OFFICE OF GOVERNOR RONNIE MUSGROVE
INTEROFFICE MEMORANDUM

TO: BOYD

FROM: RILEY

SUBJECT: NATIONAL ASSOCIATION OF STATE PERSONNEL EXECUTIVES 10/25/00 CONFERENCE CALL: TRENDS IN STATE HEALTH CARE BENEFITS

DATE: 10/25/00

CC: FILE

The National Association of State Personnel Executives conducted a conference today to discuss trends in state health care benefits. Clark J. Yaggy, senior vice president for The Segal Company discussed how both the public and private sectors are addressing soaring health care costs. The Segal Company publishes an annual survey of state employee health benefits. The below notes outline the conference call:

Joyce Brown w/ Montana (Empl Ben Mgr) intro Yaggy.

Yaggy: whole ? of increasing helath care costs in benefits plan in general is huge subject. How are states addressing rising costs, what are trends and what are solutions?

Annual survey just completed. "Trend Costs Survey" really the inflationary rates of healthcare. First survey 3 years ago of largest insurance cos and PPO and TPAs and PBMgrs. Abstract is on web site. Co's in survey represent 50 million covered lives, so rep sample. For 2001, what kind of inflationary or trend rates can people expect in benefit plans? The unexpected news is that medical care costs will continue to rise, were relatively flat for a few years some years ago. Managed care plans, HMOS in part, probably increase 10%/yr, Point of Service plans (HMOS allow some outside) expect 11% increase in 2001, PPO plans expected to increase in costs by 12.5% and unmanaged indeminity plans expected increase of 15%.

See industry has faith in HMOs able to control costs a little more tightly than POS, than PPO,e tc.

We're in period do double digit inflation in med costs. About same increase as this year and as occurred in 1999.

Plans having to focus on prescrip drug components. This is rapidly increasing health care costs and will continue. Retail plans (card plans) expect 20% increase and mail order increase almost 19.5%.

What are states doing in medical care plans?

Answer is no magic bullet. Mge care and tightening it up is probably most frequent state action. Mgd care has been whipping boy for things not going well, but has expanded industry, made health care an organized market, and made borad based initiative possible. Providers are credentialed and data collected to id inconsistent treatment. Not time to say mgd care not doing good things.

What do we mean mgd care? Also includes hosp pre-certification (most plans have), case mgt, second surgery opinon (not too many now). Carved out programs for behavioral health care. Includes wellness and prevention and disease mgt. Mgd care is here to stay and most staetes want to continue to refine.

Plans should steer embers intop networks and steer towards savings. No reason to let go of networks and start paying retail medicine again.

Action taken by states?

Plans need to have better data – how treated, hospitiationz rate, financial facts? Should mg networks – PPOs should have oversight and contractual mgt. Plans should explore more "demand mgt" and disease mgt strategies. Plans conducting qual assessent of PPOs and HMOs. Performance agreements w/ penalties for non-compliance where vendors not meeting set priorities.

Data and financial facts: data can indicate where the money is being spent and why, so you can make judgement as to how plan should be restructured to react to costs. Share facts w/ your PPOs and push them to tighten deals they offer. Target high rate disease and design disease prevention strategy. Plans should manage their networks – ensure competitive pricieng and out of area rules are adequate and adqeqwua provider access and member satisfaction in vitial areas.

Look at HMS and PPS as health mgrs. Reward vendors that focus on provider education and consumer satisfaction. Ask what it does to modify physician behavior. Know that there is info flowing to the mgd care org and it si being used to modeify phys behavior.

Demand mgt and disease mgt: demand refers to a patient centerd prog that supports helath care deci making and lets patient decide. Uses nurse lines open to patients. Can give limited advice. Provide triage services (high fevers, etc can be addressed after questioning by nurse, so save hospital visit costs).

Disease mgt: based on data. Means of systematic approach of activitly mging certain popos with chronic disease (depression, asthma, cong heart failure, high blood pressure). Typical 15% of coverd pop accuoutnt for 80% of costs and 70% of plan costs are related to chronic diseases. Allow people to mange their situation and can affect plan costs.

Quality assessment of vendors – matter of conducting toods (interview, suvery, et.c) Joint Cmsn on Accrediting Health Care Orgs. Qualitiative and proprietary tools are available.

Plan sponsors need quality assessment and need priorty performance agreements (satisfaction, payment of claims, ratio of primary care phys v. specialist).

What can be done in prescription plans?

Conduct a throrough review of pharmacy benefit mgr. Strategies more and more being reviewed include:

Typical pharmacy mgr has a copay per prescription at pharm counter for generic drugs. One strategy is to change from fixed copay to a percentage and maybe a high and low (ex. Generic cost 10% w/ a min of $3 and max of $10). Percentages keeps cost sharing between patien and plan at a level that rises at same rate of inflation and health care cost.

Use front end deductible. Typcially copay plans don't have deducatibles.

Intro benefit maximusm (annual, lifetime or categrorical)

Three-tier copays – generic, brand name (in formulary – more cost effective brands) , brandname wi/out formula (have greatest co pay)

More focus on prescip limit and exclusion. Have as much generic use as possible.

Increase patient and physician indication.

