National Governors Association

ISSUE BRIEF

Strategies for Curbing Health Insurance Costs for State Employees: Benefit Design, Wellness Programs, and Data Mining

Executive Summary

States, like other public and private employers, are increasingly challenged by the rising cost of health care and the corresponding rise in health insurance premiums for employees. With strained state budgets, governors face the challenge of doing more with less in all categories of state spending, including reigning in costs and finding ways to provide state employees with access to quality care at lower costs rather than simply raising premiums or cutting health benefits. This paper will examine some of the innovative models for employees' insurance plans, including:

Introducing Newly Designed Health Benefit Plans for State Employees

To improve the long-term value of health care expenditures and health outcomes for state employees, states can offer employees newly designed health benefit plans such as (1) high-deductible or consumer-driven health plans; (2) health plans designed to maximize the value of expenditures; and (3) health plans that offer tiered or limited provider networks. Each approach offers unique opportunities and challenges, but all three of those approaches are intended to move away from the traditional model of payment for volume-based health care in which all providers and treatments are deemed to be of equal value and patients have no incentive to actively engage in prevention, early intervention, or evaluation of the value of medical services.

Offering Wellness Programs and Incentives for State Employees

State employees tend to stay in their positions longer than employees in the private sector, making it more likely that state employees' longer term health will affect a state's cost of providing insurance coverage.[1] Because states are typically among the largest employers in a state, wellness programs offer an opportunity to improve health outcomes measured for the state population as a whole by preventing chronic diseases and reducing the costs of treating them.

The two most common wellness programs offered by employers are programs to reduce obesity and smoking, two common health cost drivers, and a large number of states have implemented wellness programs or incentives focusing on those problems. The *Guide to Community Preventive Services* developed by the Community Preventive Services Task Force recommends that worksite programs that focus on reducing the use of tobacco include social support groups, workplace smoke-free policies, and financial incentives to quit using tobacco.[2] It recommends that worksite programs to reduce obesity include behavior change support through individual and group counseling, inclusion of coworkers to build support systems, and access to healthy foods in the workplace.[3]

[1] Employee Benefit Research Institute, "Employee Tenure Trend Lines, 1983-2010," EBRI Notes, vol. 31, no. 12, December 2010, http://www.ebri.org/pdf/notespdf/EBRI_Notes_12-Dec10.Tenure-CEHCS.pdf (Accessed October 9, 2012).
[2] Community Preventive Services Task Force, "Decreasing Tobacco Use Among Workers: Incentives & Competitions to Increase Smoking Cessation," Guide to Community Preventive Services, http://www.thecommunityguide.org/tobacco/worksite/incentives.html (accessed October 9, 2012).
[3] Community Preventive Services Task Force, "Obesity Prevention and Control: Worksite Programs," Guide to Community Preventive Services, http://www.thecommunityguide.org/obesity/workprograms.html (accessed October 9, 2012).

Mining Health Claims and Cost Data to Develop Cost-Savings Strategies

Collecting and analyzing data to understand reasons for rising health care costs, both current and past, is critical to inform decisions about changes in health plans offered to state employees. However, obtaining such data can be a challenge. Some insurers are reluctant to share cost and contracting information with states, citing "gag" clauses with health care providers on pricing, or other legal restrictions on information sharing. In response, some states have data-sharing requirements with penalties for noncompliance written into their contracts with third-party administrators.

Introduction

In most states, the single largest purchaser of health care is the state itself, buying on behalf of Medicaid enrollees, active and retired state employees, prisoners, injured workers and sometimes teachers and the employees of the state's cities and towns. Across the country, nearly 10 percent of the workforce is covered by a state or local employee health insurance plan.[4]

States, like other public and private employers, are increasingly challenged by the rising cost of health care and the corresponding rise in health insurance premiums for employees. With strained state budgets, governors face the challenge of doing more with less in all categories of state spending, inlcuding reigning in costs and doing more with less in terms of providing state employee health care benefits.

One way to do more with less is to improve states' health care purchasing and insurance design. Rather than just raising premiums or cutting health benefits to constrain the cost of benefits for state employees, some states are adopting innovative models for their employees' insurance plans and considering ways they can facilitate change in their overall health care delivery and payment system by leading with state employees.

