Report
to
The LEGISLATIVE FINANCE COMMITTEE

Interagency Benefits Advisory Committee
Oversight of Public Employee Health Benefit Plans
November 22, 2013

Report #13-13

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David Abbey
Director

November 22, 2013

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Mr. Tom Sullivan, Chairman
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4308 Carlisle Blvd. N.E. Suite 104
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Dear Secretary Burckle, President Irby, Superintendent Brooks, and Chairman Sullivan:

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the evaluation Oversight of Public Employee Health Benefit Plans for the Interagency Benefits Advisory Committee (IBAC). The program evaluation team assessed the role of utilization, provider rates, and other factors in inflating costs for IBAC, the benefits and barriers to consolidation, and the potential impact of the Affordable Care Act on New Mexico public employee health care. The report will be presented to the Committee on November 22, 2013. An exit conference was conducted with IBAC agencies on November 12, 2013 to discuss the contents of this report. The committee expects a corrective action plan from the department within 30 days from the date of the hearing.

I believe this report addresses issues the committee asked us to review and hope the Interagency Benefits Advisory Committee will benefit from our efforts. We very much appreciate the cooperation and assistance we received from your staff.

Sincerely,

David Abbey, Director

DA:AR:MG/jl

Cc: Representative Luciano "Lucky" Varela, Chairman, LFC
Senator John Arthur Smith, Vice-Chairman, LFC
Representative Henry "Kiki" Saavedra, Chairman, HAFC
Dr. Tom Clifford, Secretary, DFA
Mr. A.J. Forte, Division Director, Risk Management Division, GSD
Mr. Sammy J. Quintana, Executive Director, NMPSIA
Mr. Mike Wilson, Director, Risk Management Department, APS
Mr. Mark Tyndall, Executive Director, NMRHCA

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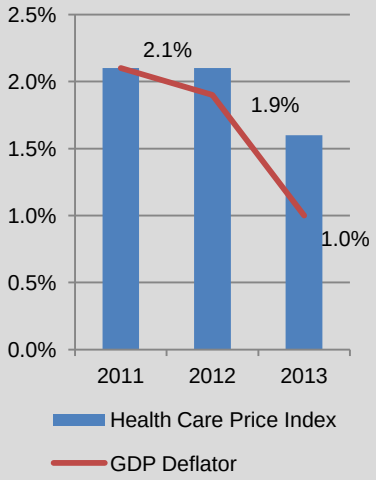
Inflation slowed between 2011 and 2013, however health care prices outpaced overall prices in the economy.

Health Care Cost Inflation Compared to Overall Inflation 2011-2013



Source: Altarum Institute

In 2010, LFC staff completed a program evaluation of two IBAC agencies, NMPSIA and RMD. None of the evaluation's recommendations were implemented.

Since the recession began in December 2007, health care prices have increased 12.5 percent, while overall prices in the economy increased 8.2 percent. Inflation slowed between 2011 and 2013, however health care prices outpaced overall prices in the economy. Moreover, as of March 2013, year-over-year hospital prices grew 2 percent for Medicare and fell 0.8 percent for Medicaid, yet all other payers combined saw hospital prices increase 4.8 percent, including private payers.

The Interagency Benefits Advisory Committee (IBAC), created by the Health Care Purchasing Act is comprised of four state entities providing healthcare benefits for public employees in New Mexico: the New Mexico Public School Insurance Authority (NMPSIA), the Risk Management Division (RMD) of the General Services Department, the New Mexico Retiree Health Care Authority (NMRHCA), and Albuquerque Public Schools (APS.) The Act requires member agencies to jointly go through a request for proposal for services, however the agencies do not have to jointly participate in contracted services for employee healthcare benefits.

In 2010, LFC staff completed a program evaluation of two IBAC agencies, NMPSIA and RMD. The report found the state had not maximized purchasing power for health benefits nor taken advantage of comprehensive quality improvement initiatives that would better contain costs. Agencies focused little on the price of medical care or the outcomes the care provides. The evaluation included various recommendations, none of which were implemented.

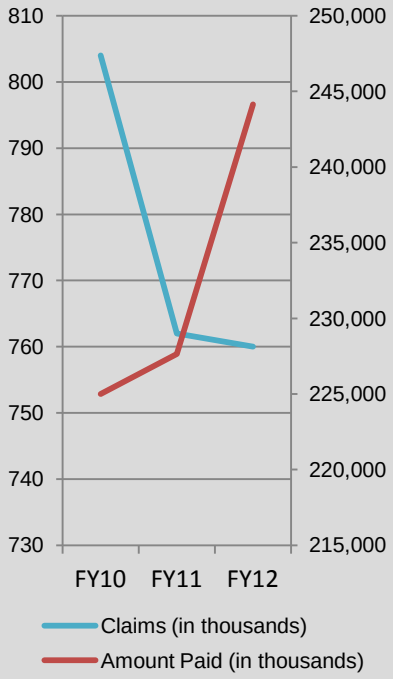
All four IBAC agencies are self-funded plans, meaning the state assumes the risk for providing health coverage. There are various benefits to being a self-funded health plan such as complete freedom in plan design and provider contracting, better cash flow management, and not being subject to state premium taxes. However, IBAC agencies have not maximized the flexibility of being self-funded to effectively manage costs.

IBAC agencies have generally done a poor job of controlling health care costs for public employees. Instead of focusing on cost saving measures, the agencies have shifted costs onto employees and employers through higher premiums. This practice is unsustainable in the long run. Merging NMPSIA, RMD, and APS would put the agencies in a better position to negotiate on cost and implement cost-saving measures.

The federal Affordable Care Act (ACA) continues to be a major factor in health care. Various aspects of the law affect how the state designs and purchases health care for employees. Medicaid expansion and the federal health exchange will offer additional health coverage options to public employees, while new fees and regulations will have to be considered in IBAC budgeting and plan design decisions.

Despite some progress, IBAC has not fulfilled its intent and perpetuates duplicative and costly administrative functions.

RMD Total Claims Cost Relative to Number of Claims Filed



Source: LFC Analysis of Plan Data
*Claims on left axis. Cost on right axis.

RMD increased premiums 15 percent for FY14 and NMPSIA increased premiums 19.1 percent between FY11 and FY14.

KEY FINDINGS

Lack of effective oversight of provider rates and quality improvement has made employee health care less affordable. In 2010, LFC staff made a series of recommendations to contain healthcare costs. LFC staff performed a program evaluation of the two largest IBAC agencies in 2010 NMPSIA and RMD which included the following findings:

- NMPSIA and RMD increased premiums, employee out-of-pocket expenses, and used fund balances as strategies to manage rising healthcare costs;
- Increasing provider rates appear responsible for a greater portion of rising healthcare costs; utilization of services remained relatively flat for both NMPSIA and RMD;
- Despite some progress, IBAC has not fulfilled its intent and perpetuates duplicative and costly administrative functions; and
- The lack of data warehousing, from all state-sponsored health benefit plans, limits administrators' access to information to better manage their own plans and to benchmark against other publicly-funded plans.

Health care spending for IBAC agencies has continued to rise at unsustainable levels. From FY11 to FY12, the combined total amount paid in claims for the New Mexico Public School Insurance Authority (NMPSIA) and the Risk Management Division (RMD) increased from $398 million to $419 million, an increase of over five percent. From FY10 to FY12, NMPSIA and RMD each saw substantial increases in the amount paid in claims. For NMPSIA, the two-year change in the amount paid was over 10 percent, with costs increasing from $159 million to $174 million. RMD experienced a $20 million increase in costs from FY10 to FY12, as costs grew from $224 million to $244 million. This is equal to a 7.8 percent increase.

Pharmaceutical costs continue to increase despite an overall membership decline and a contractual requirement to increase use of generic drugs. All IBAC agencies, except NMRHCA, have experienced a decline in membership from 2011 to 2012, but each of the plans has experienced an increase in drug costs during that time. The 2012 drug costs for all IBAC agencies were nearly $111 million. The increased pharmaceutical costs from 2011 to 2012 added nearly $10 million in expenses for the IBAC agencies and health plan members.

Both RMD and NMPSIA have implemented or plan to implement premium increases between 19 and 25 percent. RMD increased premiums 15 percent for FY14, after not having an increase in at least the last five years. RMD has proposed another 10 percent increase in FY15, for a two-year total of 25 percent. NMPSIA increased premiums 19.1 percent between FY11 and FY14.

Raw claims data for NMPSIA and RMD show that increased costs are not the result of increased utilization.

Continued price increases, not utilization or enrollment, are driving rising costs. Healthcare costs are comprised of the cost of the service (provider rate) multiplied by the frequency of services (utilization.) If utilization is declining, yet overall costs are increasing, it can be inferred that provider rates are driving the increases.

Healthcare costs have continued to increase despite a decrease in the number of claims and enrollment. Raw claims data for NMPSIA and RMD show that increased costs are not the result of increased utilization. Comparable data was not available for APS and NMRHCA, so the analysis uses NMPSIA and RMD as examples. From FY10 to FY12, the number of claims filed decreased by more than one percent for NMPSIA and by five and a half percent for RMD. From FY11 to FY12, the number of claims filed decreased minimally for RMD, and for NMPSIA, claims increased.

Improving plan oversight could result in lower costs and better outcomes. Fee-for-service is still the prevalent payment model for health care in both private and public systems. While paying based on each health service provided encourages productivity, it does not support accountability for patient care as volume is emphasized over quality.

IBAC entities continue to issue a common request for proposal but enter into separate contracts with the health plans. The only example of IBAC performing consolidated purchasing was for a pharmaceutical benefits manager (PBM.)

Previous studies and legislation sought to improve the state's health care purchasing power. In its 16 year history, IBAC has not consolidated purchasing for medical services. IBAC entities continue to issue a common request for proposal but enter into separate contracts with the health plans. Furthermore, many standard contract provisions, such as for reporting, contain language allowing each individual IBAC agency to negotiate terms independently with the health plan. The only example of IBAC performing consolidated purchasing was for a pharmaceutical benefits manager (PBM.)

Combined, the IBAC pool of enrollees is over 150 thousand, with NMPSIA and RMD being the vast majority of that total.

Consolidating NMPSIA and RMD into a single entity is still a relevant recommendation. Despite decreasing enrollment, IBAC and other public health benefit programs compose a large portion of the health insurance market in New Mexico. Combined, the IBAC pool of enrollees is over 150 thousand, with NMPSIA and RMD being the vast majority of that total. Funding redundant administrative functions across these two agencies reduces their ability to take advantage of opportunities to perform more beneficial functions like data analysis, quality improvements, and claims management. Combining these two agencies would also increase their pool, spreading risk more effectively, and allow them to better negotiate provider rates. This recommendation was also made in the 2010 LFC report.

Health care costs are no longer significantly lower for APS than they are for other IBAC agencies.

Further examination of health care costs and plans shows that APS is now a viable candidate for consolidation with NMPSIA and RMD. Data analysis performed by LFC staff indicates health care costs are no longer significantly lower for APS than they are for other IBAC agencies. Increasing health care costs for APS indicate that their premium contributions to a consolidated agency would not subsidize higher costs for other employees around the state. Increasing costs coupled with a recent plan design change makes APS more similar to NMPSIA and creates a viable consolidation argument.

To avoid federal monetary penalties, large employers must provide access to health coverage which is affordable and adequate.

If the amount of premium paid by the employee for individual coverage does not exceed 9.5 percent of the household income, the plan is deemed affordable.

IBAC agencies are subject to new fees under the Affordable Care Act.

The Affordable Care Act (ACA) continues to impact public employee health benefits. Cost savings would occur if employees seek coverage through other publicly-funded programs. However, IBAC agencies will be subject to new fees.

The Affordable Care Act includes a mandate on affordability and adequacy, creating maximums on employer and employee healthcare costs. To avoid federal monetary penalties, large employers must provide access to health coverage which is affordable and adequate. If the amount of premium paid by the employee for individual coverage does not exceed 9.5 percent of the household income, the plan is deemed affordable. Because it may be impossible for employers to determine household income, individual income can be the deciding factor. If the employer health plan pays for at least 60 percent, on average, of the total allowed cost for health benefits covered, the plan meets the adequacy requirement. IBAC agencies must remain aware of these requirements as they make plan changes related to premiums and out-of-pocket cost sharing such as deductibles, co-pays, and co-insurance.

The ACA will have budgetary impact for IBAC agencies through research and transitional reinsurance fees. The two fees within the ACA which impact IBAC agencies are membership driven. The ACA provides for the establishment of the Patient-Centered Research Institute, a non-profit, private corporation to be funded by fully- and self-funded health plans. Annual payments for policy years ending prior to October 1, 2013 are $1 multiplied by the average number of covered lives for that year. The fees increase to $2 from November 1, 2013 through October 2014. From 2014 until October 1, 2019, the fee will be increased each year based upon the projected per capita amount of national health expenditures. As of this evaluation date, the fee is slated to continue until October 1, 2019. The ACA also imposes a transitional reinsurance fee of $63 per covered life for 2014.

KEY RECOMMENDATIONS

The Legislature should:

- Create a consolidated health care finance entity to administer health benefits on behalf of governmental entities, including state and local governments, school districts, and institutions of higher education. Merge the employee health benefits function at APS into this entity as well. While risk funds managed by IBAC agencies were not reviewed in this evaluation, the Legislature should consider moving the management of risk funds into the newly established entity or consider other viable options for oversight of these funds.

- Require the New Mexico Retiree Health Care Authority participate in the joint purchase of health care and ancillary services with the consolidated health care finance entity; and

- Include responsibilities to coordinate and where appropriate, consolidate purchasing, quality improvement, and fraud and abuse surveillance activities with other state-funded health programs, including Medicaid. Direct the new authority to evaluate the feasibility of a data warehouse and claims processing function using the existing systems in Medicaid.

The Interagency Benefits Advisory Committee (IBAC) should:

- Actively participate in provider rate development by establishing acceptable rates for state-sponsored programs, allowing no rate changes without state approval, continuing active involvement in negotiations with high-cost providers, and developing contractual reporting mandates for insurance companies for more in-depth reporting on cost drivers including regional data;

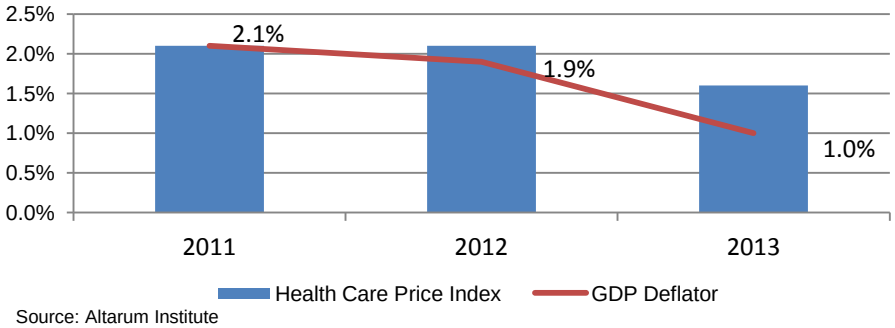
- Consider incentives or disincentives to health plans relating to the increase or decrease of provider rates;

- Update health plan contracts to require health outcome peformance measures based on a uniform set of criteria such as HEDIS measures; and

- Partner with Human Services Department (HSD) to inform state employees of Medicaid coverage expansion available beginning in January 2014.

