New Mexico Human Services Department
Pamela S. Hyde, JD, Cabinet Secretary

Report to the Legislative Health and Human Services Committee

Senate Joint Memorial 1,
"Health Care Services Common Interests"

November 1, 2009

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Sincerely,

Pamela S. Hyde, JD
Cabinet Secretary
New Mexico Human Services Department

INTRODUCTION

Senate Joint Memorial 1 (SJM1) passed during the 2009 Regular Legislative Session (http://legis.state.nm.us/Sessions/09%20Regular/final/SJM001.pdf), requests that a meeting be convened of public and quasi-public health coverage entities engaged in the administration, delivery and payment of health care services in New Mexico to elicit their cooperation in identifying areas of common interest and opportunities for consolidation. The entities include the New Mexico Health Insurance Alliance (HIA); New Mexico Medical Insurance Pool (NMMIP); the Human Services Department's (HSD) State Coverage Insurance Program (SCI), Premium Assistance for Kids Program (PAK), and Premium Assistance for Maternity Program (PAM); and the Interagency Benefits Advisory Committee (IBAC) agencies that include the General Services Department's Risk Management Division/Employee Benefits Bureau (GSD), New Mexico Retiree Health Care Authority (RHCA), Albuquerque Public Schools (APS) and New Mexico Public Schools Insurance Authority (NMPSIA). Also included in the process were representatives from the New Mexico Public Regulation Commission's Division of Insurance (DOI) and the New Mexico Health Policy Commission (HPC).

SJM1 states there are undoubtedly many elements that are similar among the plans and programs that would benefit from a more consolidated and efficient approach to administration. The memorial asks for consideration of ideas regarding consolidation of public health care programs and plans and reform of the publicly funded programs' and plans' "silos of administration, delivery systems and payment for health care services". SJM1 emphasizes cooperation and collaboration to lead to creative solutions that will benefit all New Mexicans, and the memorial requests a meeting of public and quasi-public entities engaged in the administration, delivery and payment of health care services to elicit their cooperation in identifying areas of common interest and opportunities for consolidation, as well as development of specific recommendations for implementing cooperative and collaborative efforts.

No overarching structure currently exists to convene all of these public and quasi-public health care entities, collect common data, report out on common issues, or collaborate on cost savings. Each agency is more or less autonomous and operates independently even though their policy decisions have an impact on the state's general fund revenue via either direct appropriations or assessments; or via indirect fiscal impacts such as public education appropriations, costs to personnel, or the impacts on statewide economic performance affecting taxes and spending behaviors.

The Human Services Department responded to SJM1 and convened the public and quasi-public health care entities and staffed a series of 12 meetings from

May to October 2009.[1] These meetings consisted of the following: 1) *Insure New Mexico!* Partners (i.e., HSD for the SCI, PAK and PAM programs, NMMIP, HIA); 2) the IBAC Partners (i.e., GSD, NMRHCA, NMPSIA, APS); 3) the *Insure New Mexico!* Partners Strategic Policy Workgroup and Marketing Workgroup; 4) a meeting of the *Insure New Mexico!* and IBAC Partners with all the commercial carriers that are vendors for the public health care programs in the State of New Mexico; 5) combined collaborative meetings of all the public and quasi-public health care entities along with participation by the HPC and DOI at these proceedings. In addition, data was collected on the public and quasi-public entities health care claims and administration costs; revenue and funding; and demographic data on clients ages and location in New Mexico.

This report reflects the ideas, recommendations and issues for further consideration that ensued from this process in an effort to identify cost savings and areas for collaboration and consolidation among New Mexico's public health care entities.

It should be noted that staff of the Legislative Finance Council (LFC) and the Department of Administration and Finance (DFA) attended all but the first of the meetings held about this memorial. Collaboration and efficiencies to gain costs savings became especially critical for all parties during the time this activity was underway, due to the reduction in revenue estimated for the state's general fund and the deepening economic difficulties in New Mexico and nationwide. It should also be noted that without specific funding or sufficient time to study the possible recommendations in this report, some of the recommendations may need further work before consideration or adoption by the Legislature or the other parties.

Other States' Public Health Coverage Agencies' Collaboration and Consolidation Efforts

States that have acted to consolidate their public health coverage purchasing and administration under one authority include Oregon and Kansas, while Washington and Arkansas have also advanced consolidated purchasing strategies, with the exception that high risk pools were not included in the consolidations. Additionally, in a study conducted by UnitedHealthcare (UHC) that analyzed nine states[2] for which UHC is either the sole carrier or has the majority of the consolidated public agencies' membership, the study found:

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[1] Note: SJM1 requested that the Health Policy Commission (HPC) convene this meeting and deliver this report. However, HPC's FY10 budget was severely reduced in the 2009 Legislative Session, and no budget was appropriated for the work of this memorial. At the time the work began on this memorial, HPC's Deputy Director position had been eliminated in the 2009 legislative session and the HPC Executive Director had not yet been named. Since HSD has been the lead on issues of health care coverage and organization since 2003 and has worked with each of the entities named in the memorial, HSD took the lead on both the meetings and the development of this report.

[2] Note: States in the study included Tennessee, Iowa, Rhode Island, Florida, Louisiana, Ohio, Wisconsin, Arizona and Georgia.

- States pay 14 percent more in medical costs than the UnitedHealthcare national commercial accounts average;
- The benefit offering for state employees is seven percent richer than for commercial accounts;
- The average age of a state employee is 50; the aggregated age/gender factor for states is 1.17, 10 percent above the norm;
- State members are being admitted to the hospital 16 percent more at a cost of 38 percent above the norm;
- Emergency room (ER) utilization is 17 percent greater than the UHC norm, however the average cost per visit is below, indicating conditions being treated in the ER are likely not appropriate;
- Musculoskeletal and cancer diagnoses account for almost 25% of total medical spending;
- Back pain is the single highest cost diagnostic category representing 5.3 percent of all medical spending;
- There is a high prevalence of heart disease, breast cancer and diabetes;
- Sixty-six percent of employees are either considered older singles or persons with chronic condition in which they have a lifelong disease (diabetes, heart disease, asthma); and
- These two life stages represent 76 percent of total medical spending.

However, these data are NOT specific to New Mexico and may not reflect New Mexico reality. The data are also not a reflection of all such employees, but rather are specific to those whose care is managed by UHC. However, it is valuable to know that such trends exist. New Mexico specific data for state employees, school employees and other public employees, compared to national data or commercial data are not currently available.

The UHC study found the following solutions to have provided the greatest cost savings for the analyzed states' consolidated public health coverage programs:

- Nurseline to reduce ER costs;
- Coronary artery disease management;
- Heart failure disease management;
- Increase coinsurance or deductible;
- Increase office visit co-pay;
- Pharmacy benefit with optimal benefit design;
- Premium program for OB/GYN;
- Cancer resource services accompanied by cancer support;
- Worksite wellness with exercise program to address modifiable health risks;
- Cancer screening and/or educational events;
- Kidney resource services;
- Healthy pregnancy program;
- Premium program for neurological, orthopedic and spine services;

- Smoking cessation education;
- Evaluate food selections at the workplace;
- Mobile mammography screening;
- Online health coach program for heart health (myuhc.com);
- Radiology notification program;
- Incentives to manage hypertension.

While the study may not be specific to New Mexico, it does suggest areas that could be explored further by the plans addressed in this memorial report. Most of the plans have all or some of the cost-saving ideas built into current plan designs. Specific actuarial and other data analyses across all the plans would be required to identify areas for potential cost savings across these public or quasi-public programs.

Costs and Benefits of Prevention and Wellness Programs and Incentives

A 2009 study published in the American Journal of Public Health indicates that "primary prevention could improve the health and longevity of future cohorts of elderly person in the United States at a relatively low cost." The report concludes effective prevention could substantially improve the health of older Americans, and—despite increases in longevity—such benefits could be achieved with little or no additional lifetime medical spending.[3]

However, a 2009 Employer Health Benefits Survey released by the Kaiser Family Foundation[4] indicates that more than half (58 percent) of employers offering health plans provide wellness benefits such as weight loss programs, gym membership discounts or on-site exercise facilities, smoking cessation programs, personal health coaching, classes in nutrition or healthy living, web-based resources for healthy living, or a wellness newsletter. Nonetheless, health plan premiums have increased by a total of 131 percent since 1999, far more rapidly than workers' wages (up 38 percent) or inflation (up 28 percent) for the same time period. Among those firms offering benefits, 21 percent report they reduced the scope of health benefits or increased cost sharing due to the economic downturn, and 15 percent report they increased the worker's share of the premium.

