

Healthcare Cost Containment Committee Report

August 2009

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Executive Summary

The formation of a Blue Ribbon Committee on moderating healthcare costs was announced in February, 2009, by Indiana University (IU) President Michael McRobbie. The Committee was asked to identify ways to contain healthcare plan costs while continuing to deliver high-quality healthcare to employees and their families on IU campuses.

Healthcare costs have increased by 8 to 12 percent a year at IU for the past several years. In the long run, these increases are not sustainable. The Committee deliberated options for change in health promotion, healthcare delivery, and healthcare benefits. From the options reviewed, the Committee makes five recommendations. Options 1 and 3-5 are complementary and are likely to be synergistic. As articulated, however, these recommendations are not radically interdependent and could be implemented in a stepwise strategy.

1. Design and implement a system of care for the provision of comprehensive, cost-effective healthcare services to IU employees and their dependents in partnership with two IU-affiliated organizations (Clarian Health and the Indiana Clinic).
2. Develop plans for an IU ambulatory care center, informed by planning and design for option #1 (Clarian joint venture).
3. Increase the scope and enhance the organization of health promotion/disease prevention services for IU employees and their families. Implement these services through an opt-out health risk appraisal and coaching program, implemented by Clarian and the University Health Center.
4. Identify any additional administrative options for improving the cost-effectiveness of IU healthcare expenditures that might be implemented in the short run. These may include various elements of our recommendations (as listed) that have already been deployed and could be further incented or extended to a wider population.
5. Form and support a measurement and evaluation working group to assess the impact of actions #1, #3, and #4 on care cost, care quality, and health of IU populations.

Introduction

IU spent approximately \$146 million on healthcare benefits for its 17,300 full-time employees and their families and more than \$7 million on healthcare benefits for over 4,400 graduate assistants in FY 08/09. In all, for every \$1 that IU pays for employee salaries, it spends an additional 16 cents for employee healthcare coverage. Ninety-four percent of expenses for medical care are payments to providers (hospitals, physicians, pharmacies), and only six percent cover third-party administrative costs (provider network contracts, claims adjudication, customer services, case management services). If current trends continue, healthcare benefit costs will increase to over \$200 million in four years. This rate of increasing expenditures is more than double the rate of general inflation. Clearly, as these healthcare cost increases continue unabated, they reduce resources available for IU's central mission of excellence in education, research, and service to the citizens of Indiana, the nation and global partners.

Containing the rate of increase in healthcare expenditures is essential if IU is going to progress as a university. At the same time, IU must provide employees with comprehensive and affordable access to high-quality healthcare. A comprehensive set of benefits, consistent with those provided by IU's peer universities, is essential for the recruitment and retention of highly qualified faculty, staff, and graduate students. Simply shifting costs of healthcare to IU employees clearly would erode the position of IU in competing for talented people, its most important resource.

IU is not alone, of course, in facing these challenges. The burden of unsustainable increases in healthcare costs, exacerbated by cost-shifting to cover expenditures for the uninsured, and compounded by concerns for quality and continuity of care in our fragmented and segmented healthcare environment, is adversely affecting American society at large. As this document is written, Congress is deliberating its options for healthcare reform. The final focus of the reform dialogue is as yet indeterminate. Key congressional concerns are improved quality of care and health outcomes, slowing the growth of spending, insuring the uninsured, and stimulating the emergence of "Accountable Care Organizations (ACO)." In the near term, reforms under active consideration are not likely to change the pluralistic nature of the insurance and delivery system. In this context the major public insurers (Medicare and Medicaid) are likely to be interested in any and all measures that might reduce fragmentation, incoherence, and resultant waste/risk in the delivery of healthcare. Financial interventions that provide incentives to organizations to coordinate and integrate care are to be expected. These measures might include bundled pricing for episodes of care, compensation for successful control of chronic diseases over time, and other pay-for-performance financial mechanisms. What changes might emerge from these deliberations, how they would affect the financing of healthcare in general, and how – in particular – they would affect the position of IU, a self-funding employer in the healthcare marketplace, are all matters of conjecture.

Given his responsibilities for managing wisely in this parlous situation, President McRobbie sought input from a Blue Ribbon Expert Committee on Healthcare Cost Containment chaired by Dr. Thomas Inui, M.D., President and CEO of the Regenstrief Institute. Other members include David Daleke, Associate Professor of Biochemistry and Molecular Biology and Associate Dean of the University Graduate School, IU Bloomington; Diana Ebling, M.D., Medical Director of the Health Center, IU Bloomington; Mary Fisher, Associate Vice Chancellor for Academic Affairs and Professor of Nursing Administration, IUPUI; John Fitzgerald, M.D., Associate Dean of Clinical Affairs and President and Chief Executive Officer of the IU Medical Group-Specialty Care, IU School of Medicine, IUPUI; Ed Marshall, O.D., Professor, IU School of Optometry and Vice President for Diversity, Equity and Multicultural Affairs; Kathleen McNeely, Associate Vice President for Financial Management Services; Nasser Paydar, Chancellor, IU East, Richmond; Bernice Pescosolido, Distinguished Professor of Sociology, IU Bloomington, and Director of the Indiana Consortium for Mental Health Services Research; Dan Rives, Associate Vice President for University Human Resources Services; Steve Wantz, Senior Vice President of Administration and Human Resources, Clarian Health; Eric Wright, Professor, School of Public and Environmental Affairs, IUPUI, and Director of the Center for Health Policy. The Committee was formed and issued its charge in February, 2009.