Since the recession began in December 2007, health care prices have increased 12.5 percent, while overall prices in the economy increased 8.2 percent. Inflation slowed between 2011 and 2013, however health care prices outpaced overall prices in the economy. Moreover, as of March 2013, year-over-year hospital prices grew 2 percent for Medicare and fell 0.8 percent for Medicaid, yet all other payers combined saw hospital prices increase 4.8 percent, including private payers.

Chart 1. Health Care Cost Inflation Compared to Overall Inflation 2011-2013



Source: Altarum Institute

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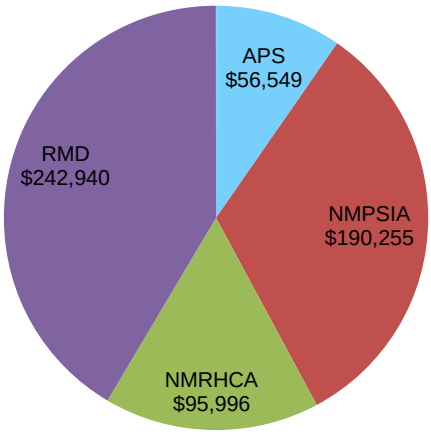
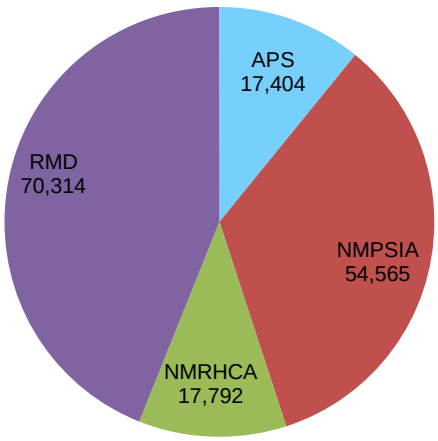
Chart 2. FY13 Medical Claims Paid
(In thousands)
Total: $586 million



Source: FY13 Health Plans Annual Reports
*APS data is for CY2012 (last annual data reported).

Chart 3. FY13 Employee Enrollment
Total: 160,075



Source: FY13 Health Plans Annual Reports
*APS data is for CY2012 (last annual data reported).

Table 1. Total Claims Filed

Fiscal Year	Total Claims	NMPSIA Claims	RMD Claims
FY10	1,388,043	584,231	803,812
FY11	1,332,739	570,944	761,795
FY12	1,336,653	577,087	759,566

Source: LFC Analysis of Plan Data

In 2010, LFC staff completed a program evaluation of two IBAC agencies, NMPSIA and RMD. The report found the state had not maximized purchasing power for health benefits nor taken advantage of comprehensive quality improvement initiatives that would better contain costs. Agencies focused little on the price of medical care or the outcomes the care provides. The status of this evaluation's recommendations is located on page 14 of this report.

Various issues impact the state's ability to provide and adequately finance health care for over 160 thousand public employees, including how health plans are structured and paid for, different strategies available for billing and generating cost savings, and most readily, the provisions of the federal Affordable Care Act.

SELF-FUNDED HEALTH BENEFIT PLANS

All four IBAC agencies are self-funded plans, meaning the state pays all claims directly after the covered person pays out-of-pocket expenses (co-pays, deductibles, coinsurance, etc. as defined in **Appendix B.**) Payments are made from funds generated through employee premiums and legislative appropriations to state agencies for employee benefits. There are various benefits to being a self-funded health plan, as described by the Health Care Administrators Association:

- The employer can customize the plan to meet the specific health needs of its workforce, as opposed to purchasing a "one-size-fits-all" insurance policy;
- The employer maintains control over the health plan reserves, enabling maximization of interest income, which would be generated by an insurance carrier through the investment of premium dollars;
- The employer does not have to pre-pay for coverage, thereby providing for improved cash flow.
- The employer is not subject to conflicting state health insurance regulation/benefit mandates, as self-funded health plans are regulated under federal law;
- The employer is not subject to state health insurance premium taxes, which for health insurers in New Mexico is four percent; and
- The employer is free to contract with the providers or provider network best suited to meet the health care needs of its employees.

Self-funded plans typically contract with a third party administrator (TPA) that can perform claims processing, but also can manage the provider network and provide other ancillary services. IBAC agencies contract with Blue Cross Blue Shield of New Mexico (BCBS), Presbyterian Health Plan, Lovelace Health Plan, or a combination of these organizations, for TPA services. Two agencies (RMD and NMPSIA) contract with another TPA to manage enrollment and financial processes.

Table 2. IBAC Agency Contracted Health Plan Administrators

RMD	Presbyterian Health Plan, Lovelace Health Plan, Blue Cross Blue Shield of New Mexico, and Erisa (Data Management, Enrollment, and HSA Plan Management Services)
NMPSIA	Presbyterian Health Plan, Blue Cross Blue Shield of New Mexico, Erisa (Eligibility and Premium Payment Services)
APS	Presbyterian Health Plan and Lovelace Health Plan
NMRHCA	Presbyterian Health Plan and Blue Cross Blue Shield of New Mexico

Source: RMD, NMPSIA, APS, NMRHCA Plan Documents

AFFORDABLE CARE ACT

The federal Affordable Care Act (ACA) continues to be a major factor in health care. Various aspects of the law affect how the state designs and purchases health care for employees. The following table identifies ACA mandates, some of which are already in place, which will have significant budget implications.

Table 3. ACA Standards for Self-Insured Health Plans

No lifetime or annual limits	In effect: Plans are prohibited from limiting the lifetime dollar value of benefits. Effective January 1, 2014 annual limits are banned.
Preventive services	In effect: Plans must offer first dollar coverage (no co-payments or deductibles) for certain preventive services
Dependents under 26 years of age	In effect: Plans must allow adult children under age 26 to enroll in parent's plan
Prior authorizations	In effect: Plans are prohibited from requiring a referral to an OB-GYN and from requiring prior authorization
Out-of-pocket maximums	By 2014: Out-of-pocket costs are limited to $6,400 for single coverage and $12,800 for family coverage.

Source: DHHS

Medicaid Expansion. The state decided to expand its Medicaid program, which would allow anyone meeting 138 percent of the federal poverty level, or an annual salary of $15,856 (based on 2013 levels), to enroll in the program. HSD estimates enrollment will increase by 123 thousand in FY14. Under the ACA, new enrollees will be subsidized at 100 percent by the federal government through 2016, with the subsidy percentage stepping down to 90 percent in 2020. State employees who meet the eligibility requirement could enroll in Medicaid and would not have to pay a premium or co-pay.

Health Insurance Exchange. The federal government and states have created health insurance exchanges under the provisions of the ACA, which serve as a marketplace for health insurance plans. State employees could seek coverage through the federal exchange, and could be eligible for subsidies through the exchange if the state fails to meet specific criteria under the ACA. Qualification for a subsidy would mean the employer did not meet affordability and adequacy mandates. The impact of state employees seeking health care coverage through the federal exchange is unknown at this time.

Cadillac Plans. Beginning in 2018, the ACA will impose a 40 percent excise tax on employer-sponsored health plans deemed high cost or "Cadillac" plans. A health plan is considered to be high cost if the total of employer and employee premium costs is above $10,200 per employee for single coverage and $27,500 per employee for family coverage. These plans usually offer more generous benefits, including broader provider networks and more expensive services. However, a plan's high cost cannot always be explained by the richness of the plan. Costs may be attributable to health status, age, and gender of the workforce covered by the plan, as well as the work industry or geography of the covered group.

Adjustments to this section of the ACA are being considered for those plans which cover a large number of older workers, women, or people in high-risk jobs. Recent increases have been made to the ACA thresholds for pre-retiree plans, but no changes have yet been made for plans which may have gender disparities, such as school teachers. The health plans in place prior to July 2013 for both APS and NMRHCA could have been identified as near to or high cost plans. APS is enacting plan changes, decreasing the likelihood of becoming a Cadillac plan and NMRHCA's board voted to make necessary changes to avoid additional taxation under this provision before 2018.

Common Law Employees. An employment relationship exists if an employee is subject to the will and control of the employer not only as to what work shall be done, but how it will be done. The working definition, although not finalized, for a common law employee is a working relationship when the person for whom the services are performed has the right to control and direct the individual who performs the services not only in the result, but also the ways and means by which that result will be accomplished.

Table 4. Common Law Employee Definitions Under the ACA

Receives detailed direction about how a task is to be performed by the agency hiring the contractor
The employer determines the work hours
The employer provides the equipment to do the job
The employer dictates how the work is done
The worker is expected to work primarily and exclusively for that employer
The worker performs a function key to the employer's business
The relationship is expected to continue indefinitely.

Source: Segal

All common law employers, including federal, state, local, and tribal governmental entities can be subject to penalties under this provision of the ACA. New Mexico requires all contractors certify that their employees are offered health insurance. Contractors also must agree to maintain records of employees who have accepted or declined coverage and advise all employees of state publicly-financed healthcare coverage.

WELLNESS PROGRAMS

The National Conference of State Legislatures (NCSL) collected information on wellness programs and found studies that demonstrate that well-designed programs can reduce employer and employee health expenditures. Large employers' wellness programs saved an average of $358 in annual health care costs per employee at a cost of $144 per employee per year. For example, in FY14, RMD will pay an average of $76 per employee per year for wellness programs. However, in the same document, a University of Pennsylvania official questioned the beneficial effects of work-site wellness programs, citing that long-term change in behavior is difficult; it is tricky to measure and often does not pay off for employers.

According to the 2012 NCSL state survey, at least nine states, including Indiana, Missouri, and North Carolina, authorize lower premiums for non-smokers. States, including Kentucky, Alabama, Georgia, Kansas, South Carolina, and South Dakota, have all instituted surcharges to employee premiums of tobacco users. The CDC has determined that on average, the annual cost of a smoker's health care, is $1,300 more than a non-smoker. The average monthly cost to smokers is $36 per month. Georgia adds another $80 per month for dependents who are tobacco users. In 2013, APS employees were required to complete a tobacco affidavit. Tobacco users will be required to complete a 12-week online tobacco cessation program. However, smoking cessation programs may have only short-term, positive outcomes because of high recidivism rates.

LACK OF EFFECTIVE OVERSIGHT OF PROVIDER RATES AND QUALITY IMPROVEMENT HAS MADE EMPLOYEE HEALTH CARE LESS AFFORDABLE

In 2010, LFC staff made a series of recommendations to contain healthcare costs. LFC staff performed a program evaluation of the two largest IBAC agencies in 2010, NMPSIA and RMD, which included the following findings:

- NMPSIA and RMD increased premiums, employee out-of-pocket expenses, and used fund balances as strategies to manage rising healthcare costs;
- Increasing provider rates appear responsible for a greater portion of rising healthcare costs; utilization of services remained relatively flat for both NMPSIA and RMD;
- Despite some progress, IBAC has not fulfilled its intent and perpetuates duplicative and costly administrative functions; and
- The lack of data warehousing from all state-sponsored health benefit plans limits administrators' access to information to better manage their own plans and to benchmark against other publicly-funded plans.

The evaluation also found the state has not maximized purchasing power for health benefits nor taken advantage of comprehensive quality improvement initiatives that would better contain costs. Agencies focused little on the price of medical care or the outcomes the care provides.

The evaluation made various recommendations, none of which were implemented.

Table 5. 2010 LFC Recommendations and Status

Recommendation	Status
Actively participate in provider rate development by establishing acceptable rates for state-sponsored programs, allowing no rate changes without state approval, continuing active involvement in negotiations with high-cost providers, and developing contractual reporting mandates for insurance companies for more in-depth reporting on cost drivers including regional data.	No action taken.
Negotiate with health plans to decrease the administrative fees to the FY09 level.	No action taken.
Perform an independent rate validation study to compare with other plans and other states.	No action taken.
Consider incentives or disincentives to health plans relating to the increase or decrease of provider rates.	No action taken.
Improve the utilization review process.	No action taken.
Evaluate and implement other cost-saving strategies being used by other large employers or states, to include changes in the benefit design.	No action taken.
Determine reporting requirements and mandate health plans to report in the same format, using the same definitions, on the same time schedules. Use the data to provide increased oversight of program administration.	No action taken.
Impose a surcharge on employees with spousal coverage, where the spouse has a health benefit plan option with their employer.	No action taken.
Create a New Mexico healthcare finance authority to administer health and risk benefits on behalf of governmental entities, including state and local governments, school districts, and institutions of higher education. Abolish NMPSIA and RMD, as separate entities, and merge the functions for health benefits and risk funds administered by the agencies into the new authority.	No action taken.
Include responsibilities to coordinate and where appropriate, consolidate purchasing, quality improvement, and fraud and abuse surveillance activities with other state-funded health programs, including Medicaid and NMRHCA. Direct the new authority to evaluate the feasibility of a data warehouse and claims processing function using the existing systems in Medicaid. Additionally, consolidate health benefit funds formerly administered by NMPSIA and RMD and also consider the feasibility of merging APS and other governmental entities into the administration of the new healthcare finance authority and possibly merging funds.	No action taken.

Source: LFC Files

One of the recommendations advised to implement a surcharge for spouses who had access to other healthcare coverage. Since the evaluation was published, various public and private entities have introduced a spousal surcharge or have eliminated spousal coverage altogether when other coverage options exist. Most notably, United Parcel Service announced in 2013 that they would no longer offer spousal coverage, removing an estimated 15 thousand people from their health plan. Lovelace Health System will similarly drop spouse and domestic partner health benefits when other coverage is available. In the public sector, the University of Virginia has limited access for spousal coverage.

Both the public and private sector are implementing other cost saving strategies by offering consumer-driven health plans. For example, most states include an employee option for a high deductible health plan. These plans require employees to pay a greater share of initial care than do conventional plans, but offer lower employee monthly premiums, giving employees greater flexibility and discretion over how health care dollars are used. Enrollees are encouraged to select lower cost providers and actively participate in preventive services. In 2009, Georgia limited employee health plan options to only high deductible plans. Indiana introduced their first high deductible plan in 2006.

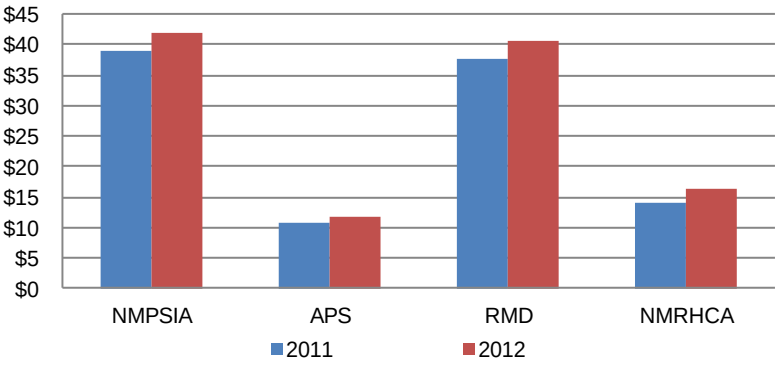
The Risk Management Division is the only IBAC agency that offers a high deductible plan. However, the difference between the premium costs of this plan and others offered may not be enough to promote selection of the high deductible plan by enrollees. This plan also includes a health savings account which the employer funds at $600 per year, with the employee also able to contribute to the account.

