Health Notes

Program Evaluation Unit
Legislative Finance Committee
Date: August 18, 2017

IBAC Cost and Utilization Trends, 2012—2016

AT A GLANCE

The Interagency Benefits Advisory Council (IBAC), created by the Health Care Purchasing Act in 1997, has yet to reach the full fiscal promise of the combined purchasing power of the state's public employees and retirees. The IBAC agencies include Albuquerque Public Schools (APS), the General Services Department (GSD), the New Mexico Public School Insurance Authority (NMPSIA), and the Retiree Health Care Authority (RHCA). Together they provide coverage for over 150 thousand members and are second only to the Medicaid program in terms of state dollars spent on health care. The IBAC agencies are challenged to contain health care costs that are rising faster than utilization. Although the agencies have used an array of techniques to try to manage expenditures, they have not been able to address one of their key cost drivers: the relatively high payment rates negotiated on their behalf by the commercial carriers with virtually no transparency or accountability.

As this Health Note demonstrates, the IBAC agencies are paying higher average rates than Medicare, which in turn pays higher rates than Medicaid. The primary tools IBAC agencies have used to attempt to contain rising costs are increased premiums and out-of-pocket costs like deductibles and copayments, but this approach simply shifts more costs to members—and the state—and does not address the root cause. Rising healthcare costs and higher premiums also impact compensation for state employees as more money is locked up in benefits rather than take-home pay.

In 2010, 2013, and 2015, LFC evaluations found the IBAC agencies generated significant savings from their one venture into truly consolidated purchasing, the contracting of a common pharmacy benefits manager (PBM). Other opportunities for savings previously recommended by the LFC, including consolidation of all purchasing as well as administrative tasks such as data collection and analysis, and actuarial and auditing functions, remain promising but elusive.

This brief reviews IBAC cost and utilization trends from FY12 through FY16, and identifies key cost drivers such as outpatient services, emergency room utilization, and high-cost claimants. The brief also offers a first-of-its-kind direct benchmarking of IBAC agency expenditures to Medicare. The comparison to Medicare costs shows IBAC frequently pays higher rates for similar services. In addition to the previous LFC recommendations listed above, there are further opportunities for state savings through greater IBAC agency participation in negotiating provider rates rather than continued and potentially unsustainable cost-shifting to members. True consolidation of the IBAC agencies could likely facilitate greater influence over rates, as may a shift away from straight fee-for-service payments.

Health Notes are briefs intended to improve understanding of healthcare finance, policy, and performance in New Mexico.

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

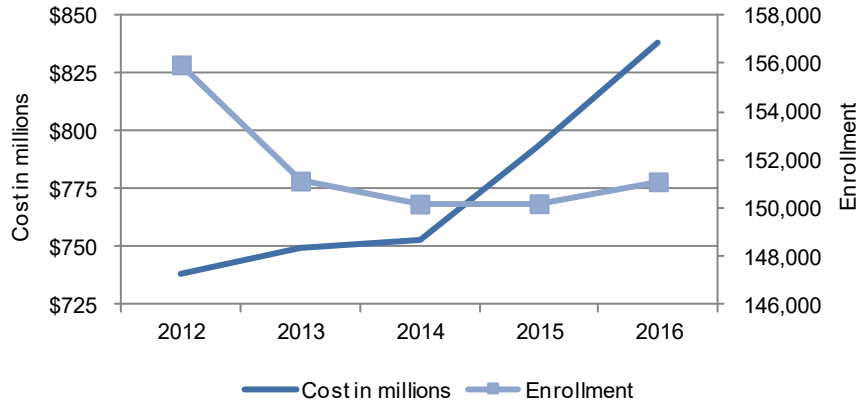
The IBAC agencies in brief

IBAC enrollment overall has declined 3 percent since FY12, while total healthcare costs have risen by nearly 14 percent, driven more by high prescription drug prices and spiraling payment rates than increased member utilization.

The four IBAC agencies each run their own self-funded healthcare plans and each is able to design its plan independently, but they are required by law to combine the negotiating power of their populations and issue joint requests for proposal (RFP) for health care and pharmacy benefit management services. The IBAC estimates it saves approximately $25 million per year through joint purchasing, about $10 million of which is associated with pharmacy spending.

IBAC's escalating healthcare costs are driven more by the combination of steep prescription drug price increases and spiraling payment rates than member utilization. In FY12, the IBAC agencies had a total enrollment of 155,976 members – by FY16, that number had dropped to 151,662, approximately a 3 percent decline. Total healthcare costs, which include medical claims paid, prescription drug costs net of rebates and discounts, and member out-of-pocket deductible and copayment amounts, have gone in the other direction, rising from $738 million to $838 million, or almost 14 percent. The role of payment rates can also be seen in overall higher claims costs per member, which have increased by 16 percent.

Chart 1: IBAC Health Care Costs and Enrollment
Total costs include medical claims paid, prescription drug costs and member out of pocket costs.



Source: LFC analysis of agency data

Albuquerque Public Schools (APS) runs its own health benefits program and covered over 18 thousand school employees and their eligible dependents in FY16. APS enrollment data shows a 6 percent increase in total covered lives from FY12 through FY16. Notably, that increase is driven by a 14 percent increase in employee spouses and eligible dependents, counterbalanced by a 3 percent drop in enrolled employees. During the same period, APS's total healthcare costs increased by about 3 percent, driven largely by a 28 percent increase in prescription drug spending, second highest among the IBAC agencies.

The General Services Department's (GSD) Risk Management Division is the employee health benefits purchasing agency for state government as well as an array of local public bodies and higher education institutions. GSD is experiencing declining enrollment, although with over 62 thousand covered lives in FY16 and over $285 million in healthcare spending it is still the largest IBAC agency. From FY12 to FY16, GSD had a 4 percent decrease in enrollment; during the same period, total healthcare costs rose by over 11 percent.

Table 1. IBAC Five-Year Growth Rates

IBAC Agency	Covered Lives Growth	Medical Cost Growth	Rx Cost Growth
APS	6.1%	-6.5%	28.1%
GSD	-4.2%	8.9%	12.8%
NMPSIA	-5.2%	19.4%	20.1%
RHCA	-1.4%	15.6%	43.1%

Source: LFC analysis of IBAC agency and health carrier data

The New Mexico Public School Insurance Authority (NMPSIA) is the health insurance purchasing agency for public school districts, post-secondary educational entities, and charter schools, and currently covers over 52 thousand school employees and eligible dependents. NMPSIA is also experiencing declining enrollment with rising medical and pharmacy costs. From FY12 to FY16, NMPSIA had a 5 percent decrease in enrollment. During the same period, its total health care costs grew by 16 percent, driven almost equally by rising prescription drug spending and increased medical costs.

