Report
to
The LEGISLATIVE FINANCE COMMITTEE

General Services Department and Public Schools Insurance Authority
Program Evaluation of Public Employee Health Benefits
November 18, 2010

Report # 11-01

State of New Mexico
LEGISLATIVE FINANCE COMMITTEE

325 Don Gaspar, Suite 101 • Santa Fe, NM 87501
Phone: (505) 986-4550 • Fax: (505) 986-4545

David Abbey
Director

November 18, 2010

Mr. Arturo J. Jaramillo, Secretary
General Services Department
PO Box 6850
Santa Fe, New Mexico 87504

Mr. Sammy J. Quintana, Executive Director
New Mexico Public Schools Insurance Authority
410 Old Taos Highway
Santa Fe, New Mexico 87501

Dear Secretary Jaramillo and Mr. Quintana:

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the *Public Employee Health Benefit Program Evaluation.* The evaluation review team assessed the New Mexico Public School Insurance Authority's and the General Services Department's Risk Management Division's cost control efforts and oversight of health plan administration to ensure the delivery of affordable and quality services; and reviewed the opportunities to coordinate and strengthen public healthcare purchasing and benefit alignment. The report will be presented to the Committee on November 18, 2010. An exit conference was conducted with Risk Management Division, New Mexico Public School Insurance Authority, Albuquerque Public Schools, and New Mexico Retiree Health Care Authority staff to discuss the contents of the report. The Committee would like a plan to address the recommendations within this report within 30 days from the date of the hearing.

I believe this report addresses issues the Committee asked us to review and hope the public-funded health plans benefit from our efforts. We very much appreciate the cooperation and assistance we received from the staff from each agency.

Sincerely,

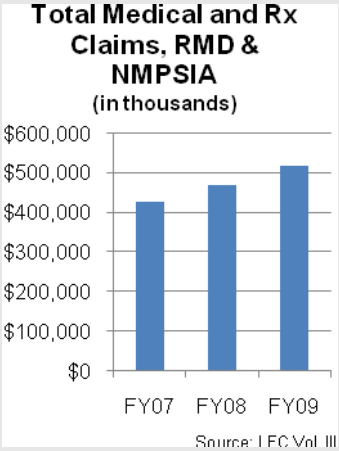
David Abbey, Director

cc: Representative Luciano "Lucky" Varela, LFC Chairman
Senator John Arthur Smith, LFC Vice-Chairman

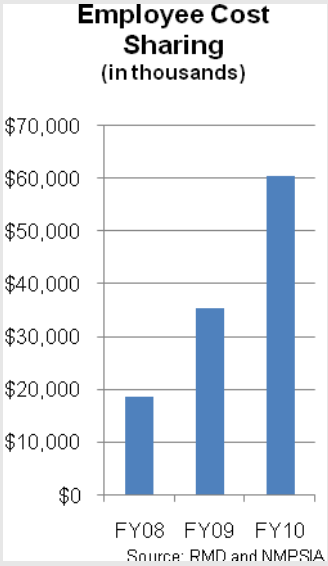
DA/mt

Table of Contents

Page No.



RMD and NMPSIA paid $518 million for public employee healthcare in FY09.



Rising healthcare costs have been increasingly paid by employees, increasing 225 percent in three years.

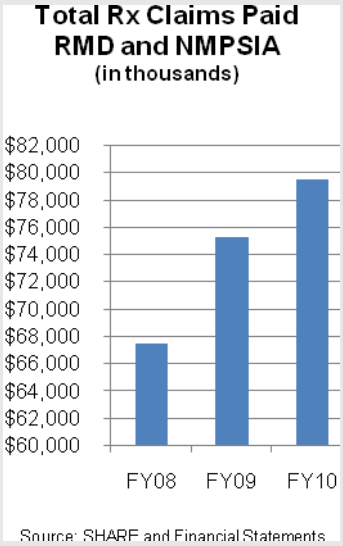
The Risk Management Division (RMD) of the General Services Department and the New Mexico Public School Insurance Authority (NMPSIA) administer self-insurance plans for health benefits. Other public entities such as municipalities and institutions of higher education may join the state pools. The two agencies provide coverage to over 135,000 public employees and their eligible dependents. In FY10, combined spending for both entities was over $520 million dollars for health benefits. This amount includes medical and pharmacy claims and the administrative costs for each agency. Responsibilities also include administration of property and casualty liability, life and disability insurance, loss control, and worker's compensation insurance programs.

The evaluation review team assessed the New Mexico Public School Insurance Authority and the General Services Department Risk Management Division's cost control efforts and oversight of health plan administration to ensure the delivery of affordable and quality services; and reviewed the opportunities to coordinate and strengthen public healthcare purchasing and benefit alignment.

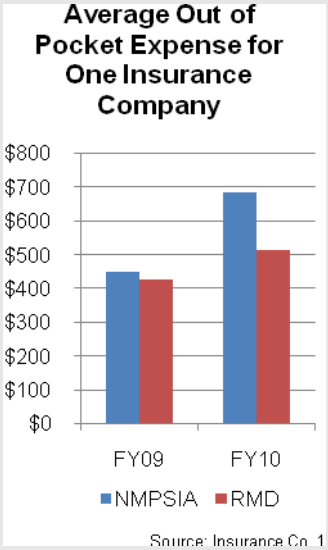
Neither agency has provided the administrative oversight necessary to impact the pricing for medical services or to ensure that enrollees are receiving quality services. Programs expenses have continued to climb in spite of decreasing enrollment and utilization.

Overall the state has not maximized the purchasing power for health benefits nor taken advantage of comprehensive quality improvement initiatives that would better contain costs. There is little focus on the price of medical care or the outcomes the care provides. Utilization and provider rates are the key components of medical costs. With utilization remaining flat or decreasing, it appears as if provider rates are the primary cost driver.

Collectively, the New Mexico Retirees Health Care Authority, Albuquerque Public Schools, RMD and NMPSIA form the Interagency Benefits Advisory Committee (IBAC). The committee was created by the Health Care Purchasing Act (13-7 NMSA 1978) to jointly issue request for proposals, but do not require consolidated purchasing. The agencies are allowed to maintain separate administrative structures resulting in duplicative administrative costs, redundant administrative services, disparate benefits plans, and differing cost structures. The fragmentation of administration inhibits effective use of state resources.



The State paid $12.1 million more in FY10 for pharmaceutical claims than it did in FY08.



Data from one insurance company, average out of pocket expense for NMPSIA and RMD grew $234 and $89 a year respectively.

Many attempts, to consolidation IBAC entities or require consolidated purchasing of health benefits has not been successful. The IBAC reached an important first step toward consolidation by procuring pharmaceutical benefits for all four participating entities with a single vendor and thereby leveraging the state's procurement power. This resulted in a projected four-year savings of $51.5 million.

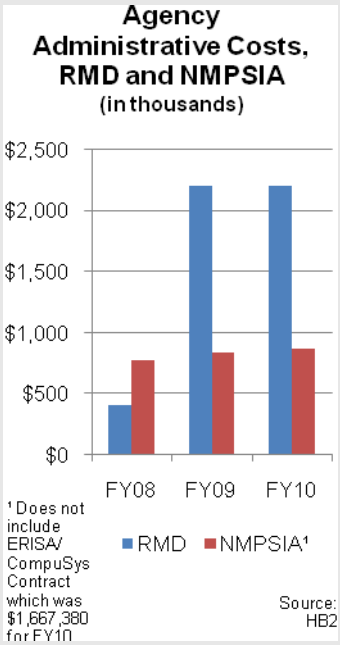
Agencies lack standardized reports and a centralized repository of public employee health claims data. With each agency collecting and analyzing just its own data, there is no comparison of cost or quality factors within the IBAC agencies or other public funded health benefit programs.

The state should centralize all insurance functions of NMPSIA and RMD under a single entity to leverage the state's purchasing power, remove duplicative government functions, and improve the efficiency of government operations.

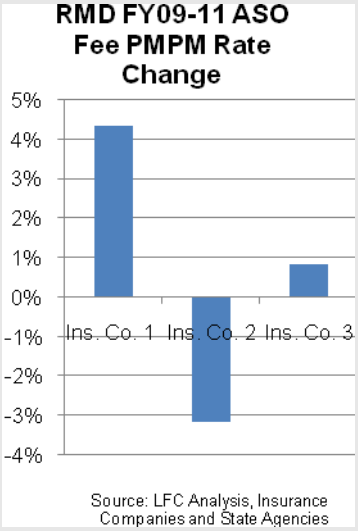
KEY FINDINGS

Better Oversight Of Provider Rates And Quality Improvements Will Make Healthcare More Affordable For Employees And The State.

- *NMPSIA and RMD have increased premiums, employee out-of-pocket expenses, and used fund balances as strategies to manage rising healthcare costs.* From FY09 through FY10, the shift in costs has increased out-of–pocket expenses to employees by $51.5 million.
- *Increasing provider rates appear responsible for a greater portion of rising healthcare costs; utilization of services has remained relatively flat or decreasing for both agencies.* Based upon assumptions for medical trends made for FY11 and FY12, medical spending will increase by an estimated $96.5 million in the two years across both agencies. Assuming no provider price increases, the estimated increase over the same time period would be approximately $36.7 million. These assumptions consider rising rates of utilization, which has mostly been flat or decreasing in practice. Also, RMD does not assume projected savings from the new pharmacy benefit program in its actuarial projections. This results in $3.3 million more in projected expenses than may be necessary.
- *Both agencies can improve oversight of administration of plans and emphasis on quality improvements.* Negotiations with insurance companies focus on administrative fees paid to those



RMD's administration costs were $2.2 million in FY10. NMPSIA's administration costs were $867 thousand and do not include a professional services contract for $1.6 million.



RMD increased rates from the FY09-10 levels for an insurance company by over 4 percent during this budget crisis.

companies rather than provider rates. Administrative fees for both agencies in FY09 were $31.7 million and $28.8 million in FY10. The decrease in fees primarily is accounted for by the decrease in enrollees.

Streamlining Benefit Plans, Expanding Purchasing Pools, And Eliminating Redundant Administration Could Save Millions.

- *The State of New Mexico has long been interested in maximizing the benefits of various purchasing strategies for healthcare services, including enlarging and coordinating purchasing pools by multiple public entities.* Legislators have attempted, without success, to strengthen the consolidation of IBAC agencies purchasing.
- *Despite some progress, the IBAC has not fulfilled its intent and perpetuates duplicative and costly administrative functions.* Although a recent action consolidated the purchasing for pharmacy benefit services, the IBAC agencies still contract separately for the majority of health benefits, losing the purchasing power the larger pool could bring to negotiations.
- *Combining NMPSIA and RMD into a new healthcare finance authority would better position the state to contain costs, improve quality, and attract other public entities to participate and reduce administration.* Operating as a consolidated agency, the state might be able to better exert influence on provider rates, the major cost driver. The existing structure also negates opportunities to eliminate duplicate processes and administrative costs, inhibits quality improvement, and fragments claims management oversight. Creating a single entity will afford the opportunity to work towards parity in health plans across employees and develop one cost structure as it relates to employee cost-sharing.
- *The lack of a data warehousing, from all state sponsored health benefit plans, limits administrators access to information to better manage their own plans and to benchmark against otherpublic funded plans.* Without a single data warehouse, agencies are not able to compare metrics across populations in order to maximize purchasing power or implement more global quality improvement initiatives that would have a greater impact on cost containment.

Cost Saving Strategies

Perform an independent rate validation to compare with other plans and other states.

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

Improve the utilization review process performed by state agencies.

Evaluate and implement other cost saving strategies being used by other large employers or states, to include changes in the benefit design.

An analysis of Virginia's program by Mercer estimated that if 10 percent of spouses left the state plan, the state would save between $17 million and $22 million per year.

UNM's current contract for a dependent eligibility verification study projects between 3 percent and 8 percent of dependents are ineligible. If such cost savings were applied to the state, it could result in an estimated savings of $500 thousand to $1.5 million.

KEY RECOMMENDATIONS

The Legislature should consider the following statutory changes:

Create a New Mexico Healthcare Finance Authority (HCFA) to administer health and risk benefits on behalf of governmental entities, including state and local governments, school districts and institutions of higher education. Abolish NMPSIA and RMD, as separate entities, and merge the functions for health benefits and risk funds administered by the agencies into the new HCFA.