Health care spending for IBAC agencies has continued to rise at unsustainable levels. From FY11 to FY12, the combined total amount paid in claims for the New Mexico Public School Insurance Authority (NMPSIA) and the Risk Management Division (RMD) increased from $398 million to $419 million, an increase of over five percent. From FY10 to FY12, NMPSIA and RMD each saw substantial increases in the amount paid in claims. For NMPSIA, the two-year change in the amount paid was over 10 percent, with costs increasing from $159 million to $174 million. RMD experienced a $20 million increase in costs from FY10 to FY12, as costs grew from $224 million to $244 million. This is equal to a 7.8 percent increase.

NMRHCA is challenged both by increasing retiree rolls and medical costs. LFC staff noted in the 2013 Appropriation Recommendation (Volume II) that NMRHCA was facing an average 5 percent annual increase in enrolled retirees and medical cost increases of 8.3 percent for the Pre-Medicare retiree population, where the average age is 54. NMRHCA's actuary projected that health care funds would reach a negative position by 2029, with expenses forecasted to outpace revenues by $265 million.

Pharmaceutical costs continue to increase despite an overall membership decline and a contractual requirement to increase use of generic drugs. All IBAC agencies, except NMRHCA, have experienced a decline in membership from 2011 to 2012, but each of the plans has experienced an increase in drug costs during that time. The 2012 drug costs for all IBAC agencies were nearly $111 million. The increased pharmaceutical costs from 2011 to 2012 added nearly $10 million in expenses for the IBAC agencies and health plan members. The pharmacy benefits manager identifies inflation (brand drug and average wholesale price inflations), drug mix, and utilization as the primary cost drivers.

Chart 4. 2011 and 2012 IBAC Agency Drug Costs
(in millions)



Source: 2012 Express Scripts Annual Report

From 2011 to 2012, each of the IBAC agencies increased the use of generic drugs compared to patented drugs. The IBAC contract with Express Scripts obligates the pharmacy benefits manager to specific generic dispensing rate targets. Small increases in the use of patented drugs can cause drug costs to rise dramatically.

In 2012, IBAC agencies experienced inflation for brand name drugs from 11 percent to 14 percent. With successful efforts to increase the use of generic drugs, as NMRHCA improved generic dispensing from 80 to nearly 85 percent, the increasing costs can be attributed to higher vendor prices. The cost of a brand compared to a generic drug is illustrated by a comparison of antibiotic therapies. A commonly used antibiotic is available as a patented or generic drug. The table below shows the cost savings possible using the generic drug.

Table 6. Comparison of Brand and Generic Drug Costs

Category	Plan Cost per Month	Patient Cost
Brand	$686.17	$45.00
Generic #1	$29.35	$5.00
Generic #2	$17.86	$5.00

Source: 2011 Medco NMPSIA Report

Opportunities do exist for cost decreases of brand drugs when the manufacturer's patent expires. In the NMPSIA 2011 annual report, the pharmacy benefits manager predicted over $5 million in NMPSIA's plan costs would lose patent by 2013. The amount represents 15 percent of NMPSIA's total plan costs, which could eventually be replaced by lower cost generic drugs.

Both RMD and NMPSIA have implemented or plan to implement premium increases between 19 and 25 percent. RMD increased premiums 15 percent for FY14, after not having an increase in at least the last five years. RMD has proposed another 10 percent increase in FY15, for a two-year total of 25 percent. NMPSIA increased premiums 19.1 percent between FY11 and FY14. Rising healthcare costs have outpaced collected revenues, causing IBAC agencies to increase premiums to maintain solvency.

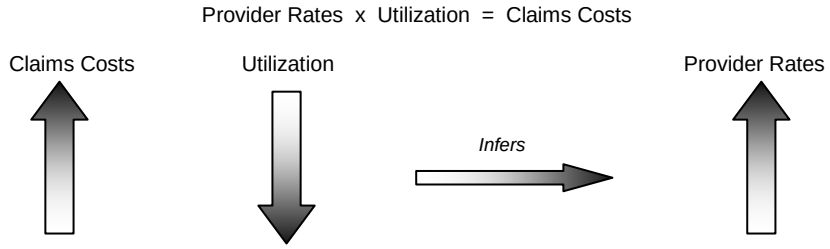
RMD health care premium increases are greater than legislatively-approved salary increases and could negatively impact the state's ability to be competitive as an employer. RMD distinguishes how premiums are divided between employees and the state based on the following annual salary categories: salaries $50 thousand or less, salaries between $50 thousand and $59.999 thousand, and $60 thousand or greater. Reviewing scenarios where the one percent salary increase enacted in FY14 moved an employee from one salary category to another either eliminated the salary increase for employees holding employee-only health coverage and resulted in as much as a two percent pay cut for employees holding family coverage as noted in **Appendix C.** RMD has proposed a 10 percent premium increase for FY15. Assuming zero salary increases, the same employees would receive an effective pay cut whether they carry employee-only coverage or family coverage.

State employees pay more than double the share of monthly health benefit premiums when compared to national data. The Kaiser Family Foundation notes in their 2013 Employee Health Benefits survey that state and local government employees pay an average 13 percent share of health premiums for the three types of health plans the State of New Mexico offers public employees (HMO, PPO, and HDHP). RMD has an average employee premium share of 30 percent. However, at the most subsidized level, employees are paying 20 percent of premiums, which is still above the national average. Across all industries included in the Kaiser survey, employees pay an average 18 percent of health benefit premiums, making New Mexico state employees' share high when considering the overall marketplace.

Out-of-pocket expenses have doubled in some cases, and employees are paying a much larger share of health care costs. In FY14, RMD increased deductibles for its HMO (133 percent) and PPO plans (75 percent), and raised out-of-pocket maximums by 17 percent as shown in **Appendix D**. Increasing out-of-pocket costs has been seen as a method to induce consumers to better manage their health care. However, high out-of-pocket costs can also negatively impact a consumer's health care or spending decisions. The New England Journal of Medicine described how many insured patients burdened by high out-of-pocket costs from cancer treatment reduced their spending on food and clothing to make ends meet, or reduced the frequency with which they took prescribed medications.

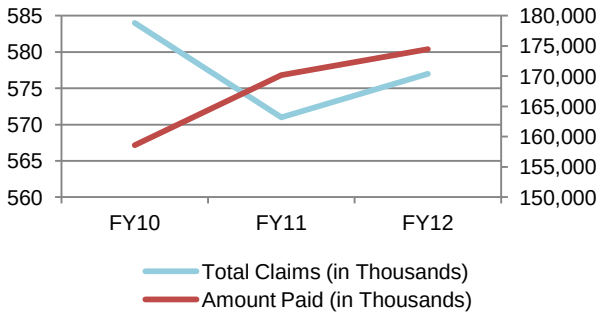
Continued price increases, not utilization or enrollment, are driving rising costs. Healthcare costs are comprised of the cost of the service (provider rate) multiplied by the frequency of services (utilization.) If utilization is declining, yet overall costs are increasing, it can be inferred that provider rates are driving the increases.

Figure 1. Healthcare Cost Drivers



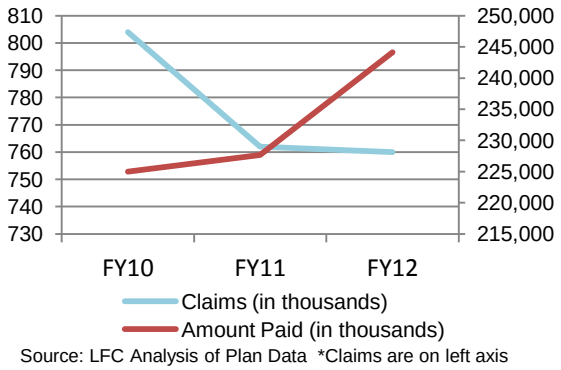
Healthcare costs have continued to increase despite a decrease in the number of claims and enrollment. Raw claims data for NMPSIA and RMD show that increased costs are not the result of increased utilization. Comparable data was not available for APS and NMRHCA, so the analysis uses NMPSIA and RMD as examples. From FY10 to FY12, the number of claims filed decreased by more than one percent for NMPSIA and by 5.5 percent for RMD. From FY11 to FY12, the number of claims filed decreased minimally for RMD, and for NMPSIA, claims increased. This is consistent with national trends in healthcare utilization following a recession.

Chart 5. NMPSIA Total Amount Paid Relative to Total Number of Claims



Source: LFC Analysis of Plan Data

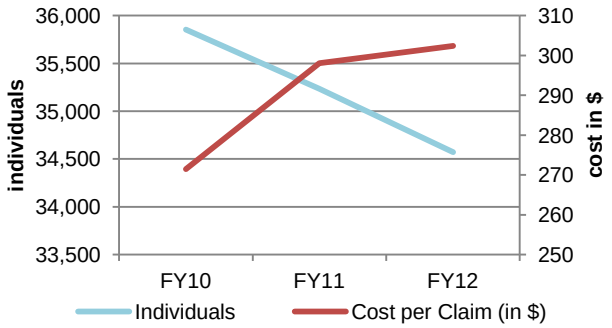
Chart 6. RMD Total Amount Paid Relative to Number of Claims



Source: LFC Analysis of Plan Data *Claims are on left axis

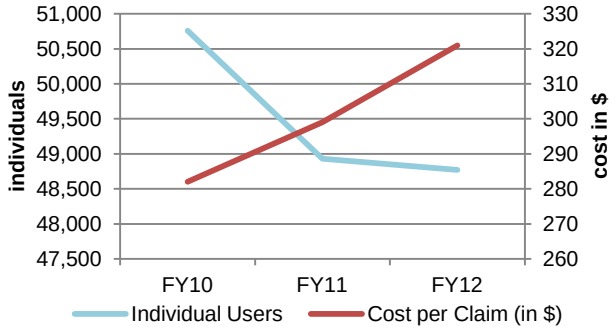
Individual utilization also decreased, as the number of people filing claims dropped by over 3.5 percent for both agencies from FY10 to FY12. The decrease in individual utilization of health care benefits has not resulted in a decrease in cost. This decrease in individual utilization is consistent with an overall decline in the number claims filed. Although fewer individuals are using the system the cost per claim increased from FY10 to FY12.

Chart 7. NMPSIA Individual Utilization and Cost per Claim



Source: LFC Analysis of Plan Data

Chart 8. RMD Individual Utilization and Cost per Claim



Source: LFC Analysis of Plan Data

These declines in individual utilization coincide with decreased enrollment for both NMPSIA and RMD. NMPSIA saw a slight decline in enrollment of 0.6 percent from FY10 to FY12. For RMD, enrollment decreased by over five percent.

The New Mexico Retiree Health Care Authority has different cost drivers than the other IBAC agencies. Utilization and increased membership are pushing up costs for NMRHCA. In FY12, the agency experienced a 16 percent increase in total cost, and a 15 percent increase in the number of claims filed. NMRHCA's enrollment grew by over four percent from FY11 to FY12. Individual utilization increased by seven percent. A combination of new users and increased utilization drove the increase in total cost.

Administrative service fees continue to grow at a high rate, driven by costs to administer wellness programs. The 2010 LFC evaluation of public employee health benefits expressed concern at increasing fees to administer health benefits at a time when state revenues were declining. The evaluation recommended reducing these fixed health plan administration costs to FY09 levels. In the case of RMD, BCBS reduced its fees 3.2 percent for FY14 from FY11 levels. However, Lovelace and Presbyterian increased administrative service (ASO) fees 28 percent and 31 percent respectively, creating a net increase in ASO fees of 19.2 percent from FY11 levels. This was after a 4.5 percent increase for FY11 for one of its health plans. A 2012 Oliver Wyman survey of healthcare costs noted that among responding health carriers, administrative service (ASO) fees had grown at a stable median rate of 3.5 percent between 2010 and 2012. The majority of increases are related to wellness services such as health risk assessments, health coaching, biometric screenings and other value-added services.

Table 7. RMD Administrative Services Only Fees FY11 and FY14

	BCBS		Lovelace		Presbyterian	
	FY11	**FY14**	**FY11**	**FY14**	**FY11**	**FY14**
Basic Administration	$15.74	$16.35	$14.87	$14.37	$14.33	$14.29
Disease Management	$1.80	$2.00	$2.15	$2.49	$1.22	$1.74
Behavioral Health	$5.50	$0.00	$1.01	$0.00	$0.00	$0.00
Other		$5.42		$6.24	$2.33	$7.39
Total Fixed Cost per Member:	$23.04	$23.77	$18.03	$23.10	$17.88	$23.42
Percent Fixed Cost Change from FY11 to FY14:		3.2%		28.1%		31.0%
Net Change:						19.2%

Note: Other represents wellness services and other value-added services.

Source: LFC Files and RMD

For RMD alone, LFC staff estimates ASO fees to be approximately $20 million for FY14, or 8 percent of total claims paid in FY13, with almost a third of that going to support wellness initiatives.

Table 8. Estimated FY14 RMD Administrative Service Fees

Plan	FYE13 Enrollment	FY14 Estimated ASO Fees	Percent of Fees for Wellness Programs
Lovelace	8,298	$2,300,206	27.0%
BCBS	19,687	$5,615,520	22.8%
Presbyterian	42,329	$11,896,142	31.6%
Total	70,314	$19,811,868	28.5%

Source: FY13 Health Plan Annual Reports

Wellness and disease management programs have not shown a positive return on investment in the short term. A Rand Corporation report issued in 2013 states, "Our statistical analyses suggest that participation in a wellness program over five years is associated with a trend toward lower health care costs and decreasing health care use. The state is uniquely positioned to impact employee health care over a span of twenty years or more as they move from other IBAC pools to NMRHCA, as returns on investment in wellness may not be immediate, but long-term gains could materialize.

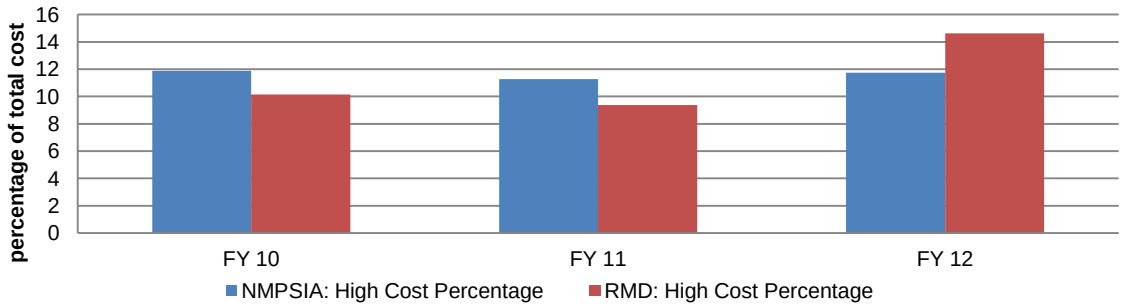
High cost claimants have a fiscal impact to the State. Individuals can amass a high volume of claims or have a few high cost claims. Both can result in high health care costs. Currently, the state pays out most high cost claims, making these individuals potential cost drivers for the state.