The Retiree Health Care Authority (RHCA) members come from the state's public schools, state agencies, and over a hundred local public service and governmental entities. The agency provides healthcare coverage to two distinct populations of retirees: those under age 65 not yet eligible for Medicare, and those older than age 65 who are enrolled in Medicare, as well as their eligible dependents. This Health Note will focus only on the pre-Medicare fully insured population because that is the area fully under state control and funding. From FY12 to FY16, RHCA had a 17 percent increase in total enrollment, but the pre-Medicare population declined by about one and a half percent, likely related to a nationwide trend of fewer individuals opting to retire before age 65. Despite declining enrollment, total healthcare costs for the pre-Medicare population grew by 19 percent, driven largely by a 43 percent increase in prescription drug spending.

See Appendix A for more detailed data for each IBAC agency.

IBAC agencies cannot provide meaningful oversight of the health carriers they contract with because they do not receive consistent and comparable data from all carriers. For the same reasons, the cost and utilization information presented in this report is as accurate as possible but does contain some estimates as noted. If all the IBAC agencies used the same data warehouse the result would be improved access to truly consistent and useful IBAC-wide data. RHCA has its own data warehouse, but the other IBAC agencies are dependent on the carriers to gain access to their own information. However, both APS and NMPSIA have recently added data warehouse services to their benefits consulting and actuarial services contracts with Segal.

APS cost and utilization data had to be estimated for CY12-CY14 due to incomplete data from a now defunct carrier. For purposes of this brief APS agreed to have LFC staff use CY15 and CY16 data to approximate the missing data points. Lastly, some IBAC agencies run on calendar years and others use fiscal years, so this report smoothes calendar year and fiscal year data wherever possible.

Three IBAC agencies do not have full access to their own healthcare utilization and cost data and instead must rely on their contracted health carriers for basic information. As a result, data can be difficult to obtain and even more difficult to compare.

Premium structure and trends

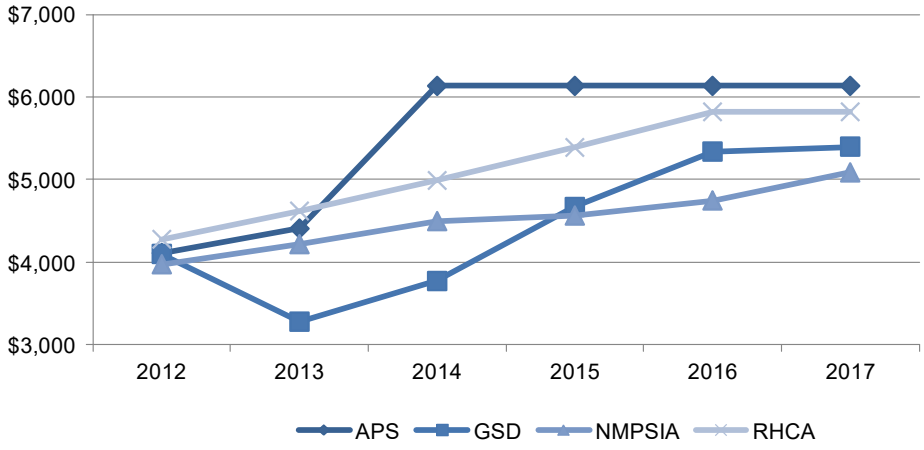
IBAC premiums have increased significantly over the last five years despite the fixed subsidy structure and the fact that in most cases the larger portion of the increase will ultimately fall on employers and the state.

Health care premiums for all IBAC agencies are, by statute, subsidized by state appropriations. For APS, GSD, and NMPSIA, subsidies are structured by employee salary, while for RHCA subsidies are based on years worked prior to retirement. Each agency offers at least two different plan options for its members, but the contribution rates for employee/retiree and the state remain the same regardless of which plan the member selects. (Appendix C has a complete chart of contribution levels.)

This fixed subsidy structure limits the agencies' ability to raise premiums to offset rising costs, since in most cases the larger portion of the increase will fall on the employer or the state. Premiums have nonetheless increased, although the IBAC agencies have approached the timing and extent of premium increases very differently, as chart 2 shows.

- APS had a 5 percent increase in 2013, a much larger 39 percent increase in 2014, and has since held premiums flat.
- GSD actually had a decrease in 2013 as it added a new high deductible plan, followed by a 15 percent increase in 2014, a 24 percent increase in 2015 (using the average of premiums for the first and second half of that year), a 14 percent increase in 2016, and then just a one percent increase for 2017.
- NMPSIA premiums increased 6 and 7 percent in 2013 and 2014, respectively, one percent in 2015, 4 percent in 2016 and 7 percent for 2017.
- RHCA held to a steady 8 percent annual increase from 2013 through 2016. Retirees had the option of avoiding any premium increase for 2017 if they were willing to switch to the agency's new leaner Value HMO plan..

Chart 2: IBAC Premiums for Lowest Cost Individual Plans



Source: Agency rate sheets

Premiums for the IBAC agencies compare favorably to the most commonly-used national benchmark, the Kaiser Family Foundation's annual survey of employer health benefits. For 2016, the national average annual individual premium for employer-sponsored health insurance was $6,435 for all types of plans, and $5,762 for the very lowest cost high deductible plans. The lowest individual premiums for the IBAC agencies ranged from $4,566 for NMPSIA to $6,135 for APS, or an average of $5,511 for all four. On the other hand, the IBAC agencies are higher than the national average in terms of employee contributions to premiums. The national average is 18 percent for individual coverage, and no IBAC member pays less than 20 percent of premium.

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Benefit plan design trends

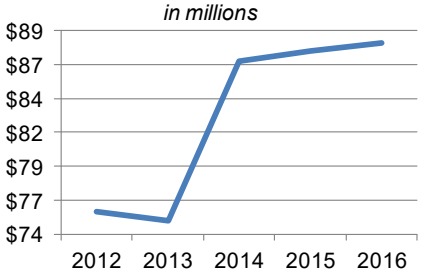
Plan design changes to deductibles, annual out-of-pocket maximums and copayments for various services can be another way to shift rising costs to members and encourage members to be more cost-conscious in their use of healthcare services.

All the IBAC agencies made some major plan revisions for 2017, some of which are described in this summary. However, due to the time frame of this brief the cost savings that may result from these recent changes are not captured here.