Therefore, the study indicates that while prevention and wellness benefits may result in improved health outcomes and reduced medical/claims spending over time, these same prevention and wellness benefits do not seem to equate to reduced costs or savings in health care premiums, at least not in the short run. It

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[3] November 2009, Volume 99, Number 11, American Journal of Public Health, Goldman et al.
[4] Kaiser Family Foundation and Health Research & Education Trust Employer Health Benefits 2009 Annual Survey, http://ehbs.kff.org/?CFID=10379322&CFTOKEN=22275380&jsessionid=6030edbce5194751ff656e4e504c234c76c4

could take several generations for prevention and wellness programs to have an appreciable impact on the cost of health care coverage.

Federal Issues

Health Insurance Portability and Accountability Act

In 1996, the federal Health Insurance Portability and Accountability Act (HIPAA) provided small employer groups with the protection of guaranteed issue and policy renewability subject to an insurance carrier's participation and contribution requirements. NMMIP and HIA are the two Federally-approved mechanisms in New Mexico for guaranteed issue to HIPAA eligible individuals. Since these insurance marketplace reforms did not apply to individuals, we have seen an impact due to HIPAA in our state's public and quasi-public health coverage entities such as HIA. HIA indicates the loss of community-rated HMOs, increases in premiums, and a loss in the HIA's original authority due to passage of HIPAA, have impacted the program and reduced enrollment to its current level of approximately 4,000 members. On the other hand, NMMIP also serves as a guaranteed issue mechanism for HIPAA-eligible individuals and has seen that population of enrollees steadily increase.

National Health Reform

SJM1 policy considerations must be considered concurrently with national health reform proposals including a state or regional health insurance exchange, plan design, eligibility and their funding ramifications. Current proposed national health reform includes guaranteed issue and renewability in both the individual and group markets; prohibition on pre-existing exclusions in contracts of coverage; rating rules that do not allow rating based on health status, and creation of a health insurance exchange. Should federal insurance reforms be adopted, New Mexico's health coverage agencies would be required to comply with these changes, so any proposed options for the public and quasi-public agencies should bear in mind federal health reform and any potential requirements for plan design, actuarial equivalencies, operation of an insurance exchange, subsidies for coverage at lower incomes, requirements for individuals to have coverage and for employers of a certain size to contribute toward coverage for employees, or other related considerations.

EXECUTIVE SUMMARY
2009 Report to the Legislative Health and Human Services Committee
Senate Joint Memorial 1, *"Health Care Services Common Interest Meeting"*

Description of Report

Senate Joint Memorial 1 (SJM1)[5] passed during the 2009 Regular Session of the New Mexico Legislature, requests a meeting of public and quasi-public health coverage entities engaged in the administration, delivery and payment of health care services in New Mexico to elicit their cooperation in identifying areas of common interest and opportunities for consolidation. The Human Services Department convened the state's public and quasi-public health care entities from May to October 2009. The meetings consisted of the *Insure New Mexico!* Partners (i.e., SCI, PAK, PAM, NMMIP, HIA); the IBAC Partners (i.e., GSD, NMRHCA, NMPSIA, APS); the NM Health Policy Commission (HPC); the NM Public Regulation Commission's Division of Insurance (DOI); and other interested persons. The meetings were designed to elicit collaboration regarding ideas and recommendations for coordination, consolidation and cost savings among the state's public health care entities with the goal of affecting further efficiencies and improvements in quasi-public and public funded health care coverage.

Part I of this report provides descriptions of the programs identified in SJM1, including the scope of the requested report, background on similar collaboration efforts in others states, and a summary of elements common to the public and quasi-public health coverage entities. **Part II** of the report summarizes the cost containment and efficiency measures implemented since FY09 by the agencies listed in SJM1. **Part III** summarizes the consensus agreements arrived at to date by the participants in the SJM1 workgroups. **Part IV** summarizes options for consideration for implementing cooperative and collaborative efforts for consolidation and cost savings pertinent to the scope of the memorial. **Attachment 1 and 2** provide the agencies' enrollment, claims and administrative cost data for all of calendar year 2008 and the first quarter of calendar year 2009. **Attachment 3** provides a breakout of the agencies' demographic data broken out by age and residence in Bernalillo County. **Attachment 4** provides APS District Worksite Wellness Initiatives. **Attachment 5** is GSD's Wellness Vendor Matrix showing information regarding additional wellness benefits of NM state employees' health plans. And **Attachment 6** provides a list of commonly used acronyms in this report.

Summary of Report Findings and Highlights

While the SJM1 partners identified many options for collaboration and potential cost savings, the group did not have the time to arrive at conclusive recommendations regarding specific actions for consolidation and cost savings.

[5] http://legis.state.nm.us/Sessions/09%20Regular/final/SJM001.pdf

The pressures on each program, the variety of missions and the vested authority for each agency (whether a board or a department) precluded the group from arriving at a consensus on most items. However, the group engaged in active collaboration pertaining to data sharing and engaging in discussions of the issues that are most important for consideration pertinent to their potential for consolidation and cost savings. The options that were considered by the SJM1 partners are listed in specificity in this report on page 30, **Part IV, Options to Consider for Implementing Cooperative and Collaborative Efforts for Consolidation and Cost Savings among New Mexico's Public and Quasi-Public Health Coverage Entities**.

For the state's public and quasi-public health coverage entities to proceed with consensus pertaining to consolidation and cost saving measures, it would likely take additional time, resources, and restructuring. The authority to act as one official group would probably need to required or mandated in some fashion such that all the entities would hold the responsibility for the whole rather than their individual specific population or program.

There was agreement by the group about the necessity to conduct an actuarial study to analyze the cost benefits that could possibly be achieved by consolidating certain populations across the agencies. An actuarial analysis could determine any potential costs savings that could be realized by consolidating all or different variations of agencies' enrollees dependent on age or other factors. However, funding would need to be allocated to conduct such analyses.

Additional analysis could determine if administrative savings could be realized by consolidating administrative functions for some or all agencies such as joint actuarial contracting; parity of benefit design and pharmaceutical formularies; bulk purchasing; common outreach and marketing and other similar functions.

Further examination could determine any savings that might be realized by combining risk pools for all public or quasi-public groups or variations thereof. Again, funding would need to be procured to advance these and other in depth analyses.

Next Steps

The Legislature and Executive may wish to consider moving forward with the passage of legislation to amend the Health Care Purchasing Act to consolidate health plan purchasing and health policy goals and objectives of the Interagency Benefits Advisory Committee (IBAC) agencies such that these agencies would have clear requirements to develop common health benefits for common populations and would be required to move towards purchasing together, not just procuring together, to save costs and increase portability.

Although the Partners did not reach consensus regarding administrative consolidation, the Legislature may wish to give further consideration to consolidating administrative functions of the state's public and quasi-public health coverage agencies: New Mexico Health Insurance Alliance (HIA); New Mexico Medical Insurance Pool (NMMIP); the Human Services Department's (HSD) State Coverage Insurance Program (SCI), Premium Assistance for Kids Program (PAK), and Premium Assistance for Maternity Program (PAM); New Mexico Health Policy Commission (HPC); and the Interagency Benefits Advisory Committee (IBAC) agencies which include the General Services Department's Risk Management Division/Employee Benefits Bureau (GSD), New Mexico Retiree Health Care Authority (RHCA), Albuquerque Public Schools (APS) and New Mexico Public Schools Insurance Authority (NMPSIA).

Lastly, it merits further discussion and perhaps funding further actuarial and other analyses to determine the merits and demerits of consolidating the state's public and quasi-public health risk pools.

PART I
Description of New Mexico's Public and Quasi-Public Health Coverage Entities Addressed in SJM1

Senate Joint Memorial 1 (SJM1) requests a meeting be convened of public and quasi-public entities engaged in the administration, delivery and payment of health care services in New Mexico to elicit their cooperation in identifying areas of common interest and opportunities for consolidation. These entities include the New Mexico Health Insurance Alliance (HIA); New Mexico Medical Insurance Pool (NMMIP); the Human Services Department's (HSD) State Coverage Insurance Program (SCI), Premium Assistance for Kids Program (PAK), and Premium Assistance for Maternity Program (PAM); New Mexico Public Regulation Commission's Division of Insurance (DOI); New Mexico Health Policy Commission (HPC); and the Interagency Benefits Advisory Committee (IBAC) agencies which include the General Services Department's Risk Management Division/Employee Benefits Bureau (GSD), New Mexico Retiree Health Care Authority (RHCA), Albuquerque Public Schools (APS) and New Mexico Public Schools Insurance Authority (NMPSIA).