Committee's Charge

The charge to the Committee was to identify ways to control increases in healthcare costs at IU in both the immediate future and over the longer term, while continuing to assure access to high-quality healthcare for employees and their families on all IU campuses.

The Committee was to explore a wide range of ways to reduce healthcare costs and make appropriate recommendations. These recommendations should ensure that the health of IU employees and their families is maintained or even improved. The exploration of creative and novel ways of reducing healthcare costs was encouraged.

The Committee was to give particular attention to ways of reducing healthcare costs that leverage services already provided by, or ones that could be provided by, the IU School of Medicine and through IU's unique relationship with other entities, such as Clarian Health and all of its associated hospitals and other facilities, the Indiana Clinic, Regenstrief Institute, and Indiana Health Information Exchange.

The Committee was asked to provide a report to the President by August 31, 2009. Noting that the IU budget for FY 2009-2010 was to be finalized in May, 2009, the Committee was also invited to make interim recommendations to the President in May that it believed should be considered for inclusion in the 2009-2010 budget.

The Committee met monthly from March-August 2009. Various relevant documents (see Appendices) were circulated for study in intervals between meetings and subsequently discussed. Input into the Committee's deliberations was solicited from relevant parts of the IU community. The Committee made its efforts known through a Website and used this site to collect input. The Committee's membership provided a rich background for its deliberations, with notable expertise in health, healthcare, healthcare policy, healthcare evaluation, university administration, delivery system administrative management, benefits management, and faculty affairs. While each member of the Committee had a distinguished position somewhere in the relevant 'organizational ecology' of IU or its related institutions, they were asked to bring their relevant expertise and experience to the Committee's discussions, setting their specific organization's interests aside. Our fealty in the work of the Committee was to IU, not narrowly to the interests of our own units or institutions. Support for the Committee was provided through the Office of the Associate Vice President for Human Resources.

Considerations

IU is a multi-campus university. This report is careful to clarify the applicability to all campuses. However, because some cost-savings measures require a sufficiently large population pool to generate a substantial return, some proposals will be most effective in the Indianapolis and Bloomington markets, where 89 percent of IU employees eligible for health benefits reside.

The Findings of Other Committees and Task Forces – An Exemplar

Given general U.S. concerns about the cost and quality of healthcare, the IU Committee was not surprised to note that their charge and remit was similar to that of other groups. One notable Commission, operating with the sponsorship of the Commonwealth Fund, reported its findings on how to control rising costs while enhancing the quality of medical care in December 2007 (*Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, see Figure 1 on the following page, full report provided in Appendix A). Remarkable for the eminence of its participants and for the depth of their research, the Commonwealth Commission advanced 15 recommendations for enhancing the value of healthcare expenditures (more quality for less cost) in the United States. From the IU Committee's perspective, some of these recommendations represented opportunities for IU itself (e.g. promoting health and preventing disease, engaging in competitive bidding, paying for performance, advocating for use of Indiana informatics platforms) while others might represent opportunities for elements of the healthcare delivery system(s) that served IU employees (e.g. strengthening primary care, patient shared decision-making). The Committee reviewed the findings of the Commonwealth Commission as background for its look at the cost and quality of care experience of IU.

Exhibit ES-1. Policy Options and Net Cumulative Impact on National Health Expenditures Over One, Five, and 10 Years

	One-Year Impact on NHE (billions)	Cumulative Five-Year Impact on NHE (billions)	Cumulative 10-Year Impact on NHE (billions)
Producing and Using Better Information			
1. Promoting Health Information Technology	\$8	\$14	-\$88
2. Center for Medical Effectiveness and Health Care Decision-Making	-\$18	-\$125	-\$368
3. Patient Shared Decision-Making	-\$1	-\$4	-\$9
Promoting Health and Disease Prevention			
4. Public Health: Reducing Tobacco Use	-\$5	-\$64	-\$191
5. Public Health: Reducing Obesity	-\$3	-\$61	-\$283
6. Positive Incentives for Health	\$0	-\$5	-\$19
Aligning Incentives with Quality and Efficiency			
7. Hospital Pay-for-Performance	-\$2	-\$14	-\$34
8. Episode-of-Care Payment	-\$17	-\$96	-\$229
9. Strengthening Primary Care and Care Coordination	-\$5	-\$60	-\$194
10. Limit Federal Tax Exemptions for Premium Contributions	-\$10	-\$55	-\$131
Correcting Price Signals in the Health Care Market			
11. Reset Benchmark Rates for Medicare Advantage Plans	-\$3	-\$20	-\$50
12. Competitive Bidding	-\$7	-\$42	-\$104
13. Negotiated Prescription Drug Prices	-\$3	-\$16	-\$43
14. All-Payer Provider Payment Methods and Rates	\$2	-\$23	-\$122
15. Limit Payment Updates in High-Cost Areas	-\$4	-\$43	-\$158

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.

Figure 1. Top 15 Policy Change Options from *Bending the Curve: Options for Achieving Savings and Improving Value in US Health Spending*, December 2007

Indiana University's Employee Medical Plans: State of Affairs – 2009

IU provides full-time employees three medical plan options. In January 2009, approximately 16,599 or 94 percent of 17,592 eligible employees enrolled in an IU-sponsored medical plan. In addition to themselves, employees may elect to cover spouses/domestic partners and dependent children up to age 24. Approximately 39,800 individuals are receiving medical benefits through these IU-sponsored employee medical plans.

