYMENT APPROACHES

In response to growing frustration with existing approaches, plan sponsors have collaborated with providers and healthcare vendors in markets around the country to create new delivery systems and payment approaches. In some cases, the "new" approaches are simply rebranded versions of existing models (e.g., some health insurance carriers have created patient centered medical homes – in name only - that do little to change how healthcare is delivered). Fortunately, some of the new models have been truly transformative and are already demonstrating real impact for improving care, reducing costs and enhancing patient satisfaction. While there is considerable overlap in the different approaches, the key categories of these new alternative delivery systems and payment approaches are summarizes in the following table:

Model	Key Features
Patient Centered Medical Homes	Primary care-based model that puts providers at risk for improving care and controlling costs for members on their panel
Accountable Care Organizations	Collaborative organization of hospitals, physicians and other providers who are at risk to manage full patient care
Tiered Networks	Allows participants to have choice of providers but offers incentives to use higher quality, lower cost providers
Narrow Networks	Provides access to only the high value providers (e.g., those with better outcomes and lower cost)
Reference-based Pricing	Establishes fix reimbursement rates for high-volume, mainly elective procedures (e.g., total hip replacements); participants pay any amount over reference-based price
Bundled Rates	Provider group receives fee for all services related to an episode of care (e.g., inpatient and outpatient charges for transplant)
Quality-based Reimbursements	Providers receive financial rewards/penalties based on quality metrics (e.g., hospital-acquired infections)
Global Budgets	Provider receives aggregate financial target for all services provided to a specific population

FORESEEABLE PROBLEMS WITH THE PRESENT SYSTEM

While costs for the State and School Employees' Health Insurance Plan have grown at a slightly slower rate comparable to other state health plans and private employers over the last decade, the Board recognizes the need to ensure the long-term viability of the Plan and take proactive steps to manage future costs. In recent years, Plan participants have enjoyed relatively reasonable out of pocket costs, few increases in premium contributions, flexibility in provider choice, and a range of free or low cost wellness offerings. However, there are a number of concerning trends in Mississippi, and the larger healthcare market, that could put the current system at risk, including:

- Increasing rates of chronic disease in Mississippi
- Aging participant population
- Stagnant wages for employees
- Rising costs of prescription drug benefits, particularly for specialty drugs
- Limited state and local school system budgets
- Changes in the regional and national vendor market place
- Uncertain legislative environment in Washington, D.C.
- More aggressive negotiations on the part of providers
- Changing expectations / demands of participants

OPTIONS AND RECOMMENDATIONS

Based on challenges and changing healthcare industry dynamics noted in the preceding sections, the Board has created the Strategic Plan to ensure the long-term viability of the State and School Employees' Health Insurance Plan. Key options and recommendations to support the three overarching goals are summarized below.

Goal #1: Improve the Overall Health and Wellbeing of Participants

There is growing consensus among experts around the nation that, to control healthcare costs, more needs to be done to improve the overall health and wellbeing of participants. This requires a focus on chronic diseases, such as diabetes and congestive heart failure, and the lifestyles / risk factors that exacerbate these conditions. It also requires a broader view of participant wellbeing, which includes physical, emotional/mental health, financial, spiritual and social wellbeing.

The benefits of improving participant health and wellbeing are significant, and could include reducing long-term medical costs, lowering disability and workers compensation costs, boosting worker productivity, increasing employee engagement and reducing strain on the state's existing healthcare system. But, the task of improving health can be daunting, particularly in light of the finite resources available to the Board, deep-seated participant lifestyle practices and particular challenges to the health of Mississippi residents. Through carefully-designed strategies and collaboration with stakeholders, however, there are opportunities for the State and School Employees' Health Insurance Plan to achieve meaningful improvements in participant health and wellbeing.

Challenges

Improving health and wellbeing across a diverse population of Plan participants is essential, but not easy. Particular challenges include:

- **Health literacy** – While most participants likely understand basic preventive messages such as the value of good nutrition and physical activity, it is harder for individuals to discern what they can realistically do to achieve better health. Not only are there confusing and contradictory messages in the traditional media, social media and advertising, participants often lack information on how small changes in their daily activities can lead to significant health improvements.
- **Environmental factors** – People tend to respond to the environment in which they live and work. For example, research has shown that those who spend time around smokers are more likely to develop the habit themselves. Moreover, if individuals lack adequate access to healthy food choices or safe/convenient places to exercise, it can be difficult to pursue a healthier lifestyle.
- **Social determinants** – A growing body of research demonstrates that a person's income, place of residence, social supports and educational level, along with other social determinants, can have a significant impact on their health and wellbeing. Mississippi faces particular challenges in a number of these social determinants of health.