Summary of Common Elements in New Mexico's Public and Quasi-Public Health Coverage Entities

SJM1 states that there are undoubtedly elements that are similar among the public and quasi-public plans and programs that would benefit from a more consolidated and efficient approach to administration. The eight public and quasi-public health coverage agencies identified in SJM1 (i.e., HIA, NMMIP, SCI, PAK/PAM, GSD, RHCA, NMPSIA and APS) together provide comprehensive health coverage and varying wellness benefits for approximately 250,000 lives from a total state population of 1.9 million. In calendar year 2008, these 250,000 covered lives represented almost $1 billion in claims costs; about $46 million in third party administration (TPA) or administrative services only (ASO) costs; and approximately $12 million in program operating expenses.

Most of these costs are funded by state funds and members' premiums, with federal revenue being the next largest revenue source, and less revenue provided indirectly by insurance carrier assessments and related tax credits and other related sources.

These agencies' covered members are spread all over New Mexico with approximately 80,000 residing in Bernalillo County. Those members residing in Bernalillo County are covered by many different programs, not just the Albuquerque-specific program (APS). Slightly more women are covered than men (116,000 and 98,000 respectively), and a wide age range is represented by these agencies' members with most covered lives falling between ages 36-54 (*see Attachments 1, 2 and 3*).

Below is a brief description of the individual public and quasi-public health coverage entities identified in SJM1:

New Mexico Health Insurance Alliance
The New Mexico Health Insurance Alliance (HIA) was created in 1994 by the New Mexico State Legislature and is composed of independent health insurers who have agreed to offer similar health plans to companies with 50 or fewer eligible employees, including the self-employed and individuals who have lost group health coverage. The HIA allows small employers to obtain coverage regardless of their employees' health status.

The HIA covers employees and their dependents of small businesses with two to 50 eligible employees, self-employed persons with at least one dependent, and individuals. HIA benefits include comprehensive HMO, PPO and indemnity packages, with the costs dependent on the plan, and with employers having no defined contribution. The HIA functions as a conduit for insurance plans as opposed to being either a direct insurer or reinsurer.

Features of the HIA include: the elimination of medical or industry underwriting; easier participation requirements for employers; and rates that are set for one year. The HIA is financed by risk adjustment charges, administrative charges, and HIA sales commissions that are exempt from gross premiums with the offsetting balance remitted to the insuring member. Insurance carriers doing business in the State of New Mexico are assessed annually for the net claims loss (net reinsurance loss) not paid for through premiums. The annual net claims loss represents the claims losses reported by insuring members for the previous calendar year, reduced by the risk adjustment charge withheld by the HIA.

Enrollment in the HIA has been as high as 8,800 people since its inception; however, the loss of community-rated HMOs, increases in premiums, and a loss in the HIA's original authority due to passage in 1996 of the federal Health Insurance Portability and Accountability Act (HIPAA) have impacted the program and reduced enrollment to its current level of approximately 4,000 members.

New Mexico Medical Insurance Pool
The New Mexico Medical Insurance Pool (NMMIP) was legislatively created in 1987 to provide access to health insurance to all New Mexicans who are denied adequate health insurance and are considered uninsurable.

The NMMIP offers comprehensive health coverage to individuals who have a qualifying medical condition, are rejected for health insurance due to a pre-existing condition, or whose current individual plan has a rider or a premium rate that is higher than NMMIP's qualifying rate. The agency also offers coverage to HIPAA-eligible individuals who are losing group coverage after at least 18 months of continuous coverage. Coverage through NMMIP is available to individuals who have a diagnosed mental illness and have current coverage on

an individual health plan which does not offer mental health coverage. The NMMIP has a number of deductible options, ranging from $500 to $10,000 deductible. There is a premium assistance program for those with incomes below 400 percent of the federal poverty level (FPL), offering a 25 percent to 75 percent reduction in premium. Prescription drug coverage is available under all plans, as are maternity and wellness benefits. There is also a Medicare carve-out plan for people who are under 65 and on Medicare due to disability.

Blue Cross Blue Shield of New Mexico is the current plan administrator, handling enrollment, member services and claims processing. The NMMIP has experienced an annual growth rate of 25 percent to 30 percent for the last few years and currently covers approximately 7,500 individuals.

State Coverage Insurance Program

The State Coverage Insurance Program (SCI) covers uninsured adults ages 19-64 with a total countable household income up to 200 percent of the federal poverty level (FPL). SCI is a public/private partnership in which the employer pays a portion ($0 to $75) of the monthly premium, the employee pays a portion ($0 to $35) of the monthly premium, and the state and federal government pays the remainder. SCI is available for small employers with 50 or fewer eligible employees, or self-employed individuals. Individuals without employer sponsorship may also enroll. The state currently assists with the premium payment for individuals making less than 100 percent of the federal poverty level (FPL). SCI has an annual benefit maximum of $100,000 per benefit year. The SCI program is subject to available state and federal funding, which may require enrollment to be managed through a waiting list process at certain times. SCI enrollment has continued to grow since the program's inception, with current SCI enrollment at approximately 44,000.

The New Mexico Human Services Department (HSD) submitted a waiver to the federal Centers for Medicare and Medicaid Services on September 30, 2009 seeking §1115 demonstration authority pursuant to §112 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) to continue operating an insurance coverage program for low-income childless adults. The demonstration project is entitled New Mexico State Coverage Insurance (SCI), and it would be the continuation of a program originally authorized under a Health Insurance Flexibility and Accountability (HIFA) waiver that utilized unspent Title XXI funds to cover adults on the basis of allotment neutrality. The purpose of this waiver application is to continue coverage for these childless adults when Title XXI funding no longer is permissible, effective January 1, 2010, by instead utilizing Title XIX funds and §1115 waiver authority. Parents will continue to have coverage using Title XXI funding under the original waiver through 2011.

Premium Assistance for Kids Program

The Premium Assistance for Kids Program (PAK) covers uninsured children ages 0 to 12 or up to 18 years of age if part of a sibling group with a child under age 12

who are ineligible for the New MexiKids program due to income. The state assists with a designated percentage of the costs of the premium for a commercial health insurance product for children. Premiums range from $70 to $180 per month. The PAK benefit package includes preventive, primary and specialty care, inpatient and outpatient hospitalization, pharmacy, lab, x-ray and physical, occupational and speech therapy. Children who do not qualify for the plan due to medical underwriting are referred to the New Mexico Medical Insurance Pool. Current enrollment is approximately 250 children.

Premium Assistance for Maternity Program

The Premium Assistance for Maternity Program (PAM) covers pregnancy-related services for women who are uninsured or have health insurance without maternity benefits and are ineligible for Medicaid due to income. The applicant pays a one-time enrollment fee per pregnancy depending on the trimester in which she enrolls. Enrollment fees during the first 20 weeks of pregnancy are lower than enrollment fees for those who begin during the second 20 weeks of pregnancy. The PAM program does not have deductibles or co-payments, and currently covers approximately 200 women.

Albuquerque Public Schools, Employee Benefits Division

Albuquerque Public Schools (APS) offers its employees and their families a comprehensive benefits package covering over 17,000 educational employees and dependents. Benefits include Medical, Dental, Vision, Basic and Additional Life Insurance, Long Term Disability, Pre-tax Insurance Premium Plan (PIPP), Flexible Spending Accounts, Long Term Care Insurance, 403(b) and the 457(b) Deferred Compensation Plan. APS' health, dental and vision plans are self-insured with members' premiums going directly toward the payment of health care claims. APS is responsible for the plan design and the setting of premium contributions with premium increases a direct reflection of increases in the cost of members' medical care and prescription drugs.

The APS District currently pays 60 to 80 percent of insurance premiums, depending upon salary level. Employees pay 20 to 40 percent of health care premiums. Plans are purchased through a co-operative arrangement with the three other state IBAC agencies: the State of New Mexico/GSD, New Mexico Retiree Health Care Authority, and New Mexico Public Schools Insurance Authority. APS indicates the volume purchase of their combined strengths enables APS to have the best quality plans that our state offers. For 2008-2009, APS indicates plan designs are evaluated to contain costs, with a minimal co-pay increase significantly decreasing the overall premium rate increase.