Utilization increases are not a major cost driver for the IBAC agencies, and rising out-of-pocket costs could be part of the explanation. Average out-of-pocket expenses per IBAC member rose 15 percent between 2012 and 2016. The IBAC agencies have all followed a pattern of some years with significant increases to their annual deductibles and out of pocket maximums, while holding both stable for most of the years from 2012 through 2017. Annual deductible increases during that time period were 67 percent for APS, 117 percent for GSD, 33 percent for NMPSIA, and 167 percent for RHCA. Out-of-pocket maximum increases were generally lower: 13 percent for APS, 17 percent for GSD, 7 percent for NMPSIA, and a 50 percent increase for RHCA in 2017. See charts 4 and 5.

Chart 3: Aggregate IBAC Member Out of Pocket Amounts

in millions

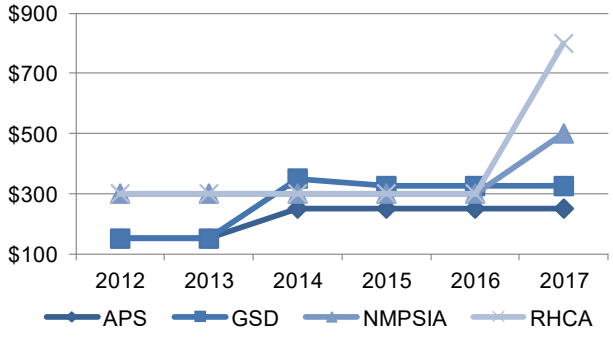


Source: LFC analysis of agency data

According to Kaiser, the national average individual deductible for 2016 was $1,478, significantly higher than any IBAC deductible. Further, average IBAC deductibles increased 31 percent between 2012 and 2016, slightly slower than the national rate of 35 percent.

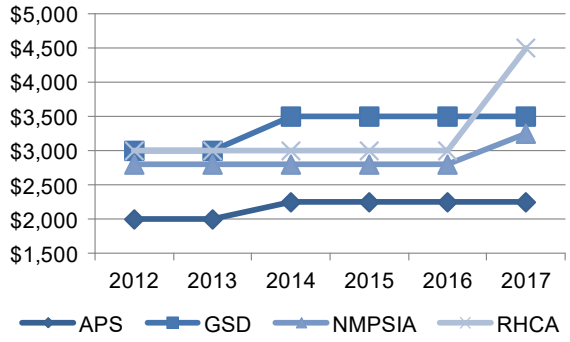
Nationally, 14 percent of workers with employer-sponsored health coverage had out-of-pocket maximums of less than $2,000 in 2016, while 18 percent had maximums of $6,000 or more. The IBAC agencies, with 2016 out-of-pocket maximums ranging from $2,250 to $3,500, fall towards the lower end of the national spectrum.

Chart 4: Lowest Individual Annual Deductible



Source: Agency benefit summaries

Chart 5: Individual Annual Out of Pocket Maximums



Source: Agency benefit summaries

A brief review of agency-level trends for copayments for select medical services and pharmacy benefits shows differing strategies for using plan design as a tool for constraining rising costs.

APS increased copayments for specialist, urgent care, and emergency room visits by about 14 to 25 percent between 2012 and 2016. Copayments for hospital stays shifted from a set $750 in CY12 to a 20 percent coinsurance in CY16. The APS pharmacy benefit plan design remained stable from 2012 through 2016, with slight increases in copayments for everything but generic drugs. For 2017, APS made a complex plan design change and implemented a new single plan with three tiers.

The IBAC agencies, with 2016 out of pocket maximums ranging from $2,250 to $3,500, fall towards the lower end of the national spectrum.

Between 2012 and 2016, GSD increased copayments for primary care, specialist visits, and hospital stays by 67 percent, 33 percent, and 25 percent, respectively. GSD's pharmacy benefit plan remained essentially the same from 2012 through 2016.

The most distinctive change to GSD's benefit package came with the September 2015 opening of the Stay Well Health Center in Santa Fe. The clinic provides urgent and routine primary care to members with no deductibles or copayments. This is an effort to provide prompt access to care as well as reduce overall medical costs as a result of better disease management through health coaching. The clinic was initially slow to attract state workers, but during 2016, the total number of patients seen (new and returning) increased by over 600 percent, with a 48 percent return rate.

GSD tracks utilization of the Stay Well Health Center separately and cost savings will be difficult to determine without more in-depth analysis.

NMPSIA increased premiums as noted above, but until 2017 held copayments for both medical services and prescription drugs relatively stable. Beginning in 2017, however, NMPSIA made significant increases to copayments for primary care, specialist visits, and urgent care, as well as for prescription drugs.

RHCA, after years of virtually no changes, made its medical plan options significantly leaner for 2017. Copayments for most medical services have increased considerably. RHCA has made no changes to its pharmacy benefit package since 2012, although it is worth noting that the existing RHCA plan already has the highest member cost sharing of the IBAC agencies.

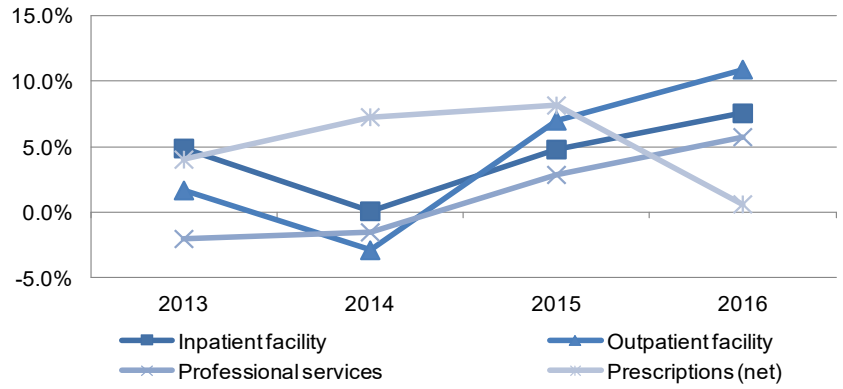
Medical Services and Prescription Drug Trends

IBAC's total medical expenditures, including inpatient services, outpatient services, professional services, and prescription drug costs (net), increased by 13 percent between 2012 and 2016, from $662 million to $750 million. In the same time period, overall IBAC enrollment dropped by nearly 3 percent. Outpatient medical costs grew from $235 million to $275 million, or 17 percent, representing the

largest portion of total medical spend over the five-year period. Inpatient hospitalization costs rose steadily from $124 million to $147 million, or 18 percent, while professional service costs declined from $125 million in 2012 to $120 million in 2014 and then rose steeply to $131 million by 2016, for a five-year growth trend of 5 percent. See charts 6 and 7.

IBAC's total medical expenditures increased by 13 percent between 2012 and 2016. During the same time period, overall IBAC enrollment dropped by nearly 3 percent.