IBAC-contracted health plans do not use the same method for calculating high cost claims, making it difficult to determine their actuarial impact. None of the health plans in New Mexico report high cost individuals in the same manner. Lovelace looks at high cost claims, Blue Cross Blue Shield analyzes high cost claimants, and Presbyterian groups high-cost claims by a patient's diagnosis. As a result, it is difficult for IBAC to assess the fiscal impact of these individuals.

Catastrophic claims and individual aggregate costs have different effects on the state's budget depending on how they are calculated. LFC staff analyzed high cost claims in two ways. The first way was to isolate single claims with a cost that was more than $250 thousand. From FY10 to FY12, 23 filed claims eclipsed that threshold with a three-year cost of $11.6 million. This method makes catastrophic claims appear to be a low cost to the state.

The other method calculated the number of individuals who generated more than $250 thousand in annual claims. From FY10 to FY12, 301 individuals generated totals that exceeded this threshold at a cost of $137 million. Despite the relatively low number of claimants, the costs are a high percentage of the total cost. NMPSIA's cost hovers between 11 and 12 percent annually, while RMD's costs ranged between nine and 15 percent.

Chart 9. NMPSIA and RMD Catastrophic Claimant Costs



Source: LFC Analysis of Provider Data

Understanding high cost claim activity would allow IBAC agencies to plan for catastrophic costs more readily, reducing the need for emergency appropriations in the future. Examples of high cost claims include dialysis and transplants for end-stage kidney disease, certain cancer treatments, and births that require services from newborn intensive care units. Stop loss insurance is usually considered once an organization has a catastrophic claims value that is more than 3 percent of their total costs. Chart 9 shows that, using the $250 thousand benchmark, both NMPSIA and RMD surpass the 3 percent where stop loss insurance could be beneficial.

Improving plan oversight could result in lower costs and better outcomes. Fee-for-service is still the prevalent payment model for health care in both private and public systems. While paying based on each health service provided encourages productivity, it does not support accountability for patient care as volume is emphasized over quality.

Current IBAC health plan designs do not emphasize health outcomes. Health outcomes can be defined as whether a disease condition improves or worsens, focusing on the results of treatment a patient receives. The Institute of Medicine identified six key components of a successful health care delivery system: safety, effectiveness, patient centeredness, timeliness, equity, and efficiency (**Appendix E**). In their current fee-for-service approach, IBAC plans cannot look at the entire health status of an enrollee but instead care is addressed in a piecemeal fashion. In contrast with the state's Medicaid program, contracts with IBAC health plan administrators do not include requirements for reporting health metrics that could better inform IBAC on how to deploy strategies such as disease management to improve health outcomes. Better analysis of how plan members use health care could help design plans more effectively, reducing costs and improving quality.

IBAC agencies use claims data to various degrees to monitor health plans. The ACA limits the percentage of a household's income that can be paid in healthcare premiums at 9.5 percent, and also limits what the state can pay for health care. Therefore, all IBAC agencies need to consider other strategies for cost containment. Performing claims analysis could provide insight to better strategies to manage continuously increasing costs.

RMD does not regularly review healthcare service utilization, and did not perform utilization analysis when addressing plan changes for FY14. RMD's contracted consultant performs a projection of expected claims annually for the forthcoming plan year looking at the most recent 12 months of claims data and applying a growth rate based on health care cost inflation over a 26-month period. While annual health care cost inflation was estimated at 9 percent for FY14, the consultant estimated claims would grow a total of 21 percent for both medical and prescription drugs when utilization and cost were also considered. Total FY14 estimated claims cost would be $335 million if RMD plan designs went unchanged. The consultants also analyzed how increasing premiums and out-of-pocket limits would impact the state's liability for healthcare costs, reducing the total estimate to $306 million. Analysis did not include looking at raw claims data to assess cost drivers or potential cost trends. While premium and out-of-pocket plan design changes increase funding and reduce the state's liability for healthcare costs, challenges exist in only using this strategy to manage increasing costs.

NMRHCA subcontracts for claims data warehousing and analysis, providing them further insight into plan management. NMRHCA uses a Segal subcontractor for data warehousing and analysis. The subcontractor receives raw data from Blue Cross Blue Shield and Presbyterian, and cleans the data to make it usable for more in-depth analysis. The cleaning process standardizes the data, allowing for more in-depth analysis like county-by-county risk assessments, which are not included in the plan's annual reports.

IBAC agencies do not sufficiently leverage data mining or statistical techniques to understand trends in healthcare costs. Only NMRHCA subcontracts out for data analysis, leaving the rest of IBAC to rely on plan provided data which is not submitted to the agencies in a standardized format. The data cleaning process makes it difficult for the agencies to compile timely analysis, and the lack of shared resources make understanding statewide trends problematic.

Claims data is compiled in neither a standardized nor easy to use format by the health plans. All of the health plans compile their own claims data, and definitions are not standardized across the plans. This makes identifying true units of analysis difficult. For example, plans use different claims tracking methods. Presbyterian uses the last two numbers of the claim number to show the status of the claim, which makes it difficult to identify the final claim because there is no single identifier for a finalized claim. Lovelace uses short and long claim numbers, where the short claim number identifies the final claim. Each plan also codes individuals differently, making it difficult to do plan-to-plan comparisons on the individual level.

The raw data received by LFC staff was not readily usable, and it required extensive cleaning and reconfiguration. One plan's data sets lacked diagnostic codes for a majority of observations. This made determining high frequency and high cost diagnoses problematic. Cost information like deductibles, co-pays, co-insurance, billings, and paid amounts were coded differently by each plan. These differences made it difficult to analyze the data for each agency as a whole. Instead the analysis was done across plans and fiscal years, and was later compiled into totals. Standardized data would allow each agency to better understand trends across plans.

Summary reports required in IBAC contracts provide different levels of data, making plan-to-plan comparison difficult. The 2010 LFC evaluation of IBAC found that summary reports provided by the health plans were not standardized, which prevented the agencies from comparing their different plans. In reviewing health plan reports for this evaluation, LFC staff found the same reporting issues continue to occur. While BCBS annual reports by far contain the most information, they do not report all data on a plan year, rather reporting on a rolling 12-month basis. This makes year-over-year analysis difficult. Lovelace reports some data, including catastrophic claims, on a four-year rolling schedule without each plan year being broken out separately. Lovelace does not report employees versus total members (spouses and dependents), which would be essential for any analysis looking at spousal surcharges.

Different health care diagnoses are influencing costs. Diagnostic codes can be looked at by frequency to determine what illnesses are occurring most often, and by cost to determine what diagnoses are inflating costs. In New Mexico, the top four high-frequency diagnostic codes are a blend of physician visits and more serious health issues like diabetes. The high-cost diagnostic codes are heavily influenced by the cost of end-stage kidney disease.

Standardized data would allow for diagnostic code trends to be effectively identified and leveraged by IBAC agencies to mitigate costs. Diagnostic codes reflect the health status of the population by indicating what medical diagnosis is being made for individuals. Frequent diagnoses could be linked to future high-cost diagnoses. For example, one common diagnosis across both the NMPSIA and RMD populations was diabetes. This disease is linked to other, costly health issues including kidney disease, heart disease, and joint issues. Diabetes appears annually as a high-frequency diagnosis, and end-stage kidney disease is the highest cost diagnosis in the data. Links like this could be used to better understand future high-cost diagnoses.

The top four high-cost diagnostic codes are a contributor to overall cost growth. New Mexico spent between $28 million and $32 million on the top four high-cost diagnoses from FY10 to FY12. End-stage kidney disease, cancer treatments particularly chemotherapy, heart disease, and joint deterioration were consistently on the list of high cost diagnoses. End stage kidney disease is the most costly of these diagnoses, accounting for more than 3 percent of annual total costs. Table 9 shows the annual amount paid for the four high-cost diagnostic codes. These costs are growing, and contributing to overall healthcare costs.

Table 9. Top Diagnostic Code Expenses

Fiscal Year	Cost of Top Four Diagnosis Codes (in thousands)	Top Four Diagnosis Code Percent of Total Cost
FY10	$28,683	7.5 %
FY11	$30,723	7.7 %
FY12	$31,145	7.4 %

Source: LFC Analysis of Provider Data

Limited incentive exists for health plan administrators to aggressively contain health care spending and the state does not exert cost containment as part of its administrative service contracts. As self-funded health plans, the state bears all the risk for claims costs, as opposed to a fully-insured plan, where the insurer bears the financial risk. Since the health plan is not impacted directly by cost increases, there is no natural motivation to contain these costs. Moreover, IBAC contracts with their health plan administrators do not provide incentives to better manage costs through provider rate negotiations, the main driver of health care cost increases for IBAC. As part of these negotiations, IBAC could set maximum payment levels for services, which other states, such as Indiana, have done.

Hospital costs compose a large portion of overall healthcare costs for the IBAC. Hospitalization costs increased from FY10 to FY12 and are putting upward pressure on total costs. The total amount paid in hospital claims was roughly 35 percent in FY12. For NMPSIA and RMD, which generate the largest share of hospital costs and claims, hospital costs generated 34 percent of total costs in FY10 and increased 36 percent of total cost in FY12. Hospital claims filed for these two agencies decreased by about four thousand annually from FY10 to FY12.

Different health plans pay hospitals different costs per claim. FY12 data for the IBAC shows that Plan A paid $1,733 per hospital claim as compared to $1,720 and $1,496 for Plan B and Plan C respectively. This analysis does not look at intensity of care, but it does illustrate the pay disparity across the plans. A lack of information on provider rates makes it difficult for the IBAC agencies to know what is being paid for different hospital services.

In some cases, plans appear to pay their own system providers more per claim, and a lack of transparency around provider rates makes it difficult to understand the cause of this. For one of RMD's plans, the affiliated hospital has a higher cost per claim than other unaffiliated hospitals. For example, the affiliated hospital has a cost per claim that is roughly $1,000 more than an unaffiliated Albuquerque area hospital. This is unexpected since the unaffiliated hospital provides many high-intensity services, making it a draw for individuals seeking high-cost care from across the state. LFC staff could not control for intensity of service, which measures the necessary healthcare resources, nor distinguish between inpatient and outpatient claims. Instead this analysis looks at the amount paid on average for each claim filed at a hospital. Other analyses indicate that looking at daily costs yields different results for hospitals across the state. The lack of transparency surrounding hospital provider rates makes it difficult to know what is being charged for different services.

Table 10. Plan C Hospital Cost Comparison of Selected Hospitals

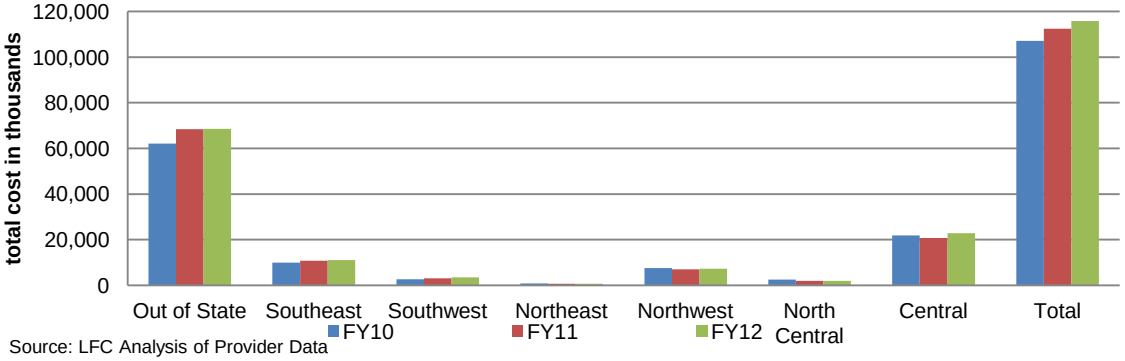
Hospital	FY10 Cost per Claim	FY11 Cost per Claim	FY12 Cost per Claim
Unaffiliated Hospital A	$1,554	$1,764	$2,120
Unaffiliated Hospital B	$810	$899	$988
Unaffiliated Hospital C	$2,173	$14,915	$4,152
Unaffiliated Hospital D	$1,312	$1,564	$2,219
Affiliated Plan Hospital E	$1,891	$1,832	$2,300
Unaffiliated Hospital F	$953	$860	$1,031
Unaffiliated Hospital G	$823	$931	$1,355
Unaffiliated Hospital H	$1,165	$1,001	$1,102

Source: LFC Analysis of RMD Plan C Data

Urban areas have higher cost hospitals than other areas of the state. LFC staff sampled 18 hospitals around the state from Blue Cross Blue Shield data. Four of six hospitals in the urban part of the state, the Central Region had a cost per claim of more than $1,500 compared to just three of the 12 hospitals in other regions of the state. This could be a result of either the type of care given at urban hospitals, which tends to be more specialized, or it may be related to provider rates. One of the urban hospitals in the sample with a cost above $1,500 per claim is UNM Hospital. This should be expected since UNM is a teaching hospital and provides many specialized services. Presbyterian, St. Vincent's, and UNM all had more than 15 thousand claims in FY12. Regional definitions are in **Appendix F,** and **Appendix G** contains a table detailing FY12 costs and claims for the hospitals sorted by region.

Total and average health care costs vary across regions of the state. Insufficient information on provider rates and a lack of data analysis make it difficult to discern the amount paid for services in different regions of the state. LFC staff used Blue Cross Blue Shield data for NMPSIA to depict variations in regional health care costs. Out-of-state costs comprise the largest share of total regional costs, and these costs have increased from FY10 to FY12. However, in the Northwest and North Central regions, total costs have decreased. In the Central region, total costs decreased from FY10 to FY11, and then increased from FY11 to FY12. This variation could be due to utilization, but the trend in costs per claim makes it appear that despite changes in the number of claims, the amount paid per claim is increasing across all regions.