General Services Department's Risk Management Division, Employee Benefits Bureau

The Employee Benefits Bureau of the Risk Management Division, General Services Department is responsible for the procurement, implementation, and

administration of all group benefit plans for approximately 81,000 State of New Mexico employees and their dependents.

All of the state's plans are available to all State of New Mexico employees, regardless of where they live. These include Medical, Prescription Drug, Dental, Vision, Employee Assistance Program, POP (pre-tax premium payment), Basic Life/AD&D Package, Supplemental Life, Short-Term Disability, Optional Whole Life, Flexible Spending Accounts, Legal Insurance Plan, Employee Assistance Program, Auto & Home Insurance, Accident, Cancer, and Universal Life. Currently, the State of New Mexico offers four different health plans from which employees may choose. Two are statewide health maintenance organizations (HMOs): Presbyterian Health Plan and Lovelace Health Plan. The other two are preferred provider organizations (PPOs): Blue Cross/Blue Shield State of New Mexico PPO and United Healthcare Open Access Choice Plus PPO.

New Mexico Public Schools Insurance Authority
NMPSIA serves as a purchasing agency for public school districts, post-secondary educational entities and charter schools. Through NMPSIA, member schools are afforded the opportunity to offer quality employee benefit and risk coverage. Because of the purchasing power of NMPSIA which covers over 39,000 educational employees and their families, the agency indicates it is able to negotiate better premiums and better benefits than an individual school district. NMPSIA's medical, prescription and dental plans are self-insured which means it is responsible for the design of the plans and the setting of contributions. The agency sets the contribution rates to provide the necessary revenue to pay for the claims it incurs. When claims exceed the contributions, the contribution rates have to go up to cover any deficit. Less than 10 percent of contributions go towards the medical plan administration (claims payment, customer service, provider networking, ID cards, booklets). The balance pays for the cost of medical care and claim reserves as recommended by NMPSIA's actuaries.

NMPSIA currently provides benefit and risk coverage to 88 school districts (all except for Albuquerque Public Schools which is excluded from NMPSIA by statute), 72 charter schools and 23 educational entities. Benefits coverage includes basic life and accidental death & dismemberment, voluntary life, long term disability, two medical plans, a dental plan with basic and comprehensive coverage, and a vision plan. The eligibility maintenance and premium billing for these plans are handled by a third party administrator.

In FY04, the NMPSIA board approved a new comprehensive health management program which provides services to assist all members with their health. Currently, this program provides outreach to members with chronic conditions or those facing a crossroads in treatment to educate these members on their options. In 2009, a diabetes pilot program was launched in Carlsbad, Artesia, and Roswell, allowing monthly counseling by certified pharmacists.

New Mexico Retiree Health Care Authority
RHCA provides core group and optional health care benefits and life insurance for approximately 43,000 persons who have retired from state agencies and certain educational institutions, counties, cities, towns, villages and other public entities in New Mexico. Eligible retirees, their spouses, domestic partners, dependents and surviving spouses receive health insurance consisting of a plan or optional plans of benefits for which they pay premiums and co-payments or out-of-pocket payments as necessary.

New Mexico Public Regulation Commission's Division of Insurance
The DOI regulates the provision of life, health, property and casualty insurance in the state, and directs agent qualifications and licensure. Additionally, it provides oversight for managed healthcare providers and workers' compensation policies written through insurance companies. The DOI Fraud Bureau investigates allegations of fraud involving insurance companies and agents.

New Mexico Health Policy Commission
HPC's mission is to provide independent research, guidance and recommendation on health policy issues that impact the health status of New Mexicans. The HPC is responsible for providing technical assistance and formulating recommendations for both the Executive and Legislative branches of state government based on objective analysis of data and information, public and professional input and staff research. The agency is administratively attached to the New Mexico Department of Finance and Administration.

PART II
New Mexico's Public and Quasi-Public Health Agencies' Cost Containment and Efficiency Actions from State Fiscal Year 2009 (FY09) through State Fiscal Year 2011 (FY11)

New Mexico Health Insurance Alliance

Since January 2009, the HIA's number of lives has decreased by 10.6 percent. This steady decrease is due to the cost of HIA's premium rates and the economic slowdown that has led some small businesses to reduce costs. These decreases in HIA enrollments mean less income for the agency resulting in the decision to implement cost containment actions.

These are the steps that HIA is taking regarding cost containment:

Plan Benefits: HIA is changing their portfolio to offer newly designed plans with lower premium rates.

Paperless: HIA has converted to e-files and is no longer utilizing paper files. Every application is scanned and saved to an outside secure server. This transition has cut down on paper and saves time looking for files, and HIA is more efficient communicating within the office and with carriers and brokers.

Premium Deposit: Check deposits are now filed electronically and HIA also offers electronic funds transfers (EFT) transactions. The HIA billing system now allows the agency to collect a fee for every non-sufficient funds check.

Eliminate Duplicate Billing: HIA has consolidated its administrative operating expenses by using one vendor for long distance and toll free services. They have eliminated one storage facility, and are looking into their employees' insurance policies to consider negotiating new prices.

New Mexico Medical Insurance Pool

NMMIP cost containment strategies for 2010 include continuing the practice of case management, disease management, negotiated network discounts, retrospective and concurrent drug utilization review, and utilization reviews by procedure codes for inpatient, outpatient, and physician. In addition, performance guarantees for the TPA have been instituted to enhance administrative efficiencies, claims management and customer service. The agency's pharmacy benefit structure is designed to encourage use of generic and less expensive drugs and has resulted in significant savings since it was instituted in 2007.

Subject to approval by the Superintendent of Insurance, the NMMIP board of directors is recommending for the first time since 2005, an increase in premiums of eight percent, setting rates at 125 percent of the standard risk rate, effective January 2010. NMMIP rates are reviewed and set every six months.

***Insure New Mexico!* Programs: State Coverage Insurance, Premium Assistance for Kids and Premium Assistance for Maternity**
FY09-FY10 cost containment measures for the SCI, PAK and PAM programs include:

- Implementing premium cost-sharing for individuals enrolled in SCI below 100 percent FPL, and discontinuing state payment of the premium for individuals at or below 100 percent FPL;
- Increasing the enrollment fees for PAM;
- Removing the existing co-pay cap on prescriptions covered under SCI, and instituting different co-pays for generic and brand name drugs;
- Changing the state share of the premium amount for PAK; and
- Instituting a waiting list for individual enrollment in SCI beginning November 2, 2009. SCI applications postmarked by October 1st, 2009 will be processed, and as many applications as possible postmarked between October 2 and November 2 will be processed for potential eligibility. Those individual applications not processed will be placed on the waiting list. Employer groups will not be subject to a waiting list.

Insure New Mexico! program cost containment activities can be divided into two parts—those that involve SCI and those that do not. SCI related activities require an approved new federal waiver for childless adults, approval of a revision of the existing federal waiver for parents, renegotiated MCO contract rates to take advantage of some cost containment activities, Omnicaid and ISD-2 changes, and financial analysis to correctly state potential cost savings. There is at least a six month window to achieve cost savings for waiver changes, while waiting list changes can be achieved within 90 days.

Non-SCI activities are simpler and easier to achieve: PAM changes have been implemented effective October 1, 2009, and PAK requires Omnicaid changes, contract notice, and member notice which could be achieved within a 90 day period and is slated for a January 1, 2010 start date.