Table 1: Medical Plan Enrollments - January 2009:

	Employee Enrollments	Total Members*** (Employee/Spouse/Children)
PPO \$900 Deductible	6,816	16,358
POS Blue Preferred*	9,497	22,793
PPO HDHP & Savings**	286	686
Totals	16,599	39,837

* POS plan will be restructured for January 2010

** HDHP & Medical Savings plan was new for January 2009

***Additional non-employee enrollments include over 400 COBRA participants and 1,660 Retirees.

Each medical plan sponsored by IU provides comprehensive benefits, from the coverage of physician office visits, surgery, hospital admissions, organ transplants, therapy, to prescription drugs. Another similar feature of each plan is that employees have access to a very broad “preferred provider network” including at least 95 percent of the physicians and hospitals in Indiana, most physicians and hospitals across the U.S., and many providers in other countries.

“Preferred provider networks” are essential for a variety of reasons, such as:

- Preferential pricing of services, as much as 60 percent off billed charges (group medical plans should rarely pay billed charges)
- Network providers are prohibited from charging members for the balance of bills
- Network providers submit claims directly to the payer (insurance company) for payment
- Network providers participate in case management and quality reviews and refer patients to hospitals and other physicians in the network
- The network manager reviews the credentials and any malpractice issues of providers

Each medical plan uses WellPoint/Anthem preferred provider networks for Indiana providers and BCBS networks for providers in other states and outside the US. In that these networks cover more lives than any other PPO, WellPoint/Anthem and BCBS entities obtain substantial preferential pricing from hospitals and physicians. Example of other large entities in Indiana that contract with WellPoint/Anthem for PPO services: State of Indiana; Cummins; Lilly; and, Ivy Tech.

Covered members are “steered” to these preferred provider networks through significant financial penalties. Members who do not use a preferred provider have higher copayments, higher out-of-pocket limits, and are responsible for differences between actual reimbursement rates and the provider’s billed charges. This last penalty is called “balance billing,” and can be a significant expense for employees.

While each plan is similar in covering a broad continuum of medical services, with similar financial protection for employees and their families, each plan has a unique structure for member cost sharing.

Total plan expenses are generally comparable across plans, for the same morbidity level, but each plan distributes member costs differently through deductibles and copayments.

Table 2: Distinguishable deductibles and copayments:

	Annual Deductible Per Member	Annual Deductible Family Limit	Copays after Deductible is Satisfied	Other Copays
PPO \$900 Deductible Plan	\$900 *	\$2,700 *	10%	\$100 – per ER visit Rx Retail \$8/\$20/\$40 Rx Mail \$20/\$45/\$90
PPO HDHP & Savings Plan	\$1,250 *	\$2,500 *	20%	(Rx included in annual deductible)

** Most wellness and screening procedures are not included in deductibles*

Deductibles and copayments are intended to allocate more costs to those members who use medical services, with limits to minimize a catastrophic financial situation for any single member. Higher deductibles and copayments are also intended to promote a more consumer-driven use of medical services. This emphasis on high deductibles and/or copayments allows IU to provide medical plan coverage with low employee payroll premiums, with total premiums that are generally less than other large employers. For example, the State of Indiana's 2009 Traditional PPO plan has total monthly premiums that equal \$514 for Employee Only coverage and \$1,442 for Family coverage, as compared to IU's PPO \$900 Deductible plan with monthly premiums of \$381 and \$1,055 respectively. This IU medical plan is approximately 26 percent less costly than the State of Indiana's PPO plan.

For 2008, IU spent approximately \$7,919 per full-time employee for medical and dental coverage. This figure compares favorably (less than) the same expenditure at both the State of Indiana and Purdue University, which is reported to be in excess of \$10,000 per employee.

IU takes advantage of IRS regulations to provide healthcare coverage as non-taxable benefits to employees. Healthcare plan payments to providers are excluded from taxable income, along with employee payroll contributions. Employees also have the option of setting up salary reduction agreements to cover deductibles and copayments on a pre-tax basis.

A very notable aspect of IU's medical program is that there is no funding liability for retirees age 65 or above, who would qualify for Medicare. These retirees may participate in a Medicare supplement plan that is sponsored by IU, but IU does not contribute toward their premiums. This is different than some peer universities that provide post-retirement medical plan contributions, and would likely have an unfunded liability for current and future expenses.

An outline of other recently deployed cost containment features includes:

- Coverage of tobacco cessation sessions
- Tax-free health reimbursement account for self-reported non-use of tobacco
- Employee assistance program for stress and personal assistance
- 24-hour nurse line (800 number) for medical assistance and advice*
- Voluntary health risk assessment and coaching for life style behavior change*
- Outbound counseling for high-risk conditions*^{**}
- Biometric assessment for HDHP plan*^{***}

** New features added in January 2009 through Clarian Health*

*** Registered nurses at Clarian Health will identify plan members with high-risk medical conditions which would benefit from counseling for disease and case management. They would then personally contact the member. This service is called outbound counseling.*

**** Members of the HDHP plan can participate in a Biometric Assessment by having an evaluation to develop a baseline of such biometric factors as: weight and body mass index, blood pressure, cholesterol, and other basic laboratory results. IU has contracted with Clarian Health to hold several on-site mini-clinics to complete the Biometric Assessments.*

IU's Current Healthcare Expenditure Situation – A Commissioned Snapshot

The University Human Resource Services office retained Mercer, a consulting firm, to assist in developing a set of metrics to provide an overall understanding of key drivers of cost and utilization at IU (see Appendix C: Mercer Report.) In addition, Mercer assisted by creating benchmarks to compare IU's experience with that of other large employers in the state of Indiana.