The HCFA should be modeled on the flexibility granted to NMPSIA and the Public School Facility Authority for personnel matters. HCFA should be subject to the state Budget Act, Accountability Act, Procurement Code at a minimum. The Legislature should maintain its appropriations, fiscal and operational oversight authority of these functions in the new HCFA. HCFA should be governed by a nine-member board, appointed by the Governor and confirmed by the Senate, with six members representing the public, one local government, one state government and one educational entity. The Legislature may want to consider authorizing other nonvoting exofficio members.

Include responsibilities to coordinate, and where appropriate, consolidate purchasing, quality improvement and fraud and abuse surveillance activities with other state funded health programs, including Medicaid and NMRHCA. Direct the new authority to evaluate the feasibility of a data warehouse and claims processing function utilizing the existing systems in Medicaid. Additionally, consolidate health benefit funds formerly administered by NMSPIA and RMD and also consider the feasibility of merging APS and other governmental entities into the administration of HCFA and possibly merging funds.

The agencies should

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

Negotiate with health plans to decrease the adminstrative fees to the FY09 level.

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

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

Establish four eligibility levels for NMPSIA, adding "employee plus child." This is specifically to target parents enrolling one child and not a spouse.

Conduct routinely scheduled claims audits by an independent auditor.

BACKGROUND

The public sector provides healthcare benefits as part of a comprehensive compensation package. Like many employers, public entities and their employees are struggling to afford maintenance of these benefits with costs that have outpaced inflation and wages.

Plan Enrollments	
APS	17,269
RMD	77,236
NMPSIA	57,992
NMRHCA	43,435

The four public insurance entities, New Mexico Public School Authority (NMPSIA), Risk Management Division (RMD) of the General Services Department, New Mexico Retiree Healthcare Authority (NMRHCA), and Albuquerque Public Schools (APS) have a primary enrollees and dependents enrollment of over 190,000 members. RMD and NMPSIA have members throughout the state, although NMPSIA has a greater number of members in rural areas.

Risk Management Division of the General Services Department.

The division was created by 15-7-1 NMSA 1978 to acquire and administer all insurance products purchased by the state entities. The main duties specified by the act include procuring insurance products through provisions of the New Mexico Procurement Code, apportioning to each state agency its contributions toward the purchase of insurance based on the reflective risks of each agency, entering into contracts for services, prescribing reasonable regulation and objective underwriting and safety standards for state entities, and developing reasonable standards for self-insurance pooling agreements with other public bodies. In addition, the Group Benefits Act, Section 10-7B NMSA 1978, specifically addresses group benefits, allowing RMD to establish and administer group benefits for life, health, vision, dental, and disability coverage for state employees and participating local public bodies. Further, the act identifies what actions fall within the review or approval of a nine-member board.

In an effort to streamline administrative costs and create a larger purchasing pool, the state allows other governmental agencies to join RMD. A list of participating entities can be found in Appendix A.

Administration. The Risk Management Division administers insurance programs for group medical, prescription, dental, and vision benefits. The division also manages programs for property and casualty liability, life and disability insurance, loss control and worker's compensation. The division is divided into three bureaus to administer these programs. In an effort to streamline administrations and create larger purchasing pools, the state statute allows for other governmental entities to join RMD's group benefit plans: local municipalities, schools, universities, and other public entities, and at 100% enrollee premium contribution, legislators, water conservation district supervisors and dependents of both.

RMD is responsible for the development of the group health benefit plans for the employees they serve. The agency has entered into administrative services only (ASO) contracts with insurance vendors to provide specific services relating to the group benefit plans: claims processing, utilization review, provider network development and maintenance, and provider rate negotiations.

For the medical programs, RMD has agreements with Lovelace Health Plan (LHP), Presbyterian Health Plan (PHP), and Blue Cross Blue Shield of New Mexico (BCBS). Pharmacy benefit management (PBM) is provided by Medco. Each of the insurance vendors, including the PBM, is paid a per-member-per-month (PMPM) fee to provide the administrative services.

Funding. The group benefit programs for RMD are funded through employer and employee contributions. The percentage of contribution for each is directed by state statute, with employee contribution level determined by annual income. RMD's employee's contribution ranges from 20 percent to 40 percent of annual income.

RMD Total Appropriations

(in thousands)

	FY08	FY09	FY10	FY11
EHB Admin.	$881.9	$2,188	$1,188	$1,626.7
RMD	$432,744.8	$480,690.4	$457,854.2	$426,300.7
RMD/GSD Admin.*	$4,711.7	$7,718.1	$7,130.3	$6,941
Total**	$437,456.5	$488,408.5	$464,984.5	$433,241.7

*Includes RMD and GSD Program Support
**Does not include EHB Admin. which is a fund transfer

Source: General Appropriations Act

New Mexico Public School Insurance Authority.

The purpose of the Public School Insurance Authority Act, Section 22-29 NMSA 1978, is to provide comprehensive core insurance programs for all participating public and charter schools, school board members, school board retirees, and public school employees and retirees. An eleven-member board is authorized to hire the agency's director, delegate duties to the director as appropriate, but maintain approval authority over the actions of the staff.

Administration. NMPSIA is responsible for development of each the plans providing group health benefits and administers the same insurance products as RMD. NMPSIA is also allowed by statute to include other local public bodies: post secondary educational institutions, regional educational cooperatives, and school board members. School board members pay 100 percent of premium costs.

NMPSIA contracts for administrative services from PHP and BCBS of New Mexico and Medco for pharmacy benefit management services, for which the plans are paid a PMPM. The vendors perform the same administrative services for NMPSIA as they do for RMD. NMPSIA also contracts with a third-party administrator (TPA) to perform other administrative functions that otherwise would require additional staffing and expertise within the agency.

The state also allows other public entities to join the NMPSIA purchasing pool. A list of the participating entities can be found in Appendix A

Funding. As with RMD, group benefits are funded through employer and employee contributions, with amounts for each determined by annual income. The contribution percentage of employee annual income ranges 20 percent to 80 percent. The percentage of employee contribution is determined by each school district.

NMPSIA Total Appropriations

(in thousands)

	FY08	FY09	FY10	FY11
NMPSIA Admin.*	$1,736.1	$1,938.2	$1,983.1	$1,944.3
NMPSIA	$319,719.8	$342,190	$344,197.5	$343,255.8
Total**	$320,877.2	$343,482.1	$345,520.5	$344,552

*Includes Benefits Other Financing Uses
** Does not include Benefits Other Financing Uses

Source: General Appropriations Act

FUNDING MODELS

Employers finance employee health benefits by providing insurance directly to employees (self-insured plan) or by purchasing health insurance from an insurance company (fully-insured plan).

Self-insured plan – Most common among large organizations, employers in self-insured plans act as their own insurer and bear the risk associated with offering health benefits, with possible administrative cost savings from five percent to eight percent from fully-funded plans. Employers using this plan pay health care claims to providers instead of paying an insurance company. Employers using self-insured plans often contract with an insurance company or other third party to deliver administrative services to the employer such as claims processing and billing.

Fully-insured plans **–** Employers using fully-insured plans pay a per-employee premium to an insurance company to provide health benefits. The insurance company assumes the risk of providing health coverage for insured events.

NMPSIA and RMD health plans are self-insured programs.

COORDINATED PURCHASING

Other large public employers provide health benefits through self-funded plans: APS, NMRHCA, city of Albuquerque, University of New Mexico, and UNM Hospitals.

The Legislature, through the Healthcare Purchasing Act, 13-7-NMSA 1978, created the Interagency Benefits Advisory Committee (IBAC) to serve as the entity designated to accomplish the mandates of the Health Care Purchasing Act (HCPA). Four entities are member of the IBAC: APS, NMRHCA, RMD, and NMPSIA. The committee was established for the purpose of jointly soliciting proposals from vendors for administrative services for the state health benefit plans.

COST

The New Mexico Legislature has expressed concern regarding the ever-increasing expense of healthcare for employees and retirees and has introduced legislation in an attempt to curb costs. State agencies have taken steps to address the cost issues, but have not adequately addressed provider rates, the major cost driver.

LEGISLATION

The Legislature has proposed or passed several bills in an attempt to solidify the four IBAC agencies into a stronger consolidation. See Appendix D.

FEDERAL HEALTHCARE REFORM

In addition to the local issues driving healthcare costs, federal healthcare reform will mandate states to expand Medicaid programs and grant options for setting up health insurance exchanges to aid individuals in obtaining health coverage, as well as other requirements. Although many requirements may not have a direct impact on state employee and retiree health plans, the increased cost of Medicaid expansion will pose funding challenges for other state priorities, including employee healthcare funding. Rules and regulations have not been promulgated for most of the federal reform legislation, and the impact to public funded and self-funded plans is not clear. For example, the role, if any, of public employee healthcare financing and the establishment of healthcare exchanges remains to be decided. In addition, whether the expansion of health coverage will reduce provider rates due to the elimination of cost-shifting techniques remains questionable. Other direct impacts of this federal legislation include whether new regulations will impact existing cost-sharing arrangements and the state plans' "grandfather status" from new requirements; imposition of a 2 percent participant tax for "comparative effectiveness research," and vouchers for employees to purchase coverage through the health insurance exchange whose household income does not exceed 400 percent of the federal poverty level.

PROJECT INFORMATION

Program Evaluation Objectives.

- Assess the effectiveness of the cost control efforts and oversight of health plan administration by the Public School Insurance Authority and Risk Management Division of the General Services Department.
- Review and assess Public School Insurance Authority and Risk Management Division performance monitoring to determine if enrollees and state are receiving quality products and services.
- Review opportunities to coordinate and strengthen public healthcare purchasing and benefit alignment, including through the Interagency Benefits Advisory Committee.

Scope and Methodology.

- Reviewed state statutes, public health insurance agencies policies, procedures, and internal management documents.
- Conducted structured interviews with state agency staff, insurance company representatives, and other nonparticipating public entities.
- Conducted structured surveys of neighboring states.
- Reviewed financial, utilization, enrollment, performance and quality data from insurance companies.
- Conducted web search for information relevant to the evaluation.

Evaluation Authority. The committee has authority under Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions, the effect of laws on the proper functioning of these governing units, and the policies and costs of government. Pursuant to its statutory authority, the committee may conduct performance reviews and inquiries into specific transactions affecting the operating policies and costs of governmental units and their compliance with state law.

Evaluation Team.
Pamela Galbraith, Lead Evaluator
David Craig, Evaluator

Exit Conference. The contents of this report were discussed with RMD, NMPSIA, NMRHCA, and APS senior staff and LFC staff on November 10, 2010.

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

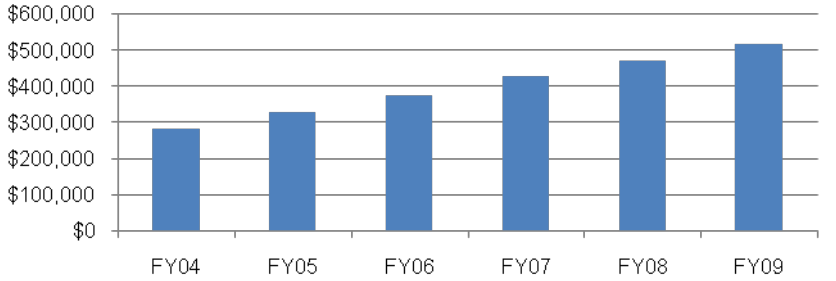
Charles Sallee
Deputy Director for Program Evaluation

BETTER OVERSIGHT OF PROVIDER RATES AND QUALITY IMPROVEMENTS WILL MAKE HEALTHCARE MORE AFFORDABLE FOR EMPLOYEES AND THE STATE.

NMPSIA and RMD have increased premiums and employee out-of-pocket expenses and used fund balances as strategies to manage rising healthcare costs. The approaches used by state agencies to curb healthcare costs threaten the viability of the health benefits' funds and places an ever-increasing financial burden on employees. These approaches are short-term remedies and cannot be sustained over time.

Healthcare spending for RMD and NMPSIA has increased by 84.6 percent, or $237.5 million, between FY04 and FY10 as shown in the table below.