Albuquerque Public Schools, Employee Benefits Division
For FY10, APS requested approximately $5.8 million to provide for the employer's share of increased insurance premiums for its members. This FY10 request did not consider the use of a reserve balance to offset the contribution increases. However, because no state funds were available to cover the increased insurance premiums, the APS Board of Education, at its August 19, 2009 meeting, approved using approximately $3.5 million in reserve insurance funds to offset five percent of the increase faced by employees, and changing the current plan year (December 1-November 30) to a calendar year, (January 1-December 31) effective January 1, 2010, by:

- Increasing by five percent the cost of medical insurance for district employees (APS per-paycheck cost to employees with family coverage will be

approximately $5 for those earning less than $29,000 per year, and approximately $11 for those earning $29,000 or more per year);

- Increasing the Physician Office Visit Copay from $15/Visit to $20/Visit
- Increasing the Specialist Office Visit Copay from $25/Visit to $30/Visit
- Increasing the In-patient Hospital Copay from $500/Admission to $750/Admission

FY09 – APS Plan Year 12/01/09 – 11/30/10 Cost Containment Measures

- Five percent Increase to Employee & Employer - Medical/RX Contribution Rates
- Salary Tiers & Contributions: Employee Share of EE/Dependent Funding Rates based on Annual Earnings: <$28,000 = 20% Employee Cost; 80% Employer Cost
- Raised Salary Threshold to: <$29,000 = 20% Employee Cost; 80% Employer Cost
- Wellness Benefit Program Enhancements—Health Risk Assessments
- Prescription RX Mail Order Pilot Program—Estimated total Gross Cost Savings = $882,504

Plan Design Changes – Medical/RX

Plan Features	Current Plan 12/01/08	Proposed Plan 12/01/09	% Claims Impact	% Rate Impact	$ Rate Impact
Office Visit Copay	$20	$25	-0.30%	-0.28%	($204,671)
Specialist Visit Copay	$25	$30	-0.85%	-0.81%	($590,621)
Inpatient Hospital	$500	$750	-0.75%	-0.71%	($520,448)
Total Projected Savings					($1,315,740)

FY10 – APS Plan Year 12/01/10 – 11/30/11 Proposed Cost Containment Measures

APS is considering the following possible proposed plan design changes:

- Wellness Benefits – Preventive and Diagnostic Screenings
- Surcharge to employee's medical if smoker
- Surcharge to employee spouse if medical coverage is offered through spouse's employer
- Increase copay for specialty injectible drugs

APS District Worksite Wellness Initiatives (*see Attachment 4)*

2009-2010 Campaign

- Know Your Numbers Campaign (blood pressure, blood sugar, cholesterol and body mass index)
- Health screenings scheduled at several high schools
- Health risk assessment

2009-2010 Plan for Employee Wellness
- District – wide wellness campaigns
- Fall: Know Your Numbers & Health Assessments, Health Fair
- Winter: Fitness & Nutrition Challenge
- Spring: Stress Management Campaign
- Monthly newsletter & suggested activities

General Services Department's Risk Management Division, Employee Benefits Bureau

GSD Cost Containment Features – FY10

Due to no premium increases for employees and employers, RMD made moderate changes to health plan deductibles, copays and coinsurance amounts for members. Pharmacy copays through Express Scripts were also moderately changed. RMD anticipates using $19 million of its reserves in the group benefit fund to assist in payment of medical, pharmacy, dental and vision claims and thus not have all costs shifted to members. RMD was able to keep member cost at $0 for annual preventive visit for adults and children, including associated laboratory and x-rays on the health plan side.

Other features RMD continues to use are administrative services only (ASO) pricing leveraged by purchasing with the IBAC. Common vendors provided scaled pricing utilizing number of total IBAC members and a four year pricing strategy with the initial two years locked-in (FY09 and FY10). Both Delta Dental and Vision Service Plan have administrative-services-only pricing with the initial two years locked-in (FY09 and FY10).

All medical plans continue their full array of cost containment for case management, disease management, negotiated network discounts, retrospective and concurrent drug utilization review, physician profiling for efficiency, utilization reviews by diagnosis by inpatient, outpatient, physician setting, and utilization reviews by procedure codes by inpatient, outpatient, and physician.

Performance guarantees for medical plans include:
- Claims processing accuracy of 95 percent measured quarterly, with monthly reporting and a penalty of 1.5 percent of quarterly ASO fees
- Financial claims payment accuracy of 99.25 percent measured quarterly, with monthly reporting and a penalty of 1.5 percent of quarterly ASO fees
- Re-processed claims less than 15 percent, with 93 percent of claims processed within 14 days with payment to providers and/or members within seven days measured quarterly, with monthly reporting and a penalty of zero to two percent of quarterly ASO fees

- Customer service telephone average speed to answer within 30 seconds or less, measured quarterly, with monthly reporting and a penalty of two percent of quarterly ASO fees
- Customer service calls unanswered (abandonment rate) not to exceed five percent, measured quarterly, with monthly reporting and a penalty of two percent of quarterly ASO fees
- Response to member inquiries, 90 percent of written inquiries within five working days of receipt, 98 percent within 15 days of receipt, 95 percent of all inquired resolved within 30 days and 98 percent of all inquiries resolved within 60 days, measured quarterly, with monthly reporting and a penalty of two percent of quarterly ASO fees
- An annual member satisfaction survey with 80 percent satisfaction with two percent increases each year, penalty negotiated to address required corrective action and not to exceed two percent of annual ASO fees
- Account team performance semi-annual appraisal overall performance is a composite score of three or better (i.e., meets expectations), $3,000 per semi-annual period with total penalty not to exceed $6,000 annually
- Ratio of disease management savings to disease management fees at 1.4, measured annually, estimated quarterly with penalty of 1.5 percent of annual disease management fees
- Contracted network savings varying by vendor with general penalty of one percent of annual ASO fees
- Many of the pharmacy, dental and vision vendor's performance guarantees are similar

The Wellness Programs offered vary by vendor but all contain a Health Risk Assessment, 24 hour 7 day a week Nurse Hotline, coaching, discounts and other concierge programs (*see Attachment 5*).

For efficiency purposes, the health plans all have integrated behavioral health programs for mental health and substance abuse components. Additionally, pharmacy claims without associated costs are sent to the health plans to integrate medical and pharmacy utilization reviews. All plans have subrogation services to assist in recovery of third party liability claims payment.

Currently, FY11 cost containment features are being reviewed by GSD, including conducting a bid for a data claims analysis tool to allow all claims data to be placed on one analysis platform for complete comparisons of plans and plan designs. GSD has indicated that such an analysis tool would be useful for all the IBAC agencies' and GSD would consider participation on the bid by all IBAC agencies to ensure uniform access to full leveraging of this analysis and cost tool.

New Mexico Public Schools Insurance Authority
For FY10, NMPSIA requested an appropriation of approximately $5.4 million to provide for the employer's share of increased insurance premiums for its

members. The FY10 benefits request did not consider the use of fund balance to offset the increases as NMPSIA had done in the past, because NMPSIA projected the June 30, 2008 unaudited fund balance of approximately $16.4 million to be "zero" by June 30, 2009. The reason for the zero fund balance, NMPSIA staff reported, was that an analysis of these claims revealed a substantial increase in both the utilization and cost of medical services, including four catastrophic claims of over $550,000 each.

To cover these increased insurance costs, NMPSIA reduced the plan's benefits, effective July 1, 2009, by:

- Implementing a $2,800 out-of-pocket limit on the co-pays, co-insurance, and deductible paid by the member. The out-of-pocket limit comprises:
  - a $300 calendar year deductible on all medical services except free in-network routine screening (copays do not count toward the deductible); and
  - 20 percent co-insurance, meaning that once the deductible is met, the member must pay 20 percent of medical costs until the $2,800 out-of-pocket limit is reached; and
- Requiring the member to pay 70 percent of the cost of non-formulary prescriptions.

NMPSIA FY11 REQUESTS

For FY11, NMPSIA has requested an appropriation of approximately $14.6 million to provide for the employer's share of increased insurance premiums for its members. The benefits portion of the FY11 budget request considers:

- A 15.8 percent increase in medical insurance premiums for NMPSIA that would go into effect for public school employees October 1, 2010;
- A 10.8 percent increase in dental insurance premiums;
- No increases for vision and life insurance; and
- A 35 percent increase for disability insurance.

NMPSIA reports that, as of June 30, 2009, its unaudited fund balance was negative $7.4 million. If NMPSIA were to retain the FY10 reduced benefits (see above), and received no appropriation for the increased premiums, the authority reports that the projected fund deficit on June 30, 2011 would be approximately $30.0 million. NMPSIA adds that in this scenario, it would be required to reduce benefits further, by:

- Increasing to $4,900 (from $2,800) the out-of-pocket limit on the copays, co-insurance, and deductible paid by the member. The out-of-pocket limit comprises:
  - a $500 deductible (increased from $300); and

- 30 percent co-insurance (increased from 20 percent), meaning that once the deductible is met, the member must pay 30 percent of medical costs until the $4,900 out-of-pocket limit is reached;

- Increasing prescription and office visit copays;
- Increasing to $100 (from $50) the dental deductible; and
- Reducing to 50 percent (from 66 and 2/3 percent) the disability benefit.