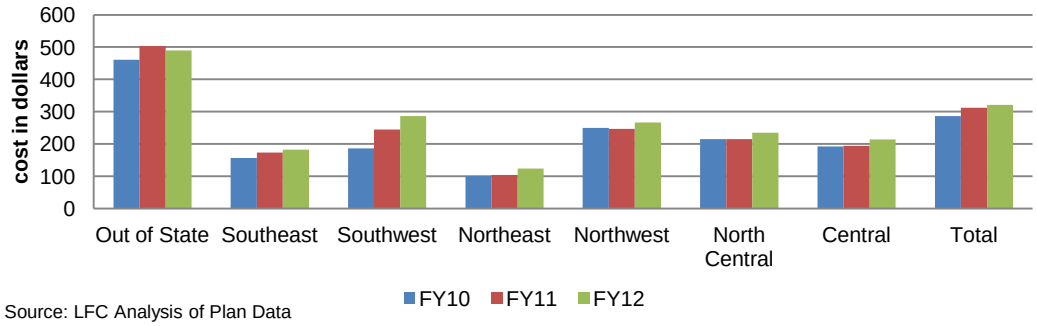
Chart 10. NMPSIA Regional Total Costs



Source: LFC Analysis of Provider Data

The number of claims decreased for all regions except for out-of-state, but the cost per claim has increased in each region from FY10 to FY12. The number of claims filed is highest in the Central Region and out-of-state. This makes sense given the quality and types of services that are provided in these regions. However, a lack of available information on provider rates makes it difficult to understand how much is being paid for similar services across the state. It also makes comparing out-of-state rates to in-state rates problematic because none of this information is readily available. **Appendix H** contains the same analysis for RMD.

Chart 11. NMPSIA Regional Cost per Claim



Source: LFC Analysis of Plan Data

Other states are actively pursuing payment reform and quality improvement. States are grappling with increasing healthcare costs and tight budgets. Furthermore, the Network for Regional Healthcare Improvement identified that more services and higher costs do not translate to better results when it comes to health care. Finding solutions that will better manage costs while still delivering quality care is a priority.

Various methods exist to reduce cost and improve the quality of health care. States are looking at payment reform within the healthcare system, with support from the federal government through the Affordable Care Act (ACA). Twenty-five states will share $300 million in funding through the ACA to design and test payment reform models. These states include:

- ***Minnesota-*** The state passed comprehensive health care legislation in 2008 to overhaul its health care delivery system to include a standard set of quality-of-care measures, a centralized claims and payment database for all providers and payers, public ranking of all providers by costs and quality, the creation of health care homes, and a standard incentive payment system to be used by public and private payers.

- ***New York-*** The state created a pay for performance program that used statewide benchmarks and customer satisfaction survey data on a variety of measures including breast cancer screenings, postpartum visits, diabetes and high blood pressure control, and post-hospitalization follow-up for mental illness. By the end of the program, the state had paid $71.5 million in bonuses and had seen an increase in enrollment in plans identified as high-quality.

- ***Oregon-*** The state is implementing a coordinated care model (CCM) that will leverage the state's purchasing power and ensure that quality, low-cost health insurance options are available and sustainable. The CCM will focus on realigning health care payments and incentives, focusing on quality over quantity and will integrate physical, behavioral and oral health.

- ***Washington-*** The state of Washington received a grant to continue designing their health care innovation plan. The state hopes to bring together a critical mass of payers and providers and agree upon transparent, evidence-based quality indicators. Additionally, the multi-payer system would have quality and payment standards for all payers.

New Mexico is not participating in this federal grant program as of the publishing of this report.

Recommendations

The Interagency Benefits Advisory Committee should:

- Actively participate in provider rate development by establishing acceptable rates for state-sponsored programs, allowing no rate changes without state approval, continuing active involvement in negotiations with high-cost providers, and developing contractual reporting mandates for insurance companies for more in-depth reporting on cost drivers including regional data;

- Negotiate with health plans to limit increases in adminstrative service fees;

- Perform an independent rate validation study to compare with other plans and other states;

- Consider incentives or disincentives to health plans relating to the increase or decrease of provider rates;

- Update health plan contracts to require health outcome peformance measures based on a uniform set of criteria such as HEDIS measures;

- Continue to evaluate and implement other cost saving strategies being used by other states, to include changes in the benefit design;

- Determine reporting requirements and mandate health plans to report in the same format, using the same definitions, on the same time schedules and use this data to provide increased oversight of program administration; and

- Impose a surcharge on employees with spousal coverage, where the spouse has a health benefit plan option with their employer.

PREVIOUS STUDIES AND LEGISLATION SOUGHT TO IMPROVE THE STATE'S HEALTH CARE PURCHASING POWER

Despite some progress, IBAC has not fulfilled its intent and continues to perpetuate duplicative and costly administrative functions. In its 16 year history, IBAC has not consolidated purchasing for medical services. IBAC entities continue to issue a common request for proposal but enter into separate contracts with the health plans. Furthermore, many standard contract provisions, such as for reporting, contain language allowing each individual IBAC agency to negotiate terms independently with the health plan. The only example of IBAC performing consolidated purchasing was for a pharmaceutical benefits manager (PBM). All four entities are contracted with the same PBM, Express Scripts. In consolidating purchasing in this way, the IBAC agencies took an important first step to leveraging its member volume to attain the best price for health care services. However, IBAC could do more to leverage consolidated purchasing, especially given the fact that all four IBAC agencies use a combination of the same four plan administrators.

In 2010, LFC staff recommended consolidating NMPSIA and RMD into a single healthcare finance authority, which did not include APS. This recommendation was not implemented. The recommendation merged the health benefits and other risk funds of NMPSIA and RMD in an attempt to eliminate redundant administrative features and to better negotiate with providers. At the time, APS was not part of the consolidation. This was largely due to cost. The previous report cited a study that analyzed the fiscal impact of consolidating APS and NMPSIA. The report found that consolidation would result in higher healthcare costs per employee per month for APS, and that maintaining separate plans would be more cost effective for APS and NMPSIA.

Consolidating NMPSIA and RMD into a single entity is still a relevant recommendation. Despite decreasing enrollment, IBAC and other public health benefit programs compose a large portion of the health insurance market in New Mexico. Combined, the IBAC pool of enrollees is over 150 thousand, with NMPSIA and RMD being the vast majority of that total. Funding redundant administrative functions across these two agencies reduces their ability to take advantage of opportunities to perform more beneficial functions like data analysis, quality improvements, and claims management. Combining these two agencies would also increase their pool, spreading risk more effectively, and allow them to better negotiate provider rates.

RMD and NMPSIA perform the same functions, which could be combined to lower administrative expenses and improve oversight of health care for public employees. Both administer self-funded plans covering health, life, disability, property, liability, and workers compensation on behalf of scores of governmental entities across New Mexico. Each agency provides duplicative functions related to administration, procurement, and customer service. For example, agencies separately contract for actuarial services; both have directors and deputy directors overseeing the same functions. In the 2010 LFC evaluation of RMD and NMPSIA, staff recommended the state of New Mexico consider the benefits of merging these two agencies into a single entity, while maintaining separate funds for each plan. Consolidating administration of risk programs currently at RMD, NMPSIA, and possibly APS would serve to provide a central authority to manage public liability, public property, workers compensation, unemployment compensation, and surety bond coverage for all public entities.

Further examination of health care costs and plans show APS is a viable candidate for consolidation with NMPSIA and RMD. Data analysis performed by LFC staff indicates health care costs are no longer significantly lower for APS than they are for other IBAC agencies. Increasing health care costs for APS indicate that their premium contributions to a consolidated agency would not subsidize higher costs for other employees around the state. Increasing costs coupled with a recent plan design change, outlined in **Appendix I**, make APS more similar to NMPSIA and creates a viable consolidation argument.

APS's health care costs are increasing and are now higher than costs across various regions of the state. The cost per claim for APS across all carriers was $275.85 for FY12. This total is only about $25 less than the FY12 cost per claim for NMPSIA, signaling that the two plans have similar, although not identical, costs. APS's cost per

claim was higher than the FY12 NMPSIA cost per claim for every region in the state except for the Southwest region. Furthermore, APS's cost per claim was higher than RMD's cost per claim in three of the rural regions across the state. This analysis indicates that APS would not be subsidizing rural health care costs across the state. Urban costs for NMPSIA and RMD were lower than the cost per claim for APS. For NMPSIA, the cost per claim for the Central Region of the State was $214 in FY12. This is significantly lower than the average cost for APS. RMD's cost was closer to APS's at $240 in FY12, but it is still lower than APS's cost.

Merging NMRHCA with the other IBAC agencies is unwarranted at this time, but consolidation of its pre-Medicare population could be a viable option in the future. Of all the IBAC agencies, the funding for NMRHCA is the most unique. Participating employers, current state employees, and retirees are responsible for the agency's funding, so NMRHCA's revenue streams do not match the other IBAC agencies. The agency becomes a secondary payer when individuals become eligible for Medicare, but their enrollee pool consists of both pre-Medicare and Medicare retirees. This segmentation in their population makes consolidation with other agencies difficult. NMRHCA actively uses data and claims analysis to better inform plan designs. These factors make the formal consolidation of NMRHCA with the other IBAC agencies unwarranted at this time. However, given the relationship between the other IBAC agencies and NMRHCA, joint purchasing agreements should be strengthened. The role of wellness programs and disease management in the other agencies has a direct impact on the health status of NMRHCA enrollees, so aligning these programs with NMRHCA's plan design can be valuable to the state.

Consolidating APS, NMPSIA, and RMD into a single entity could help contain costs and attract enrollment. Costs are continuing to increase for these three agencies despite decreased enrollment. As stated in the 2010 LFC report, consolidation could help reduce administrative costs, and put the consolidated entity in a better position to negotiate with plans and providers. Other states have seen cost savings as a result of consolidation. Consolidation of Michigan's public employee health plans had an estimated savings of $200 million. An evaluation of consolidated health plans in California found a cost savings of $40 million in premiums, and cited increased purchasing power as a benefit of the consolidation. From these examples, it is evident that effective consolidation would reduce costs and increase bargaining power with plans over provider rates.

As the enrollee pools continue to shrink, consolidation would put these entities in a better position to mitigate risk and absorb these losses. The City of Las Cruces has severed ties with RMD, and other local public bodies are also considering leaving the pool. This could shrink the size of RMD's enrollment pool to a size that more closely resembles NMPSIA's size. Effective consolidation of the suggested IBAC agencies could entice self-funded plans like the City of Albuquerque and the University of New Mexico to consider consolidating with IBAC if the entity is successful at mitigating growing health care costs. Adding these groups would strengthen the negotiating position between the state's consolidated entity and the plans.

Consolidation provides the opportunity to better leverage data through the creation of a statewide claims database. The 2010 LFC report recommended the creation of an all-payer claims database for the consolidated NMPSIA and RMD, and in 2013, legislation was proposed to create an "All-Payer Claims Database Task Force." A database would include claims data for APS, NMPSIA, and RMD. The creation of an all-claims database and the use of longitudinal analysis of public employee healthcare costs would allow for more targeted budgeting and plan design management for public employee health plans. As health care trends evolve over time, it is important to understand the trends as they occur. The creation of an all-claims database would allow the newly-formed consolidated entity to have a more global view of utilization, costs, and other trends.

Longitudinal analysis will allow IBAC to conduct different types of predictive modeling to determine who or what is driving overall costs. If an individual shows preliminary signs of a particular disease, longitudinal analysis and predictive modeling can catch this. Currently, the plans are the ones who are best equipped to analyze these types of trends, but that is only for a segment of each agency's population. Giving the agencies this tool will allow them to better leverage data and information in negotiating rates.

A New Mexico specific example of how predictive modeling and longitudinal analysis can be applied is evident in the section on diagnostic codes. The highest cost diagnosis in the state is end-stage kidney disease. One highly predictive factor associated with kidney disease is diabetes, which appeared in the LFC analysis of high frequency diagnoses. Not everyone with diabetes will suffer from kidney disease, but longitudinal analysis will give IBAC the ability to intervene with high-risk individuals before kidney disease is diagnosed. This sort of predictive modeling can be applied to other high-cost diseases where individuals with a series of factors making them high-risk for a certain outcome are identified. This will help the state cut costs by working with the individual to reduce their risk for a high-cost healthcare outcome.

Recommendations

The Legislature should:

- Create a consolidated health care finance entity to administer health benefits on behalf of governmental entities, including state and local governments, school districts, and institutions of higher education. Merge the employee health benefits function at APS into this entity as well. While risk funds managed by IBAC agencies were not reviewed in this evaluation, the Legislature should consider moving the management of risk funds into the newly established entity or consider other viable options for oversight of these funds;

- Model the consolidated entity on the flexibility granted to NMPSIA and the Public School Facility Authority for personnel matters. The new entity should be subject to the state Budget Act, Accountability Act, and Procurement Code. The Legislature should maintain its fiscal and operational oversight authority of these functions, which should be governed by a nine-member board, appointed by the Governor and confirmed by the Senate, with six members representing the public, one representing local government, one representing state government, and one representing an educational entity. The Legislature should consider authorizing other nonvoting ex-officio members;

- Require the New Mexico Retiree Health Care Authority participate in the joint purchase of health care and ancillary services with the consolidated health care finance entity; and

- Include responsibilities to coordinate and where appropriate, consolidate purchasing, quality improvement, and fraud and abuse surveillance activities with other state-funded health programs, including Medicaid. Direct the new authority to evaluate the feasibility of a data warehouse and claims processing function using the existing systems in Medicaid.

THE AFFORDABLE CARE ACT CONTINUES TO IMPACT PUBLIC EMPLOYEE HEALTH BENEFITS

Cost savings and new fees will occur through provisions of the federal Affordable Care Act (ACA). Cost savings would occur if employees seek coverage through other publicly-funded programs. However, IBAC agencies will be subject to new fees.

The Affordable Care Act includes a mandate on affordability and adequacy, creating maximums on employer and employee healthcare costs. To avoid federal monetary penalties, large employers must provide access to health coverage which is affordable and adequate. If the amount of premium paid by the employee for individual coverage does not exceed 9.5 percent of the household income, the plan is deemed affordable. Because it may be impossible for employers to determine household income, individual income can be the deciding factor. If the employer health plan pays for at least 60 percent, on average, of the total allowed cost for health benefits covered, the plan meets the adequacy requirement. IBAC agencies must remain aware of these requirements as they make plan changes related to premiums and out-of-pocket cost sharing such as deductibles, co-pays, and co-insurance.

Lower-wage state employees eligible to migrate to Medicaid under expansion in 2014 may reduce plan costs for IBAC agencies. Under the ACA, families meeting 138 percent of the federal poverty level can enroll for Medicaid, where the state will receive a 100 percent subsidy for these new enrollees through 2016. This would completely eliminate cost to employees and reduce costs to the state for these employees even after federal subsidies expire. However, it is difficult to predict the full impact to the state as an employer of Medicaid expansion. Studies conducted focus on private sector employers, where salary disparities with the public sector may exist. For example, NMPSIA's actuary conducted an analysis based on a model created by the Society of Actuaries. The model adjusted for employer size, but not salary ranges. NMPSIA's analysis estimated 1.8 percent of their pool, or 426 enrollees, would likely migrate to Medicaid, but based on average salaries of NMPSIA members, this estimate may be understated. It is also important to note the ACA prohibits inducing or incentivizing enrollment into Medicaid.