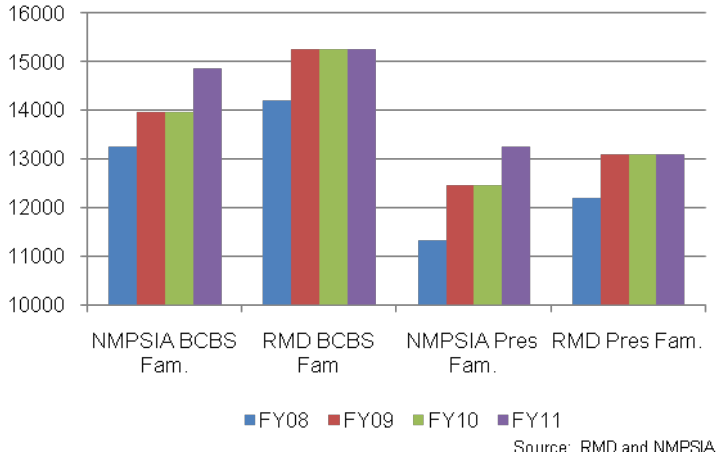
Table 1. RMD and NMPSIA Total Medical and Rx Claims Expense by Year (in thousands)



Source: LFC Volume III

From FY08 to FY10, premiums have increased between 7 percent and 17 percent and now represent the equivalent of 99 percent of some lower wage public employees' gross income. As an example, Table 2 shows premiums for family coverage are rising. RMD held premiums constant by using health benefits and premiums rates stabilization fund balance reserves. These rising premiums tend to disproportionately affect lower income employees, particularly for family coverage, as more and more of their gross wages go to pay for healthcare costs.

Table 2. RMD and NMPSIA Premium Rate Increases, FY08-FY11, High Option Family



Total premium costs (employee and employer shares) of premium contributions, can represent extremely large portions of some workers' salaries, as shown in Tables 3 and 4. This represents extremely high costs to employers. For example, an educational assistant earning $15 thousand in gross salary would have total premium costs of about $14,850; or about 99 percent of gross salary.

Table 3. NMPSIA Premium as a Percentage of Income, Family Coverage, FY10

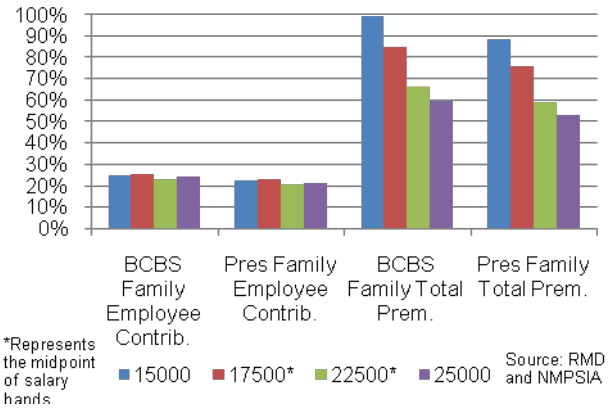
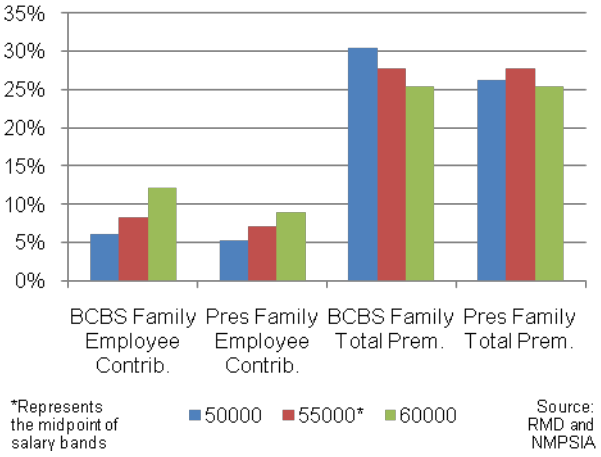


Table 4. RMD Premium as a Percentage of Income, Family Coverage, FY10



A statewide review of teacher salaries and health benefit expenses in Table 5 demonstrates that, while salaries increased 8.8 percent from FY07 through FY09, health premiums rose 13.5 percent, a $16 million increase. The cost does not include the enrollees' premium share. The premium rates represent an increase from 9.6 percent to 11.6 percent of employee salaries.

Table 5. Statewide* Public School Employees Health and Medical Premiums, FY07, FY09 & Budgeted FY11

	FY07	FY09	FY11 (budgeted)
Salary Expense - Operational Fund	$ 1,451,262,921	$ 1,592,821,774	$ 1,538,394,967
Health and Medical Premiums - Operational Fund	$ 127,409,843	$ 151,670,965	$ 167,215,952
Salary Expense - All Funds	$ 1,626,079,450	$ 1,767,751,113	$ 1,718,037,247
Health and Medical Premiums - All Funds	$ 148,534,016	$ 173,836,407	$ 193,500,692

*Does not include APS

Source: PED

Increasing costs for school employee healthcare benefits places pressure on school districts' ability to fund educational services.

Out-of-pocket expenses, such as deductibles and co-pays, have doubled in some cases as a result of agency plan redesign. Tables 6 through 8 show the changes in deductibles, annual out-of-pocket maximum amounts and co-pays for office visits to primary care providers. From FY08 to FY09, some healthcare costs were allocated to employees. This cost shifting by plan redesign is a method of decreasing the impact of health care costs to employers without increasing the employee premium contribution.

Table 6. Deductible (Single and Family)

	FY08	FY09	FY10
RMD Pres	$50/$150	$150/$450	$150/$450
RMD BCBS	$100/$300	$300/$900	$400/$1200
NMPSIA BCBS and Pres	0/0	$300/$900	$300/$900

Source: RMD and NMPSIA

Table 7. Annual Maximum Out-of-Pocket (Single and Family)

	FY08	FY09	FY10
RMD Pres	$2000/$6000	$3000/$9000	$3000/$9000
RMD BCBS	$2000/$5000	$3000/$9000	$3000/$9000
NMPSIA BCBS and Pres	$2000/$6000	$2800/$8400	$2800/$8400

Source: RMD and NMPSIA

Table 8. Primary Care, Office Visit Co-pay

	FY08	FY09	FY10
RMD Pres	$10	$15	$15
RMD BCBS	$15	$20	$25
NMPSIA BCBS and Pres	$15	$20	$20

Source: RMD and NMPSIA

Employee cost sharing toward payment of medical claims for two insurance companies increased 225 percent between FY08 and FY10 or $49.1 million as displayed in Tables 9 and 10.

Table 9. RMD Member Cost Sharing for One Insurance Company

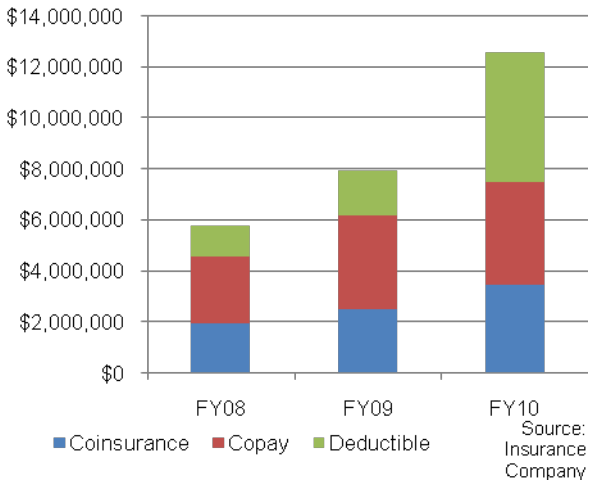
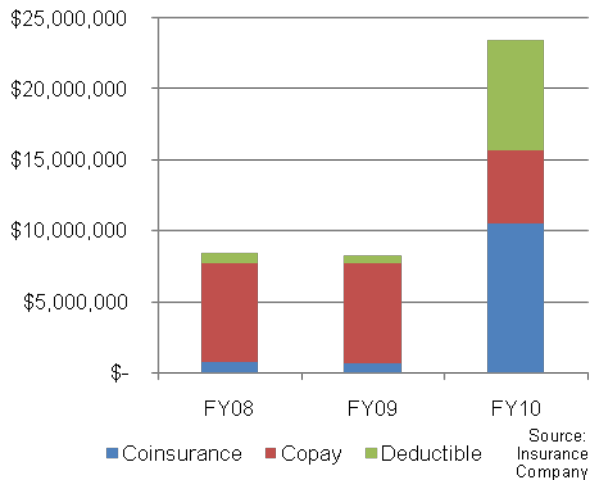
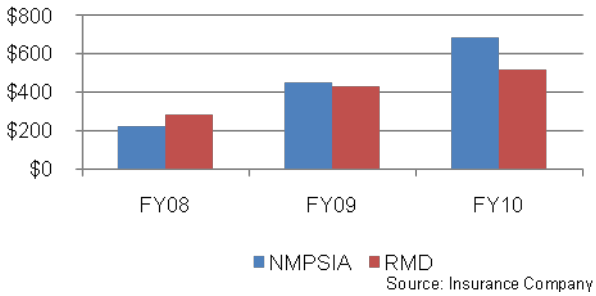


Table 10. NMPSIA Member Cost Sharing for One Insurance Company



This is reflected in the doubling of average out-of pocket expenses for RMD and NMPSIA employees as shown in Table 11.

Table 11. Average Out of Pocket Expense for One Insurance Co.



The agencies have relied on fund balances and additional one-time funding to offset premium increases, a strategy that is not sustainable over the long-term. In FY11, NMPSIA used ARRA funds to reduce the October insurance premiums for teachers. For employees who have 80 percent of their premium contributed by the employer are not eligible, which impacts 2,386 employees making $15 thousand or less per year. Both agencies have either used or are proposing partial use of fund balances to prevent premium increases. RMD, in an August 2011 presentation to the LFC, indicated GSD expects to use $8 million in reserves in FY11 to offset increasing costs.

Increasing provider rates appears responsible for a greater portion of rising healthcare costs; utilization of services has remained relatively flat for both agencies.

NMPSIA's actuarial assumptions for setting premiums include increases for provider rates, which will increase premiums by an estimated $17.6 million in FY11 and $19.3 million in FY12. NMPSIA's actuary predicts provider rate increases will increase medical costs by 6.2 percent and utilization trends will increase costs by 3.8 percent for a total estimated increase of 10 percent for each fiscal year. As a result, provider rates make up 62 percent of projected medical cost increases. Similar information was not available from RMD's actuary. However, if provider rates had a similar weight in the actuarial projections for RMD, using FY10 actual claims data, provider rates could account for increased medical costs of $14.6 million in FY11 and $8.2 million in FY12.

Currently, negotiations with insurance companies are focused on administrative services fees and not provider rates. Vendor contracts allow for the insurance companies to develop and maintain provider fee schedules. RMD and NMPSIA do not exert influence on rate development or voice what the state's tolerance is for increases, except for situations in which provider rate negotiations are at a stalemate.

Neither agency actively monitors provider rate increases, and RMD contractually allow costs due to changes in benefit coverage to increase up to 10 percent without notice. Contract language for both agencies does not favor the ability to closely monitor provider rates.

Neither agency routinely benchmarks average consumption of services, nor prices paid by other payers, to ensure reasonable pricing. NMPSIA did make adjustments to the emergency room co-payments, along with other cost-shifting strategies. However, the agencies do not routinely benchmark utilization with other plans with similar services or determine why costs are higher or lower than other plans. The New Mexico Medicaid cohort of healthy adults would represent an enrollment similar to these agencies.