IU versus Benchmarks

The Mercer Report suggested to the Committee that IU, in spite of its discouraging experience with rapidly rising healthcare costs, may be in a favored position relative to other employers providing medical plan coverage to comparable populations. Identifiable opportunities to further improve IU's position may lie in the domains of health risk management, preventive care, price advantages (where they can be found or created), and integrated, well-managed care for serious illness. The Mercer Report's major observations follow:

1. The total cost of medical care and drug expenditures per employee per year for IU is 30 percent below a comparable population based on age/gender and family size. This overall cost position is driven by utilization more than price. Favorable reimbursement rates are also a meaningful, but secondary factor.
2. Six broad clinical categories account for nearly 50 percent of IU's medical plan costs: musculoskeletal; cancer; pregnancy; cardiovascular; infections; and, respiratory disorders. With

the exception of pregnancy, all of these conditions may be amenable to lifestyle changes (smoking, eating, exercise, etc.). Further analysis of this area may identify specific opportunities. The chronic condition information indicates overall lower utilization and cost by IU members compared to benchmark, with the notable exceptions of asthma, congestive heart failure (CHF) and obesity. For asthma and obesity, the higher office visit usage indicates the desired usage of preventive care in the physician's office setting, resulting in generally lower costs for those conditions. For CHF, prevalence and inpatient admissions are lower than benchmark, but average length of inpatient days and, correspondingly, cost per patient are higher. The reasons for this are not immediately clear.

3. The average cost of an inpatient admission overall, ER visit and Outpatient Surgery are higher for IU than the age/gender-adjusted comparison group. While it cannot be determined if these differences are driven by price or the mix of services (i.e. more complex admissions and surgeries), IU should evaluate the charges for these events on a case/mix- and risk-adjusted basis. The cost for physician office visits is similar to the benchmark. IU employees' prescription drug cost sharing is near the benchmark, and IU has lower prescription drug utilization than the benchmark.
4. Relative to Mercer's comparison group, IU has a smaller portion of its population with medical claims exceeding \$50,000. Costs for those in the group with claims over \$50,000, however, represented a slightly higher portion of total costs than found in the comparator group. Less than 10 percent of IU employees were responsible for 58 percent of expenditures for medical claims in 2008. Managing this group of eligible members efficiently and equitably will be a key challenge in containing healthcare costs. These individuals typically have life-threatening conditions, particularly malignancies, and require repeated hospitalizations as well as major procedures (such as bone marrow transplantations).
5. In 2008, slightly less than 16 percent of IU's claimants had medical claims of less than \$250. This represents a smaller percentage of the population incurring claims below this amount than the Mercer benchmark. These eligible members are highlighted because the absence of medical claims may indicate a lack of routine preventive care. On the other hand, this also indicates that a large portion of the IU population (84 percent) had an encounter with a health professional during the year, and thus may be more likely to be receiving recommended preventive services.
6. The amount paid by IU's employees in medical cost-sharing (copayments, deductibles, and coinsurance) at the point of service in 2008 is slightly less than the Mercer benchmark for the same period. IU's population uses a higher number of office visits than the benchmark and has

lower utilization for services to which deductibles and coinsurance apply. This is likely to be the reason for the lower-than-benchmark cost sharing.

7. IU's inpatient utilization experience is generally lower than the benchmark of a similar age/gender population in Indiana. The admission rate is more than 30 percent below expected for the age/gender of the group. However, when admitted, patients stay on average 20 percent longer. The length-of-stay difference may be the result of patients being sicker upon admission, but this is a speculation. Other reasons for longer lengths of stay include medical conventions, complex illness, and lack of step-down care options in the continuum of care.
8. Emergency room visits are below expected while doctor's office visits are slightly higher. While this pattern of utilization does not, by itself, establish the appropriateness of decisions in seeking care, this utilization combination is generally favorable because it indicates that IU's members have established relationships with physicians and use those physicians rather than the ER for urgent care.

Quality of Care Indicators

The quality of care available to IU's eligible members has not been systematically explored. Mercer undertook a limited examination of care quality, utilizing claims data – a widely used but relatively undiscerning approach. Four quality of care measures were used in the Mercer Report: complications of obstetrical labor and delivery; avoidable admissions; hospital readmissions; and complications of prior treatment. "Avoidable Admits per 1000 Members" is the average number of acute admissions for conditions that generally would not result in an inpatient admission if appropriate prior treatment occurred, per 1000 members with medical coverage per year. The conditions included are angina without procedure, asthma, bacterial pneumonia, CHF, COPD, dehydration, diabetes, hypertension, low birth weight, pediatric gastroenteritis, perforated appendix, and urinary tract infection. "Re-admission Rate per 1000 Members" is the average number of acute admissions that occurred within 15 days of a previous acute care admission for the same patient, regardless of the diagnosis, per 1000 members with medical coverage per year.

Acknowledging the limits of this approach, a mixed picture emerged, suggesting that IU should position itself to monitor quality of care indicators on behalf of its employees.