In the spring of 2012, the National Governors Association (NGA) conducted a series of telephone based interviews and hosted a one-day experts meeting with several state health insurance purchasers, as well as private sector benefits experts, to discuss strategies that states can use to for improving their purchase of health benefits for state employees. Among the strategies for curbing the costs of state employee health insurance discussed during the interviews and meeting were the following:

- Introducing new health benefit plan designs, either alongside or as replacements to traditional health plans, and encouraging employees to participate in the newly offered plans;
- Offering wellness programs and providing incentives for state employees to participate in such programs; and
- Collecting and mining health claims and cost data to develop cost-saving strategies.

Introducing Newly Designed Health Benefit Plans for State Employees

To improve the long-term value of health care expenditures and health outcomes for state employees, one option for states is to offer employees newly designed health benefit plans such as (1) high-deductible or consumer-driven health plans; (2) health plans designed to maximize the value of expenditures; and (3) health plans that offer tiered or limited provider networks. Each approach offers unique opportunities and challenges, but all three of those approaches are intended to move away from the traditional model of payment for volume-based health care in which all providers and treatments are deemed to be of equal value and patients have no incentive to actively engage in prevention, early intervention, or evaluation of the value of medical services.

High-Deductible Plans

High-deductible health plans (HDHPs) have the po-

[4] National Conference of State Legislatures, State Employee Health Benefits, http://www.ncsl.org/issues-research/health/state-employee-health-benefits-ncsl.aspx (accessed October 9, 2012).

tential to control health care costs by providing incentives to employees to seek better value in their health care. By requiring enrollees to pay greater share of the initial cost of care than conventional plans do, HDHPs encourage employees to choose lower cost providers and engage in preventive services. An idea underlying HDHPs is that the process of shopping for lower cost providers will make employees more aware of the cost of health care services and more apt to compare providers offering the same procedure or test.

HDHPs offer participants lower monthly premiums than conventional health plans and are generally accompanied by a health savings account (HSA). An HSA is a vehicle that enables plan participants to set aside money on a pretax basis to pay for out-of-pocket health care costs. Employees (and employers) fund HSAs on a pretax basis, and HSA funds are allowed to be rolled over from year to year, allowing an employee to accumulate a sum, portable and owned by that individual, which can be used over years for out-of-pocket health expenses.

For HDHPs, the Internal Revenue Service (IRS) sets annual deductible parameters, caps on out-of-pocket costs that an enrollee must bear, and maximum HSA contributions. In tax year 2011, the IRS required that for an individual's HDHP to be eligible to be accompanied by an HSA, the annual deductible be at least $1,200 and the costs to the individual enrollee (excluding premiums) be capped at $5,950; moreover, the maximum amount the IRS permits a single person (including the employer's contribution, if any) to contribute to an HSA is be $3,100 (unless the employee is over age 55, in which case the ceiling is raised by an additional $1,000).[5]

As of 2012, nearly half of the states were offering their employees HDHPs (solely or along with other conventional plans).[6] Many of them were also contributing money to their employees' HSAs to reduce the cost of health care to their employees and to encourage their employees not to skip needed care because they have not met the deductible amount that must be paid before insurance coverage kicks in.

Indiana introduced its first HDHP to state employees in 2006. Currently, Indiana offers two HDHPs, which enroll 91 percent of state employees—an impressive number, especially given the fact that employees must pay a significantly larger premium to participate in the preferred provider organization (PPO) plan offered by the state. Only two percent of the state's HDHP enrollees have returned to the PPO plan after having enrolled in a HDHP. The two HDHPs offered by Indiana differ in the amount of their annual deductibles for an individual plan and their caps on out-of-pocket costs ($1,500 and $2,500, respectively, for the deductible for an individual plan; and $3,000 and $4,000, respectively, for out-of-pocket caps). Indiana contributes 45 percent of the deductible amount to each employee's HSA each year, amounting to $674 and $1,123, respectively, for the two HDHPs in 2012. Moreover, Indiana deposits 50 percent of its contribution to the employee's HSA in the first pay period of each year, so the employee has a reserve of funds in case of the need for expensive care early in a calendar year. [7]

HDHPs work best when consumers have access to accurate, comprehensive cost and quality data that enables them to compare providers for the type of care they need. Without information about the quality of care offered by different providers, HDHPs cannot work as efficiently as intended, leaving employees to select providers on the basis of cost data alone, which are easier to obtain and display than quality data but

[5] Internal Revenue Service, IRS Publication 969 (2011); Health Savings Accounts and Other Tax-Favored Plans, http://www.irs.gov/pub/irs-pdf/p969.pdf (accessed October 9, 2012).
[6] The Segal Group, Inc., "2011 Study of State Employee Health Benefits," Spring 2012, http://www.segalco.com/publications/surveysandstudies/2011statestudy.pdf (accessed October 9, 2012).
[7] Interview with Dan Hackler, Director, Indiana State Personnel Department, March 2012.

do not give a full picture of value.