Average spending per person has increased in many categories and regions, while the amount of services provided has remained stable, and as a result provider rate increases are likely responsible for much of the increased costs. The two major variables that contribute to per-member costs are: utilization of services and provider rates. Between FY08 and FY09, both RMD and NMPSIA experienced increased claims spending per member per month (PMPM). For FY10, both agencies increased member cost sharing, though more so by NMPSIA, which has lowered the state's share of medical claims or slightly mitigated increases, as shown in tables 12 and 13. For example, one NMPSIA health plan reported a 21 percent decline in PMPM claims, from $313 to $246 between FY09 and

Table 12. RMD - Medical Claims Paid PMPM

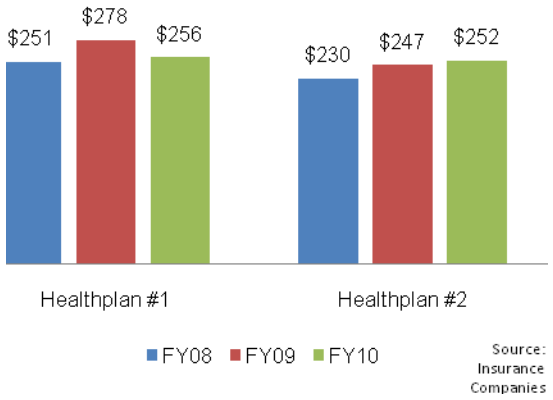
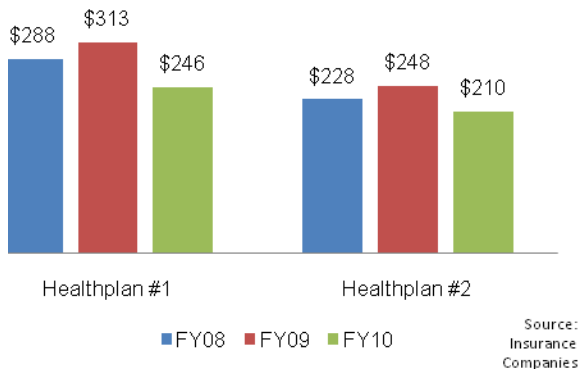


Table 13. PSIA - Medical Claims Paid PMPM



FY10. After adjusting for member cost-sharing, the medical PMPM costs still declined by about 12 percent, from $336 to $296. RMD continues to experience generally increasing PMPM medical claims costs.

RMD's increasing costs in certain areas appear driven more by possible provider rate increases, because the use of services has continued to decline in certain high cost categories. For example, member utilization of inpatient hospital services declined 11 percent between FY08 and FY10 for one health plan. PMPM spending increased 9 percent during the same period, from $51 to $56. Total spending on inpatient hospital for the same plan increased 19 percent from $24.3 to $28.8 million. In similar fashion, outpatient hospital costs increased about 17 percent from $76 to almost $89 PMPM, while utilization decreased four percent between FY08 and FY10. Total outpatient hospital spending increased 28 percent, from $35.7 million to $45.6 million.

NMPSIA has experienced acute declines in the use of services by its members, regardless of plan, between FY08 and FY10. For example, acute hospital admissions per 1,000 members decreased between 14 percent and 20 percent during this period depending on the plan. Inpatient facilities are an expensive cost center for health plans. Emergency room (ER) use is also down between 10 percent and 12 percent.

In some cases the consumption of services in New Mexico plans is less than national averages, but spending per person for those services is much higher. The magnitude of the decline in use of these services, combined with significant increases in cost-sharing requirements, may still mask provider rate increases. Data reported by the plans includes amounts paid by the plan, and thus the state agency, and does not fully account for the co-pays, deductible or co-insurance expenses of the member using these services. Within one plan, ER visits per 1,000 members declined for NMPSIA by 10 percent and for RMD by 6 percent between FY08 and FY10. However, RMD still has experienced a net cost increase of 11 percent in PMPM claims payments for ER visits.

Regional spending per member varies widely, which presents opportunities for cost savings by managing down outlier costs through targeted improvements in pricing and utilization. Analyzing regional costs allows health plan administrators to determine areas that may be outliers in cost, medical pricing and utilization, or even practice patterns from other areas in the state. Health plan administrators can coordinate use of this data to target more effective cost-containment strategies, drive efficiencies, and help inform better quality improvement activities. Regional cost variations are important to monitor because often costs are similarly high across different plans, agencies, and years in certain areas. As shown below in Tables 14 and 16, cost data is graphed by region (cost of actual medical claims paid per PMPM generated by one insurance company in FY10. County level data is available in Appendix C.

Significant savings could be achieved if regional per-member costs were brought in line with the lowest cost plan in each region. For example, for NMPSIA, one plan reported spending about $242 PMPM in northwest New Mexico counties, or about $18.5 million. If that same health plan could achieve average PMPM costs in line with the other health plan's reported cost of $205, NMPSIA could save almost $2.8 million in that region alone.

For two decades, the Dartmouth Atlas Project has analyzed regional medical practice and spending patterns, principally for Medicare beneficiaries. This research has shown wide variation in spending per person and growth in spending, primarily driven by practice patterns

Table 14. RMD Insurance Company 1, FY10 Actual Paid Claims PMPM

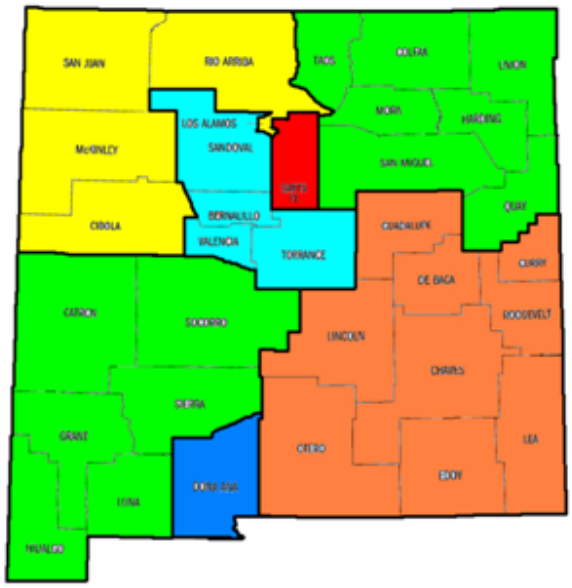
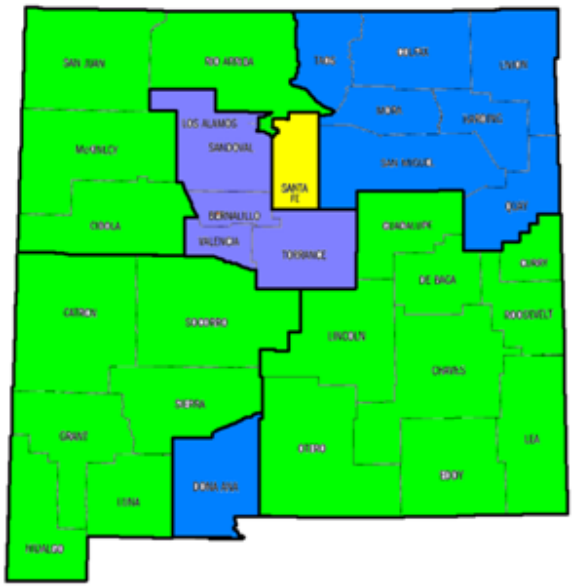
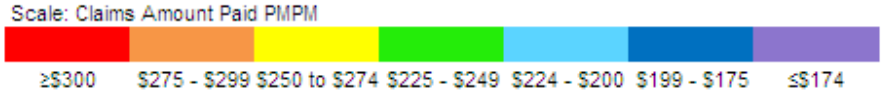


Table 15. NMPSIA Insurance Company 1, FY10 Actual Paid Claims PMPM





and the volume of care delivered. These high-volume, high-cost regions do not appear to produce better outcomes – challenging the notion that higher spending produces better quality care. While medical pricing is less of a factor in variation of spending for populations over age 65, researchers have found that medical pricing varies widely across regions for commercial markets serving those under 65 years of age.

RMD does not monitor average costs paid PMPM by region to inform oversight efforts, though RMD does receive data showing hospital-specific spending levels which can help identify hot spots. NMPSIA regularly receives regional and county-level cost data, and has used this information to help stalemate provider rate negotiations. Regularly reviewing regional and county-level costs, utilization patterns across IBAC agencies, and even other public plans such as Medicaid, would help inform understanding of various practice patterns or pricing issues.

Other factors, such as higher-priced hospitals or provider groups could contribute to variations in regional spending. A recent study by the Human Services Department (HSD) found New Mexico hospital profit margins were generally higher than the regional state and national averages. Table 16 shows the percent of net margin (net profit as a percentage of total revenue) compared with hospitals in surrounding states for New Mexico hospitals. The net national average in 2008 was 2.64 percent, with the New Mexico average at 9.86 percent. Memorial Medical Center in Las Cruces posted a 26 percent profit margin, 20th highest in the country, according to a recent analysis of hospital cost reports by *Forbes.*

Table 16. 2008 Net Profit Margin Comparison for Hospitals	
Arizona	1.65%
Colorado	4.92%
Oklahoma	6.08%
Texas	7.03%
New Mexico	9.88%

Source: Hilltop Institute Report for HSD.

Both agencies can improve oversight of administration of plans and emphasis on quality improvements. RMD and NMPSIA do not adequately oversee cost-containment activities by their administrative services contractors and do not adequately monitor provider rate development to ensure the state is paying reasonable prices. The agencies do not use of standardized management reports to monitor vendor performance or address quality of services issues. Structural and management changes could result in improved cost containment.

Limited financial incentives exist for plans to aggressively contain healthcare spending and the state does not exert cost containment as part of its administrative service contracts. Currently, negotiations with insurance companies are focused on administrative service fees and not on provider rates. Analysis of contracts shows the insurance companies develop and maintain provider fee schedules. RMD and staff do not exert influence on rate development or voice what the state's tolerance is for increases. RMD's actuary predicts about 6.2 percent of the 10 percent increase for next fiscal year is due to medical prices, and the rest is due to increased utilization.

RMD is concerned that interjecting the state in the provider rate negotiation process increases liability by opening up the state to interference of contract lawsuit. Legal concerns about possible liabilities do not relieve RMD from representing the state's interests in provider negotiations. With medical prices playing this large a part of the actuarial analysis that drives

state appropriations, it is important that RMD and NMPSIA plan administrators increase pressure on insurance companies when negotiating fees and increase oversight of fee schedules, including changes. The state should also verify that the rates it is paying match those of other self-funded entities through the use of an independent rate validation study.

RMD provided a 4.5 percent increase for one plan's administrative fees in FY11, costing the state an estimated $271 thousand and RMD did not assume estimated savings from the new pharmacy contract in its actuarial projection. Two specific actions by RMD appear to have contributed to unnecessary cost increases at a time of severe budget constraints:

- RMD increased the administrative services only (ASO) fee for one insurance company by 4.5 percent for FY11, or a little under a dollar per member per month. ASO fees are negotiated by RMD for services like claims processing, utilization review, provider network development and maintenance, and provider rate negotiations, for which they pay a PMPM. These PMPM fees may include additional costs for disease management, wellness, or behavioral health programs. Increasing ASO fees in a time of static or decreasing revenues is not a sustainable path for the state.
- RMD instructed its actuary not to include the cost savings it will generate under the new IBAC pharmaceutical benefits manager (Medco) in its actuarial projection of needed revenues for FY12. Medco expects an estimated $3.3 million in cost savings in FY11 for RMD. Not factoring this cost savings into the actuarial projection over-predicts needed revenues, and the state should not provide limited revenues for needs that are offset elsewhere.

More active use of standardized management reports on cost and use of healthcare by both agencies would help inform plan and cost-sharing decisions. Neither RMD nor NMPSIA require insurance companies to provide all reports required under the contracts, and reports are not standardized to allow comparisons of metrics across insurance companies. Health plan management reports often are not available during the same time periods, with some companies reporting metrics monthly, quarterly, annually, or on an ad hoc basis, while another company will report on a different time frame. In addition, some reports generated by insurance companies are not for the same time period year to year, making it difficult to make true comparisons.

As an example, tracking incurred but not reported (IBNR) claims costs is important, particularly at the end of the fiscal year, to forecast total cost of claims. NMPSIA routinely underestimates its year-end IBNR and must make financial adjustments from current year funding. RMD could not provide information regarding its IBNR. As a result, RMD may be assuming too large an IBNR and not reconciling the amounts with the fund balances, creating inaccurate cost projections. Not properly accounting for the IBNR inhibits accurate long-term financial planning.

Management reports, such as the Blue Cross Blue Shield Insight Report can be used as a template for all plans. However, reporting schedules for any reports should coincide with the state's fiscal year and reporting quarters of those years.