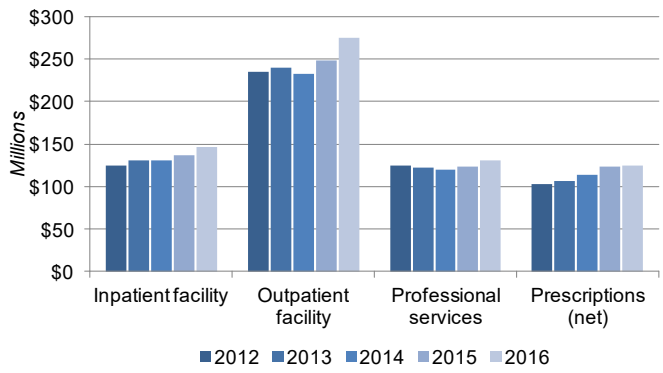
Chart 6: Year-Over-Year Growth Rates for Major Service Categories



Source: LFC analysis of agency data.

Outpatient facility services was the most costly medical cost category for all IBAC agency plans between FY12 and FY16. Similar to national trends, outpatient facility services are becoming an ever-larger portion of overall medical expenses. The Center for Medicare and Medicaid Services (CMS) Office of the Actuary reported the ratio of total hospital Medicare fee-for-service payments for outpatient services grew from 15.7 percent in 2000 to 26.5 percent in 2014, serving as the main driver of hospital payment increases. Medicare defines outpatient facility services as services provided in an eligible hospital setting including emergency or observation services, same-day surgery, hospital laboratory tests, and radiological services.

Chart 7: Total Expenditures by Major Service Category



Source: LFC analysis of agency data

Between 2012 and 2016, the amount IBAC agencies paid per claim increased at a much faster rate than the total number of claims, indicating payment rates have increased faster than utilization.

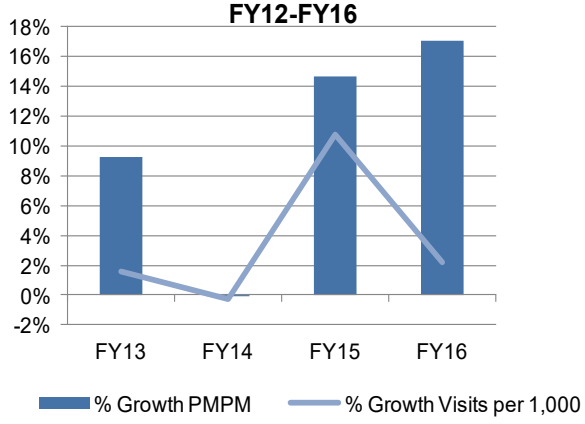
Two other utilization trends offer further support for the LFC's concern that IBAC costs are being driven more by payment rates than increases in utilization. Between 2012 and 2016, the total number of claims increased by less than one percent, while both the amount paid per claim and the amount paid per claimant increased by approximately 6 percent.

Emergency room costs increased significantly between FY12 and FY16 for GSD and NMPSIA, far outpacing growth in utilization. As the two largest membership pools within the IBAC, GSD and NMPSIA have both shown significant cost growth for emergency room visits, from $20.20 PMPM in FY12 to $29.94 PMPM in FY16, an increase of 48 percent.

Emergency room costs and utilization continue to require attention from IBAC agencies in order to control overall cost growth.

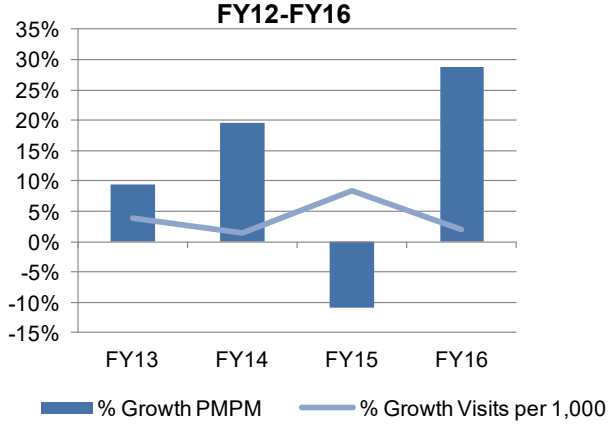
Emergency room visits per 1,000 members also increased over the same time period, but only by 16 percent. Service rates appear to be a driver in overall cost growth, especially considering the disproportionate growth rates in ER expenditures and utilization. According to New Mexico data collected by the Kaiser Family Foundation, there were an average of 490 ER visits per 1,000 New Mexicans in 2015. In FY16, GSD's and NMPSIA's combined average ER utilization rate per 1,000 members was 180.56. This total is significantly less than the state ER utilization rate, but the upward trend is still a point of concern. Emergency room costs and utilization continue to be a service category requiring attention from IBAC agencies in order to control overall cost growth. See charts 8 and 9.

Chart 8: GSD ER Cost and Utilization Growth Rates FY12-FY16



Source: LFC analysis of IBAC health plan data

Chart 9: NMPSIA ER Cost and Utilization Growth Rates FY12-FY16



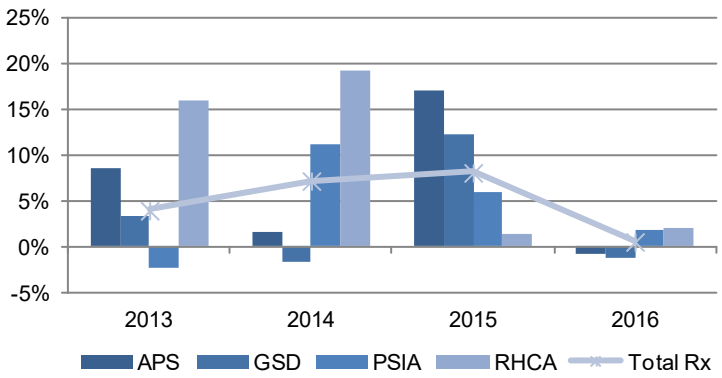
Source: LFC analysis of IBAC health plan data

IBAC prescription drug costs, net of discounts and rebates, rose from $102 million to $124 million, or 21 percent, between FY12 and FY16. Prescription drug costs are clearly a driver of overall medical costs for the IBAC agencies, but the rate of increase for all agencies has slowed over the last couple of years, from highs between 12 percent and 19 percent in 2014 and 2015 to more manageable 2 percent increases for NMPSIA and RHCA and even negative growth rates for APS and GSD in 2016 (chart 10).

The primary reason for this slowing trend is very likely less utilization of costly drugs for the hepatitis C virus (HCV). Because these drugs provide a cure for the disease, once the majority of IBAC members with HCV have received treatment agency spending in this disease area can be expected to drop significantly.