States can lend their considerable influence to improving the collection and display of comprehensive cost and quality data so consumers can better shop for value. Among the ways states can help in this regard are the following:

- Outlaw "gag" clauses or similar barriers to data sharing in contracts between providers and insurers. Contracts between providers and insurers often include provisions that prohibit either party from releasing information on pricing or quality to third parties including state purchasers. By requiring, either contractually or through legislation, that pricing and quality data be made publicly available, states can ensure that employees have access to information that will help them be better health care consumers.
- Improve quality reporting by identifying quality outcome metrics and either requiring reporting of those metrics in their contracts with third parties or going further and tying payment, at least partially, to the accurate reporting of the metrics. Releasing that data to employees in a usable format would allow employees to compare providers on both cost and quality.

Health Plans with a Value-Based Insurance Design (VBID)

Another option for states to curb state employees' health benefit costs and improve quality is to offer health plans with value-based insurance design (VBID). A VBID health plan reduces enrollees' share of costs for high-value wellness, preventive, and medical services (e.g., drugs commonly prescribed for diabetes, asthma, and hypertension) and increases enrollees' out-of-pocket share of costs for interventions of lesser value. The initial costs for VBID health plans can be high, but the idea is that over the years such plans can have the effect of improving employees' health (especially among employees with chronic conditions such as diabetes or hypertension) and thus reduce future health care use and costs.

The idea for VBID first emerged in the private sector. Companies that were trying to control their costs for employee health benefits in traditional ways, such as raising employee cost sharing, found that in some cases higher copays were creating barriers to compliance with recommended therapies, thereby failing to prevent avoidable complications and raising overall health care costs.

A few innovative companies began thinking that lowering employees' copayments for preventive services could increase compliance with recommended disease management protocols and thereby lower overall health costs. When Pitney Bowes shifted all of its diabetes drugs and devices from the 30 percent and 50 percent employee cost-sharing tier down to the 10 percent cost-sharing tier, overall direct health care costs for each plan participant with diabetes decreased by 6 percent.[8] Reducing diabetic employees' out-of-pocket costs for diabetic supplies increased the likelihood that such employees would comply with their disease management protocols, thereby reducing expensive complications associated with diabetes.

Some states that have implemented health plans with VBID require employees and dependents to have a preventive care visit within a year of signing up for the plans. That requirement encourages employees to receive their lower-cost preventive care, such as flu shots, in the hopes of preventing higher cost acute care later on. **Connecticut** implemented a VBID health plan in 2011 that requires employees and dependents to get age-appropriate preventive care, participate in disease management programs (if relevant), obtain two free dental cleanings a year, and obtain their prescribed free or low cost maintenance medications and other "high value" treatments. To help pay for the reduction in enrollee contribution for those high value

[8] N. K. Choudry et al., "At Pitney Bowes, Value-Based Insurance Design Cut Copayments and Increased Drug Adherence," Health Affairs, 29 (November 2010): 1995-2001, http://www.content.healthaffairs.org/content/29/11/1995.abstract (accessed October 9, 2012).

services, Connecticut instituted a patient copay on emergency department visits and stricter preauthorization requirements on certain high-cost imaging. VBID has not been in place long enough in Connecticut to be adequately evaluated, but health insurance premiums for next year are expected to remain level for the first time.[9]

Health Plans with Tiered or Limited Provider Networks

Other options for states seeking to curb their costs for employees' health care costs include offering health plans with tiers of provider networks that require enrollees to pay higher premiums and out-of-pocket costs for the most expensive hospitals and doctors, as well as offering health plans with limited provider networks in which more expensive providers are not an option.