Neither agency receives quality of care information about their members' healthcare, nor requires performance expectations from plans. Costly claims from one health plan contracting with both NMPSIA and RMD totaled $67.8 million for services delivered to 1 percent of the enrollees. Relatively few enrollees represent a disproportionate share of costs. Delivery of babies represent the highest number of admissions to hospitals for the state agencies. Musculoskeletal and connective diseases rank as the number 1 and 2 most costly diagnoses for RMD and NMPSIA. Analyzing such data would lead the agencies to better understand cost drivers and the need for interventions or more supporting data. Are the high cost enrollees receiving disease management services? Are pregnant women receiving appropriate prenatal care? Are delivered infants receiving wellness checks, immunizations? Are ergonomic or safety trainings needed for certain workers? The performance standards for the health plans are focused on process and not outcomes. More detailed data high cost diagnoses is available in Appendix B.

Cost-driver data is not used as a comparison with larger pools of health benefit enrollees. For example, no comparisons are made to other public funded programs, such as Medicaid.

Despite spending additional dollars on disease management and wellness programs, RMD lacks sufficient performance information to justify the additional administrative expenses. Evidence is mixed on the value of wellness programs. Frequently, data is not collectable to measure a change towards healthier behaviors. Disease management is widely used by health plans. However, the Centers for Medicare and Medicaid Services found no significant savings in their disease management demonstration projects.

In place of the disease management services provided by the health insurance plans, NMPSIA and Medco partnered with community pharmacists in a pilot project to improve the health status of individuals with diabetes, which is producing positive results.

Opportunities exist for cost savings through better oversight and plan design changes. Other state health benefit programs and other large employers are reviewing or have implemented cost-saving strategies that should be considered by the New Mexico programs:

- Increase the frequency of independent insurance plan claim audits.
- Impose a surcharge on employees with spousal coverage, when the spouse has a health benefit plan option with their employer. An analysis of Virginia's program by Mercer estimated that if 10 percent of spouses left the state plan, the state would save between $17 million and $22 million per year.
- Establish four eligibility levels for NMPSIA, adding "employee plus child." This is specifically to target parents enrolling one child and not a spouse. Spouses use an average 30 percent more services than children. Cost would decrease for these enrollees.
- Review benefit plans for opportunities to eliminate specific benefits, or at least group appropriately for billing purposes. For example, naprapathy has been excluded from the massage, acupuncture, manipulation group where 15 total visits are allowed for the group, to a single benefit where 15 visits are allowed for the one service.
- Review the value of the employee assistance programs.

- Conduct dependent enrollee verifications for state pool employees and primary and dependent enrollees for local public bodies. UNM is currently contracting for a dependent eligibility verification study that may identify between 3 percent and 8 percent of dependents ineligible. If such cost savings were applied to the state, it could result in an estimated savings of $500 thousand to $1.5 million before contractor fees.
- Utilization industry standard decision trees when state staff are addressing enrollee appeals for services.

RECOMMENDATIONS

RMD and NMPSIA should

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

Negotiate with health plans to decrease the adminstrative fees to the FY09 level.

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

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

Improve the utilization review process.

Evaluate and implement other cost-saving strategies being used by other large employers or states, to include changes in the benefit design.

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

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

Establish four eligibility levels for NMPSIA, adding “employee plus child.”

Conduct dependent enrollee verifications for state pool employees and primary and dependent enrollees for local public bodies.

Conduct routinely scheduled claims audits by an independent auditor.

STREAMLINING BENEFIT PLANS, EXPANDING PURCHASING POOLS, AND ELIMINATING REDUNDANT ADMINISTRATION COULD SAVE MILLIONS.

The state of New Mexico has long been interested in maximizing the benefits of various purchasing strategies for healthcare services, including enlarging and coordinating purchasing pools by multiple public entities. The state of New Mexico established NMPSIA and RMD to allow state and local governments, including school districts, to purchases health care through larger pools. Theoretically, consolidating multiple small entities into a large cost pool allows those entities to spread their risk and medical expense across a larger population of paying members. In addition, consolidation may afford greater purchasing power to negotiate better medical prices, the rationale for creating IBAC to conduct coordinated purchasing efforts. This approach would allow multiple entities to retain separate administrative structures and funds but attempt to increase the state's bargaining power over the purchase of healthcare services.

Some states have estimated cost savings from consolidating pools of employees and leveraging greater purchasing power, though research is limited and evidence varies. Research validating increasing the size of large employer enrollee pools increases the ability to negotiate lower provider rates is limited, particularly as it relates to self-insured plans. According to the Office of Legislative Research of the Connecticut General Assembly (ORL), California has completed an evaluation of the impact of consolidating governmental entities into a large risk pool and found that local government participation reduced the state plan's annual premium costs by approximately $40 million per year. One advantage cited was that of greater purchasing power.

A National Conference of State Legislators (NCSL) brief from June 2010 discusses the opportunities of pooling public employees to create greater cost and quality advantages. At least 24 states authorize inclusion of other public employees and retirees in the state health benefit pool. The participation is voluntary in all but two states. In 2009, the Michigan House published *An In-Depth Look at the Michigan Health Benefits Program*. The report indicated pooling of all public employees into a single program could result in an estimated cost savings of $200 million, with additional savings from quality initiatives. According to NCSL, combining small employers into large state pools may save up to 15 percent for those small employers, but savings by states is not well-documented.

Kansas, Oklahoma, and Georgia have each created a combined healthcare purchasing authority including Medicaid, state employees, and other public entities. The public employees are not financially pooled with Medicaid, but the joint administration under one management structure may provide greater purchasing power. Larger pools offer participating entities the opportunity to combine their quality improvement activities and strategies to better understand and influence the health status of their enrollees.

Despite some progress, IBAC has not fulfilled its intent and perpetuates duplicate and costly administrative functions. In spite of it's inception 13 years ago, IBAC has still not consolidated purchasing for medical services. IBAC entities issue a common request for proposal but enter into separate contracts with the health plans. However, IBAC has consolidated purchasing for the pharmaceutical benefits manager, predicted to save $51.5 million, though

projected savings are contingent on Medco maintaining the contract for four years. The IBAC entities consolidated purchasing for the PBM starting in FY10 by both issuing a common RFP and selecting the same vendor, Medco, for all four entities. In consolidating purchasing in this way, the IBAC agencies have taken an important first step to leveraging its member volume to attain the best price for medical costs.

RMD and NMPSIA perform the same functions, which could be combined to lower administrative expenses and improve oversight of healthcare for public employees. Both administer self-insured plans covering health, life, disability, property, liability and workers compensation on behalf of scores of governmental entities across New Mexico. The state of New Mexico should consider the benefits of merging these two agencies into a single healthcare finance authority (HCFA). For the near-term, separate actuarial funds should be maintained until further study is conducted on costs and benefits of merging the funds.

Each agency provides duplicative functions related to administration, procurement, and customer service. For example, agencies separately contract for actuarial services; both have directors and deputy directors overseeing the same functions.

Consolidating the risk programs administered by RMD, NMPSIA, and possibly APS and others would serve to provide a central authority to manage public liability, public property, workers compensation, unemployment compensation, and surety bond coverage for all public entities.

Combining NMPSIA and RMD into a new healthcare finance authority would better position the state to contain costs, improve quality, attract other public entities to participate and reduce administration. State and other public health benefit programs already command a significant and relatively stable segment of the health insurance market, particularly in New Mexico. Combined, the IBAC agencies alone command almost 200,000 members, as these agencies represent some of the largest employers in their state. Diluting available funding to support multiple administrators doing the same functions negates opportunities to have these positions perform other more important tasks, such as quality improvement initiatives, better claims management oversight, and elimination of duplicative expenses.

Consolidation of these agencies would allow more focus on implementing quality initiatives, rather than spending time, effort and money trying to coordinate among agencies performing the same functions for similar populations. For example, a state and local school district health benefit program could wield significant market clout to establish innovative health programs, and alternative payment reform initiatives such as funding global provider payments, medical home or accountability organizations. According to The Lewin Group report *Can We Reduce Health Care Spending*, consolidated pools such as this "can yield considerable influence in negotiations with participating health plans and provider groups, in terms of encouraging their participation in quality improvement, cost containment, and related initiatives. In addition, SEHPs [state employee health plans] may be in a position to combine their quality improvement activities and strategies with other large public and private sector purchasers, including Medicaid, other public programs, and private health plans and employer groups. The combined market leverage of such coalitions can enhance SEHPs' purchasing advantage and help to coordinate state-level quality promotion activities."

The Government Restructuring Task Force has studied options to consolidate IBAC agencies and improve consolidated purchasing options during the 2010 interim. Some of the options are similar to previously considered proposals over the past eight years, ranging from combining all four IBAC agencies' benefit functions to mandating different purchasing strategies. These proposals have been met with significant resistance, particularly with respect to the role of retiree health care. The NMRHCA benefit functions, while the same as other agencies, serve a population that presents fiscal challenges due to their claims history and present risk for inclusion in a consolidated pool. Participating in consolidated purchasing over how much to pay for services, however, makes financial sense for NMRHCA as well as other IBAC agencies.

Numerous other public entities operate self-funded programs but do not seem interested in joining a larger pool because of concerns about a loss of control over their plans and perceived cost increases. APS has been exempted by statute from inclusion in the NMPSIA. An actuarial analysis completed in FY08 determined inclusion with NMPSIA would be more costly than maintaining its own plan. Joining the RMD pool, if justified by another actuarial analysis, would be an option.

A well-run HCFA might entice other large governmental entities, such as APS, the city of Albuquerque, and the University of New Mexico to consider outsourcing their health benefits administration, and possibly plan design, to this state agency. This would further improve the state's ability to leverage quality improvements, lower administrative costs, and negotiate affordable medical prices that can help curb health cost increases.

Data warehousing, with data submitted from all state sponsored health benefit plans, provides plan administrators access to information to better manage their own plans and to benchmark against other plans. Data warehousing involves access to enrollee data from multiple vendors and allows plan data to be sorted in any way deemed valuable to plan administrators. Plan administrators should move away from the idea that they do not own the data. Requiring vendors to submit data into a state data warehouse eliminates the reliance on the insurance programs for data.

The data warehouse would allow a global picture of patterns of utilization, service quality, and cost for all enrollees with state insurance coverage. Data warehousing should be conducted on as large a scale as possible to maximize data collection and analysis possibilities, allowing the new entity to compare metrics with other subpopulations in other state pools to better manage their own pools.

RECOMMENDATIONS

The Legislature should consider the following statutory changes:

Create a New Mexico healthcare finance authority (HCFA) to administer health and risk benefits on behalf of governmental entities, including state and local governments, school districts, and institutions of higher education. Abolish NMPSIA and RMD, as separate entities, and merge the functions for health benefits and risk funds administered by the agencies into the new HCFA.

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

Include responsibilities to coordinate and where appropriate, consolidate purchasing, quality improvement, and fraud and abuse surveillance activities with other state-funded health programs, including Medicaid and NMRHCA. Direct the new authority to evaluate the feasibility of a data warehouse and claims processing function using the existing systems in Medicaid. Additionally, consolidate health benefit funds formerly administered by NMSPIA and RMD and also consider the feasibility of merging APS and other governmental entities into the administration of HCFA and possibly merging funds.

New Mexico Public Schools Insurance Authority
410 Old Taos Highway
Santa Fe, NM 87501
Phone: 505 988-2736 or 1-800-548-3724
FAX No.: 505 983-8670

November 15, 2010

Mr. Charles Sallee
Deputy Director for Program Evaluation
Legislative Finance Committee
325 Don Gaspar, Suite 200
Santa Fe, NM 87501

Dear Mr. Sallee:

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

We are in agreement with the majority of the cost containment strategies, i.e., more frequent claim audits, moving spouses to the spouse's employer plan by way of surcharge on the employee, creation of a separate premium rate for "employee plus child" versus "employee plus spouse", and dependent eligibility audits. Claim and eligibility audits would be contracted through our benefits consulting firm and would be subject to the contractual maximum.

We agree with the recommendations to actively participate in provider rate development and to create an incentive to the health plans to achieve lower reimbursement levels to providers are good. The IBAC has been involved in several negotiations with providers who were seeking an unjustifiable reimbursement increase and were successful in achieving a satisfactory outcome. Additional efforts in this area can only benefit the IBAC claim costs.

