CASE STUDY:

State of Montana Health Plan

Headquarters:	**Helena, MT**
Industry:	**Public employees**
Sector:	**Government**
Employees:	**31,000**
Plan funding:	**Self-funded**
Case study:	**2017-2019**

Key takeaways

1. A creative approach and a willingness to both examine all costs and abandon a health plan model that wasn't serving state employees and threatened to break the bank (the plan lost $29 million in 2014 alone) set Montana on a path to developing a bold, innovative approach to cost containment— by using expert advisors and changing its whole contracting model. By 2017, the health plan had bolstered its reserves to $112 million.
2. When Montana discovered that approximately 43% of its health plan costs derived from 11 hospitals, and that those hospitals' prices varied significantly, the state hired an expert TPA and adopted a Medicare-informed pricing model that capped the amount it would pay for any services.
3. Bolstering primary care, by enhancing an existing network of plan-affiliated health centers and eradicating employee copays for services rendered at those facilities, effectively reconfigured the entire services-delivery spectrum.
4. Dismantling its previous pharmacy approach and existing vendor relationships, bringing in an independent

PBM, and steering members toward cost-effective options helped the health plan save 23%.

5. Embracing such wholesale change in a public, government- run entity to achieve cost containment isn't for the faint of heart, but it can be done.

The State of Montana was experiencing a budget crisis in 2015, largely because of runaway health care expense for its 31,000 employees, when Marilyn Bartlett, a longtime health insurance executive with a background in finance, came to the rescue by stepping in as the state's health plan administrator. The trajectory was clear—and alarming. The state's health plan, self-funded through employee contributions, had lost $29 million in 2014 and its reserves were in the red by $9 million, putting it on a path toward insolvency within two years if spending continued increasing at the same rate. The state legislature issued a mandate via legislation: bring the health plan back from the brink by containing costs and restore its reserves to the required balance.

To underscore the urgency, a Senate Bill was enacted that essentially froze employee compensation until the plan could "right the ship," as Bartlett put it. "We had our marching orders from the legislature, the unions and the governor: deal with cost containment and simultaneously secure health benefits and care for the employees."

Identifying costs and cost drivers: challenging but doable

To tackle that very tall order, Bartlett first examined costs—a tough task considering that the state had no data warehouse, and vendors with which the state contracted were reluctant to divulge the requested information. Based on her experience as former controller and chief financial officer of two health plans, Bartlett instead used an actuarial database as a starting point in conjunction with Excel to figure out where the cost drivers existed.

What she discovered was no surprise but was illuminating all the same. About 43% of the plan's costs were in hospital facilities, primarily centered in 11 larger facilities and only 13% in smaller critical access hospitals. Pharmacy costs tallied at 8% and, interestingly, the state's affiliated health centers, where the bulk of primary care and chronic-condition management services were provided, accounted for only 3% of total costs. Bartlett knew then that one of the keys to cost reduction would be shifting as much care as feasible and medically appropriate to those lower-cost centers. "I really wanted to focus on that," she said, "but I also knew that there would be savings in the pharmacy section."

In Montana's case, one key to unlocking potential savings was in understanding all the "pricing" games that go on in the background in health care. What Bartlett knew was that the so-called discounts that hospitals purport to offer health plans don't really save money but instead serve as mechanisms for obtaining the business and the plan's patient population. She also understood that the whole structure of prescription drug rebates is designed to keep the money in the middlemen's—pharmacy benefit managers (PBMs)—pockets, and that those rebates never make their way to the consumers.

"One thing that's always bothered me is that price, not costs, is the issue," she said. Even if the health plan negotiated deeper "discounts" with particular provider networks or hospitals, for instance, that wouldn't do much for the state's bottom line if prices continued to rise. The key was in pinning down costs and going from there.

That's what Bartlett decided to do, and she faced a veritable wall of resistance because the hospital cost data, hidden somewhere in the hospital's charge master, is not public information. And the details on what happens between the charges and the negotiated discount is similarly hidden from public view—they're confidential and proprietary documents. "So, why would we agree to pay something based on a price," she said, "that we have no control over and is not public? We were in financial trouble. We wanted control over future reimbursement increases."

The key, she discovered, was in finding out what Medicare pays hospitals for its beneficiaries' care and using that data as both a reference point and a starting point for developing a new relationship with the entities that deliver care to state employees. That relationship would be predicated on total reimbursement transparency.

"Our goal was to [structure] Montana hospital reimbursement as a markup of Medicare for all facility services," she said. Even if Medicare, the world's largest payer, obviously doesn't cover all services—pediatrics and maternity, for example—it's a common reference point and its data's availability reveals and potentially overcomes all the differences in billing prices from one facility to the next.