Based on the member reaction to the FY10 plan changes, further erosion of their benefits will be untenable. There is a growing concern that due to the financial out of pocket, members are postponing or cancelling their medical care. Historically, NMPSIA members have enjoyed a very rich benefit package (members' report satisfaction with health benefits at 89 percent), including a broad array of health management resources, customized programs focusing on diabetes and free immunizations and free preventive care. The future of these valuable programs is in jeopardy based on the current economic climate.

New Mexico Retiree Health Care Authority

FY2008 / FY2009

RHCA's Board of Directors took important steps to improve its rating structure over this timeframe to ensure that expenditures did not exceed revenues. Past rating structures had provided a higher subsidy level for richer (i.e. lower deductibles and co-payments) plans thereby providing financial incentives for members to select plans that were the most expensive to the agency. Additionally, the rating structure had imposed an arbitrary cap to premium increases regardless of what the plan's actual cost increases (trend) were. Recognizing this, the Board took the following steps:

- Brought down the subsidy level for the richer plans in line with other offerings.
- Adopted rules to ensure that premium increases kept pace with spending increases.

FY2010 / FY2011

RHCA's approximately 15,000 pre-Medicare members have had the choice of three different PPO plans varying in deductibles from $100 to $800. The actuarial value of these plans (especially the two richest) had not been consistent with the types of risk (membership health status) each plan has incurred. This created an environment of adverse selection and extreme rate instability.

RHCA also wanted to ensure that its 25,000 Medicare-eligible members were in plans that provided the most value possible. Approximately 20,000 of these members were in a custom-designed, extremely rich (virtually no cost-sharing at all) Medicare supplement plan and the remaining 5,000 members were in much less expensive Medicare Advantage plans.

Additionally, RHCA's prescription plan utilization had created a situation whereby the plan was actually providing a higher level of reimbursement (as a percentage of cost) for brand name drugs than for generic.

In response to these circumstances, the Board took the following steps to be effective January 1, 2010:

- Reduce the number of pre-Medicare PPO options from three to two in order to minimize adverse plan selection and stabilize rate increases over a period of time.
- Initiate a new procurement process (RFP) for all of its Medicare plans which resulted in modest cost sharing for the Medicare supplement and provided additional options to increase Medicare Advantage membership.
- Reduced co-payments for generics while raising co-payments for brand name drugs to provide equitable reimbursement levels (and also generate approximately $2 million in savings).

PART III
Consensus Cooperative Agreements to Date Among New Mexico's Public and Quasi-Public Health Coverage Entities

The Human Services Department responded to SJM1 and convened the public and quasi-public health care entities and staffed a series of 12 meetings from May to October 2009. The series of meetings consisted of meetings of the *Insure New Mexico!* Partners (i.e., SCI, PAK, PAM, NMMIP, HIA); the IBAC Partners (i.e., GSD, NMRHCA, NMPSIA, APS); the *Insure New Mexico!* Partners Strategic Policy Workgroup and Marketing Workgroup; a meeting of the *Insure New Mexico!* and IBAC Partners and all the commercial carriers that are vendors for the public health care programs in the State of New Mexico; and combined collaborative meetings of all the public and quasi-public health care entities with participation from HPC and DOI. In addition, data was collected on the public and quasi-public entities health care claims and administration costs; revenue and funding; and demographic data on clients ages and location in New Mexico.

The following are areas where the groups listed above collaborated together to reach consensus on actions that can be implemented immediately or in the near future. It should be mentioned that implementation of the items below is dependent on the programs' funding level given the state's current and future volatile fiscal environment.

IBAC Collaboration

The Interagency Benefits Advisory Committee (IBAC) was created in 1998 through the passage of the Health Care Purchasing Act [NMSA 13-7]. The purpose of the act is "to ensure public employees, public school employees and retirees of public employment and the public schools have access to more affordable and enhanced quality of health insurance through cost containment and savings affected by procedures for consolidating the purchasing of publicly financed health insurance". The IBAC is made up of the State of New Mexico General Services Department's Risk Management Division, the New Mexico Public Schools Insurance Authority (NMPSIA), the New Mexico Retiree Health Care Authority (NMRHCA), and Albuquerque Public Schools (APS).

Since the passage of this act, the IBAC has jointly initiated and executed nine separate procurements for services including:

- Medical coverage (both fully and self-insured)
- Pharmaceutical Benefits Managements (PBM) services
- Dental coverage
- Vision coverage
- Basic Life Insurance
- Supplementary Life Insurance
- Disease Management programs
- Wellness/Preventive Care programs

While not all contract awards have been executed in concert, all nine procurements (request for proposals) were issued with the full leverage associated with the IBAC's approximately 200,000 members. Contracts do share standardized performance measurements and administrative requirements where appropriate.

Outside of the procurement processes, the IBAC meets together on a monthly basis with all of its partners (i.e., health plans, etc.) to discuss operational highlights and share best procedural practices. This has resulted in a large degree of plan design parity amongst the entities (e.g., RHCA decided to model its new health plan designs based on APS).

The IBAC hosted a Diabetes Summit with all of its health plan partners and their Medical Directors to discuss the disease's prevalence in the IBAC population and prudent preventive and treatment options.

The IBAC has also collaborated with assisting health plan negotiations with provider groups across the state over the past eight years. These collaborations have had a positive financial impact on each IBAC entity as they have often resulted in more favorable contractual agreements with the health plans once the providers are also forced to negotiate with their public payers.

In the coming year, the IBAC will issue joint proposals for all of its prescription drug benefits management (PBM) as well as its basic and supplemental life insurance programs.

Also, the General Services Department, Risk Management Division, Employee Benefits Bureau is currently reviewing FY11 cost containment features, including conducting a bid for a data claims analysis tool to allow all claims data to be placed on one analysis platform for complete comparisons of plans and plan designs. GSD has indicated that such an analysis tool would be useful for all the IBAC agencies' and GSD would consider participation on the bid by all IBAC agencies to ensure uniform access to full leveraging of this analysis and cost tool.

Additionally, the Human Services Department's Medicaid actuarial contract is due for renewal in July 2010. HSD has agreed to add on to this RFP the scopes of actuarial work from HIA, NMMIP and all of the IBAC agencies in an effort to gather information to determine whether cost savings could be achieved if all of the agencies combined their actuarial work together under one contract, while assuring that the actuarial needs of each group are still met in an effective manner.

***Insure New Mexico!* Collaboration**

The *Insure New Mexico!* Partners are comprised of the New Mexico Health Insurance Alliance (HIA), New Mexico Medical Insurance Pool (NMMIP), State

Coverage Insurance (SCI), Premium Assistance for Kids (PAK), and Premium Assistance for Maternity (PAM).

Marketing and Outreach

Websites:

- PRC will host a website featuring both the *Insure New Mexico!* and IBAC Partner agencies.
- NMMIP, HIA and PRC agreed to add a link to the *Insure New Mexico!* website, which has links to all "Partners".
- HIA will also add a link to the Division of Insurance website.

Outreach:

- HSD is attending "Rapid Response" events with the NM Department of Workforce Solutions. Some of these events have been followed up with a specific enrollment event for businesses that are laying-off employees. HSD gives information about NMMIP and HIA at these events and will ensure it has up-to-date brochures from NMMIP and HIA to share at these events.
- The PRC is required to participate in enrollment events and will partner with the agencies at their events. PRC also has the capability to input information on a laptop for follow-up and will share this capability. The PRC also attends Town Hall Meetings across the state and will invite the "Partners" to collaborate around these events.
- HIA hosts approximately 10 events per month, primarily with chambers of commerce and business groups. HIA has found success with its outreach utilizing e-advertisements, radio and billboard, with Yellow Page advertising proving less successful. HIA has the opportunity to do monthly radio interviews and will work to include NMMIP and HSD in these radio interviews.
- The *Insure New Mexico!* Partners will create and maintain a joint events and outreach calendar.
- The Partner agencies will share news releases for wider distribution to their networks.