The recommendation to decrease the administrative fees to the FY 09 level may be problematic. Our administrative fees represent 5.2% of the health plan costs and we have successfully negotiated lower fees than originally requested at renewal. To achieve this recommended reduction, it may be necessary to cut some of the services the health plan administrators perform for our members. We do, of course, want to squeeze every dollar of savings out of it we can. To have any chance of success to get back to 09 levels would require us to exercise our 30 day notice and go out to the market with a full-blown bid. We can do that, but must keep in mind that the costs of bidding may equal or exceed any savings.

Uniformity in reporting requirements will allow us to better judge the results of each health plan in controlling costs and improving quality.

We have taken into account employee input in benefit redesign and have conducted surveys of our members when steps had to be taken to either reduce coverage or increase premiums. Not surprisingly, we have not been able to respond positively to employee input because of the financial issues faced by the state.

We would like to have an independent rate validation done to compare us with other plans and other states.

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

We specifically want to thank Pamela Galbraith and David Craig for their professionalism in the evaluation process.

Sincerely,

Christy Edwards
Deputy Director

Copy: NMPSIA Board of Directors

BILL RICHARDSON
NEW MEXICO GOVERNOR

ARTURO L. JARAMILLO
CABINET SECRETARY
GENERAL SERVICES DEPARTMENT

NEW MEXICO
GENERAL SERVICES DEPARTMENT

ADMINISTRATIVE SERVICES DIVISION
(505) 827-0620

BUILDING SERVICES DIVISION
(505) 827-2349

PROPERTY CONTROL DIVISION
(505) 827-2141

PURCHASING DIVISION
(505) 827-0472

RISK MANAGEMENT DIVISION
(505) 827-0442

STATE PRINTING & GRAPHIC SERVICES BUREAU
(505) 476-1950

TRANSPORTATION SERVICES DIVISION
(505) 476-1902

November 16, 2010

Pamela Galbraith, Program Evaluator
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87501

Dear Ms. Galbraith:

This is in regard to the recently completed LFC Performance Audit of the GSD/RMD Employee Benefit Programs. As with previous Performance Audits of GSD in the past, the focus has been predominantly on agency shortcomings with little regard for the efficiencies and achievements of the GSD/RMD Self-Insured Health Programs. Furthermore, it must be said that meeting the expectations of the Performance Audit will require additional resources.

Having an impact on increasing rates through active negotiation will require capable and experienced negotiators and systems for modeling and tracking rates in relevant markets throughout the State and the Nation. These resources come at a cost.

With respect to consolidation of the IBAC for efficiency and cost savings, GSD/RMD supports this initiative if the following criteria are applied:

1. That realistic goals and objectives are set by the Executive and the Legislature;
2. That the needs of the diverse memberships are met;
3. That resources necessary to achieve the goals and objectives are provided; and
4. That the consolidated system can be operated at a lower cost

Attached please find the GSD detailed rebuttal to the EBB Performance Audit.

If you have any questions, please let me know.

Sincerely,

for Mike Wilson, Director
Risk Management Division, GSD

Administration

The Performance Audit does not describe adequately the extensive workload and responsibility of RMD Employee Benefits Bureau (EBB).

RMD is comprised of the Legal, Alternative Dispute Resolution, Employee Benefits, Workers Compensation, Loss Control, Finance, and Property and Casualty bureaus.

RMD currently provides health benefits for 103 local public bodies (28 counties, 29 Municipalities, 37 other governmental entities such as hospitals, water conservations, housing authorities etc…, 3 groups of retirees, 5 Higher Education Institutions, and Legislators).

RMD performs contract oversight for Medical, Prescription, Dental, Vision, Term Life, Whole Life, Universal Life, Accident Life, Cancer and Accident, Auto and Home, Legal, and Flexible Spending Accounts and the associated vendors. In this regard the EBB holds each of these carriers accountable for the proper management and administration of employee benefits. RMD, designs plans and performs actuarial analysis and ensure carriers meet their performance guarantees.

RMD self-administers COBRA, Disability, domestic partner eligibility, and premium only plan utilizing RMD staff without external contracts for a greater savings and service to the State of New Mexico taxpayers.

RMD, DFA, and DOIT are program owners of the State's SHARE Human Capital Benefits Module which oversees system configuration and use for benefit administration.

RMD program development performed by the Employee Benefits Bureau includes Procurement, Contracting, Plan Design, Premium Development, Communication, Reserve Setting, Utilization Management, Experience Rating, Training, HIPAA compliance, IT support, COBRA administration, LPB billing, Compliance with all Federal and State Mandates. RMD employees provide customer service, technical support, communication, and trainings for all state Human Resource (HR) offices, state employees, local public body HR offices, and local public body employees approximately 81,000 (77,000 in Medical, 81,010 in Dental and 68,706 in Vision) individuals.

Prior to 2004 the pricing arrangement for Administrative Services Only (ASO) Fees was accomplished individually with each IBAC member. Since 2004 the ASO fees were determined on the basis of a consolidated IBAC membership.

Funding.

RMD's employee's contribution ranges from 20 percent to 40 percent of annual income.

The performance audit concludes that RMD's employee's contribution ranges from 20 percent to 40 percent of annual income. The state statute (NMSA 1978 10-7-4) provides three tiers for employee premium contributions based on annualized salary and not percentages of annual income.

Enrollment

RMD does not concur; RMD has greater enrollment membership in rural areas than does New Mexico Public School Insurance Authority (NMPSIA).

Self-insured plan
The Federal Health Care Reform Act of 2010 and current State law require that 85% of premiums go directly to Healthcare providers and only 15% to administrative costs. In fact, since 2000, RMD has exceeded the percentage going to healthcare providers (93% of its premiums received to employee/dependent claims and only 7% to covered administrative costs).

Fully-insured plans
The performance audit fails to point out in addition to RMD and NMPSIA that Albuquerque Public Schools (APS) and Retiree Healthcare Authority (RHCA) are also self-insured plans.

COST
The issue of provider rate increases is not unique to New Mexico, those increases occur on a nationwide basis. The statement that RMD does not address provider rates is not accurate. IBAC contractors are required to notify IBAC on a regular basis. IBA members confer and strategize on the best steps to control provider increases. A recent example is Christus St. Vincent and Lovelace where RMD took an active role in guiding Lovelace of an acceptable agreement.

LEGISLATION
RMD is an active participant in the process and the development of statutory and regulatory initiatives.

FEDERAL HEALTH REFORM
Prior to the passing of HCR 2010 RMD has been proactive in benefit design changes.

- Covering Dependents to age 25;
- 100% wellness benefits;
- Domestic Partners;
- No lifetime or annual limits;
- No discrepancy in mental health and major medical;
- No limits on women's health or options;
- Domestic Partner for COBRA;
- Alternative Medicine

BETTER OVERSIGHT OF PROVIDER RATES AND QUALITY IMPROVEMENTS WILL MAKE HEALTHCARE MORE AFFORDABLE FOR EMPLOYEES AND THE STATE. NMPSIA and RMD have increased premiums, employee out-of-pocket expenses, and used fund balances as strategies to manage rising healthcare costs.
For the last three years RMD has not increased premiums nor utilized reserve funds. The adjustments have been in plan design.
Healthcare spending for RMD and NMPSIA has increased by 84.6 percent or $237.5 million between FY04 and FY10 as shown in Table 1.
This analysis does not consider increase cost caused by increased enrollment and improperly suggest that healthcare costs were the sole factor.
In FY 04 RMD membership was at 60,000 and grew to 80,000 between FY08 and FY09. Membership growth means increased revenue to pay for increased number of claims.

From FY08 to FY10, premiums have increased between seven percent and seventeen percent, and now represent 99 percent of some lower wage public employees' gross income.

In FY09 RMD increased premiums by 7.4% on Medical and have held premiums flat for FY 10 and FY 11.

Out-of-pocket expenses, such as deductibles and co-pays, have doubled in some cases as a result of agency plan redesign.

For FY 10 and FY 11 RMD was directed by the executive and the legislature not to increase premiums and to shift costs by program design to deductibles and co-pays.

Increasing provider rates appear responsible for a greater portion of rising healthcare costs; utilization of services has remained relatively flat for both agencies

The increase in provider rates is a result of the cost of medical technology, staffing, overhead costs, and costs to maintain a quality provider network in New Mexico. RMD has no ability to control these costs with current staffing and resources.

Neither agency actively monitors provider rate increases and contractually allows rates to increase up to 10 percent without notice.

RMD does not concur; the contract clauses stipulate the following and have nothing to do with provider rate increases.

"Contractor is hereby authorized, without the consent of the Agency to add and/or delete the names of network providers contracted. Significant additions and/or deletions ("significant" defined as +/-10%) will be shared by Contractor with the Agency as quickly as possible, at least monthly. Contractor agrees that it will use its best efforts not to delete the names of providers to the extent that the deletion materially alters the availability of services to Members, unless the Contractor has received the prior written consent of the Agency. No deletion of a network provider will be construed to adversely reflect upon the quality or qualifications of the provider."

In addition our contract with carriers also reads:

"Contractor has also agreed to extend to the Agency, with regard to provider discounts and administrative fees, the most favored arrangements that have been negotiated with other comparable clients and benefit plans/products in NM that contract with the Contractor. "

Neither agency routinely benchmarks average consumption of services, nor prices paid by other payers, to ensure reasonable pricing.

RMD conducts a quarterly review of provider services and pricing.

To compare RMD with a Medicaid plan would be erroneous. No self-insured program can obtain entitlement rates like Medicaid.

Average spending per person has increased in many categories and regions, while the amount of services provided has remained stable and as a result rate increases are likely responsible for much of the increased costs.

RMD could not substantiate the increased claim by the performance audit. Both NMPSIA and RMD share the same providers therefore there should be no differential in cost.

In some cases the consumption of services in New Mexico plans is less than national averages, but spending per person for those services is much higher

RMD concurs; if a smaller utilization for emergencies occurs it stands to reason there would be an increase of outpatient services which is attributed to increases in technology, centralization of service providers etc.

Regional spending per member varies widely which presents opportunities for cost savings by managing down outlier costs through targeted improvements in pricing and utilization.
Provider rates are established by the regional and local markets supply and demand, and in some cases, providers with market power drive higher rates in certain areas.

Both agencies can improve oversight of administration of plans and emphasis on quality improvements.

RMD contracts for industry best practices for quality medical care without dictating particular products or approaches.

Limited financial incentives exist for plans to aggressively contain healthcare spending and the state does not exert cost containment as part of its administrative services contracts.
Please see previous response on page 3 about 10% increases and contract language.

RMD provided a 4.5 percent increase for one plan's administrative fees in FY11, costing the state an estimated $271 thousand and RMD did not assume estimated savings from the new pharmacy contract in its actuarial projection

This statement is completely out of context. RMD negotiated favorable ASO fees across the board with all vendors and achieved a lower than original contracted rate. The Performance Audit statement is premature regarding savings and RMD will not know its savings until the end of FY2011.

More active use of standardized management reports on cost and use of healthcare by both agencies would help inform plan and cost sharing decisions.
RMD uses standardized management reports. RMD uses an actuary (Gallagher) to determine claim costs and project future claims and IBNR needed for fiduciary soundness.

Neither agency receives quality of care information about their member's healthcare, nor requires performance expectations from plans.
This is not accurate during quarterly reviews RMD anlyzes top ten diagnosis, top services utilized,and top hospital cost to determine possible spikes or declines in exposure and adjust benefits accordingly. Furthermore RMD monitors quality and effectivesness of care through programs such as disease management and "Precious Beginnings" which assists women with pregnancy programs for better prenatal and post natal care.

Opportunities exist for cost savings through better oversight and plan design changes.

LFC Suggestion: Increase the frequency of independent insurance plan claim audits.
Currently annual audits are prepared; to increase frequency would be an additional cost to the employee via premiums.

LFC Suggestion: Impose a surcharge on employees with spousal coverage, where the spouse has a health benefit plan option with their employer. An analysis of Virginia's program by Mercer estimated that if ten percent of spouses left the state plan, the state would save between $17 million and $22 million per year.

This is a policy suggestion that would need to be reviewed and discussed by the Executive and Legislature.

LFC Suggestion: Eliminate the RMD employee assistance program.

Due to budget costs the plan has already been reduced significantly. Due to Federal Department Of Transportation(DOT) Regulation, EAP may be a required benfit for NM DOT employees. RMD is aware of agencies purchasing additional coverage for lost EAP services such as critical incidents and employee counseling as part of management performance referrals .