- **Increased levels of stress** – As life gets more hectic at work and home, and as financial pressures grow, many participants face increased strain on their mental and emotional wellbeing. Moreover, increased stress can lead to more unhealthy lifestyle choices (e.g., overeating or drug/alcohol abuse), which exacerbates individuals' health issues.
- **Lack of motivation / self-efficacy** – Numerous studies have documented how Americans lack the motivation to sustain healthy habits (e.g., avoiding fatty foods or getting enough sleep) on a daily basis. Moreover, many perceive themselves as "just not able" to lead a healthy lifestyle, because they do not have the willpower, time, resources or social supports they perceive are necessary.
- **Access to care –** Participants, especially those who live in more rural parts of the state, may lack adequate access to healthcare providers, particularly in certain primacy care and special areas.
- **Lack of transparency / access to meaningful health information** – Consumers generally find it difficult to access information on selecting the optimal medical treatment, or choosing the best healthcare provider. Where information is available regarding provider quality or costs, this information is often difficult to understand for purposes of "comparison shopping".
- **Dearth of adequate shared incentives** – Despite growing interest in outcomes-based payment arrangements, most providers and healthcare vendors lack meaningful incentives to work with participants to improve their health in a sustained way.

Strategies

To address the challenges noted above, and drive sustained health improvement among participants, the Board will continue to evaluate and potentially implement a range of strategies over the next five years. These will expand on the work done to date and may include:

1. **Increase utilization of preventive care and screenings** – DFA will explore ways to increase the percentage of participants who obtain age/gender appropriate preventive care and screenings. These tactics may include:

    - **Boost incentives for participants** – Offer perks to those who obtain appropriate screenings, such as reduced deductibles or access to richer benefits.
    - **Remove barriers to care** – Identify and address factors that keep participants from taking advantage of the 100% coverage the Plan offers for preventive services rendered by network providers (e.g., if access is an issue, determine whether additional worksite, telehealth or mobile screenings be a cost-effective way of increasing the number of individuals who participate).
    - **Create more effective messaging** – Find ways to more effectively and efficiently communicate simple messages to produce action.
    - **Provide incentives for vendors and provider groups** – Determine if performance guarantees should be enhanced, and identify whether additional incentives should be offered to provider groups treating Plan participants.

2. **Actively engage participants in programs that can help them sustain healthier lifestyles** – The Board will explore ways to increase participant engagement in wellness programs. Examples include:

    - **Drive more participation in health coaching** – Draw more participants into health coaching to target leading risk factors for chronic diseases, including poor nutrition, physical inactivity, tobacco use, insufficient sleep, drug or alcohol abuse and stress.
    - **Support technologies that enable healthier habits** – Tap into growing consumer interest in health-related technologies (e.g., fitness trackers, real-time glucose monitoring) by promoting and possibly subsidizing these resources, particularly for vulnerable populations.
    - **Promote jobsite wellness initiatives** – Enhance a culture of health at worksites throughout the state by promoting programs that allow participants to build healthy habits (e.g., cooking classes, exercise/yoga classes, peer to peer coaching)
    - **Forge community partnerships** – Collaborate with other state agencies, local health departments, hospitals and other provider groups, health care non-profits and other entities to build healthier communities throughout the state (e.g., promoting local community efforts to enhance walking paths / bike trails or offer diabetes prevention classes)

3. **Improve participants' ability to navigate the healthcare system** – Opportunities will be explored to help participants become better healthcare consumers. This may include:

    - **Offer more information on provider quality and costs** – Enable participants to compare treatment options and providers based on meaningful, easy to understand information on clinical outcomes and costs.
    - **Provide access to patient advocates** – Help members, particularly those with complex medical care needs, secure the support of patient advocates and/or facilitated access to proven national experts for second opinions to assist them in understanding their options and overcome potential barriers to the best care.