Marketing:

- HIA is the only "Partner" that is currently advertising. HIA indicates 25 percent of their calls come from their radio ads. Of all HIA calls, about 80 percent are directed to the *Insure New Mexico!* Solutions Center and NMMIP. Less than 1 percent of HIA's calls come from newspaper ads.
- The *Insure New Mexico!* Partners agreed to add a tag line to all marketing materials—"An *Insure New Mexico!* Partner"—and will add the *Insure New Mexico!* logo to their materials.
- All *Insure New Mexico!* Partners were interested, funding permitting, in getting radio advertisements on the air through the NM Broadcasters Association's Public Education Program (PEP), formerly the NCSA program. Details can be found at http://www.newmexicobroadcasters.org/NCSA/index.php.

Enrollment, Strategic Planning and Policy

Enrollment:

- The *Insure New Mexico!* Partners have agreed to conduct joint referral of clients to each others agencies as appropriate, in an effort to make enrollment in these programs easier and more seamless for clients.

Brokers:

- The *Insure New Mexico!* Partners have agreed to conduct a joint broker certification process and utilize a combined broker listing database.
- The Division of Insurance will collaborate in this process by offering continuing education credit for brokers who attend the *Insure New Mexico!* Partner's broker certification classes.
- The *Insure New Mexico!* Partners will enhance their efforts at Native American outreach by utilizing Native American brokers and tribal and pueblo chambers of commerce.

PART IV
Options to Consider for Implementing Cooperative and Collaborative Efforts for Consolidation and Cost Savings among New Mexico's Public and Quasi-Public Health Coverage Entities

The items below provide a categorized and summarized listing of options to be considered and were generated by the public and quasi-public health care entities and others who participated in the SJM1 process.

Cost Savings

- Commercial carriers indicate statewide public risk pool aggregation with Albuquerque metro area public plans could lead to cost savings. Albuquerque market cost savings are a factor of administrative savings and value-based program enhancements, and with inclusion of pools outside of Albuquerque, Albuquerque public plans could adjust costs in multiple areas to limit the impact on Albuquerque market premiums while benefiting non-Albuquerque public plans. Given a lack of consensus on this issue, an actuarial study is recommended to determine if the above thesis is correct and could be accomplished without causing an additional increase in premiums specifically for APS plan members.
- Third party administration (TPA) and administrative services only (ASO) costs could be reduced by administering similar benefit plans and larger risk pools.
- Although there is not consensus, administrative savings could possibly be leveraged with health plans and within public and quasi-public agencies.
- Conduct joint outreach and marketing.
- Cost savings may be possible using similar plan design among agencies. Consider uniformity and commonality in plans and benefits across all public and quasi-public agencies.
- Although there is not consensus, consolidating customer service at public and quasi-public insurance entities could potentially reduce costs (MCOs have already done this to some extent for their public plan offerings).
- Consolidating pharmaceutical formularies and pharmacy benefits management for all public and quasi-public entities should be explored, but may have minimal cost savings if these costs are already pooled with larger commercial groups.
- Consider implementation of a fixed payment methodology for rural hospitals' outpatient services (i.e., similar to Medicare).
- Could possibly reduce costs for laboratory services by limiting hospital lab services and increasing reference labs.
- Savings may be found in consumer-driven reduced benefit plans.
- Consider using one actuary for all public and quasi-public plans consulting.
- Restrict coverage options such that if two state employees have GSD coverage, require that higher paid employee must take up coverage.
- Consider limiting out-of-state coverage.
- Reduce benefit plan and design, and increase copays, deductibles and office visit charges, or reduce dependent coverage options.

- Consider decreased use of third party administration (TPA) and administrative services only (ASO) agreements.
- Implement a common reinsurance program or other approaches to insuring outlier clients. In 2004, APS had reinsurance but it was too expensive, but consideration could be given to revisiting a pooled approach among public and quasi-public health coverage agencies with NMMIP maybe serving as state reinsurer manager.
- Consider implementing medical homes and accountable care organizations.
- Consider implementing pay for performance.

Enhanced Coverage

- Although there is not consensus, possibly consider consolidation of public and quasi-public insurance entities, and cover those individuals not protected by the Health Insurance Portability and Accountability Act (HIPAA).
- Focus coverage on chronically uninsured in NM (i.e., people at 200-400% FPL).
- Continue to explore offering more plan options at the NM Medical Insurance Pool.
- Ask Division of Insurance to approve SCI benefit plan so the plan can be part of the Health Insurance Alliance offerings.

Modify Current Pooling Arrangements/Risk Management

- Consider consolidation of risk pools (e.g., Georgia consolidated schools and municipalities' pools) moving towards "mega-pools."
- Consider placement of those under age 65 and over 65 in common pools.
- Consider implementing risk stratification aimed at getting the right care to the right patients by treating people according to their available risk information (i.e., grouping patients by severity of illness is a practice known as risk stratification).
- Consider joint carrier/vendor contracting wherein the state could become its own MCO and bear risk itself.

Plan and Benefit Design

- Encourage wellness and prevention (although this may not save money in the short term).[6]
- Institute similar plan design including common wellness plans, as multiple plan design may contribute to increased risk and adverse selection.
- Consider uniformity and commonality in plans and benefits across all public and quasi-public agencies.
- Design value-based benefits that lower barriers for individuals with chronic diseases (i.e., no charge for insulin for diabetics).

[6] Note: The latest scoring by the Congressional Budget Office (CBO) in the context of national health care reform suggests that prevention may not save money even over the long term, although it may in fact result in healthier people.

- Incentivize lifestyle changes and motivate wellness with financial incentives.
- Conduct biometric screening to encourage a healthy workforce and determine who needs disease management although this could result in short-term cost increases.
- Consider inclusion of health savings account-type options.
- Consider limiting out-of-state coverage. Could consider enhanced regulation and coordination of this benefit including stricter utilization review.
- Offer buffet selection of state benefits (e.g., optional maternity benefits) or exempt agencies from benefits mandates.

Pharmaceutical

- Consolidation of pharmaceutical formularies and pharmacy benefits management for all public and quasi-public entities may provide some benefits unless current purchasing of pharmaceuticals is already achieving cost efficiencies through volume purchasing with larger commercial groups. For those entities in which pharmaceuticals are part of larger health plans or contracts that also manage commercial or national groups, a consideration of "carving out" pharmacy purchasing and management would need to begin by determining whether there would truly be a cost savings or actually a cost and administrative increase.[7] This approach would have to include significant protections to assure adequate information flow for care management purposes.
- Introduce plan changes shifting more out of pocket costs to members and encouraging the use of formulary prescription drugs by increasing copay for non-formulary drugs (i.e, similar to NMPSIA).
- Increase use of clinical pharmacists as health care extenders.
- Quality, centralized data needed by care managers working on consolidation of pharmaceutical services.
- Do not carve out pharmaceutical from Medicaid unless using an administrative services organization with good data availability.
- Increase utilization review.
- Clinical pharmacists patient data would need to be reported back to patients' doctors; clinical pharmacists pay would need to be enhanced accordingly; and care coordination would need to be enhanced.

Data

- Designate an entity to regularly gather and compile common data reporting from the public and quasi-public health coverage entities as it has proven difficult to compile data for purposes of this report since there were no common definitions, reporting periods or data compilation in existence for these agencies.

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[7] Note: Funding for a study to determine the impact on various agencies was requested several years ago in the context of legislation or a memorial that requested state agencies look at this possibility. This funding was not appropriated so the study was not accomplished.

- Determine a common data reporting year (e.g., state fiscal year) and a common plan year. Currently, the agencies utilize differing plan years varying from members' anniversary dates, state fiscal years, federal fiscal years and calendar years. This variance in plan years is an obstacle to collecting and maintaining "apples-to-apples" data.
- Increase data compilation and analysis for use in designing optimal health plans.
- Consider implementation of an all payers claims database.
- Consider institution of a health information exchange.
- Pool disease management data.
- Pool pharmaceutical data.
- Consider creation of a NM Consolidated Data Warehouse to enable more in depth analyses and compare NM data to other states and nationally.[8]
- Add IBAC and all public entities to GSD's current RFP for a data warehouse.
- Increase internet use of reporting on public and quasi-public agencies' costs and solvency as well as costs of MCOs, PPOs, etc.
- Ask DOI to require uniform reporting from all HMOs, PPOs, etc.