- IU had a higher percentage of delivery complications than the Mercer benchmark. IU also had a higher rate of members developing complications resulting from a healthcare intervention.
- IU had a lower rate of avoidable admissions and lower re-admission rates than Mercer benchmarks.

In its discussions, the Committee observed that three main challenges/opportunities were apparent from our review of the Mercer report. Stated as questions, these are:

- How can IU manage health risks to prevent the subsequent onset of various lifestyle-related diseases and their consequences?
- How can IU encourage appropriate use of clinical preventive services to assure early detection of established conditions, retard their progress, and prevent their sequeli?
- How can IU ensure coordinated, integrated, cost-effective medical care for employees with chronic conditions and severe illness?
- Are there additional price advantages that IU might secure in the marketplace in which it purchases healthcare services, either acting alone or in combination with other purchasers?

Options for Controlling Healthcare Expenditures at IU – The Major Categories

Relatively early in its deliberations, the Committee decided that IU's options for actions that would target these challenges and opportunities were likely to emerge in one of three large categories:

(1) Population Health Improvement

All activities IU might sponsor or undertake itself that would enhance, through incentives for personal behavior change or through changes in the general environment in which IU employees worked, health improvement, health risk reduction, and the use of cost-effective clinical preventive services. The Committee's belief was that some actions of this nature had been shown to be cost-effective (affordable and effective, e.g. influenza vaccination), others might be cost-effective within a university environment (e.g. incentives for health risk appraisal followed by behavioral coaching, tobacco use cessation campaigns with monitoring and special incentives), and still others are of unknown cost-effectiveness but should be undertaken by IU as a forward-thinking and ethical employer as it attempts to reduce the rate of increase in healthcare expenditures (e.g., enhanced opportunities for healthy nutrition and exercise).

(2) Delivery System Changes

The Committee's belief was that, absent changes in the medical care delivery system itself – alterations in the way care is organized, implemented, received, integrated, monitored, and managed – any changes that IU, acting as a purchaser of care, might make in negotiating for better prices, incentivizing its employees, or overseeing expenditures for healthcare services, would have a limited impact on the cost and quality of care. In the long run, nothing on the demand side (e.g. incentivizing healthy behavior) of the demand-supply equation, is likely to have as great an effect as favorable changes on the supply side, that is, in the way care is delivered.

(3) Administrative Strategies

While IU as a buyer and provider of health benefits cannot drive all change that moves in the direction of moderating growth in costs and incentivizing cost-effective patterns of employee utilization, any actions it can take on the demand side of the demand-supply equation (especially those made in concert with synergistic supply-side changes) are sensible and perhaps influential.

Options for Controlling Healthcare Expenditures at IU – The Committee Process

After having establishing these major categories, the Committee set about developing an exhaustive list of options. Within and across the categories, using a two-wave modified Delbecque process, the action options were discussed, refined and prioritized. The observations and recommendations cited below are the Committee's final, prioritized set.

Options for Controlling Healthcare Expenditures at IU – the Committee's Consensus

In Tables 1-3 we summarize the Committee's consensus on IU's possible actions with greatest potential to moderate the rate of growth in healthcare expenditures. Each of the three major categories has been rated by the Committee on its likelihood of exerting a cost-saving impact from 0-10, where 0 = no cost-saving impact and 10 = major cost-saving impact. While these ratings have no external validity, within this framework of options, the Committee's ratings indicate its belief that *delivery system changes have the potential to exert the greatest cost-saving impact (impact rating 6.6), administrative changes the next greatest (impact rating 6.3), and population health improvement strategies the most modest impact (impact rating 4.6).*

Within each large category, all members of the Committee cast three votes each for their highest priority options. Within a category, the highest possible vote total for a particular option would be 12.

University population health improvement strategies (cost impact rating = 4.6)

The Committee acknowledges the difficulties in achieving meaningful behavior change in health-related habits, but also believes that stemming the rising tide of health risks (particularly obesity with its attendant complications of metabolic syndrome, diabetes mellitus, hypertension, hyperlipidemia, and subsequent cardiovascular disease) is imperative in the long run if expenditures for healthcare are to be moderated. Evidence (at least in limited experimental demonstrations) is available to support the feasibility of health risk behavior change interventions, given sufficient incentives, support, and access to advice and

counseling. In other domains of prevention, well-organized and efficiently delivered clinical preventive services such as smoking cessation counseling, annual focused informational and motivation campaigns for influenza vaccination, and depression screening can all have a positive impact on reducing health risks, reduce work absenteeism, and even create a financial return on investment in employed populations. The numbers of Committee members ranking specific strategies among their “top 3 priorities” are indicated in Table 3 on the next page.

Programs are already underway at IU that represents early manifestations of some of the health promotion/disease prevention strategies the Committee supports as options. The Committee recommends extending the scope of these programs, considering a biometric monitoring strategy for behavior change (e.g. cotinine saliva or urine testing for documentation of smoking cessation, weight monitoring for obesity control programs, pedometer monitoring or HDL monitoring for exercise program adherence) paired with targeted supportive incentives (co-pay waivers for smoking cessation drugs, workday time for exercise, extra paid days of leave for a year as an incentive for smoking cessation, achieving weight control goals, or a sustained pattern of annual influenza vaccination).