The LFC completed a comprehensive review of prescription drug spending among state agencies in 2016; please see that brief for more detailed information about IBAC trends for specific conditions and drugs.

Chart 10: IBAC Prescription Drug Costs Year-Over-Year Rate of Increase



Source: LFC analysis of agency data

Differences in demographics of each IBAC agency lead to some interesting differences in cost trends. Highlights of agency-specific trends include:

APS is the one IBAC agency that appears to run counter to the trend just identified: its total number of claims has increased very little over the five-year time span of this review, but average amounts paid per claim and per claimant have decreased by 14 percent and 20 percent, respectively. In CY16, APS spent nearly 46 percent more on outpatient facility than inpatient, in line with IBAC trends overall, although the agency has seen a 30 percent increase in inpatient costs over the last five years, including a nearly 87 percent increase in per admission costs. Between CY12 and CY16, APS experienced a 28 percent increase in prescription drug costs, the second highest growth rate of all IBAC agencies; the agency's plan design changes may be turning this trend around as CY16 prescription costs were lower than CY15.

APS appears to have a trend unique among IBAC agencies: its total number of claims has increased very little over the five year time span of this review, while average amounts paid per claim and per claimant have actually decreased.

For GSD, total claims dropped by nearly 2 percent between FY12 and FY16, while the average amount paid per claim rose by 10 percent. In the same time period, GSD saw a 13 percent increase in prescription drug costs, the lowest growth rate of all the IBAC agencies. GSD's outpatient medical costs grew from $97 million to $108 million, or 12 percent, between FY12 and FY16, representing the largest portion of total medical spend over the five-year period. Inpatient hospitalization costs increased by nearly 15 percent, from $52 million to $60 million, while professional services costs rose 8 percent, from $28 million to $39 million.

NMPSIA's total number of claims increased nearly 3 percent over the last five years, while the average amount paid per claim increased 17 percent. NMPSIA's medical expenditures were dominated by outpatient facility costs, which increased 29 percent between FY12 and FY16, and by FY16 made up 46 percent of total expenditures. Inpatient facility costs increased by 24 percent, but still made up only 23 percent of total FY16 costs. Between FY12 and FY16 NMPSIA experienced a 20 percent increase in prescription drug costs, although the rate of cost increases leveled out somewhat from FY15 to FY16.

RHCA's total claims dropped by one and a half percent between FY12 and FY16, while the average amount paid per claim rose by 17 percent. In the same time period, RHCA saw the highest rate of increase in prescription drug costs, 43 percent, with spending rising from about $18 million in FY12 to nearly $26 million in FY16. Almost half of RHCA's total pre-Medicare medical expenses were related to outpatient care, which increased by 26 percent between FY12 and FY16, from $36 million to nearly $46 million, and by FY16 made up 44 percent of total medical expenditures. Inpatient hospitalization costs increased by 18 percent, from $21 million to $25 million, while professional service costs rose just over 2 percent, from $33 million to about $34 million.

High-cost clients are another key IBAC cost driver

The percentage of clients deemed high-cost is significantly higher for IBAC agencies when compared to other large employers, and represent a much larger portion of total expenditures. For the purposes of this analysis, a high-cost client is defined as a claimant with greater than $50 thousand in claims in a single year. In 2016, the non-partisan American Health Policy Institute (AHPI) conducted a survey of 26 large private employers, looking specifically at high-cost clients. In the table below, some of the metrics from the AHPI survey are listed with corresponding measures for IBAC agencies.

Table 2: IBAC Agency High-Cost Client Comparison, 2016

	AHPI Survey	APS	GSD	NMPSIA	RHCA
Percent of plan members identified as high-cost clients	1.2%	0.8%	1.2%	2.8%	2.2%
Average annual high-cost client cost	$122,382	$117,915	$116,628	$124,355	$127,147
Percent of total plan expenditures associated with high-cost clients	31.0%	17.2%	34.5%	37.4%	46.9%

Source: LFC analysis of FY16 IBAC health plan data (CY16 APS data) and AHPI

IBAC agencies were more heavily impacted in all three categories measured in the AHPI survey by high-cost clients, with a few exceptions. For example, GSD had an equal percentage of plan members designated as high-cost clients and a lower annual average cost per high-cost client than AHPI-surveyed employers. However, it is noteworthy all but one IBAC agency had a noticeably higher percentage of expenditures related to high-cost clients than the 26 participating employers in the AHPI survey, as noted in Table 2. APS scored the best in two out of three metrics when compared to both other IBAC agencies and the AHPI-surveyed employers. RHCA's average annual cost per high-cost client and percent of expenditures associated with high-cost clients are likely heavily influenced by the health characteristics of retirees including greater prevalence of chronic disease and increased medical acuity.

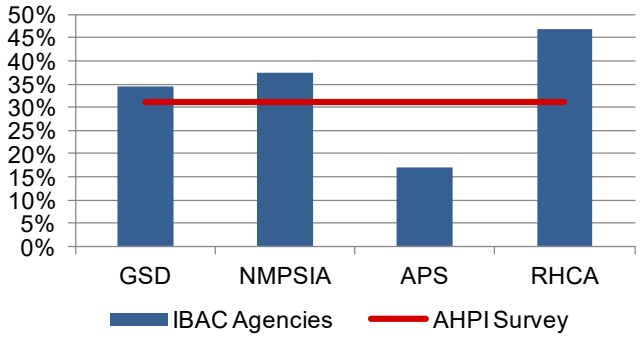
Looking broadly at the three performance metrics identified in the survey, IBAC agencies generally performed worse when cost was a factor. IBAC had a low per-

centage of plan members deemed high-cost, but when expenditures for these clients are considered, it becomes clear how much of a cost driver they are. While it is possible higher acuity could be a contributing factor, as is the case with RHCA, it stands to reason price is also a driver of high average annual cost and percent of expenditures associated with high-cost clients.

The AHPI survey also identified the percentage of high-cost client expenditures related to acute medical episodes and those tied to chronic illness. For surveyed employers, 53 percent of high-cost client medical expenditures were tied to chronic conditions.

This data could prove very useful in targeting disease management and wellness initiatives. However, this type of data is not reported by the health carriers administering IBAC plans.