IBAC employees may be eligible for insurance coverage through other publicly-funded programs such as CHIP or the federal health insurance exchange. Children of lower wage employees could be eligible for coverage through the Children's Health Insurance Program (CHIP). Prior to 2010, children of state employees could not receive health insurance through CHIP. The ACA responded to state requests to allow access to health coverage through CHIP. If New Mexico chooses to provide this coverage option, a Medicaid state plan amendment will be needed.

Finally, employees could purchase insurance through the federal health exchange. The ACA requires the federal government and or states to create health insurance exchanges, marketplaces that will offer a choice of health plans. If employees of IBAC agencies found a lower cost health plan on the exchange, they could purchase insurance there. However, individuals would not be eligible for subsidies if IBAC plans maintain the affordability and access standards as required in the ACA.

The ACA will have budgetary impact for IBAC agencies through research and transitional reinsurance fees. The two fees within the ACA which impact IBAC agencies are membership driven. The ACA provides for the establishment of the Patient-Centered Research Institute, a non-profit, private corporation to be funded by fully- and self-funded health plans. Annual payments for policy years ending prior to October 1, 2013 are $1 multiplied by the average number of covered lives for that year. The fees increase to $2 from November 1, 2013 through October 2014. From 2014 until October 1, 2019, the fee will be increased each year based upon the projected per capita amount of national health expenditures. As of this evaluation date, the fee is slated to continue until October 1, 2019.

The ACA also imposes a transitional reinsurance fee of $63 per covered life for 2014. This fund is created to stabilize premiums for those individuals covered through health exchanges. The fee is scheduled to terminate after 2016, but fees for 2015 and 2016 cannot be established until the number of individuals or groups who will purchase insurance through the exchange are known.

Without contract revisions, contractors could be determined to be eligible for health benefits through the state under the ACA. Under the ACA, state contractors can be deemed as common law employees, making the state responsible for offering them health care. This is especially relevant in situations where contract employees are being used in the same capacity as public employees. As an example, with the difficulty associated with nurse recruitment, vacancies and changes in workload may require contracting for nursing services. To protect the state from liability, the Internal Revenue Service suggests that all agreements should include a clause in which the contractor agrees to maintain full compliance with the Affordable Care Act for the full term of the contract. This issue should be addressed by all state agencies using contractors to ensure the state is not forced to take on this additional liability.

Recommendations

The Interagency Benefits Advisory Committee should:

- Partner with the Human Services Department to inform state employees of Medicaid coverage expansion available beginning in January 2014.

All state agencies should:

- Partner with the Department of Finance and Administration to ensure the standard contract template contains language to protect the state from having to offer health insurance to contractors under the common law employee provision of the ACA.

New Mexico Public Schools Insurance Authority
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FAX No.: 505 983-8670

November 19, 2013

The Honorable Lucky Varela, Chairman
Legislative Finance Committee
325 Don Gaspar, Suite 200
Santa Fe, NM 87501

Dear Chairman Varela:

On behalf of the Public School Insurance Authority, we would like to thank you for the opportunity to respond to the LFC Program Evaluation Report.

While the PSIA Board has come to some of the same conclusions contained in the report, there are four areas we would like to focus on in our response to the Committee. These four topics represent the main issues for your consideration in future legislative initiatives.

1. The primary driver in recommending consolidation under a "super-agency" is the reduction in administrative costs. It should be clarified that there will be no co-mingling of each agency's fund balances which were built by employer and employee contributions. During the exit interview, it was acknowledged that separate divisions would need to be established due to different constituencies served and different payroll systems and eligibility rules. This is not dissimilar to the current separate agency approach and we believe the savings which will materialize will be lower than anticipated once the super-agency is completely implemented.

2. There is a recommendation to eliminate duplicative Executive Director's and Deputy Director's positions on the basis that they perform the same job functions. This is not true for PSIA, as the Executive Director oversees the Risk program and the Deputy Director oversees the Benefits. Further, the report concludes that all state risk programs be consolidated, despite extreme differences in risk exposures between RMD and PSIA, and recommends this without the benefit of any analysis in this area.

3. The report concludes that the IBAC does not positively impact provider reimbursement levels. We point out IBAC's direct involvement over the years with negotiating fees with the San Juan IPA, St. Vincent's, UNMH, Covenant Health Systems, and many years ago, the now defunct Carlsbad IPA. The IBAC takes a strong stand against the pushback on fees charged to the IBAC plans when providers are seeking to replace revenue due to cuts in their fees from Medicaid and Medicare. We try to balance access versus cost while successfully keeping our increases below national trend. Providers in this post-ACA environment are hesitant to provide reduced fees as they are uncertain on the impact of the ACA. In addition, we also negotiated significantly reduced pharmacy network fees during the last joint purchase of PBM services by the IBAC.

4. Costs continue to increase at an unsustainable rate. Unfortunately, this is true in New Mexico as well as across the country. We trust the Committee will factor in the cost of the Affordable Care Act. For PSIA alone, we will spend $2 to $3 million more in claims due to the elimination of the pre-existing conditions clause and other coverage mandates. As the Exchanges begin to report their loss ratios, the tax we will pay to subsidize the Exchanges will likely increase (this year our cost is $3.6 million).

The recommendation to the legislature concerning the creation of a Health Care Financing Authority and merging the benefits program and risk program of NMPSIA and RMD into the Authority is not supported by the NMPSIA Board. In 2002, the Board adopted a policy statement regarding consolidation which in summary states that too much would be sacrificed in terms of the ability of schools and employees to control their benefits and insurance risk management programs. This position remains unchanged today, but if consolidation takes place, it makes good sense to use contractors who are experts in the necessary fields.

We specifically want to thank Maria Griego, Pamela Galbraith, and Andrew Rauch for their professionalism in the evaluation process.

Sincerely,

Christy Edwards
Deputy Director

Copy: NMPSIA Board of Directors
Charles Sallee, Deputy Director for Program Evaluation
Maria Griego, LFC
Andrew Rauch, LFC

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November 19, 2013

The Honorable Lucky Varela, Chairman
Legislative Finance Committee
325 Don Gaspar, Suite 200
Santa Fe, NM 87501

Chairman Varela,

The New Mexico Retiree Health Care Authority (RHCA) has reviewed the Legislative Finance Committee's (LFC) Program Evaluation Team assessment of the Interagency Benefits Advisory Committee (IBAC) to be presented on November 22, 2013 and provides the following response.

Evaluation Process

NMRHCA would like to thank your entire team for their professional and collaborative adjudication of this evaluation. We would like to especially note our positive interactions and impressions of Maria Griego, Andrew Rauch and Pamela Galbraith. The team as a whole demonstrated a solid understanding of health care financing, a clear goal of providing data-driven analysis and the willingness to spend time with NMRHCA in order to understand our unique challenges and discuss our strategies moving forward.

Key Findings

NMRHCA accepts the findings of the evaluation with the following comments.

"Lack of effective oversight of provider rates and quality improvement has made employee health care less affordable."

NMRHCA absolutely agrees that the industry as a whole needs to evolve beyond the traditional fee-for-service reimbursement methodology to medical providers. This system does not adequately take into consideration either quality of service or clinical outcomes and, therefore, would not seem to offer providers the proper incentives to provide high quality, cost-effective care. In acknowledgement of this method's limitations, the IBAC included "value-based reimbursement" as a separately scored category during its last procurement cycle. Further, we have met separately with the largest health care delivery systems in New Mexico to discuss the furtherance of their "coordinated care" models. We will continue to emphasize the need to make progress in this crucial area.

"Health care spending for IBAC agencies has continued to rise at unsustainable levels."

NMRHCA would like to note that its spending on a per member basis in FY2009 was approximately $417 per month. In FY2014, it is projected to be $418 per month. Over the past five years, NMRHCA spending per member has remained relatively flat. While we acknowledge that one of the major factors in keeping costs flat can be attributable to retirees choosing higher deductible plans (and, therefore,

incurring larger out-of-pocket expenses), an improved contract for prescription drugs, an increase in the use of generics and a decrease in emergency room utilization also play a major role.

Key Recommendations

NMRHCA accepts the recommendations of the evaluation with the following comments.

"***Require the New Mexico Retiree Health Care Authority participate in the joint purchase of health care and ancillary services with the consolidated health care finance entity;"***

NMRHCA is an active and committed participant in the IBAC as a purchasing collaborative. The IBAC as a whole saved over $50 million during its last joint procurement of pharmaceutical benefits services and continues to pay less in administrative fees as a combined group then it would as individual purchasers. NMRHCA will continue to work with the IBAC to maximize its purchasing power as a group and is supportive of strengthening purchasing activities wherever possible.

"Actively participate in provider rate development by establishing acceptable rates for state-sponsored programs, allowing no rate changes without state approval…."

NMRHCA agrees with the premise of ensuring that acceptable rates be paid to health care providers and will continue to work through our health plan partners as well as directly with health care delivery systems to improve efficiencies in this area. NMRHCA would also like to stay aware of its role as a responsible community purchaser. Provider reimbursements are being pressured by all major sources. As Medicaid, Medicare and commercial payers all look to limit or reduce their reimbursements, it is important that the combination be managed in a manner that does not exacerbate an already existing provider shortage in New Mexico.

Conclusion

NMRHCA commends the LFC's Program Evaluation Team and is in general acceptance of its key findings and recommendations.

We look forward to discussing the evaluation at the November 22, 2013 meeting.

Sincerely,

Mark Tyndall

Executive Director
NM Retiree Health Care Authority

Cc: NMRHCA Board of Directors
Charles Sallee, Deputy Director for Program Evaluation
Maria Griego, LFC
Andrew Rauch, LFC

ALBUQUERQUE PUBLIC SCHOOLS
Accelerate Progress for Students

Winston Brooks
Superintendent

November 19, 2013

The Honorable Luciano Varela
1709 Callegjon Zenaida
Santa Fe, NM 187501

Dear Chairman Varela:

This letter is Albuquerque Public Schools (APS) official agency response to the program evaluation completed by the Legislative Finance Committee staff regarding the Interagency Benefits Advisory Committee (IBAC) Oversight of Public Employee Health Benefit Plans. On behalf of APS, I would like to thank the professionalism the Legislative Finance Committee program evaluators practiced as they completed this review of the IBAC. Specifically, we would like to thank Maria Griego and Pam Galbraith who were our main contacts during the evaluation process.

APS is one agency in the IBAC which has autonomous authority over its health benefits and risk plan to establish our own health care plans, premium rate schedule and enrollment policies. APS has long appreciated the ability to establish its own plan for many reasons. We would disagree with the program evaluation results that conclude that it would be a plausible benefit to the state to consolidate APS, the New Mexico Public School Insurance Authority (NMPSIA) and the Risk Management Division (RMD). Our reasons are listed throughout this letter but we appreciate the opportunity to communicate directly with the Legislative Finance Committee (LFC) about our employee benefits and risk program. As the report focused primarily on employee benefits, so does this agency response.

APS believes it is unique in terms of the rich benefits we offer our employees and the wellness program we require employees to participate in to decrease the rising cost of health care. It is true that APS has increased premiums and made plan design changes over the last four fiscal years to combat decreasing financial support from the general fund and increasing costs of health care. However, even considering these changes to health benefits, APS still offers a richer benefit plan than our colleagues in NMPSIA and RMD. When looking at a direct comparison of benefits to employees, the APS preventative care is free for members so we can catch health problems early and treat illness before it is a high cost problem. APS chose to do this even before it was required to by the Affordable Care Act. APS deductibles, which will be implemented for the first time in January 2014, are less than those in NMPSIA. APS is able to do this because medical service provider discounts within the Albuquerque metropolitan area are better than in the rest of the state.

Due to our autonomy, APS is able to create a wellness plan which provides incentive to employees through discounts in their monthly premiums to exercise healthy life practices. The wellness plan also assists employees in identifying personal information that educates them about their own health and the risks they may face. APS shared with the LFC the information regarding the wellness program. Though APS now identifies more medical conditions, APS actually spends less on these medical conditions than it did before the wellness program was created.

APS appreciates its independence from other state entities in developing its health plan because our employees view their benefits package as a top priority. We are able to negotiate with each of our six collective bargaining units so we guarantee that the needs of our employees are met.

APS agrees that regardless of the facts above, something must be done regarding the cost of health care plans for public employees. We question, however, the timing of the recommendation of consolidation and challenge the presumption that now would be the best time to consolidate. APS believes that due to the Affordable Care Act (ACA), now is not the time for consolidation. There are too many unknowns and potential opportunities that may play into APS's total rewards strategy. For example:

- For the first time, spouses of APS members, and other public employer members, have a guaranteed alternative for health care in the New Mexico Health Insurance Exchange. The impact of that guarantee must be examined by each of the entities examined in the LFC program evaluation so we may fully understand the importance, or non-importance, of continuing to offer coverage to spouses.
- APS also recognizes that for some members, the "marketplace" created by the health insurance exchange may be a more attractive option than the APS health benefits package, thereby potentially benefitting both the member and APS. APS is exploring how our health plan may make it easier for those members to take advantage of the marketplace for coverage in 2015.
- Recent changes in wellness rules, tied to the ACA, allow health plans to differentiate rewards for meeting certain health outcomes up to 50% of the gross premium rate. APS is exploring the use of outcomes based or "health contingent" rewards for our wellness program in 2015.
- APS is exploring the implementation of district wellness clinic(s). Initially, we believe we can achieve a better quality of care for our employees at a cheaper cost for the employee. This would also help us meet requirements under the ACA.

In addition to the information above, APS believes there is no comprehensive consolidation plan provided in the evaluation. For example, there is no clear strategy on how to deal with different payroll systems from RMD, NMPSIA and APS. There is no clear understanding or plan on how to deal with insurance fund balances that cannot be consolidated since they belong to the individual agency's employees. Without a clearer understanding on the specifics of how consolidation would work on the ground, APS is apprehensive about supporting a move in that direction in our state.

The LFC program evaluation does show areas that we agree are in need of improvement. We embrace some of the recommendations of the report and make a commitment to pursue better solutions to those areas of weakness.

Primarily, APS agrees that we have not done enough to leverage our purchasing power to negotiate better discounts and fees for service. We agree that fee for service reimbursement models reward providers for volume not value. The ACA has added momentum to alternative payment models and the need to create Accountable Care Organizations. APS is and will be evaluating alternative payment models for the 2015 plan year so we can reward value, not volume. APS is also fighting for more transparency in provider rates and participates in a quality health care task force to expose the best priced provider in Albuquerque so we may be good stewards of tax pater dollars.

APS also agrees that more must be done to control the demand for health care. APS commits to expand its wellness program to control increasing costs from a utilization of our health care plan.