The Committee believes that a well-planned and effective program of health promotion/disease prevention services should be a specific element of any delivery system with which IU enters into an ‘accountable healthcare system’ special relationship (see delivery system changes below), but that a coherent package of benefits, incentives, and educational and behavior change materials might also be developed for an IU employee to use when accessing the services of any healthcare provider. Delivering these services under the auspices of an IU-sponsored health risk appraisal, coaching, and monitoring program might offer the greatest assurance of uniform implementation. Since telephone-based counseling can substitute for in-person coaching, a health-promotion/disease prevention program could serve employees at all IU campuses.

Table 3: Population health improvement strategies

Strategies	Priority votes
Tobacco cessation support, incentives and disincentives. Tobacco users pay a higher portion of plan expenses by either increasing payroll contributions or having higher deductibles. Smokers who achieve documented cessation receive special benefits, such as extra days of paid personal leave.	9
Health risk appraisal and coaching. This service, if sponsored by IU or part of an accountable healthcare organization could organize and support all health-promotion/disease prevention services. If sponsored by IU, this program could be integrated into the activities of the University Health Center in a collaboration of Clarian and UHC staff.	6
Incentives and disincentives for weight loss. Obese employees should pay higher premiums.	6
Incent evidence-based preventive care.	5
Influenza vaccination campaigns.	4
Incentives/disincentives for other appropriate/inappropriate lifestyle practices, including promotion and support of healthy eating choices. The IU campuses could host 'farmers markets' for the sale of fresh fruits and vegetables on site; provide free consultation with dietician, etc.	3
Promote exercise. Create walking paths on campus; give out pedometers to track number of steps walked; have competitions among departments for cumulative weight lost; have affordable campus recreational facilities; and/or give workday time for supervised exercise.	2

Indiana University-initiated delivery system changes (cost impact rating = 6.6)

The Committee judged this category of options for IU's action to offer the greatest potential leverage on increases in expenditures for healthcare in the short and intermediate run (after whatever start-up investments might be necessary). Taken together, this set of options resonates with the recommendations of the Commonwealth Commission, since they encompass changes in the way in which care is delivered, integrated, managed, financed, monitored and evaluated.

One or more of the highest-priority items in this category of actions, could be executed in partnership with IU's emerged multispecialty medical group (the Indiana Clinic) and the Clarian Health System, the healthcare delivery system formed through merger of IU Medicine Center and Methodist Hospital in 1997. Clarian Health made presentations to the Committee (see Appendix D), proposing a relationship with IU that would accomplish all the actions in this category, potentially realize immediate savings in healthcare expenditures (particularly in expenditures for drugs), include health promotion/disease prevention

services, support quality reporting and accountability, and (under negotiated circumstances) even share financial risk with IU. These choices include several options listed in the table below.

Table 4: University-initiated delivery system changes

Strategies	Priority votes
Develop a University Ambulatory Care Clinical Facility. Develop multi-specialty university health service as ‘medical home.’ Establish an ambulatory care clinic that includes a pharmacy and could be managed by Clarian and the Indiana Clinic for enrollees.	12
Case Management for Chronic Conditions: Change from "passive" to "active" benefit coverage for a variety of case, utilization, and preventive elements, including Case Management, Disease Management, Discharge Planning, Health Risk Assessments, Biometric Assessments, and other outbound counseling services; Mandatory (opt out) case management for chronic disease, once diagnosed; and, Telephone chronic disease management for patients with appropriate conditions (asthma, diabetes, heart failure, depression).	12
Incent use of Clarian, Indiana Clinic and other participating providers, while bargaining for price breaks with measurable evidence of superior quality. Value-based purchasing approach to chronic disease therapies, preventive services, and pharmaceutical tiers.	7
Promote and support the implementation of Health Information Systems: Integrate Bloomington providers into Indiana Health Information Exchange (IHIE) and participate in collaboration of all four HIEs in the state to develop a statewide HIE; Deploy the Quality Health First Program (IHIE quality review linked to pay-for-performance incentives) within primary care provider communities, wherever there is a meaningful population of covered IU eligible members; Work with other large employers in Indiana to require providers and managed care companies to join a fully integrated information exchange system, including: (i) eligibility and coverage, (ii) financial data, and (iii) clinical data for all levels of services along with Rx and labs; and, Use this informational platform as a prevention- oriented health education resource.	5
Evaluation of proper level of care in long-term care, including appropriate use of hospice, outpatient vs. inpatient, etc.	0
Improve end-of-life care by: Developing strategies to foster clinically and ethically appropriate end-of-life care, including palliative and hospice care, based upon best scientific evidence; and, Ask patients, upon entry to a nursing home, home health agency or other critical point of access, to complete an advanced directive.	0

Explanatory comments are needed to capture (briefly) the Committee’s deliberations on the development, staffing, and operation of an operational ambulatory care facility in a potential joint venture with Clarian Health and the Indiana Clinic as a ‘medical home’ for IU populations.