Chart 11: Percent of Total Plan Expenditures from IBAC High-Cost Clients vs. AHPI Survey Results

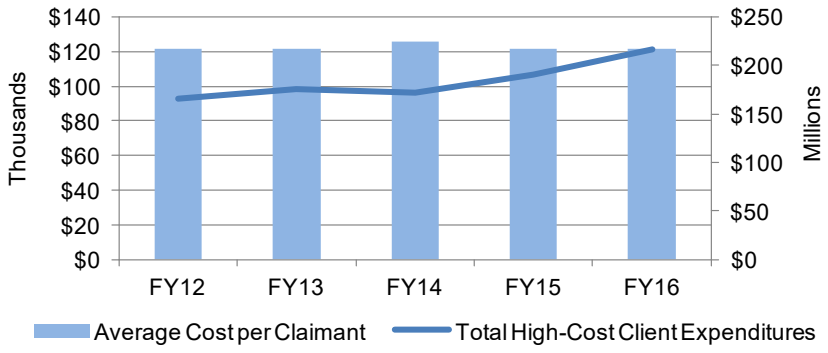


Source: LFC analysis of FY16 IBAC health plan data (CY16 APS data) and AHPI

While average cost per high-cost client remained relatively flat between FY12 and FY16, total high-cost client expenditures increased 30 percent. Average cost per client for annual claims over $50 thousand remained stable as the number of clients falling into this cost category also increased 30 percent between FY12 and FY16.

This trend is most likely driven by the increasing cost of health care. Further solidifying this is the fact more general diagnoses are costing over $50 thousand in annual claims, making what were previously somewhat routine acute interventions into high-cost claims.

Chart 12: IBAC High-Cost Claims Cost per Client FY12-FY16
**Excludes APS*



Note: LFC was unable to calculate APS data for this metric.
Source: LFC analysis of IBAC health plan data

Comparing IBAC and Medicare costs

Medicare data is the best available benchmark for IBAC expenditures, with data that is transparent, consistent, and available on the state level. Despite demographic differences between the Medicare population and the workers and retirees covered by IBAC plans, evaluating how Medicare costs in New Mexico compare with IBAC costs is informative.

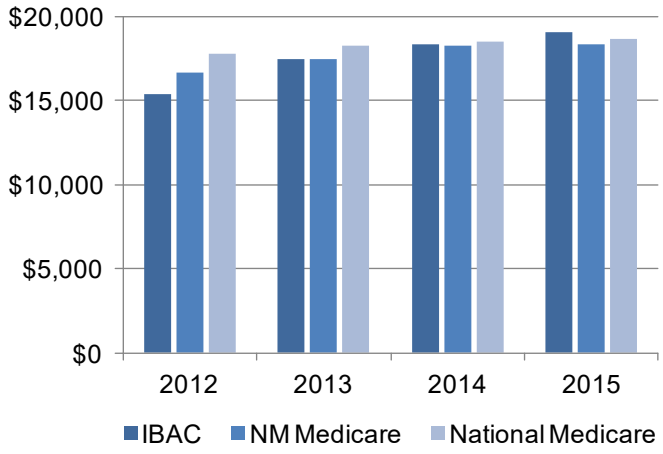
The Kaiser Family Foundation annual report on employer health benefits is the national standard for benchmarking the type, scope, and cost of benefits for employers and workers; unfortunately, there is no similar national benchmark for expenditures. Healthcare costs in general are not transparent, as health plans and providers generally consider cost and payment information proprietary. Costs can also vary greatly by a host of factors including everything from patient demographics, conditions, and acuity, to provider availability, healthcare infrastructure, and geographic location.

One available benchmark with data that is transparent, consistent, and available on the state level is Medicare. While there are demographic differences between the Medicare population and the workers and retirees covered by IBAC plans, evaluating how Medicare costs in New Mexico compare with IBAC costs takes us a step closer to understanding the degree to which IBAC costs are driven by payment rates. The most recent data available for Medicare is 2015, so the range of comparison for this section is 2012 through 2015.

The IBAC agencies have higher cost hospital stays—despite the fact that their members are generally younger and healthier than Medicare recipients—at least in part because they are paying higher rates than Medicare.

From 2012 through 2015, IBAC inpatient per user costs – the actual cost of an average hospital stay – caught and then surpassed Medicare costs. In 2012, IBAC costs were about 8 percent lower than New Mexico Medicare costs and 15 percent lower than national Medicare costs, while by 2015 they were approximately 4 percent and 2 percent higher, respectively. The Medicare population has different demographic characteristics than IBAC members, including an average age of 70, and Medicare patients may have more acute or multiple reasons for a hospital stay, and may stay longer in the hospital than the average IBAC member. However, there does not seem to be any meaningful economic impact of those differences when comparing average inpatient costs per user.

Chart 13: Inpatient Per User Costs



Source: LFC analysis of IBAC and Medicare data

A reasonable conclusion to draw from this information is that the IBAC agencies, despite their younger, generally healthier members, end up with higher cost hospital stays at least in part because they are paying higher rates than Medicare.

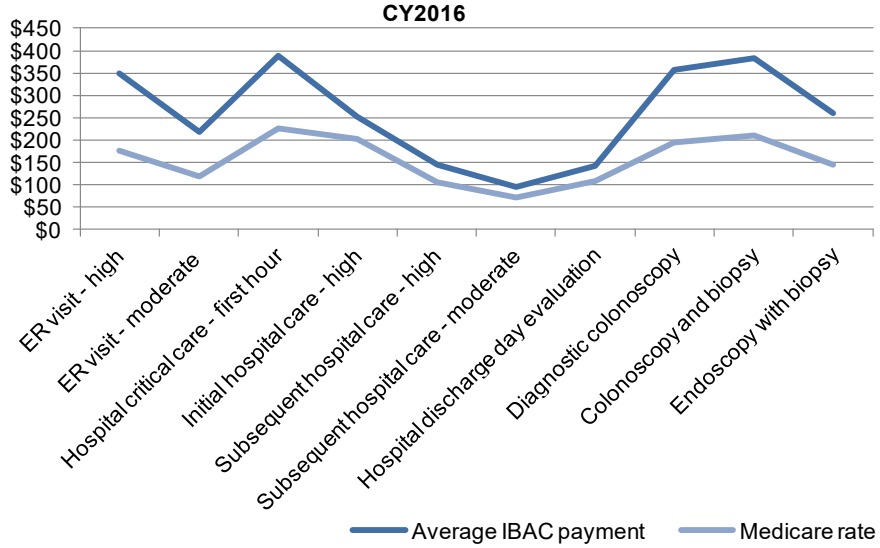
Evidence from one IBAC agency shows that agency pays higher rates than Medicare for many facility-based services. The full cost of facility-based procedures typically includes payments to multiple providers of different types as well as facility charges and fees. Total costs for the same procedure can vary widely from facility to facility and provider to provider, depending on agreements reached between providers, facilities, and health plans. The amount IBAC agencies eventually pay is based on a formula that begins with billed charges and is then reduced by a series of health plan discounts, coverage limits, patient cost sharing, and other adjustments. The details of these payment arrangements are considered proprietary.