Plans with Tiered Provider Networks. In health plans with tiered provider networks, hospitals and doctors are ranked by cost and quality measures and enrollees are required to pay higher out-of-patient costs for providers in higher tiers if they want to receive their care from them. The intent of requiring higher cost sharing for providers in higher tiers is to change physicians' behavior as well as patients' behavior.

Health plans can use claims data to identify doctors who order high-cost tests or treatments but do not produce better quality outcomes for their patients relative to their peers and should therefore be placed in a higher tier. A physician who practices at a relatively expensive hospital or orders tests from relatively expensive providers without observably better results could be placed in a high-cost tier. **Massachusetts** analyzed claims data to tier specialists, requiring all of its contracted health plans to pool their entire claims database (not just claims for their state employee patients) to view specialists' patterns across their entire patient caseload.[10]

Plans with Limited Provider Networks. Some states offer their employees limited provider networks, which typically exclude the most expensive hospitals, and charge reduced premiums as an incentive for individuals to enroll in those plans. **Massachusetts**, for example, offered a 20 percent employee premium differential for its limited network plans. In the first year the limited network plan option was offered in the state, 31 percent of state employees joined the plan, thereby saving money for both themselves and the state. State officials expect to see enrollment in those products grow over time.

Limiting provider networks for state employees is an option for some states, but not all states. For a limited provider network to be an option, a state must have enough providers in all regions where state employees live to be able to exclude some providers while not unreasonably reducing access to care. In states where many state employees are concentrated in a single city that has some hospitals that charge substantially more than others, limited networks can be a way to reduce the costs of health care for employees.

Reference Pricing. Reference pricing is another tool that states can use to limit their employees' use of high-cost providers. A reference price is the maximum price that a health plan will pay for a specified procedure, such as a knee or hip replacement. If an employee chooses to get a procedure with a reference price at a hospital that has not agreed to accept that price, the employee must pay the difference between the established reference rate and the hospital charge.

Procedures that lend themselves to reference pricing are procedures that are frequently performed and for which providers' charges span a wide range. Health plans setting reference prices typically analyze the

[9] Interview with Robert Dakers, Executive Finance Officer, Connecticut Office of Policy & Management, Office of Finance, May 2012.
[10] Interview with Delores Mitchell, Executive Director, Massachusetts Group Insurance Commission, December 2011.

available data about what different providers charge for the same procedures and then set a reference price that balances cost reduction and access to care in a geographic market.

Hospitals are more likely to accept reference prices set by plans covering state employees when those employees constitute a large percentage of their patients. In **California**, CalPERS, which provides retirement and health benefits to more than 1.6 million public employees, retirees, and their families, for example, found the costs for routine hip and knee replacements for state employees to range from $15,000 to $110,000, with an average cost of around $30,000. CalPERS therefore set the reference price for those two procedures (hip replacement, knee replacement) at $30,000, and at least one hospital in every major area where state employees live accepted that price.[11]

Engaging Employees and Getting Them to Change Their Behavior

Engaging employees and getting them to changing their behavior is essential to the success of states' efforts to reduce the cost of state employees' health benefits. An effective outreach and education strategy among employees when a newly designed health benefits plan is introduced can help ensure that employees give full consideration to the new plan and facilitate the plan's favorable reception.

States that have made major changes to their health benefits plan have publicized examples of how the newly designed plans would cover common health care scenarios such as maternity care or care for a chronic condition, included small group meetings for employees to ask questions, and organized peer-to-peer outreach sessions led by "early adopters" of the new design. **Indiana** saw the rate at which employees enrolled in the CDHP rise considerably over the previous year when a comprehensive employee engagement plan was put in place.[12]

For states that are introducing new plan designs alongside existing health plans, it is important that the reduction in premium and copayments paid by employees opting for the new plans be large enough to gain the employee's serious consideration. Thus, for example, when **Massachusetts** added two new limited network plans to its existing limited network plans, it waived the premium for employees who switched to one of the new plans for the first three months of coverage.

In addition, when introducing a new health plan design, a state should consider requiring its employees to actively evaluate and enroll (or reenroll) in a health plan rather than simply allowing employees to enroll by default to the plan they have had for the past year. After many years of allowing state employees to enroll by default in their existing plan, **Massachusetts** combined an active enrollment strategy with the premium waiver incentive to encourage employees to strongly consider enrolling in a limited network plan.