- Developing this option would require considerable advance planning. Building on an existing (but dated) Crowe Chizek report (see Appendix E), a business plan exploring various options would be required, including study of choices for: locating this facility, serving various subpopulations, provision of selected versus comprehensive primary care and consultant services (including chronic disease and case management), provision of routine laboratory services, pharmacy services, health risk appraisal, counseling and coaching services.
- As envisioned by the Committee, this facility would be managed by Clarian and the Indiana Clinic and would be established as an Accountable Care Organization (ACO) acting in partnership with IU. Cost-effectiveness would be maximized if there was only one ACO and would leverage greater purchasing power by partnering with other universities and institutions. This ACO would seek to improve healthcare delivery for IU members by selecting providers who are willing to become accountable for the overall quality and cost of care for the populations they serve.
- The providers will be given incentives to provide low-cost and higher-quality care and to make local capacity decisions that support efficient care. Providers will be able to share in the savings created by improving quality and slowing spending growth. The providers will be encouraged to make decisions on how best to align current resources and future investments with the needs of the population. Innovations that improve quality while reducing overall utilization (and costs) can be rewarded or at least not penalized.
- Cost-effectiveness of care can be supported by the use of health information technology (IT), care coordination, and/or proven effective care management strategies. The performance of this organization, including indicators of cost-effectiveness and quality would be tracked over time and IU negotiations on prices for care services 'held accountable' to the organization's performance.
- As envisioned by Clarian (see Appendix E), it is recommended that a limited network for dispensing prescription drugs with greater discounts be established for all IU campus locations in addition to having commonly prescribed medications available at the University Health Center in Bloomington. Clarian-enrolled patients would be eligible for the least expensive pharmaceuticals, since all Clarian patients qualify for drugs purchased under the auspices of Federal poverty programs. Other cost-effective dispensing enhancements would include the development of 'robotic' drug dispensing equipment ('ATMs' for medications) for dispensing of frequently prescribed medications in a statewide network.

Case management for chronic conditions. Even without (or before full implementation of) a joint venture for healthcare with the Indiana Clinic and Clarian, it is recommended that case management for chronic conditions be changed from passive to active benefit coverage for a variety of case, utilization, and

preventive elements. These services should include Case Management, Disease Management, Discharge Planning, Health Risk Assessments, Biometric Assessments, and other outbound counseling services. Chronic disease management for patients with appropriate conditions (asthma, diabetes, heart failure, depression) could be done by telephone to expand access to these services to IU campuses statewide.

Incenting use of Clarian-provided services. Should no joint venture with Clarian be developed (for comprehensive service provision in an ambulatory care facility or for selected services like chronic disease management), it would still be possible to move IU employees in the direction of utilizing a system of care with demonstrated superior cost-effective performance. Differential co-pays or IU cost-sharing with its employees could be instituted to reward employees who use a system with better performance indicators.

Information and quality monitoring systems. Promote IU advocacy for the integration of Bloomington-area providers and clinical organizations into the Indiana Health Information Exchange. This integration will be important to the ongoing management of IU employees with complex, severe illness in interactions with IU medical center clinical operations in Indianapolis, chronic disease management, and tracking the quality performance of providers and organizations.

Long-term and end-of-life care. Two Committee recommendations in this category deserve special mention, though they did not receive priority votes in the final balloting. This non-prioritization may be an artifact of the multi-vote process itself, where other options command the attention and votes of all members of a consensus group. These recommendations targeted enhancing the cost-effectiveness and quality of long-term care services and care near the end of life. These issues are sometimes considered especially important to the elderly, and IU health benefit-eligible populations are demographically young, since IU does not provide health benefits to its retirees. Young individuals with severe and disabling conditions, however, may require end-of-life and even long-term care services. As IU contemplates the possibility of entering into a joint venture with any delivery system, it should assure its employees that long-term care quality and the quality of palliative care are part of the accountability of that system for provision of state-of-the-art services.

Administrative strategies (cost impact rating = 6.3)

In deliberating options for enhancing the cost-effectiveness of care received by IU covered members, the Committee gave the second highest impact rating to all those strategies, taken together, in which IU might exercise the leverage of a 'prudent buyer' in the marketplace.

None of these options require IU to enter into a special relationship with a specific, accountable comprehensive healthcare system, though several would require developing a special relationship to a provider of a specific, focused service (e.g., pharmacy network, laboratory, administrative service organization). Virtually all of these strategies, if executed by IU itself, would impose an additional administrative burden on IU staff, and actions 1-5 are all likely to be part of standard operations within any ACO.

Ironically, of the options in this category, the single most powerful intervention on rising IU expenditures for health is the last listed, which received the lowest priority in the Committee's multi-vote. While this action would most assuredly lower IU expenditures, it does nothing (by itself) to enhance quality of care or the health of IU eligible populations, and simply shifts the costs from IU to its employees. In our review of IU healthcare benefits (Appendix F) with explicit comparisons to other Big 10 Universities and selected others, it appeared that IU employees experienced (1) lesser costs than their peers as contributions to their healthcare benefits, (2) higher out-of-pocket costs in deductibles and co-payments, and (3) received less in retirement health benefits than their peers at some universities. Shifting costs of healthcare to IU employees under these circumstances might indeed reduce IU's attractiveness to faculty recruits and pose a problem for recruitment and retention.