?? and answer:

Bill Crane (OK ed and local govt) – define pharmacy carvd ougt progr?

Prescrip drubs in past in indemnity plan, were part of major med package and covered if met decductible and then costs covered at 80%. Now pharm benefit mgr created contracts w/ manu and offered to take drug costs out of major med plan and set aside so drugs handled by a PBM who issues a plastic cared to covered employee who present card at member networks and at point fo service, the pharm calls benefit plan up on screen which tells pharmacist how much of a copay to collect from the patient and then charge PBM any balance left. PBM aggregates all charges/data and issues a bill to plan sponsor of the costs, the copays and then the balance.

Jerry Clayvall Iowa Dpt of Personnel – what do we do without data?

Ecourage a deep level of data gathering as possible. TPA may be collecting. Need to knows per 1,000 utilz of hospital ? avg lengthy of staty of hosp? A vg cost/day of hps? % of generic v. brand name drugs?

Iowa again – (req HMOs to be one of 2 NCQH or JACH acred) - seeing states use. NCQH data for performance or is it window dressing?

Using more and more in real sense. Encourage use 1 of 2.

Iowa agina – plan sponsors using consumer satisfaction assessment? Level of interest seems to be waning? Is this common?

One employer doing longest is GTE Corp who combined member satisfaction and NCQA data and pricing and specific disease measurement int a report card presented to coverees at open enrollment .

John Vinson – given aging popu, will inflation continue to increase due to increased use of drugs and other disease? Do you see prublic inflatiopm hogher than private b/c of makeup of employ group?

Last question first, havent' heard anybody make a big deal between differenc,e but no real data. Most situations, public feels insurer of last resourt, but don't know if true. No docu to support prublic over privat. W/ respect to continued increase primarily b/c of reteirre population, costs generally increase at these rates for next few years and hope they modify b/c we can't afford year after year. Retirees probably causing some increae. When survey conducted asked if mgrs ahd different % increase costs fo over 65 v. unde4r 65 and they were and expected over 65 to have 1% more .

Cory Ward – WY – any states that pressure politically from pharm to stay out of mail order business?

Could name 50 – its universal. Mail order can be tyupical of carved out pahrm progr where PBM has own factory pharmacy to mail in prescip w/ more favorable copay rates and pricing. Strong pharm lobby in general not liking pharmacy business mailed to an outside state.

WY – nobody tried to get around politics?

No. politics differ from state to state. Plan spornors has to show effectiveness to Legislature and others. Some states, local pharm agreed to the same cost pattern and charge pattern if prescrip filled in pharm rather than mail.

Joyce – relative value of 3-tier v. percentage approach?

Are really complimentary approaches, not one or the other. 3 tier compared to 2 tier. She talking % v. flat. Joyce sacrificed % for going to 3 tier w/ 3 fixed copays. In theroitical sense, he said taking step backward b/c went to flat 3 tier rather than % 3 tier. Going to % b/c of cost erason – if drug costs increase 20% and copay doesn't, then state has to fund even higher rate each year than %.

Budd Johnson (MN) – MN does quality satisfiactio survey on biennieal basis for report card – at plan level and care level. www.doer.state.mn.us. Speaker said MN is sa step ahead and should be used as moedel – do you use national data? No, just MN interviews w/ employees who have interfaced w/ system.

Budd's question – we don't have copays for office visits and are going to push to intro w/ tradeoff to intro a copay as an offset some form of point of service option to carry across the board for all plans. If looking at 10% trend rate for HMOs but Point of Service will increae to 11.4% will get immediate satisfaction , but set up for a higher trend?

Yes. But onely a 1.5% difference maybe mangeable for adjusting deductible and out of network utilziaiton. A lot depends on how broad exisintg HMO networks are, may not have a lot of out of service work. More option for outside will result in higher trend rates.

Cary Brenakis (KS) – most states having retiree program, but employees covering costs. Are you seeing trend in employee reduction or droppin retiree s?

Survey of state plans and collect extent of retiree benefits coverd by plan – only Nebraska and Indiana don't provide coverage after 65 to retirees – years ago, much more common for free health care to retirees, trend seeing is that away from paying full cost of retiree coverage and towards asking retirees to ask for more – employers reluctant to make changes b/c promised to employees at regtiremenmt – some changing to dates in the future effective

Cary – defined contribution (# of years, then # of dollars)?

Some staes looking at. Requires a lot of info as to what ytpe of service retireers have. Many plans for retireers operated by retirement systems and they tend to have this formula basis. ($5month up to 30, so if 30 years, then set amount of coverage)

Cary – inclusion of non-employees in plan? Southeast incl. Municipalities.? Expanding?

He sees trend in SE and California where all employees of all schools are part of plan. Simply by legislation. Individual districs don't have to provide. He doesn't see a massive push to change, but does see more and more staets saying that they want opened up to indivudal school districts, definite trend in recent years and includes cities and counties.

Theresea Planch – survey include disease prevention and what major disease?

Didn't ask, so no quant figures. But disease mgt candidates are sthma, depression, chronic cong heart failure

Theresa – seeing implemented by staes more quickly than in plast?

Don't know, but hope so b/c makes sense. No clear handle on why hasn't been priorty in past.