LFC Suggestion: Conduct dependent enrollee verifications for state pool enrollees and primary and dependent for local public bodies

This will require additional resources. The primary RMD focus is to save dollars. RMD must prioritize verification audits or other monitoring systems to assure that the employee receives the best service possible.

RECOMMENDATIONS

Regarding the recommendation to establish a Data Warehouse to standardize claims data from all the medical and pharmacy vendors onto one software platform reporting base and access consistent data reports from all vendors. RMD concurs and will work with other IBAC members.

RMD does not concur with the plan to decrease ASO fees to the FY09 level. Current ASO fees constitute less than 1% of the overall cost of doing health care business for New Mexico

RMD concurs with evaluations of cost saving strategies. RMD currently particpates in to National studies regarding challenges and current practices in state employee healthcare such as National Association Of State Personnel Executives (NASPE) and State And Local Government Benefit Association (SALGBA).

RMD does not concur with disincentivizing health plans for the sake of reducing provider rates. This would shrink our network of providers and limit quality of care.

RMD concurs if we have a standardized datawarehouse and supporting resources this can be accomplished.

RMD does not concur with the statement of enrollee input into benefit redesign. RMD utilizes the rest of the IBAC and other similar entities for comparisons regarding benefit redesign.

STREAMLINING BENEFIT PLANS, EXPANDING PURCHASING POOLS, AND ELIMINATING DUPLICATIVE ADMINISTRATION COULD SAVE MILLIONS **The State of New Mexico has long been interested in maximizing the benefits of various purchasing strategies for healthcare services, including enlarging and coordinating purchasing pools by multiple public entities.**

Currently IBAC is utilizing the larger pool of membership for negotiating and bargaining power to receive healthcare services. The policy issue to consider would be mandating that all public entities become part of the larger pool. RMD would support this policy as it did when it began marketing its programs to Local Public Bodies.

Some States have estimated cost savings from consolidating pools of employees and leveraging greater purchasing power, though research is limited and evidence varies.

Currently IBAC is using buying power which has allowed vendors to not only use Medicaid and IBAC membership to negotiate with providers but also to incorporate all commercial business which would cover all New Mexicans.

RMD and NMPSIA perform the same functions which could be combined to lower administrative expenses and improve oversight of healthcare for public employees

Please see below

LFC Suggestion: A well run HCFA may entice other large governmental entities, such as APS, the City of Albuquerque and the University of New Mexico to consider outsourcing their health benefits administration, and possibly plan design to this state agency. This would further improve the state's ability to leverage quality improvements, lower administrative costs and negotiate affordable medical prices that can help curb health cost increases.

The legislature needs to set goals and objectives to accomplish the consolidation and must evaluate existing resources to determine which resources and systems are most efficient and necessary to accomplish the task

APPENDIX A

RMD's PARTICIPATING LOCAL PUBLIC BODIES (LPB's) AND PARTICIPATING NMPSIA ENTITIES

RMD Local Public Bodies

Alto Lakes Water & Sanitation District	High Plains Regional Coop #3
Arch Hurley Conservancy District	Housing Authority of City of Las Cruces
Carlsbad Irrigation District	Lea County
Catron County	Lincoln County
Central Reg. Educ. Coop	McKinley County
Chaves County	Med Supp LPB Retiree Otero County
Cibola County	Medicare Group
City of Alamogordo	New Mexico Military Institute
City of Aztec	New Mexico State Fair
City of Deming	New Mexico State University
City of Espanola	NM Association of Counties
City Of Las Cruces	NM Beef Council
City of Las Vegas	NM Highlands University
City of Moriarty	NM School for the Blind and Visually Impaired
City of Portales	NM Soil & Water Conservation District Insurance
City of Raton	North Central NM Economic Development District
City of Roswell	North Central Regional Transit District
City of Santa Rosa	North Central Solid Waste Authority
City of Sunland Park	Northeast Reg.Educ.Coop
City of Truth or Consequences	Northwest Regional Solid Waste Auth.
Colfax County	Otero County
County of Luna	SJC Pre 65 / Med Supp Retiree
Curry County	Don Ana Pre 65 Load 10 Retirees
De Baca Family Practice	Quay County
DeBaca County	Region I Housing Authority
Dona Ana County	Region III Housing Authority
Eddy County	Region IX Education Cooperative
El Prado Water and Sanitation District	Region V Housing Authority
El Valle de los Ranchos Water & Sanitation Dist.	Region VI Housing Authority
Eldorado Water and Sanitation	Regional II Housing Authority
Elephant Butte Irrigation District	Regional Substance Abuse Treatment Ctr
Eunice Special Hospital District	Regional VII Housing Authority
Ft. Sumner Housing Authority	Rio Arriba County
Grant County	Rio Arriba Housing Authority-sub of RA County
Guadalupe County	Roosevelt County
Guadalupe County Hospital	Roosevelt Cty.Gen. Hospital
Harding County	San Juan College
Hidalgo County	

RMD Local Public Bodies (Cntd.)

San Miguel County
Santa Fe Civic Housing Authority
Santa Fe County
Sierra County
Sierra Vista Hospital
Socorro County
Socorro County Housing Authority
South Central Council of Gov.
South Central NM Cotton Boil Weevil (SCNMCBWCC)
Southwest NM Council of Governments
SouthWest REC #10
T or C Housing Authority
Taos County
Timberon Water & Sanitation District
Torrance County
Town of Clayton
Town of Elida
Town of Estancia
Town of Hagerman
Town of Mesilla
Town of Silver City
Town of Taos
Town of Vaughn
Union County
Valencia County
Valencia Soil and Water Conservation District
Village of Angel Fire
Village of Columbus
Village of Eagle Nest
Village of Floyd
Village of Ft. Sumner
Village of Milan
Village of Roy
Village of Wagon Mound

NMPSIA Participating Entities

Academia de Lengua y Cultura	Cuba Independent Schools
Academy for Technology and the Classics	Deming Cesar Chavez Charter High School
Academy of Trades and Technology	Deming Public Schools
ACE Leadership High School	Des Moines Municipal Schools
Active Board Members	Dexter Consolidated Schools
AFT New Mexico	Digital Arts and Technology Academy (DATA)
Alamogordo Public Schools	Dora Consolidated Schools
Albuquerque Institute of Math & Science	Dulce Independent Schools
Albuquerque School of Excellence	East Mountain High School
Albuquerque Sign Language Academy	El Camino Real Academy
Aldo Leopold Charter School	Elida Municipal Schools
Alice King Community School	ENMU-Portales
Alma D Arte Charter High School	ENMU-Roswell
Amy Biehl Charter High School	Espanola Public Schools
Anansi Charter School	Estancia Municipal Schools
Animas Public Schools	Eunice Municipal Schools
Anthony Charter School	Farmington Municipal Schools
Artesia Public Schools	Floyd Municipal Schools
Aztec Municipal Schools	Fort Sumner Municipal Schools
Bataan Military Academy	Gadsden Independent Schools
Belen Consolidated Schools	Gallup-McKinley County Public Schools
Bernalillo Public Schools	Gilbert L. Sena Charter High School
Bloomfield Municipal Schools	Gordon Bernell Charter School
Capitan Municipal Schools	Grady Municipal Schools
Career Academic & Technical Academy	Grants/Cibola County Schools
Cariños de los Niños	Hagerman Municipal Schools
Carlsbad Municipal Schools	Hatch Valley Municipal Schools
Carrizozo Municipal Schools	Hobbs Municipal Schools
Central Consolidated Schools	Hondo Valley Public Schools
Central New Mexico Community College	Horizon Academy West Charter School
Cesar Chavez Community School	House Municipal Schools
Chama Valley Independent Schools	Inactive Grandfathered Board Members
Christine Duncan Community School	Jal Public Schools
Cien Aguas International School	Jefferson Montessori Academy
Cimarron Municipal Schools	Jemez Mountain Public Schools
Clayton Public Schools	Jemez Valley Public Schools
Cloudcroft Municipal Schools	La Academia de Esperanza Charter School
Clovis Municipal Schools	La Academia Dolores Huerta
Cobra	La Promesa Early Learning Center
Cobre Consolidated Schools	La Resolana Leadership Academy
Cooperative Educational Services (CES)	Lake Arthur Municipal Schools
Corona Municipal Schools	Las Cruces Public Schools
Corrales International School	Las Montanas Charter School
Cottonwood Classical Preparatory School	Las Vegas City Public Schools
Cottonwood Valley Charter School	Lea Regional Educational Coop #7

NMPSIA Participating Entities (Cntd.)

Creative Ed Prep Institute #1	Lindrith Area Heritage Charter
Logan Municipal Schools	Nuestros Valores Charter School
Lordsburg Municipal Schools	Pecos Independent Schools
Los Alamos Public Schools	Pecos Valley REC #8
Los Alamos Schools Credit Union	Penasco Independent Schools
Los Lunas Public Schools	Pojoaque Valley Public Schools
Los Puentes Charter School	Portales Municipal Schools
Loving Municipal Schools	Public Academy for Performing Arts
Lovington Public Schools	Quay Schools Federal Credit Union
Luna Community College	Quemado Independent Schools
Magdalena Municipal Schools	Questa Independent Schools
Maxwell Municipal Schools	Ralph J. Bunche Academy
Media Arts Collaborative Charter School	Raton Public Schools
Melrose Public Schools	REC #2
Mesa Vista Consolidated Schools	Red River Valley Charter School
Mesalands Community College	Regional Educational Center #6
Middle College High School	Reserve Independent Schools
Monte del Sol Charter School	Retirees
Montessori of the Rio Grande	Rio Gallinas
Mora Independent Schools	Rio Rancho Public Schools
Moreno Valley Charter School	Robert F. Kennedy Charter School
Moriarty-Edgewood School District	Roots and Wings Community School
Mosaic Academy	Roswell Independent Schools
Mosquero Municipal Schools	Roy Municipal Schools
Mountain Mahogany Community School	Ruidoso Municipal Schools
Mountainair Public Schools	San Diego Riverside Charter School
Native American Community Academy	San Jon Municipal Schools
NEA	Santa Fe Community College
New Mexico School for the Arts	Santa Fe Public Schools
NM Activities Association	Santa Rosa Consolidated Schools
NM Coalition of School Administrators	School of Dreams Academy
NM Junior College	School of Integrated Academics & Technology
NM School Board Association	Sidney Gutierrez Middle School
NM School for the Deaf	Silver City Consolidated Schools
NMPSIA	Socorro Consolidated Schools
North Valley Academy	South Valley Academy
Northern NM College	South Valley Preparatory School

NMPSIA Participating Entities (Cntd.)