Offering Wellness Programs and Incentives for State Employees

Offering wellness programs and providing incentives for state employees to participate in them is in states' interest. State employees tend to stay in their positions longer than employees in the private sector, making it more likely that state employees' longer term health will affect a state's cost of providing insurance coverage.[13] Moreover, many states are more likely than private employers to retain at least partial responsibility for their employees' retiree health costs. Because states are typically among the largest employers in a state, wellness programs offer an opportunity to improve health outcomes measured for the state population as a whole by preventing chronic diseases and

[11] Interview with Doug McKeever, Chief, CalPERS Health Policy Research Division, April 2012.
[12] Interview with Dan Hackler, Director, Indiana State Personnel Department, March 2012.
[13] Employee Benefit Research Institute, "Employee Tenure Trend Lines, 1983-2010," EBRI Notes, vol. 31, no. 12, December 2010, http://www.ebri.org/pdf/notespdf/EBRI_Notes_12-Dec10.Tenure-CEHCS.pdf (Accessed October 9, 2012).

reducing the costs of treating them.

Well-designed and well-promoted wellness programs can encourage state employees to improve their health and can also reduce state health care costs related to lifestyle-influenced diseases and employee absenteeism. In a review of the literature on costs and savings associated with such programs, one research group found that medical and absenteeism costs fell when workplace wellness programs were implemented, although the authors cautioned that most existing studies lacked a comparison group, leaving open the possibility that selection bias led to better results than would occur over an entire workplace.[14] More research is needed to determine the characteristics of the most effective wellness programs as well as the most effective level and type of incentives to create the behavior change states are seeking among employees.

The two most common wellness programs offered by employers are programs to reduce obesity and smoking, two common health cost drivers, and a large number of states have implemented wellness programs or incentives focusing on those problems. As of 2010, at least nine states differentiate premiums between smoker and nonsmoker state employees.[15] The *Guide to Community Preventive Services* developed by the Community Preventive Services Task Force recommends that worksite programs that focus on reducing the use of tobacco include social support groups, workplace smoke-free policies, and financial incentives to quit using tobacco.[16] It recommends that worksite programs to reduce obesity include behavior change support through individual and group counseling, inclusion of coworkers to build support systems, and access to healthy foods in the workplace.[17]

Wellness programs require strong leadership and participation from governors and other high- level officials to ensure widespread employee participation. Some states have monitored agency-wide participation rates in wellness programs and used such rates as an evaluation measure for agency managers, giving such managers an incentive to encourage employee participation. In addition to leadership involvement, cash awards, extra vacation days and reduced copayments or insurance premiums can provide incentives for participation.

Leadership may also need to address bureaucratic obstacles to providing worksite wellness programs. Those obstacles can include drawn out bidding processes that impact employee access to farmers markets on state grounds, time for employees to serve on wellness committees, and ability to offer incentives for wellness program participation. **North Carolina** created a partnership between the state health department, state personnel office, and other state agencies to address those obstacles and now has established a model worksite wellness program. [18]

Mining Health Claims and Cost Data to Develop Cost-Savings Strategies

Participants at the spring 2012 NGA meeting repeatedly underscored the importance for states of collect-

[14] K. Baicker, D. Cutler, and Z. Song, "Workplace Wellness Programs Can Generate Savings," Health Affairs, 29 (February 2010):304-311, http://www.content.healthaffairs.org/content/29/2/304.abstract?sid=1df31382-3b7a-4283-bfc1-e97fd6e33a17 (accessed October 9, 2012).

[15] National Conference of State Legislatures, State Employee Health Benefits, http://www.ncsl.org/issues-research/health/state-employee-health-benefits-ncsl.aspx (accessed October 9, 2012).

[16] Leeks KD, Hopkins DP, Soler RE, et.al., Worksite-Based Incentives and Competitions to ReduceTobacco Use: A Systematic Review, American Journal of Preventive Medicine, 38 (2010), 263-274. http://www.thecommunityguide.org/tobacco/worksite/Worksite2010Incentives_Leek.pdf.(accessed October 10, 2012).

[17] Anderson LM, Quinn TA, Glanz K, et.al, The Effectiveness of Worksite Nutrition and Physical Activity Interventions for Controlling Employee Overweight and Obesity: A Systematic Review. American Journal of Preventive Medicine, 37 (2009), 340-357, http://www.thecommunityguide.org/obesity/EffectivenessWorksiteNutritionPhysicalActivityInterventionsControllingEmployeeOverweightObesitySystematicReview.pdf (accessed October 10, 2012).