Goal #2: Promote More Efficiency in Healthcare Delivery

In addition to improving participant health and wellbeing, there are a myriad of other ways the Board can manage short and long-term costs. While the strategies outlined under Goal #1 focus primarily on *reducing the need for care*, Goal #2 focuses more on *ensuring the greatest value* in care that is delivered to Plan participants. Fortunately, there have been significant innovations in healthcare markets around the country in recent years, providing new opportunities for savvy plan sponsors to drive more value in how care is financed and delivered. By expediting the take up of these strategies in the local market, there could be significant opportunities to better manage costs between now and 2023.

Challenges

To drive more value in the delivery of healthcare services to participants, the State and School Health Insurance Management Board will need to address a number of key challenges, including:

- **Increasing costs of chronic conditions** – Mississippi ranks among the nation's top states in prevalence for diabetes, hypertension and other chronic conditions. Costs for treating these conditions continue to rise, particularly when factoring in high cost medications and specialty drugs. Without changes to the status quo, these costs will likely continue to grow.
- **Limits to cost-shifting –** As treatment costs rise, there are reasonable limits to how much of the increase can be passed on to participants. Not only because of cost-sharing limits under the Affordable Care Act, but the limited economic resources of many Plan participants will curtail the state's ability to cost-shift to participants. Additionally, as cost shifting continues, some participants will merely forego necessary and appropriate care.
- **Continued prominence of traditional fee-for-service provider reimbursement approaches** – Despite promising developments around the U.S. in innovative payment approaches, most health care providers in Mississippi continue to be reimbursed via a fee-for-service model that rewards more care, not better care.
- **Conflicting economic incentives** — Healthcare providers, particularly hospitals, often have conflicting interests with other providers, making them hesitant to voluntarily collaborate.
- **Lack of participant concern or knowledge of costs and quality** – While new resources are being developed to bring more transparency to healthcare, consumers continue to have only a limited understanding of true costs of care, and the significant variations in cost and quality among providers.
- **Limitations of existing vendors / current contractual terms** – Current contracts with vendors would need to be negotiated, or new procurements would potentially need to be launched, in order to fully benefit from new vendor offerings in the marketplace.
- **Potential for simply shifting costs from one bucket to another** - As new innovations in healthcare delivery and financing are evaluated, the Plan will need to avoid simply shifting costs from one bucket to another (e.g., potentially generating higher emergency room costs when physician office visit costs are reduced).
- **Cost of new technologies / life-sustaining care** – Medical breakthroughs in treating chronic conditions (e.g., congestive heart failure), acute conditions (e.g., infections) and genetic conditions (e.g., cystic fibrosis), allow patients to live longer, but also continue to drive up medical and pharmacy costs.
- **Insufficient provider access limits Plans' ability to negotiate** – In rural parts of the state, it will likely be more difficult to negotiate innovative financial terms with providers.
- **Initial investments required to design and implement long-term solutions** – The transition to more innovative delivery models detailed in this section can require significant upfront costs for providers. Local providers may look to the Plan to help offset some of these development costs.

Strategies

In light of the challenges outlined above, it is imperative that the Board proactively pursue strategies to drive more value in how care is delivered to participants. This will include building on strategies implemented to date with various vendor partners and providers and may include:

1. **Redefine provider networks** – Pursue arrangements that steer care to higher quality / more efficient providers. Examples include:
    - **Centers of excellence** – Designate hospitals who have demonstrated better outcomes and lower costs for complex procedures and types of care, including cardiac surgery, transplants, joint replacements and oncology care; participants who use these providers would pay reduced out of pocket costs and possibly receive additional perks (e.g., concierge services and reimbursed travel expenses).
    - **Reference-based pricing** – Establish a fixed price for certain high volume, elective procedures (e.g., joint replacements, colonoscopies or cataract surgeries); participants using providers who charge more than the reference-based price would pay for the difference.
    - **Direct contracting** – Negotiate directly with providers (e.g., not through a third party, such as Advanced Health Systems) to secure better financial arrangements.
    - **Tiered networks** – Create different provider tiers within the Plan's network based on demonstrated quality and cost metrics; participants who use higher tier providers enjoy lower out of pocket costs and potentially other benefits (e.g., free patient advocacy services).
    - **Custom / limited networks** – Eliminate lower quality / higher cost providers from the Plan's network, providing a significant incentive for participants to use higher performing providers.
2. **Pursue shared savings arrangements** – Create financial incentives for providers and vendors who want to play a more active role in driving down costs and improving outcomes. This could include:
    - **Expand bundled pricing arrangements** – Identify high cost procedures and types of care that could be reimbursed on bundled basis rather than fee-for-service, covering inpatient and outpatient costs.
    - **Accountable Care Organizations** (ACOs) – The Centers for Medicare & Medicaid Services (CMS) has designated several ACOs in Mississippi for the Medicare program. Evaluate the effectiveness and explore potential collaboration with one or more of these organizations for Health Insurance Plan participants.
    - **Outcomes based performance guarantees** – Negotiate arrangements with Plan vendors and local provider groups to offer financial incentives for measurable improvements in population health, such as lowering rates of diabetes or hypertension within the covered population.
3. **Offer appropriate incentives to participants** - Encourage individuals to choose higher value providers and treatment options. Potential strategies could include:
    - **Reduced out of pocket costs** – Offer participants who use designated higher quality / lower costs providers (e.g., Tier I) lower copays and / or a reduced deductible or other incentives for being a "smart shopper".
    - **Premium holidays** – For individuals who choose a Limited Network plan during open enrollment, waive employee contributions for the first two or three months of the year.

- **Patient navigators** – Contract with a patient navigator and offer this service at no cost for members who participate in health management programs.

Goal #3: Ensure Participant Satisfaction with Health Insurance Benefits

In addition to improving the health of the covered population and promoting greater efficiencies in the delivery of care, it will be imperative to ensure continued participant satisfaction with the Plan. Historically, the Plan has been able to balance the needs for controlling costs while offering competitive benefits. In light of the changes in the healthcare system and Plan's need to control future costs, the Board will maintain its commitment to ensuring the Plan continues to meet the diverse needs of its covered population.

Challenges

Challenges that will need to be addressed to ensure continued participant satisfaction with the Plan include:

- **Preferences for the status quo** – Research has shown that individuals tend to fear change, even when it brings clear benefits; this is particularly true for employee benefit programs.
- **Significant diversity in the covered population** – The Plan currently covers a wide spectrum of members, with significant variations in participants' ability to pay for services, their health literacy, health habits, demographics, healthcare needs, access to care, and expectations about healthcare.
- **Lack of accountability among providers and vendors** – While market changes have brought increased accountability for quality and costs, providers and vendors continue to experience little accountability for improving participant satisfaction.
- **Challenges in communicating** – Within the state's diverse population, participants have differing preferences in how they would like to receive information on their benefits.
- **Consumer mistrust** – Studies have documented how little consumers trust health insurance vendors, making it more difficult to engage them in programs offered by these vendors.

Strategies

To address these challenges and ensure continued participant satisfaction with the Plan, the Board will evaluate and implement strategies to:

- **Achieve an optimal balance of participant cost-sharing and payroll deductions** - Ensure cost is not a barrier to appropriate care, while helping nudge patients away from unnecessary care.
- **Offer sufficient choice in providers** – Continually evaluate adequacy of provider options throughout the state.
- **Support participants' ability to access care** – Incorporate new developments in telemedicine, onsite clinics and other innovative modes of care, particularly in areas of the state that may be underserved by traditional providers.
- **Enhance communications** – Make sure participants understand how to utilize benefits and recognize the value provided by the Plan.

CONCLUSION

While the challenges are significant, a strong business case can be made for continuing to explore innovative strategies the Mississippi State and School Employees' Health Insurance Plan can implement to fulfill its mission in the coming years. As the health care system continues to evolve, and participant needs change, it is important to stay focused on certain core goals of the Plan, including:

- Improving the overall health and wellbeing of participants
- Promoting more efficiency in healthcare delivery
- Ensuring participant satisfaction with health insurance benefits

Meeting these goals will require a continued focus on understanding key cost drivers, vigilant monitoring of changes in the market, a willingness to make investments and embrace new ideas, and perhaps most importantly, effective collaboration with participants, vendors, providers, community organizations and other stakeholders. The benefits of this continued focus will likely justify the ongoing efforts on the part the Board and its administrative staff.