Administration

- Consider expanding the authority of the Health Care Purchasing Act and require joint procurement and purchasing by the IBAC agencies.
- Implement a common enrollment process that is electronic to enhance speed and efficiency and utilize joint referral processes and procedures.
- Implement joint broker certification for HIA, NMMIP and SCI programs with CEUs awarded by DOI.
- Determine a common data reporting year (e.g., state fiscal year) and a common plan year.[9]
- Create common websites amongst all agencies that link to each other.
- Conduct joint outreach and marketing.
- Implement common actuarial and other contracts.
- Although there is not consensus, possibly consider implementing common purchasing of other goods/services by requiring quasi-public health coverage agencies to purchase goods/services off of state's reduced price purchasing lists.
- Decrease third party administration if administering similar health plans and larger risk pools.
- Establish a healthcare exchange or connector to assist New Mexicans in one-stop shopping for insurance coverage.

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[8] Note: The implementation of a health information exchange may create some of this possibility for shared and aggregated data, but privacy issues would need to be explored.

[9] Note: HIA renews plans every six months; NMMIP renews plans annually by calendar year; SCI utilizes a rolling year that begins with clients eligibility date; PAK's plan year is dependent on the MCOs methodology; PAM has coverage for the duration of the pregnancy and post-partum period; APS renews plans annually by calendar year; GSD utilizes state fiscal years; NMPSIA's benefit year is based on a calendar year with premium changes in October; and RHCA utilizes calendar years.

- Although there is not consensus, possibly consider consolidating customer service, information and referral for public and quasi-public insurance entities. (MCOs have already done this to some extent for their public plan offerings.)
- Although there is not consensus, consideration could possibly be given to conducting a cost analysis of options for consolidation of infrastructure, assessments, and claims management. Possible options might include:
    - Combine IBAC agencies into a single administering entity (GSD/RMD or a single board, commission or state department);
    - Combine NMPSIA with APS into a single public schools insurance authority, covering just health care issues;[10]
    - Combine NMPSIA and GSD/RMD for health insurance and other risk management products;
    - Require public colleges and universities to participate in publicly administered plans (i.e., one or more of the IBAC agencies);[11]
    - Combine agencies into HIA operating as an insurance exchange;
    - Expand HIA to offer different benefit plan options, and expand to include a self-employed individual as a group of one;
    - Combine agencies into *Insure New Mexico!* Solutions Center operating as an insurance exchange;
    - Combine HIA and NMMIP;[12]
    - Combine HIA with HSD's *Insure New Mexico!* programs;
    - Combine all eight (8) entities/programs into a single existing administrative entity such as GSD, NMPSIA, or HSD, or create a new administering entity, commission or department (e.g., a NM Health Coverage Commission or NM Risk Management Department), determining whether such an entity covers just health care for all public entities.[13]

[10] Note: APS is concerned that combining Albuquerque coverage with non-Albuquerque coverage would increase APS employees' costs. While there was a study done years ago looking at these two options, there has not been a study ever or at least not recently about the impacts of combining APS and other IBAC or *Insure NM!* Partners, all of whom have Albuquerque based individuals in their programs.
[11] Note: University of New Mexico, NM Institute of Mining and Technology, Clovis Community College, Southwestern Indian Polytechnic Institute, and DINE College are the only state higher education institutions whose employees and/or retirees do not have health coverage offered by an IBAC agency. UNM offers its own plan and currently covers 5,543 employees and 1,843 retired employees.
[12] Note: Federal health reform may have a bearing on this option, depending on how any exchange or gateway is structured and what role Medicaid chooses or is required to play in that process (see Introduction).
[13] Note: APS, NMPSIA and GSD/RMD are also responsible for other risk programs (property, liability, workers' compensation) which are outside the scope of this memorial, but could be considered if consolidation is proposed.

ATTACHMENT 4
APS District Worksite Wellness Initiatives
Health & Wellness Department With Support from
APS-Sponsored Health Plans - Presbyterian and Lovelace Health Plan

Wellness Benefits Offered to All Employees Enrolled for Medical – At No Cost!

Presbyterian Members	Lovelace Members
Healthy Advantage Program	**Healthy Steps Program**
Healthy Advantage Focus: • Prevention • Screenings • Wellness Program Participation	Baby Love – Baby's Health
At Risk: • Obesity • High Cholesterol • Hypertension	Healthy Steps Coaching
Acute Illness/Discretionary Care Doctor Visits – Emergency Room • Nurse Advice Line • Web Tools • Consumer Directed Health Plan	Healthy Trails
Chronic Illness • Diabetes • CAD	Healthy Roads
Catastrophic Head Injury – Cancer • Case Management • Predictive Modeling	Healthy Steps Personal Health Risk Assessment Health Weight S.T.O.P. On-Line Education Tools Nurse Advice & Health Information Line Behavioral Health Outreach and Education
To obtain additional information, Presbyterian Members visit: www.phs.org	**To obtain additional information, Lovelace Members visit: www.lovelacehealthplan.com**

ATTACHMENT 5--Wellness Benefits of NM State Employees Health Plans

Wellness Benefits are in addition to covered items in health plans that have copays and deductibles.

	Blue Cross & Blue Shield of NM	Lovelace	Presbyterian	United
Web address	www.bcbsnm.com	www.lovelacehealthplan.com	www.phs.org	www.myuhc.com
Or contact:	877-994-2583	877-480-9368	505-923-5600 or 888-275-7737	866-633-2446
Complementary/ alternative medicine (CAM)	Up to 30% off services such as yoga, Pilates, massage therapy, acupuncture	Discounts on massage, acupuncture, supplements	Through benefitsource.org for massage & acupuncture	Info at www.unitedhealthallies.com
Health risk assessment	Online as part of Personal Health Manager tool	Online or call 877-480-9368	Online on Member Portal page - Web MD Health Manager	Online
Health tracking tools	Online through Personal Health Manager	Online	Online on Member Portal page- Web MD Health Manager	Online
Discounts	For weight management facilities, complementary medicine items	Discounts through Body Balance for massage, acupuncture, chiropractic, vision, supplements	Through benefitsource.org for massage, acupuncture, Defined Fitness membership, vision	Gym, spa discounts Info at www.unitedhealthallies.com
Lifestyle coaching	Email	877-480-9368	Online on Member Portal page - Web MD Health Manager	Online
Nurse Advice Line for Wellness	24/7 Online	24/7 877-725-2552	24/7 866-221-9679	24/7 800-842-0241
Nutrition information	Online	877-480-9368	Online recipes & tips Online on Member Portal page - Web MD Health Manager	Online
Exercise assistance	Workout guidance, tips online	Personalized programs	Exercise plan guidelines available from med. Provider or Online on Member Portal page - Web MD Health Manager	Online coaching
Quit smoking	Lifestyle coach	7 free, individual counseling sessions 877-480-9368	No cost 1-888-840-5445	50% co-insurance
Weight management	Lifestyle coach	10 individual counseling sessions	Online on Member Portal page - Web MD Health Manager	Online
Preventive health screening reminders	By email	Online or by mail	Online	Online
Other	Blue Points Program - activities earn points to be redeemed for health equipment, gift cards- online	Life Points online incentive program for wellness initiatives & worksite consultants	Wellness education classes in Albq.; fee free or up to $45. And Online on Member Portal page - Web MD Health Manager	Personalized home page tracks health changes Health dollars redeemable for incentives

ATTACHMENT 6 – ACRONYMS

ASO	Administrative Services Only
CMS	U.S. Centers for Medicare and Medicaid Services
COBRA	Federal Consolidated Omnibus Budget Reconciliation Act
DOI	New Mexico Public Regulation Commission's Division of Insurance
FPL	U.S. Federal Poverty Level
GSD/RMD	New Mexico General Services Department/Risk Management Division
HIA	New Mexico Health Insurance Alliance
HIPAA	Federal Health Insurance Portability and Accountability Act
HPC	New Mexico Health Policy Commission
HSD	New Mexico Human Services Department
HSD/MAD	New Mexico Human Services Department/Medical Assistance Division
IBAC	Interagency Benefits Advisory Committee groups joined to improve insurance purchasing power: GSD, Retiree Health Care Authority (RHCA), Albuquerque Public Schools (APS) and Public Schools Insurance Authority (NMPSIA)
LHHS	New Mexico Legislative Health and Human Services Committee
MCO	Managed Care Organization
NMMIP	New Mexico Medical Insurance Pool
PPO	Preferred Provider Organization
PRC	New Mexico Public Regulation Commission
RFP	Request for Proposals
SCHIP	U.S. State Children's Health Insurance Program
SCI	New Mexico State Coverage Insurance Program
TPA	Third Party Administrator