One IBAC agency's data showed higher payment rates than Medicare for all of its top ten facility-based physician services.

However, one IBAC agency was willing to share with the LFC the average payment amounts for the physician services portion of its top ten facility-based and outpatient services (based on total costs). Although there are clearly limits to extrapolating from this limited set of data, it is reasonable to assume no one IBAC agency is, on average, being charged substantially more or less for the same services than the others, and analysis of this payment-specific information provides a new glimpse into how much IBAC costs are being driven by high payment rates.

The one IBAC agency's data showed it is paying higher rates than Medicare for all of its top ten facility-based physician services. For emergency room visits of high and moderate complexity, average IBAC payments appear to be between 81 percent and 97 percent higher than Medicare rates; for hospital critical care and high and moderate complexity visits, average IBAC payments appear to be between 25 and 71 percent higher than Medicare. Average IBAC payments for diagnostic colonoscopies, colonoscopies with biopsies, and endoscopies with biopsies appear to be between 80 and 84 percent higher than Medicare. See chart 14.

Chart 14: Comparison of Payment for Select Facility-Based Procedures
CY2016

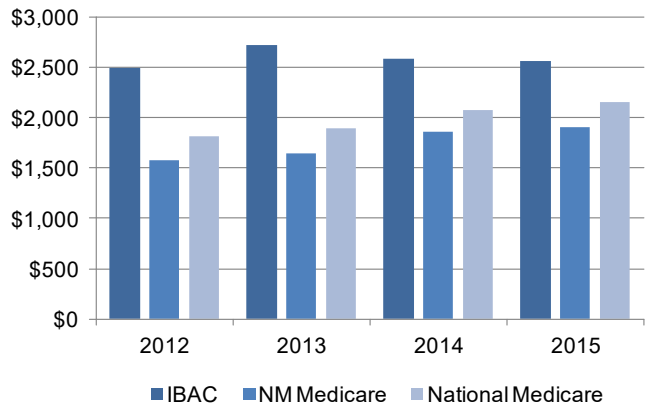


Source: LFC analysis of IBAC and Medicare data

IBAC per capita outpatient costs have been even more markedly higher than Medicare both in New Mexico and nationally.

IBAC per user outpatient costs have been even more markedly higher than Medicare both in New Mexico and nationally. As noted previously, high outpatient costs are a key driver of healthcare costs around the country, but the per user gap between IBAC and Medicare is large enough to offer further evidence IBAC agencies, through their contracted health carriers, appear to be paying considerably higher rates for services than Medicare does. See chart 15.

Chart 15: Outpatient Per User Costs

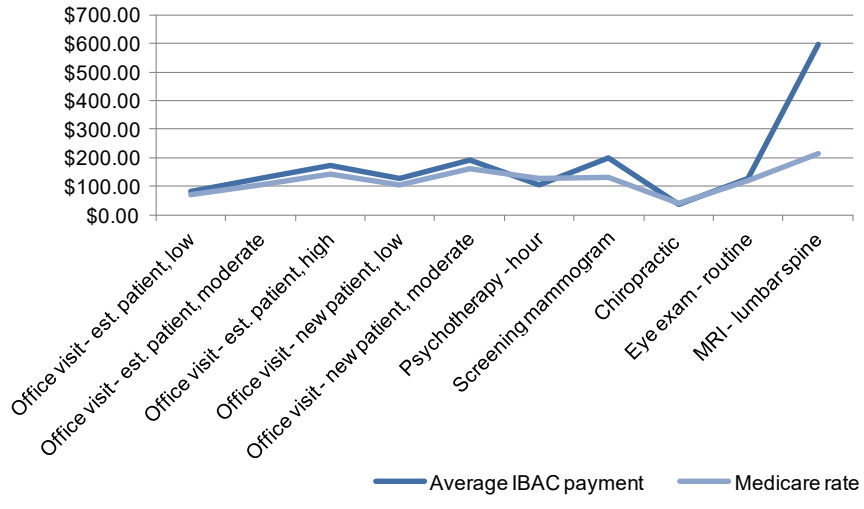


Source: LFC analysis of IBAC and Medicare data

IBAC agencies also paid higher rates than Medicare for many outpatient services. For all but two of the outpatient services the one IBAC agency provided payment data for, physician service payments were higher than Medicare rates for the same services. For office visits for new and established patients, ranging from low to high complexity, average IBAC payments appear to be between 16 percent and 21 percent higher than Medicare rates. For screening mammograms, average IBAC payments appear to be 53 percent higher than Medicare rates, and for MRIs of the lumbar spine, average IBAC payments appear to be nearly 180 percent higher than Medicare rates.

On the other hand, average IBAC rates for routine eye exams appear to be only about 6 percent higher than Medicare rates, while psychotherapy and chiropractic visits appear to be about 17 percent and 13 percent lower than Medicare rates, respectively. See chart 16.

Chart 16: Comparison of Payment for Select Outpatient Services CY16



Source: LFC analysis of IBAC and Medicare data

Conclusion

Review of IBAC cost and utilization trends from 2012 through 2016 found while IBAC agencies have used an array of techniques at their disposal to work to contain rising healthcare costs, they have not been able to address one of their key cost drivers: the relatively high payment rates negotiated on their behalf by the commercial carriers with virtually no transparency or accountability.

This lack of involvement with payment rates is characteristic of the basic administrative services nature of the IBAC agencies. Some influence in this area could be gained through redesign of agency contracts with the carriers. However, the issue can likely only be fully addressed by true consolidation of the individual agencies into a state healthcare purchasing organization with wider decision-making authority. It may also be worthwhile to explore options other than straight fee-for-service purchasing, such as the bundled rates for certain conditions that Medicare is piloting.

The high facility and provider rates IBAC is paying can likely only be fully addressed by true consolidation of the individual agencies into a state healthcare purchasing organization with broader decision-making authority.

Appendix A:
Agency-level Overviews

Albuquerque Public Schools - Employee Health Insurance

(Medical, rx and total are in thousands of dollars)	FY12	FY13	FY14	FY15	FY16	Change
Covered Lives	17,308	17,465	19,452	18,862	18,359	6.1%
year-over-year change		0.9%	11.4%	-3.0%	-2.7%	
Medical*	$58,411	$58,277	$58,392	$52,898	$54,601	-6.5%
year-over-year change		-0.2%	0.2%	-9.4%	3.22%	
Prescription Drugs (Rx)*	$10,270	$11,154	$11,327	$13,259	$13,153	28.1%
year-over-year change		8.6%	1.6%	17.0%	-0.8%	
Total Medical and Rx*	$68,681	$69,431	$69,719	$66,157	$67,754	-1.3%
year-over-year change		1.1%	0.4%	-5.1%	2.4%	
Per Member Medical/Rx Claims Paid Per Year	$3,968	$3,975	$3,584	$3,507	$3,691	-7.0%
year-over-year change		0.2%	-9.8%	-2.1%	5.2%	

* Prescription costs are net discounts and rebates; Total includes medical and prescription only, does not include dental, vision, life and disability.