[18] S. Young et al., "Establishing Worksite Wellness Programs for North Carolina Government Employees, 2008," Preventing Chronic Disease, 8 (March 2011): A48, http://www.cdc.gov/pcd/issues/2011/mar/10_0069.htm (accessed October 9, 2012).

ing and analyzing data to understand their health care costs, both current and past, and to inform decisions about changes in health plans offered to state employees. They said a data warehouse—a database of detailed claims information of all the employees enrolled in the state health insurance plan—is essential. Moreover, they strongly recommended that the state rather than an insurer or administrative services organization own the data warehouse to ensure that data analysis can be done to the precise specifications and needs of the state.

States trying to set up their own data warehouses reported having had disputes with their contracted third-party administrators about the ownership of their employees' claims data even though states are widely self-insured. Some insurers have been reluctant to share cost and contracting information with states, citing "gag" clauses with health care providers on pricing, or other legal restrictions on information sharing. Some states eliminated or reduced such disputes by having data-sharing requirements with penalties for noncompliance written into their contracts with third-party administrators.

The collection and analysis of health claims data can provide information that is useful in decisions about state employees' health benefits throughout the purchasing lifecycle. Analyzing data can help decision makers to pinpoint their cost drivers for specific groups—the quantity of services received, the price per service, the intensity of their members' care, or the sites that their members are using. It also enables decisionmakers who are planning a program or planning a change to contain costs to identify on a clinical level, what diseases or procedures are disproportionately driving costs, and whether a subpopulation of covered lives is disproportionately drives costs.

For example, **Virginia** has routinely performed its own analysis of readmissions, considering them both an indicator of poor quality and a significant driver of cost, observed a surprisingly high number of costly readmissions for nearly 25 percent of its employees undergoing a particular elective surgical procedure, regardless of where the procedure was performed in the state. That observation led the state to institute a number of steps that an employee had to comply with before being approved for the procedure, as well as a joint effort with the surgical specialty society in the state to examine how the care for this procedure could be improved.[19]

The analysis of health claims data is also critical to evaluating the outcome of changes to a health benefit plan. Once significant changes are made to a health plan, states must evaluate whether they are getting the desired results from the changes and what unintended consequences have occurred. Virginia was able to track the effectiveness of its interventions related to the elective surgical procedure with which its employees had previously had difficulties and was also able to show the improved outcomes to the surgical society after the changes were implemented. The state was also able to share those improved outcomes with state employees so that those employees did not think that the state was trying to impose barriers to care for cost savings alone.

The collection and analysis of data can be used not just to determine what steps should be taken to help control costs but also to obtaining cooperation from employees in undertaking such steps. About half of all state workforces are unionized, making benefit change a negotiated process rather than a unilateral decision. During such negotiations, plan changes that are backed by evidence are likely to be more accepted by employees. Data can also show how changes to a health plan figures into an employee's overall compensation package. In states with strong collective bargaining, some changes may be easier to present to membership than others and states must decide how much political capital they are willing to spend to achieve desired savings.

[19] Interview with Sarah Wilson, Director, Virginia Department of Human Resource Management, March 2012.

Conclusion

States are addressing rising health care costs in their state employee benefit programs in a variety of innovative ways. Recognizing that there is no one best way to slow increasing costs and support improvements in employee health both short and long term, states have begun to introduce new health plan designs either alongside or as replacements to traditional plans. Evaluation of those models and parallel innovations taking place in the private sector will provide crucial data to health care purchasers that will likely lead to more change in the future as the most successful strategies emerge.

Well-designed and targeted wellness programs, especially those that address lifestyle choices that drive chronic disease costs, are likely to continue to be a part of state employee health programs given the large role that chronic disease morbidity plays among working age individuals. More research needs to be done to pinpoint the most effective balance of incentives and penalties to change behavior long term, but states are beginning to catch up to many large private employers in raising employee awareness of taking actions to improve their health status.

As the purchasers of health care for state employees, states affect the health of a large number of state residents, and they should capitalize on their clout to make data-driven changes whose results will continue to inform other states and private sector employers.

Jason Hsieh
Program Director, Health Division
NGA Center for Best Practices
202-624-7803

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