Southwest Intermediate Learning Center
Southwest Primary Learning Center
Southwest Secondary Learning Center
Springer Municipal Schools
Taos Academy Charter School
Taos Charter School
Taos Integrated School of the Arts
Taos Municipal Schools
Tatum Municipal Schools
Texico Municipal Schools
The Albuquerque Talent Development SCS
The Ask Academy
The International School
The Learning Community
The Masters Program
The Montessori Elementary School
The New America School
Tierra Adentro of New Mexico
Tierra Encantada Charter High School
Truth Or Consequences Municipal Schools
Tucumcari Public Schools
Tularosa Municipal Schools
Turquoise Trail Charter School
Twenty First Century Public Academy
Vaughn Municipal Schools
Village Academy
Vista Grande High School
Wagon Mound Public Schools
Walatowa Charter High School
West Las Vegas Public Schools
Western NM University
Zuni Public Schools

HIGH COST DIAGNOSES

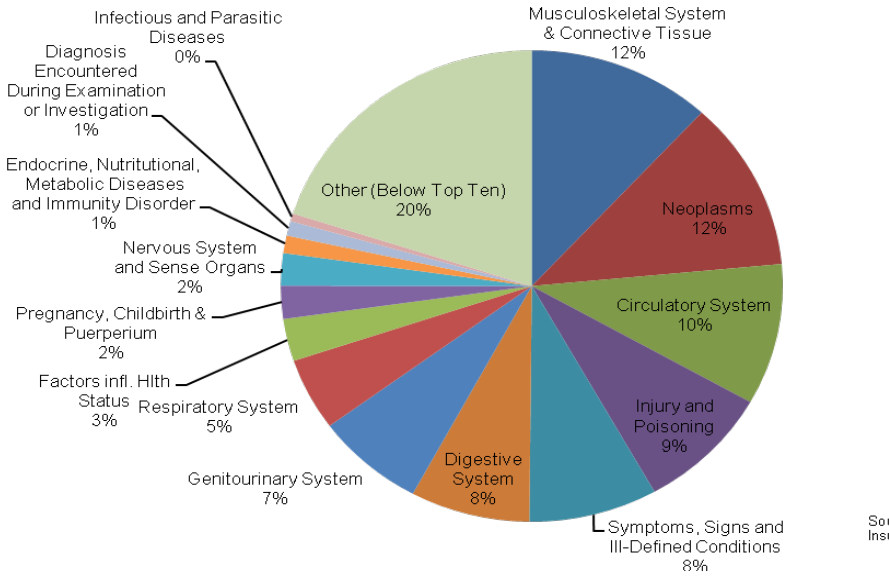
FY10 Top Ten Most Costly Diagnoses, RMD and NMPSIA

NMPSIA FY10	Paid Claims	RMD FY10	Paid Claims
Neoplasms	$13,765,076	Musculoskeletal System and Connective Tissue	$19,422,903
Musculoskeletal and Connective Tissue	$11,515,215	Genitourinary System	$18,137,216
Circulatory System	$10,653,118	Neoplasms	$16,737,835
Genitourinary	$10,280,132	Injury and Poisoning	$14,990,640
Injury and Poisoning	$7,721,547	Circulatory System	$14,660,636
Symptoms, Signs and Ill-Defined Conditions	$7,122,651	Symptoms, Signs and Ill-Defined Conditions	$14,536,566
Digestive System	$6,708,075	Digestive System	$13,415,237
Respiratory System	$5,393,127	Respiratory System	$7,575,413
Factors infl. Health Status	$4,508,172	Pregnancy, Childbirth and Puerperium	$5,907,986
Diagnosis Encountered During Examination or Investigation	$2,617,766	Nervous System and Sense Organs	$5,799,652

*For all insurance companies where data was available. Omits one insurance company.

Source: Insurance Company Annual Reports

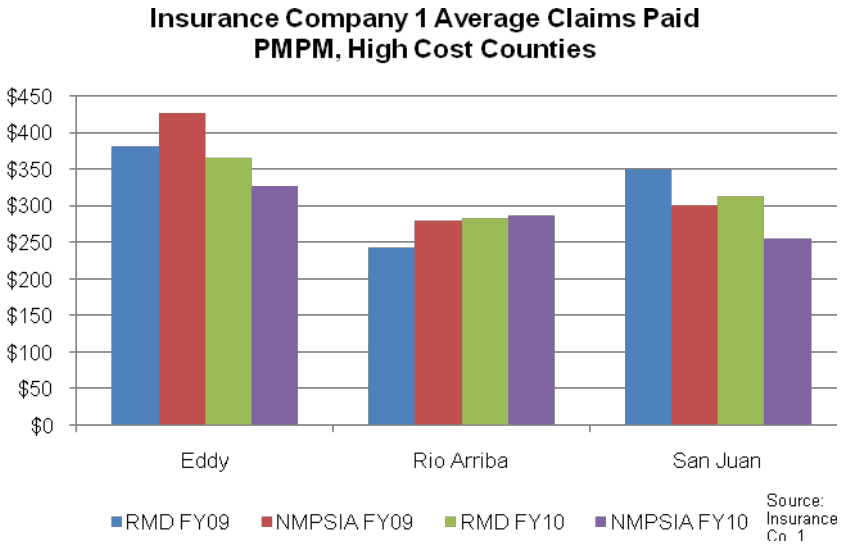
NMPSIA and RMD Combined Top Ten Most Costly Diagnoses, FY10



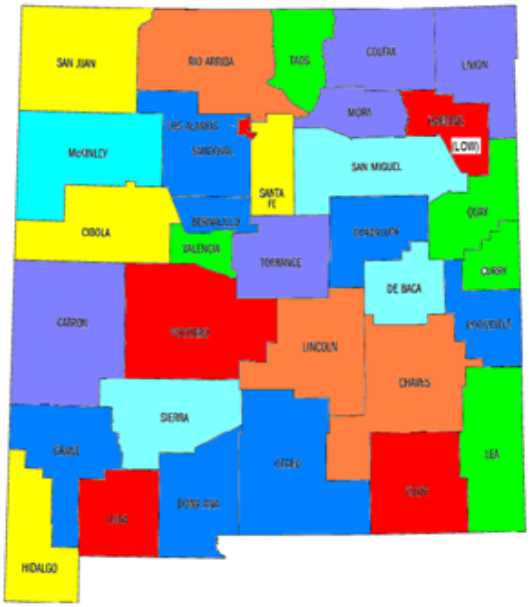
Source: RMD, NMPSIA and Insurance Companies

APPENDIX C

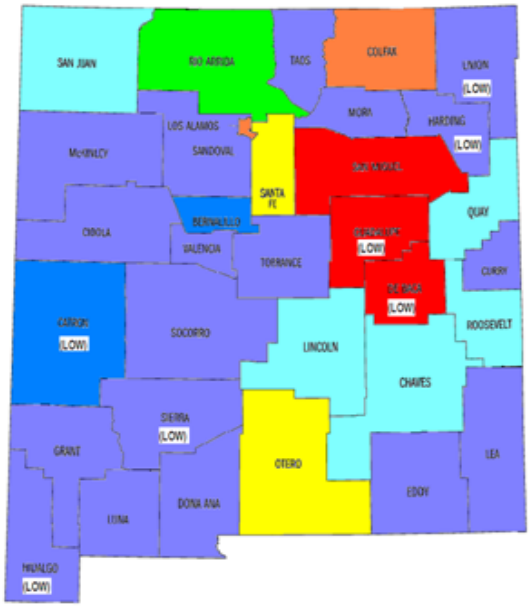
REGIONAL COSTS BY COUNTY



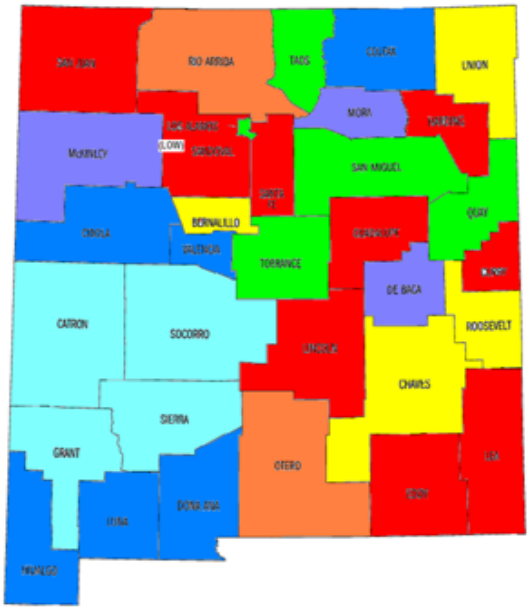
NMPSIA Insurance Co. 1 FY10 Claims Paid PMPM



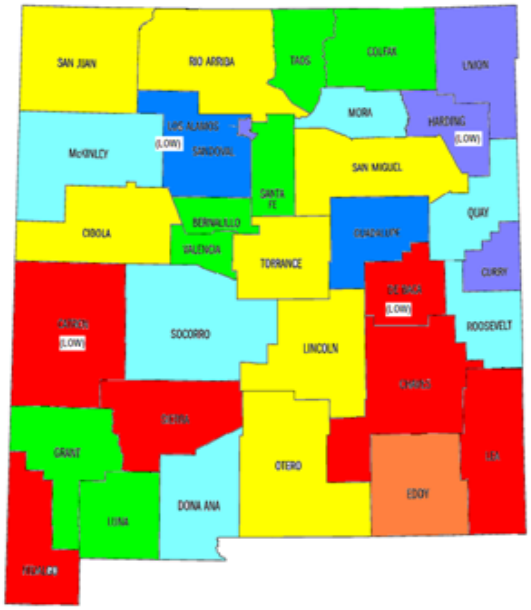
NMPSIA Insurance Co. 2 FY10 Claims Paid PMPM



RMD Insurance Co. 1 FY10 Claims Paid PMPM



RMD Insurance Co. 2 FY10 Claims Paid PMPM



Scale: Claims Amount Paid PMPM

Source: Insurance Companies

(LOW)						
Low Enrollment	≥$300	$275 - $299	$250 to $274	$225 - $249	$224 - $200	$199 - $175	≤$174

APPENDIX D

LEGISLATION TIMELINE

Legislative Initiatives

YEAR	LEGISLATION	INTENT
1986	Public School Insurance Authority, 22-29 NMSA 1978	Created the New Mexico Public Schools Insurance Authority
1989	Risk Management Division 15-7-1 NMSA 1978	Created the Risk Management Division within the General Services Department
1989	Group Benefits At 10-7B-1 NMSA 1978	Created the group benefit committee for Risk Management Division
1990	Retiree Healthcare Act 10-7C-1 NMSA 1978	Creates the Retiree Healthcare Authority
1997	Healthcare Purchasing Act 13-7-NMSA 1978	Created the Interagency Purchasing Collaborative
2008	HB 147- Picaraux	Proposed creation of a healthcare authority to include administrative reorganization or consolidation of state agencies involved in public sector healthcare financing (did not pass)
2009	SJM 1- Feldman	Required the NM Health Policy Commission to convene a meeting of public entities engaged in administration of healthcare services to identify opportunities for consolidation
2010	SB155-Harden	Proposed consolidated of public insurance entities' purchasing (did not pass)

Source: NM State Statutes

APPENDIX E

GLOSSARY

ASO- Administrative Service Only- The services purchased and the company from which those services are purchased by self-funded health benefit plans. Such administrative services include such activities as the preparation of an administration manual, communication with employees, determination and payment of benefits, and preparation of reports.

Claim- A request for payment by a medical provider for a given medical service or item. An actual claim is the amount paid for services, less discounts, deductibles, co-pays, and co-insurance.

Co Pay- A per occurrence payment paid by the insured person each time a medical service is accessed. Copayments do not usually contribute towards any policy out-of-pocket maximums.

Co-Insurance- A percentage payment after the deductible up to a certain limit. It must be paid before any policy benefit is payable by an insurance company.

Data Warehouse- A data warehouse is a repository of an organization's electronically stored data from which queries and analysis may be made.

Deductible- A fixed dollar amount during the benefit period - usually a year - that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles. Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. Deductibles may differ if services are received from an approved provider or if received from providers not on the approved list.

EBH- The Employee Benefits Bureau of the Risk Management Division (RMD), General Services Department (GSD) is solely responsible for the procurement, implementation, and administration of all group benefit plans for State of New Mexico employees and their dependents.

Fully-insured plans – Employers using fully-insured plans pay a per-employee premium to an insurance company to provide health benefits. The insurance company assumes the risk of providing health coverage for insured events.

Insurance Pool- The total of enrollees participating in a health insurance program.

IPA- (Independent Practice Association) - A type of physician alliance in which the physicians own the practice, as opposed to physicians employed by an entity such as a health maintenance organization. Physicians in the IPA are legally organized as a corporation, partnership, professional corporation, or foundation to contract as a group to provide services.

LPB- Local public bodies- The part of the economy concerned with providing basic government services. In this report it refers to other than state agencies; primarily counties, municipalities and some state higher education institutions.

Out-of-pocket expenses- The amount of money the patient has to pay from their own funds for deductibles, co-insurance and co-payments. These are expenses not paid for by the employer.

PBM- Pharmacy Benefit Manager- A third party administrator of prescription drug programs. They are primarily responsible for processing and paying prescription drug claims.

PMPM- Applies to a monthly revenue or cost for each enrolled member in an insurance plan.

Premium- The amount to be charged for a certain amount of insurance coverage.

Self-insured plan – Most common among large organizations, employers in self-insured plans act as their own insurer and bear the risk associated with offering health benefits, with possible administrative cost savings from five percent to eight percent from fully-funded plans. Employers using this plan pay health care claims to providers instead of paying an insurance company.

Utilization Review- A process for monitoring the use, delivery, and cost-effectiveness of services, especially those provided by medical professionals. An analysis to determine the necessity, appropriateness, and efficiency of medical and dental services, procedures, facilities, and practitioners.