APS believes that consolidation of the IBAC will continue to be an idea that is explored by our state legislature. APS also believes that we cannot conclusively and honestly say that consolidation either is or is not in the best interest of all members of the IBAC based on the results of this evaluation. APS does support an independent actuarial study being conducted to answer definitely if consolidation of NMPSIA, APS and RMD would be a benefit to the state. In 2006-2007 APS and NMPSIA retained the services of an independent actuarial and consulting firm to determine the financial feasibility of consolidating specified APS benefit programs for active employees with the corresponding NMPSIA benefit program. The results of the analysis demonstrated an increase cost to APS enrolled employees. The analysis also demonstrated an increased cost for the taxpayers in the State of New Mexico and no substantial cost

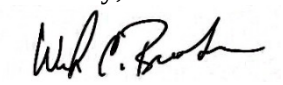
savings for the state. Based on these findings in 2006-2007, APS recommends the LFC support legislation to fund an independent actuarial study of the costs of consolidation and the feasibility for consolidation of administrative services for administering the employee benefit programs for employees of APS, RMD and NMPSIA. APS recommends the scope of services include:

- Provide a study and report on the relative benefits to employees and taxpayers of consolidating APS, RMD and NMPSIA and report the effects of such with respect to the costs and efficiency of service.
- Create a three-year cost projection for the consolidated groups assuming a status quo scenario. The study should exam the value of the current APS, RMD and NMPSIA medical, prescription drug and dental plan designs and determine the difference in plan design value between the programs.
- Review and compare the demographic risk factors for the consolidated and non-consolidated benefits-eligible populations.
- Review Administrative Services Only (ASO) fees and insured plan rates.
- Evaluate the discounts available through the current plan providers for APS, RMD and NMPSIA to determine which are most beneficial to the covered employees.
- Develop an incurred but not reported (IBNR) claims projection for the APS, RMD and NMPSIA medical, prescription drug and dental programs.

Again, APS commends the Legislative Finance Committee program evaluation team. Though we disagree with portions of the program evaluation results, we do believe that all agencies of the IBAC can improve performance in several areas as demonstrated by the evaluation recommendations.

APS staff will be present on November 22, 2013 to answer your questions. Should you need any additional information, please do not hesitate to contact Carrie Robin Menapace at carrie.menapace@aps.edu or (505) 238-3153.

Sincerely,



Winston Brooks

cc: Frances Maestas, Director of the Legislative Education Study Committee
APS Board of Education
APS Leadership Team
Vera Dallas, APS Director of Employee Benefits
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November 19, 2013

The Honorable Lucky Varela, Chairman
Legislative Finance Committee
325 Don Gaspar, Suite 200
Santa Fe, NM 87501

Dear Chairman Varela:

The State of New Mexico's Risk Management Division, Employee Benefits Bureau, thanks you for the opportunity to respond to the LFC Evaluation on the Interagency Benefits Advisory Committee (IBAC) and the Oversight of Public Employee Health Benefit Plans. We thank the LFC Committee for conducting this evaluation.

While we appreciate the underlying cost saving purpose of the LFC evaluation, the Executive has not made a decision at this time whether to support the creation of a Health Care Financing Authority and merging three of the four IBAC entities.

If the proposals do indeed reduce costs to the State and its members, we are more than happy to work with the LFC and their membership if they choose to pursue legislation.

Thank you,

AJ Forte
Director, Risk Management Division

APPENDIX A: EVALUATION OBJECTIVES, SCOPE, AND METHODOLOGY

Evaluation Objectives.

- Assess healthcare cost drivers by reviewing service utilization and analyze how provider rates have affected costs overall, by service type, and by region.
- Identify effects of the Affordable Care Act on IBAC health benefit plans.
- Review how benefit costs impact total employee compensation compared to other public plans and analyze proportions of employee premiums compared to salary.
- Evaluate potential impact of Medicaid expansion and availability of a healthcare exchange to IBAC plans.
- Identify the benefits and barriers to consolidation of IBAC agencies and/or joint rate negotiation.

Scope and Methodology.

- Reviewed state statutes, departmental and division policies, procedures, and internal management documents.
- Analyzed claims data provided by health plans.
- Conducted structured interviews with each IBAC agency's staff, contracted health benefit consultants, health plan staff, third party administrator staff, and the Internal Revenue Service and U.S. Department of Health and Human Services.
- Reviewed contract, financial, performance, and quality data from the agencies.
- Reviewed published literature on other state practices, press releases, and media reports relevant to the evaluation.

Evaluation Team.

Maria D. Griego, Lead Program Evaluator
Pam Galbraith, Program Evaluator
Andrew Rauch, Program Evaluator

Authority for Evaluation. The LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. The LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, the LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conference. The contents of this report were discussed with the General Services Department, the New Mexico Public School Insurance Authority, the New Mexico Retiree Health Care Authority, and Albuquerque Public Schools during the exit conference on November 12, 2013. A report draft was provided to all four agencies for formal written response at that time.

Report Distribution. This report is intended for the information of the Office of the Governor, the General Services Department, the New Mexico Public School Insurance Authority, the New Mexico Retiree Health Care Authority, Albuquerque Public Schools, the Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

Charles Sallee
Deputy Director for Program Evaluation

APPENDIX B: DEFINITIONS

RELEVANT HEALTH CARE TERMS

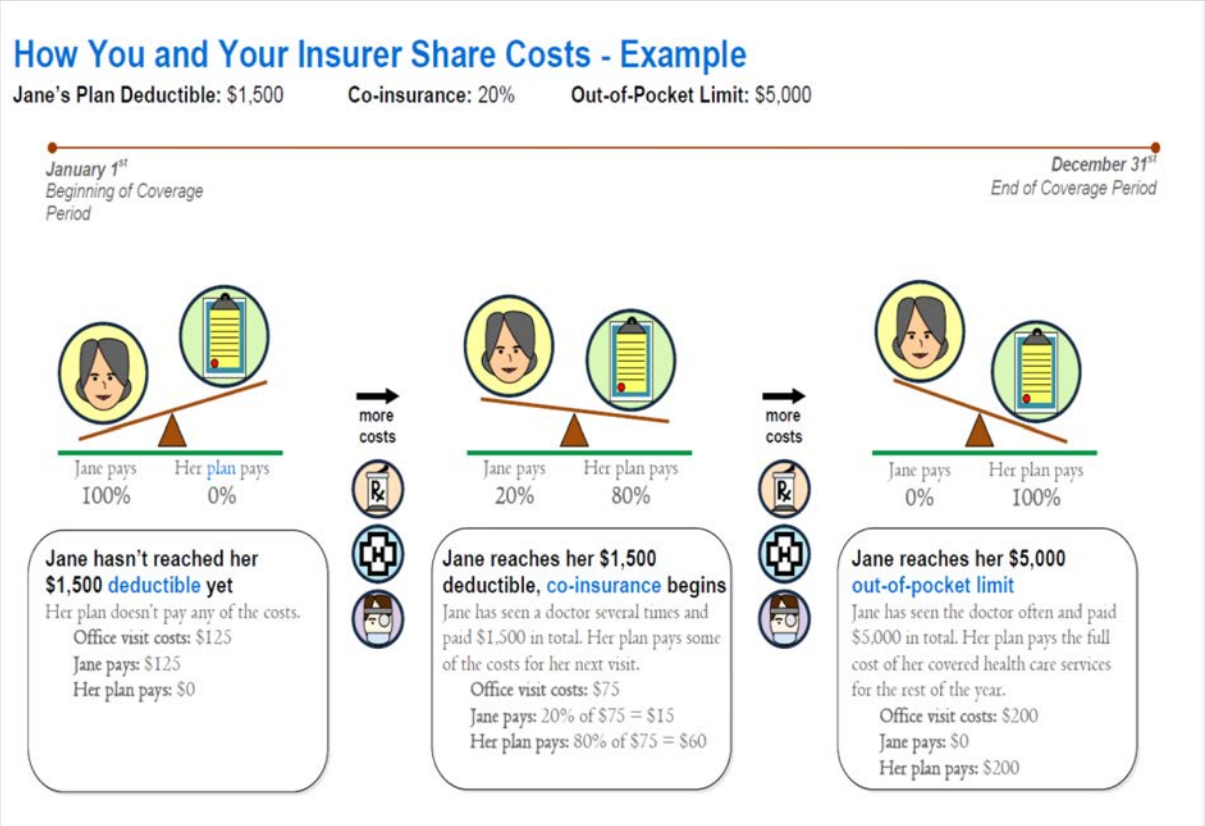
Co-insurance- The insured's share of costs of a covered health care service of the allowed amount for that service

Co-payment (co-pay)- A fixed amount the insured pays for a covered health care service, usually when the insured receives the service. The amount can vary by the type of covered health care service. Example: $20 co-pay for a physician office visit.

Deductible- The amount the insured owes for health care services the health plan covers before the plan begins to pay. For example, if the deducible is $1,000, the insured's plan will not pay anything until the insured has paid $1,000 for covered health care services that are subject to this deductible. The deductible may not apply to all services.

Out-of-Pocket Limit (Maximum)- The most the insured will pay during a plan period (usually a year) before the health plan begins to pay 100 percent of the allowed amount. This limit never includes premiums or health care not covered by the plan. Some health plans do not include all co-pays, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Premium- The amount that must be paid for the health plan coverage. The employer and the plan enrollee contribute to premiums which can be paid monthly, quarterly, annually, etc.



Source: U.S. Department of Labor

APPENDIX C: IMPACT OF RMD PREMIUM INCREASES ON EMPLOYEE SALARIES

	FY14		FY15	
Scenario: Pay Increase from Premium Low Range to Mid Salary Range	**Employee Only**	**Family**	**Employee Only**	**Family**
Salary:	$49,525	$49,525	$50,020	$50,020
Add 1% Pay Increase:	$495	$495	$0	$0
New Salary:	$50,020	$50,020	$50,020	$50,020
FY13 Average Annual Employee-Contributed Premium	$1,012	$2,986	$1,518	$4,479
FY14 Average Annual Employee-Contributed Premium (>$50 Thousand Annual Salary)	$1,518	$4,479	$1,670	$4,927
Deduct Premium Increase from Salary Increase:	($11)	($998)	($152)	($448)
Effective Salary Increase Rate after Premiums:	-0.02%	-2.02%	-0.30%	-0.90%
	FY14		**FY15**	
Scenario: Pay Increase from Premium Midrange to High Salary Range	**Employee Only**	**Family**	**Employee Only**	**Family**
Salary:	$59,410	$59,410	$60,004	$60,004
Add 1% Pay Increase:	$594	$594	$0	$0
New Salary:	$60,004	$60,004	$60,004	$60,004
FY13 Average Annual Employee-Contributed Premium	$1,518	$4,479	$2,024	$5,972
FY14 Average Annual Employee-Contributed Premium (>$60 Thousand Annual Salary)	$2,024	$5,972	$2,227	$6,570
Deduct Premium Increase from Salary Increase:	$88	($899)	($202)	($597)
Effective Salary Increase Rate after Premiums:	0.15%	-1.51%	-0.34%	-1.00%

Source: LFC Analysis of RMD rates and 2013 GAA

APPENDIX D: RISK MANAGEMENT PLAN DESIGN CHANGES FROM FY13 TO FY14

		FY13	FY14
BCBS	Calendar Year Deductible	Individual: $400 2-Person: $800 Family: $1,200	Individual: $700 2-Person: $1,400 Family: $2,100
	Calendar Out-of-Pocket Limit	Individual: $3,000 2-Person: $6,000 Family: $9,000	Individual: $3,500 2-Person: $7,000 Family: $10,500
Presbyterian HDHP	Calendar Year Deductible	Individual: $1,200 Family: $2,400	Individual: $1,250 Family: $2,500
	Calendar Out-of-Pocket Limit	Individual: $3,000 Family: $9,000	Individual: $3,500 2-Person: $7,000 Family: $10,500
Presbyterian HMO	Calendar Year Deductible	Individual: $150 2-Person: $300 Family: $450	Individual: $350 2-Party: $700 Family: $1,050
	Calendar Out-of-Pocket Limit	Individual: $3,000 2-Person: $6,000 Family: $9,000	Individual: $3,500 2-Party: $7,000 Family: $10,500
Lovelace	Calendar Year Deductible	Individual: $150 2-Party: $300 Family: $450	Individual: $350 2-Party: $700 Family: $1,050
	Calendar Out-of-Pocket Limit	Individual: $3,000 2-Person: $6,000 Family: $9,000	Individual: $3,500 2-Party: $7,000 Family: $10,500

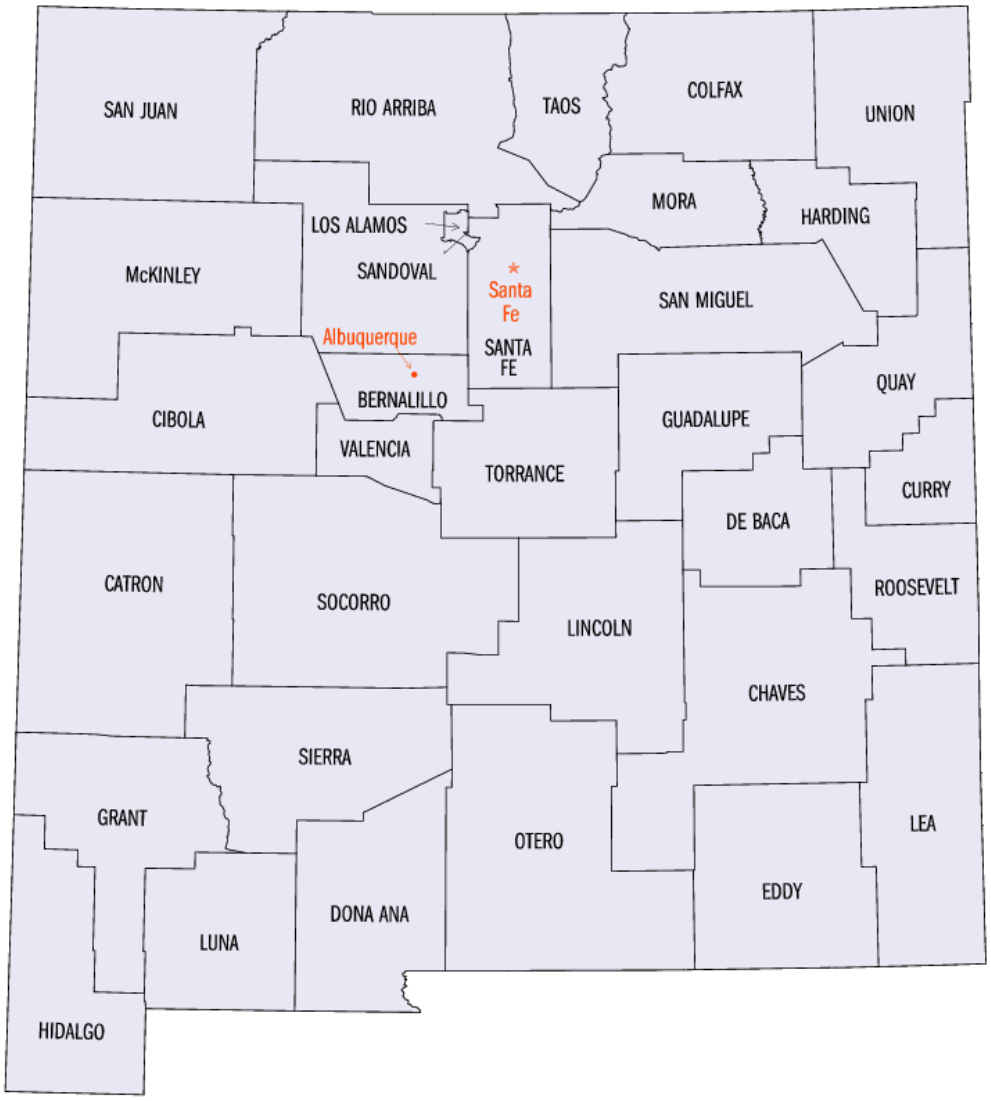
Source: RMD

APPENDIX E: INSTITUTE OF MEDICINE DESIRED HEALTH OUTCOMES

Key Component	Definition
Safety	Protecting patients from injuries and harm from the care intended to help them.
Effectiveness	Using the latest scientific data to provide all those who could benefit from treatment with the correct care, and keeping those who will not benefit from treatment from receiving it.
Patient Centeredness	Giving care based on a patient's values, needs, and preferences, and letting patient values guide medical decisions.
Timeliness	Reducing potentially harmful waits and delays for those who wait and those who administer care.
Equity	Providing care irrespective of gender, ethnicity, geographic location, socioeconomic status, etc., unless it is medically necessary to differentiate.
Efficiency	Avoiding waste. This includes equipment, supplies, ideas, and energy.