Source: APS

General Services Department State Health Benefit Utilization

(Medical, rx and total are in thousands of dollars)	FY12	FY13	FY14	FY15	FY16	Change
Covered Lives	65,490	61,509	59,021	60,383	62,724	-4.2%
year-over-year change		-6.1%	-4.0%	2.3%	3.9%	
Medical *	$224,537	$221,113	$198,991	$227,689	$244,550	8.9%
year-over-year change		-1.5%	-10.0%	14.4%	7.4%	
Prescription Drugs (Rx)*	$36,700	$37,900	$37,300	$41,900	$41,400	12.8%
year-over-year change		3.3%	-1.6%	12.3%	-1.2%	
Total Medical and Rx*	$261,237	$259,014	$236,291	$269,589	$285,951	9.5%
year-over-year change		-0.9%	-8.8%	14.1%	6.1%	
Per Member Medical/Rx Claims Paid Per Year	$3,989	$4,211	$4,003	$4,465	$4,559	14.3%
year-over-year change		5.6%	-4.9%	11.5%	2.1%	

* Prescription costs are net discounts and rebates; Total includes medical and prescription only, does not include dental, vision, life and disability.

Source: GSD

Public School Insurance Authority Health Benefit Utilization

(Medical, rx and total are in thousands of dollars)	FY12	FY13	FY14	FY15	FY16	Change
Covered Lives	55,520	54,345	53,624	53,260	52,643	-5.2%
year-over-year change		-2.1%	-1.3%	-0.7%	-1.2%	
Medical*	$185,841	$193,627	$194,953	$202,257	$221,984	19.4%
year-over-year change		4.2%	0.7%	3.7%	9.8%	
Prescription Drugs (Rx)*	$37,400	$36,514	$40,621	$43,035	$43,848	20.1%
year-over-year change		-2.4%	11.2%	5.9%	1.9%	
Total Medical and Rx*	$223,241	$230,141	$235,574	$245,292	$265,832	19.1%
year-over-year change		3.1%	2.4%	4.1%	8.4%	
Per Member Medical/Rx Claims Paid Per Year	$4,021	$4,235	$4,393	$4,606	$5,050	25.6%
year-over-year change		5.3%	3.7%	4.8%	9.6%	

* Prescription costs are net discounts and rebates; Total includes medical and prescription only, does not include dental, vision, life and disability.

Source: PSIA

Retiree Health Care Authority Health Benefit Utilization for Non-Medicare Members

(Medical, rx and total are in thousands of dollars)	FY12	FY13	FY14	FY15	FY16	Change
Covered Lives	17,620	17,803	18,070	17,678	17,365	-1.4%
year-over-year change		1.0%	1.5%	-2.2%	-1.8%	
Medical*	$90,557	$93,909	$99,774	$99,150	$104,450	15.3%
year-over-year change		3.7%	6.2%	-0.6%	5.3%	
Prescription Drugs (Rx)*	$18,100	$20,999	$25,036	$25,390	$25,903	43.1%
year-over-year change		-16.0%	19.2%	-1.4%	2.0%	
Total Medical and Rx*	$108,657	$114,908	$124,810	$124,540	$130,353	20.0%
year-over-year change		5.8%	8.6%	-0.2%	4.7%	
Per Member Medical/Rx Claims Paid Per Year	$6,167	$6,454	$6,907	$7,045	$7,507	21.7%
year-over-year change		4.7%	7.0%	2.0%	6.6%	

* Prescription costs are net discounts and rebates; Total includes medical and prescription only, does not include dental, vision, life and disability.

Source: RHCA

Appendix B:
Current IBAC Medical and Pharmacy Benefit Plans

Table 2: IBAC Medical and Pharmacy Benefit Plans
Lowest Cost Options
2017

	APS	GSD	PSIA	RHCA
	Preferred narrow network	*HMO network only*	*HMO network only*	*HMO network only*
Annual Deductible *Individual/Family*	$250/ $750	$350/ $1,000	$500/ $1,000	$1,500 (individual only)
Annual Out-of-Pocket Limit *Individual/Family*	$2,250/ $6,750	$3,500/ $10,500	$3,250/ $6,500	$5,500 (individual only)
Medical Copayments				
Preventive	$0	$0	$0	$0
Primary care[1]	$25	$25	$25	$35
Specialty[2]	$40	$45	$35	$55
Urgent Care[2]	$50	$50	$45	$40
Emergency room[2]	$150 + 20%	$225	$150 + 20%	$175
Hospitalization[3]	20%	$500	$500 + 20%	30%
Pharmacy Copayments - retail				
Generic	20% ($10 - $25)	$6	$10	$5 - $15
Brand formulary	30% ($35 - $65)	30% ($35 - $95)	30% ($30 - $60)	$20 - $50
Non-formulary	40% ($70 - $140)	40% ($60 - $130)	70%	$40 - $100
Specialty[5] Generic Brand formulary Non-formulary	 $70 $100 $150	 $60 $85 $125	 $55 $80 $130	 Specialty through mail order only
Diabetes insulin and supplies - formulary	$0	n/a	$0	$0

[1]Not subject to deductible.
[2]Per visit.
[3] Per admission after deductible. Includes medical/surgical, acute care and maternity-related admissions.
[4]Specialty meds must be filled through mail order after 2 refills at retail.
Source: Agency summaries of benefits.

Appendix C:
Current IBAC Premium Contributions

Table 3: IBAC Employer and Employee Contribution Percentages		
Salary	**Employee**	**Employer**
APS		
< $30,000	20%	80%
$30,000 +	40%	60%
GSD		
< $50,000	20%	80%
< $60,000	30%	70%
$60,000 +	40%	60%
NMPSIA		
< $15,000	25%	75%
< $20,000	30%	70%
< $25,000	35%	65%
$25,000 +	40%	60%
RHCA		
Years of service	**Retiree**	**RHCA**
5 years	96%	4%
10 years	76%	24%
15 years	56%	44%
20+ years	36%	64%
Source: APS, GSD, NMPSIA and RHCA		

Appendix D:
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