With this knowledge base, Bartlett was equipped to begin negotiating and contracting with Montana hospitals individually and to establish requirements, via legislation, to protect both the plan and state employees—the patients. One requirement was to prohibit any balance billing to patients post care episodes.

Addressing the challenges—one by one

One of the hitches to getting the new plan model off the ground was that Bartlett—or anyone else, for that matter— was not permitted, by virtue of the state's procurement regulations, to build facility networks without going through an RFP process. So, Bartlett created an RFP for a third-party administrator (TPA) to provide network-building services.

The opposition to the state's planned network, which after all would cover a large number of Montanans, was, in a word, fierce. Carriers were opposed because the model would disrupt highly profitable provider networks, and the hospitals pushed back because the reconfigured and newly empowered health plan would disrupt their payment model and force them to lose control of their charge structure. Even legislators, some of whom sat on hospital boards, contested the shift.

"We were very public about what we were doing, and we tried to keep all stakeholders involved. But there comes a point when, if you can't do something through consensus you have to keep your goal in mind and do what's best for the plan," Bartlett recalled.

The state did just that, terminating its existing carrier contract and putting out an RFP for TPA-managed reference-based pricing services. Only one TPA, a local company with national reach called Allegiance Benefit Management, expressed interest and came on board to help the state procure and use the Medicare data to assess the plan's position and to assist with contracting.

After digging into the data, Bartlett found discrepancies between what the hospitals were being reimbursed and what was actually going into their pockets from the supplemental payments they received from the Centers for Medicare & Medicaid Services (CMS) for Medicaid services. She also discovered issues with the plan reimbursing hospital pharmacies for outpatient medications that should have been covered at the plan's contracted rate.

To deal with hospitals' concerns about incurring financial risk and potential losses with the new Montana health plan, Bartlett assured hospitals that they could receive up to 250% of Medicare if warranted, but in most cases no more than that—250% would be the cap. In essence, the plan wouldn't set prices *per se*, but with the cap in place, based on the cost data the state had available, the Montana plan would still save money over the previous arrangement. The state also built in some adjustment time to adapt to the new model.

Ironically, the two hospitals that agreed to come online first under the new arrangement also happened to be lowest-cost, highest-quality facilities in the mix. "Those hospitals really helped us figure out how we would model maternity services and process claims, and our TPA really helped us through this whole process," Bartlett said.

On to the next targets: pharmacy costs and improved primary care

Montana then turned to reducing pharmacy costs, by using a purchasing cooperative and removing its existing pharmacy benefits manager (PBM) from the network after Bartlett discovered that the health plan was getting a bad deal out of the arrangement. That single move saved 23% because the PBM had been benefiting from what's called "spread pricing" (the difference between what the manufacturer charges and what the retail pharmacy charges). Montana also reconfigured the pharmacy structure to be more transparent and to ensure that the state received 100% of any rebates the pharmaceutical company provided. In many cases in the United States, PBMs, which are essentially loosely regulated entities, can pocket high percentages of those rebates.

Further, Montana launched a collaborative effort with Montana independent pharmacists, the University of Montana pharmacy school and the state's new PBM to increase medication adherence among members and help steer patients toward cost-effective options for obtaining their medications.

Those two major initiatives yielded dramatic savings for Montana, even in the first year of the new plan. It saved $7.4 million in the first year alone, significantly whittling the $9 million drain on reserves. At the same time, the plan had also improved its health centers, with help from a third-party vendor, to bolster primary care and entice members to use those services by instituting a $0 copay for preventive services and chronic disease management. Today, the centers have a robust roster of services that include not only clinicians but also health coaches, behavioral health services and exercise physiologists, and chronic disease support services. "We removed any barriers to care access so that members could more easily use the centers, which now serve 73% of our members," Bartlett said. That shift resulted in fewer referrals for specialty services and possibly unnecessary

testing that typically occurred when members obtained services at hospital-owned clinics.

"I think we're seeing this nationwide—that primary care really does need to be the focus. And that one of the best ways to manage costs is to improve patient health by enhancing primary care," Bartlett said.

Racking up the successes

By 2017, just two years into the new health plan initiative, Montana had not only eradicated the reserves deficit but actually bolstered its reserves—to an impressive $112 million. Further, employees didn't have any rate increases and none were projected for the ensuing three years—all without any reduction in the benefits the members had in the health plan. Members also saw no increases in their out-of-pocket expenses under the new plan. In an ironic twist, the plan's savings were at one point used to help bolster the state's General Fund.

"It's a lower-cost plan," Bartlett said, and it's no longer a drain on the state's finances. Quite the opposite, in fact. The initiative has been so successful that Montana has been able to reallocate some of the savings for use in other areas.

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> *–Marilyn Bartlett,*
> *former Montana state health plan administrator*