Source: Institute of Medicine

APPENDIX F: REGIONAL DEFINITIONS



Central Region: Bernalillo, Doña Ana, Sandoval, Santa Fe, Torrance, and Valencia Counties.
North Central Region: Los Alamos, Rio Arriba, and Taos Counties
Northwest Region: Cibola, McKinley, and San Juan Counties
Northeast Region: Colfax, Guadalupe, Harding, Mora, Quay, San Miguel, and Union Counties
Southwest Region: Catron, Grant, Hidalgo, Luna, Sierra, and Socorro Counties
Southeast Region: Chaves, Curry, De Baca, eddy, Lea, Lincoln, Otero, Roosevelt.

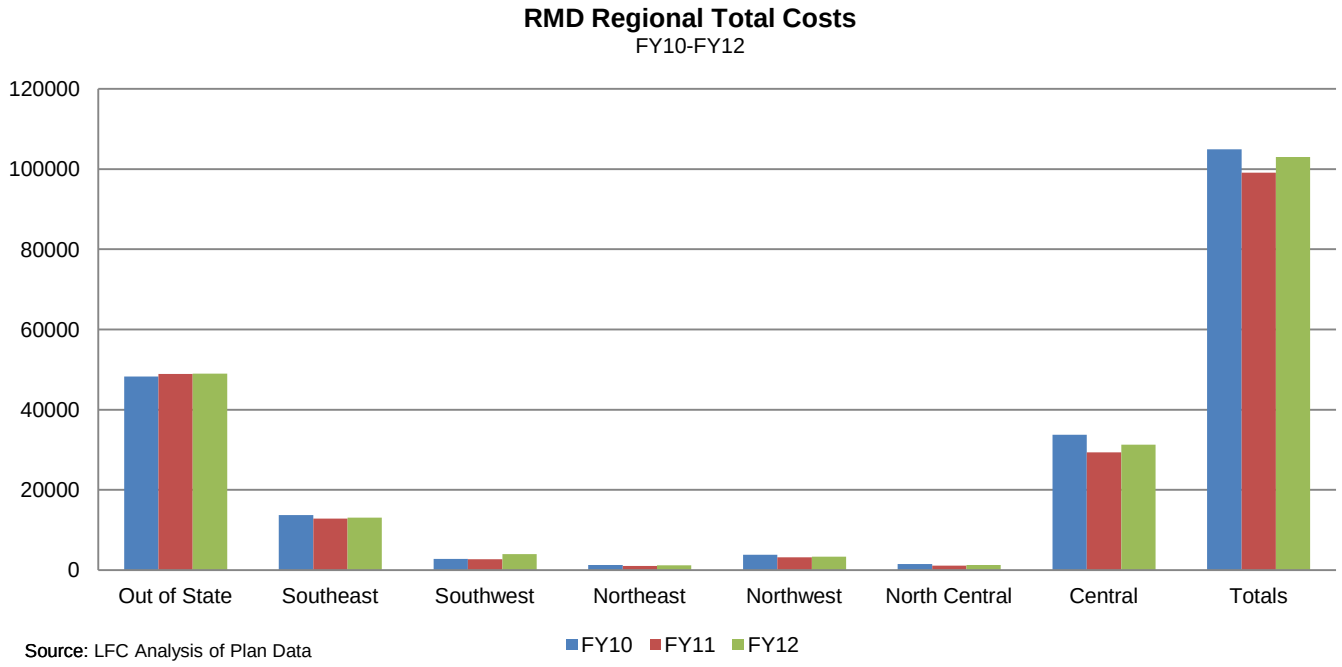
APPENDIX G: REGIONAL HOSPITAL ANALYSIS

FY12 Regional Analysis of Hospital Costs and Claims

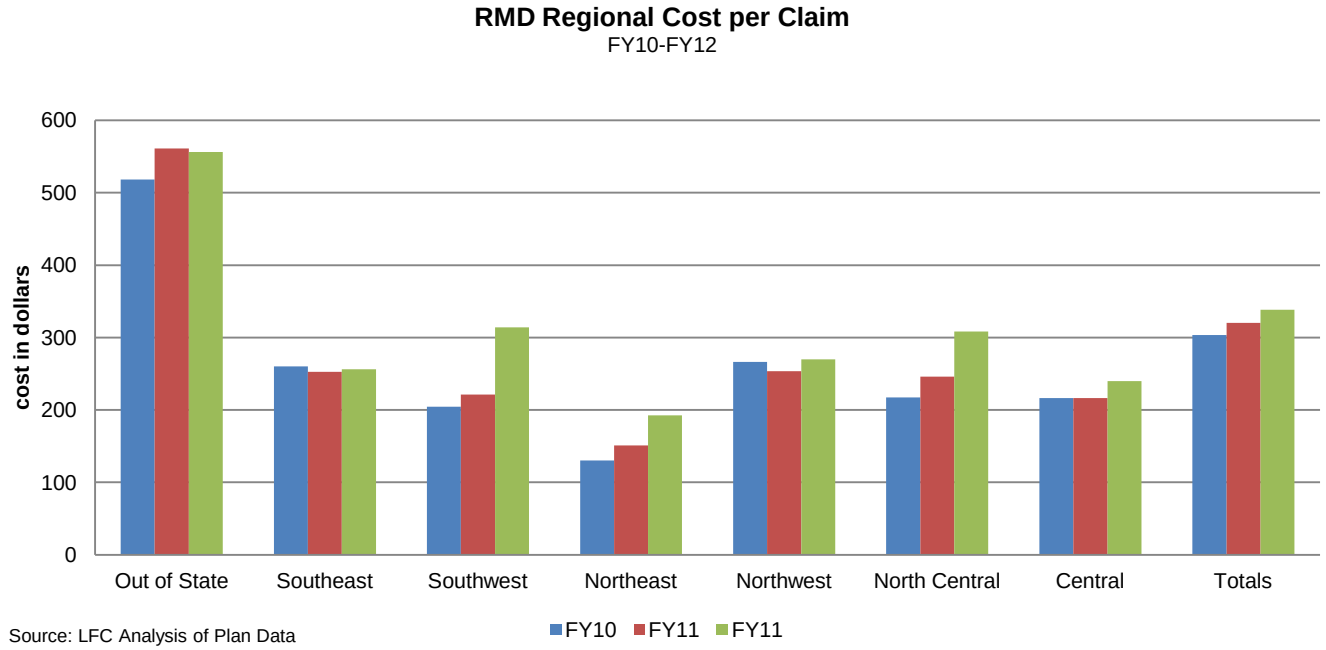
Central Region	Total Amount Paid (in thousands)	Claims	Cost per Claim
St Vincent's	$29,000	20,920	$1,386
Memorial	$23,505	9,825	$2,392
Mountain View	$11,037	6,076	$1,816
UNM	$18,756	15,011	$1,250
Lovelace	$14,438	3,536	$4,083
Presbyterian	$41,418	18,910	$2,190
North Central Region	**Total Amount Paid**	**Claims**	**Cost per Claim**
Presbyterian Espanola	$4,031	3,960	$1,018
Holy Cross	$3,561	5,068	$703
Northwest Region	**Total Amount Paid**	**Claims**	**Cost per Claim**
San Juan Regional	$8,706	9,856	$883
Rehoboth McKinley	$2,937	3,485	$843
Cibola General	$1,517	2,009	$755
Northeast Region	**Total Amount Paid**	**Claims**	**Cost per Claim**
Alta Vista	$8,952	4,587	$1,952
Guadalupe	$192	699	$274
Southeast Region	**Total Amount Paid**	**Claims**	**Cost per Claim**
Gila Regional	$7,446	5,514	$1,350
Mimbres	$3,088	1,616	$1,911
Southwest Region	**Total Amount Paid**	**Claims**	**Cost per Claim**
Eastern New Mexico	$9,747	4,836	$2,016
Gerald Champion	$5,219	5,229	$998
Lea Regional	$4,498	2,894	$1,554

Source: LFC Analysis of Provider Data

APPENDIX H:RMD REGIONAL TOTAL AND AVERAGE HEALTH CARE COSTS



Source: LFC Analysis of Plan Data



Source: LFC Analysis of Plan Data

This analysis was done with Blue Cross Blue Shield and Lovelace data for RMD. It excludes Presbyterian, which is RMD's largest enrollee group.

APPENDIX I: APS PROPOSED PLAN DESIGN CHANGES

Benefit	In Network	
	Current	Assumes 5% rate increase
Deductible (3 x family)	None	$250
Coinsurance (3 x family)	None	20%
Coinsurance Maximum	$2,000	$2,000
Out of Pocket Maximum (ded & coins)	$2,000	$2,250
PCP and Primary Care Copays	$25	$25
Specialist Copays	$40	$40
IP Hospital Admission,	$750 copay	Ded /Coins
OP Surgery	$250 copay	Ded /Coins
Advanced Radiology	$100 copay	$100 copay, then Ded/Coins
Emergency Room	$150 copay	$150 copay, then Ded/Coins
Urgent Care Copay	$50	$50
Radiation, Dialysis, Chemotherapy	Paid at 100%	Ded/Coins

Source: Willis on behalf of APS

APPENDIX J: 2013 NEW MEXICO RETIREE HEALTH CARE AUTHORITY PREMIUMS

NMRHCA Medical Plan Monthly Premium Contributions for January 1, 2013 - December 31, 2013 *(applicable if retirement date is after June 30, 2001)*

Years of Service	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
NON-MEDICARE MEDICAL																
Premier Plus (BCBS or Presbyterian)																
Retiree Rate	$690.41	$661.18	$631.94	$602.71	$573.47	$544.24	$515.00	$485.77	$456.53	$427.29	$398.06	$368.82	$339.59	$310.35	$281.12	$251.88
Spouse Rate	$633.68	$617.43	$601.19	$584.94	$568.69	$552.44	$536.19	$519.95	$503.70	$487.45	$471.20	$454.95	$438.70	$422.46	$406.21	$389.96
Child Rate*	$246.94	$246.94	$246.94	$246.94	$246.94	$246.94	$246.94	$246.94	$246.94	$246.94	$246.94	$246.94	$246.94	$246.94	$246.94	$246.94
Premier (BCBS or Presbyterian)																
Retiree Rate	$369.43	$353.78	$338.14	$322.50	$306.85	$291.21	$275.56	$259.92	$244.28	$228.63	$212.99	$197.35	$181.70	$166.06	$150.41	$134.77
Spouse Rate	$406.63	$396.21	$385.78	$375.36	$364.93	$354.50	$344.08	$333.65	$323.22	$312.80	$302.37	$291.95	$281.52	$271.09	$260.67	$250.24
Child Rate*	$134.32	$134.32	$134.32	$134.32	$134.32	$134.32	$134.32	$134.32	$134.32	$134.32	$134.32	$134.32	$134.32	$134.32	$134.32	$134.32
MEDICARE MEDICAL																
BCBS Medicare Supplemental Plan																
Retiree Rate	$292.25	$282.83	$273.40	$263.97	$254.54	$245.12	$235.69	$226.26	$216.83	$207.41	$197.98	$188.55	$179.12	$169.70	$160.27	$150.84
Spouse Rate	$296.97	$292.25	$287.54	$282.83	$278.11	$273.40	$268.68	$263.97	$259.26	$254.54	$249.83	$245.12	$240.40	$235.69	$230.97	$226.26
Child Rate*	$301.68	$301.68	$301.68	$301.68	$301.68	$301.68	$301.68	$301.68	$301.68	$301.68	$301.68	$301.68	$301.68	$301.68	$301.68	$301.68
Lovelace Medicare Advantage Plan I																
Retiree Rate	$60.64	$58.69	$56.73	$54.78	$52.82	$50.86	$48.91	$46.95	$44.99	$43.04	$41.08	$39.13	$37.17	$35.21	$33.26	$31.30
Spouse Rate	$61.62	$60.64	$59.67	$58.69	$57.71	$56.73	$55.75	$54.78	$53.80	$52.82	$51.84	$50.86	$49.88	$48.91	$47.93	$46.95
Child Rate*	$62.60	$62.60	$62.60	$62.60	$62.60	$62.60	$62.60	$62.60	$62.60	$62.60	$62.60	$62.60	$62.60	$62.60	$62.60	$62.60
Lovelace Medicare Advantage Plan II																
Retiree Rate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Spouse Rate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Child Rate*	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Presbyterian Senior Plan I																
Retiree Rate	$94.94	$91.88	$88.81	$85.75	$82.69	$79.63	$76.56	$73.50	$70.44	$67.38	$64.31	$61.25	$58.19	$55.13	$52.06	$49.00
Spouse Rate	$96.47	$94.94	$93.41	$91.88	$90.34	$88.81	$87.28	$85.75	$84.22	$82.69	$81.16	$79.63	$78.09	$76.56	$75.03	$73.50
Child Rate*	$98.00	$98.00	$98.00	$98.00	$98.00	$98.00	$98.00	$98.00	$98.00	$98.00	$98.00	$98.00	$98.00	$98.00	$98.00	$98.00
Presbyterian Senior Plan II																
Retiree Rate	$75.56	$73.13	$70.69	$68.25	$65.81	$63.38	$60.94	$58.50	$56.06	$53.63	$51.19	$48.75	$46.31	$43.88	$41.44	$39.00
Spouse Rate	$76.78	$75.56	$74.34	$73.13	$71.91	$70.69	$69.47	$68.25	$67.03	$65.81	$64.59	$63.38	$62.16	$60.94	$59.72	$58.50
Child Rate*	$78.00	$78.00	$78.00	$78.00	$78.00	$78.00	$78.00	$78.00	$78.00	$78.00	$78.00	$78.00	$78.00	$78.00	$78.00	$78.00

*Multiple Child Subsidy may apply.