Table 5: Administrative strategies

Strategies	Priority votes
Establish a limited retail network for dispensing prescription drugs at retail, for all campus locations; with greater discounts. May include collaboration with other universities, such as Purdue and Ivy Tech, and other members of a "buyer association.	11
Direct contract with reference laboratory providers. Contract with a laboratories that provide tests at preferential prices and consistent with evidence-based standards for best practice.	7
Aggressive utilization management of high cost, discretionary tests/procedures. Examples include MRI for back pain, tonsillectomy/myringotomy for recurrent pharyngitis/otitis, etc. May include a third-party review and pre-authorization of physician treatment plans, for benefit plan coverage.	6
Establish a formulary for preferred generic and brand drugs, with benefit plan disincentives for the use of non-formulary drugs.	3
Emphasize provider network "value-based buying" focused on outcomes, versus the current fee-for-service model.	3
Only offer HDHP & Medical Savings plans for employees and their dependents; either a single plan or two plan options where one is low HDHP and other is high HDHP. Both would have a mandatory Medical Savings Account feature. (For 2010, a qualified HDHP has to have a minimum deductible of \$1,200 for employee and \$2,400 for family).	3

Amend IU's policy for determining employer contribution amounts by lowering the cap for growth in IU contributions. (Trustees' current policy is "the growth in Indiana University's employee-adjusted healthcare program contributions is to be no more than 14 to 18 percent per year.") This action would <i>de facto</i> shift costs to employees when the cap is exceeded.	3
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Controlling Healthcare Expenditures at IU – Recommendations for University Action

Among the various options for IU action, the Committee recommends five:

1. Co-design a system of care for the provision of comprehensive, cost-effective healthcare services to IU employees and their dependents, acting in partnership with two IU-related organizations (Clarian Health and the Indiana Clinic). Create, empower, and support a design task force, including representatives of IU administration, faculty and staff, the University Health Center, the Indiana Clinic and Clarian, to develop a proposal for such a system and the populations it would serve, with or without new physical facilities. Require a proposed timeline for stepwise implementation of the plan, a business plan, and proposed indicators for evaluation. Consider a strategy that would at the outset preserve provider choice for IU employees, but that would also progressively use financial incentives to stimulate greater enrollment in this IU/Clarian system if/when cost-effectiveness and quality of care indicator measures make the case for this system's superior performance evident.
2. Develop plans (architectural design, financing, staffing) for an IU ambulatory care center, informed by planning and design for option #1 (Clarian joint venture), but not radically dependent on the success of this venture. Evaluate current facilities available vs. building new ones. Funds to support this planning may have already been set aside in response to the Committee's request for the AY 2009-2010 budget in May 2009.
3. Increase the scope and enhance the organization of health promotion/disease prevention services for IU employees and their families. Invest in creative incentives with an expected return on investment that are designed to change entrenched habits adding to the burden of health risk, disease, and disability among IU eligible member populations. Deliver the services, organized under the auspices of an opt-out health risk appraisal and coaching program already offered by Clarian. Make this service more visible, consistent across all coachable conditions, and mandatory.
4. Identify any additional administrative options for improving IU community health and cost-effectiveness of care that might be implemented in the short run, with or without option #1. These may include various elements of our recommendations (as listed) that have already been

deployed and could be further incented or extended to a wider population. The feasibility of some of these options may require new discussions with other potential partner organizations (Purdue, Ivy Tech, Clarian, others?) focused on enlarging the pool of employees/organizations for cost-effectiveness enhancements IU is considering. Is IU making optimal choices in its allocations of funds to health benefits? While the Committee has tried to benchmark IU's health benefits with other Big 10 university benefits, it would be useful to have an insurance industry benchmark for these innovations from an industry consultant as a part of the planning process in #1.

5. Form and support a measurement and evaluation working group to propose discerning approaches to assessing the impact on cost, quality, and the health of IU populations of actions #1, #3, and potentially #4. Invest in the work of this group and in the implementation of special measures that may be needed to inform IU policy (e.g. special surveys of IU employees, data pulls from the IHIE database, etc.).

Concluding Notes on Strategies

Cost Impact. These recommended strategies would make a variable impact on IU expenditures for health. The Committee believes that strategies 1, 3, and 4 all might reduce the rate of increases in expenditures, especially if implemented together. If a risk-sharing venture can be negotiated with Clarian, strategy #1 is apt to have the largest impact. Strategy 3 would be expected to exert a lesser, but positive impact on growth of healthcare expenditures. This impact would be realized over a long term and only with sustained IU effort. Strategy 4 has significant potential for positive impact, but will require IU interaction with other entities to exert as much influence as possible. Strategies 2 and 5 generate additional costs.

Reach. Strategies #1 and #2 would clearly enhance services in the Bloomington-Indianapolis central corridor for IU employees. Some elements of a joint venture with Clarian are extensible to other areas of the state, especially as Clarian and the Indiana Clinic extend their network of practices and facilities. Strategy 3 generates services that have the potential for reaching IU employees statewide, as do some elements of Strategy 4.

List of Appendices

Appendix A: Bending the Curve: The Commonwealth Fund Commission on a High Performance Health System (2007)

Appendix B: Indiana University Administrative Services Provided by Anthem Blue Cross & Blue Shield

Appendix C: Mercer Consulting Report on Indiana University Healthcare Cost and Utilization (2009)

Appendix D: Clarian Health presentation to the Committee (2009)

Appendix E: Executive Summary of a Crowe Chizek Report on Proposed Ambulatory Care Center Action Plan (2007)

Appendix F: Comparison of healthcare benefits with the Big Ten Universities (2009)

Appendix G: Indiana University sponsored employee medical plans Provider Profiles – 2008 (2009)

Appendix H: Summary of employee healthcare program changes from January 2000 to January 2009

Appendix I: Elliott S. Fischer et al., “Fostering Accountable Health Care” (2009)

(Appendices are located at the following website: <http://www.indiana.edu/~uhrs/blueribbonhealth.html>)