

MANAGED RISK MEDICAL INSURANCE BOARD DETERMINATION

The Board hereby determines, in accordance with the provisions of Section 11125.3 of the California Government Code, that there exists a need to take immediate action and that the need for action came to the attention of the Managed Risk Medical Insurance Board subsequent to the agenda for the April 21, 2010 meeting being posted as specified in section 11125 of the Government Code.

Specifically, in the context of the state budget crisis, it is immediately necessary for the Board to consider cost savings through modifications to Healthy Families Program benefits. This is necessary as a result of circumstances including the Maintenance of Effort provisions in the recently-enacted federal Patient Protection and Affordable Care Act (sections 2101 and 10203 of H.R. 3590, P.L. 111-148), which reduce states' options for cost-savings through eligibility-related program changes. The necessity of considering benefit-related cost savings at the April 21, 2010 meeting came to the Managed Risk Medical Insurance Board's attention subsequent to the April 9 posting of the meeting agenda. These benefits-related cost savings are the subject of Agenda Item 7.I.

CERTIFICATION

I, Lesley Cummings, Executive Director for the Managed Risk Medical Insurance Board, do hereby certify that the foregoing Determination was duly unanimously passed and adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on April 21, 2010.

Dated this day of April 21, 2010.


Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board

Healthy Families Benefit Review: Preliminary results

Managed Risk Medical Insurance Board
April 21, 2010



Kelch Associates
In consultation with Mercer Consulting

Healthy Families Benefit Review

- ▶ Scope of the project:
 - Develop a framework for review of benefit options
 - Identify options for cost-savings consistent with federal CHIP law
 - Look at other state benefits, including “Secretary-approved” plans
 - Work with Mercer to complete an actuarial analysis of selected benefit designs

Healthy Families Benefit Review

- ▶ March meeting – Board direction to model potential cost savings from the following benefit designs:
 1. Benchmark–equivalent with the minimum benefits required under federal law
 2. Benefit plan with annual and lifetime maximums (similar to Wyoming)
 3. Coverage with benefit limits (i.e., number of hospital days or office visits per year), to the extent benefit limits have been approved in other state CHIP programs

Kelch Associates

Healthy Families Benefit Review

- ▶ Research found that most other states do not have approved benefit limits (such as capped number of days or visits) in CHIP programs, except for limits related to mental health coverage and substance abuse
 - Pennsylvania has a 90-day inpatient day limit per year
- ▶ Mental health and substance abuse benefit limits will likely be revised to comply with federal mental health parity

Healthy Families Benefit Review

- ▶ Other options for Mercer to analyze:
 4. Pharmacy savings options based on a review of existing health plan pharmacy management
 5. Subscriber contribution options – specifically the maximum cost sharing that could be imposed in HFP under the federal 5% limit

Healthy Families Benefit Review

- ▶ Federal health care reform passed after the last Board meeting and while this research was in process
- ▶ Potentially changes the context for design of CHIP programs, including HFP
- ▶ For example, HR 3590 prohibits any lifetime limits on private coverage and establishes state maintenance of effort requirements for CHIP

Healthy Families Benefit Review

- ▶ Have not evaluated the impact of federal health care reform on the choices and options that might be considered for HFP benefits
- ▶ Proceeded to model and have Mercer analyze the options discussed at the March meeting

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Consulting. Outsourcing. Investments.



MARSH MERCER KROLL
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Healthy Families Program Benchmark Equivalence and Cost-Savings Analysis



Overview

- Mercer conducted the following analyses in support of potential cost savings
 - Minimum Benchmark Equivalence for HFP
 - Implementation of an annual benefit maximum on HFP coverage
 - Cost-sharing options available under the CHIP 5% of income threshold
 - Potential cost savings related to prescription services

Overview (cont'd)

- To identify potential savings, it is instructive to understand current HFP spending

Service	% of Medical
Inpatient	9.5%
Outpatient Fac/ER	23.5%
Physician	51.2%
Rx	10.7%
Lab/Radiology	1.2%
Other	3.9%
Total	100.0%

Source: HFP contracted health plans' financial data reported in the Rate Development Templates (RDTs)

Data Sources

- HFP-specific encounter data is not available
- The HFP Rate Development Templates (RDTs) are at a high level and it is difficult to draw many conclusions from that data
- The following data sources were utilized for this project to supplement the HFP RDT data
 - Medi-Cal encounter data
 - Medi-Cal FFS data
 - Proprietary commercial database for the Southwest United States
- Medi-Cal data and commercial database are claim-level data
- Since Medi-Cal data represents populations with lower income levels than HFP and commercial data represents populations with higher income levels than HFP, we would expect HFP experience to fall somewhere in the middle

Minimum Benchmark Equivalence

- Federal law requires CHIP benchmark-equivalent health benefits coverage to include the following services:
 - Inpatient and outpatient services
 - Physicians' surgical and medical services
 - Laboratory and x-ray services
 - Well-baby and well-child services
 - Age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP)
 - Emergency services needed to evaluate, treat or stabilize an emergency medical condition
 - If the benchmark coverage package used for comparison purposes includes coverage for prescription drugs, mental health services, vision services or hearing services, then the benchmark plan must have an actuarial value of at least 75% for each of these services (in California, all three benchmark plans do cover these four services)

Minimum Benchmark Equivalence (cont'd)

- HFP coverage currently meets the requirements above but the following services currently covered in HFP are not required in federal law

Service	% of Capitation
Home Health (including Hospice)	0.0%
DME & Supplies	0.4%
Physical & Occupational Therapy	0.3%
Speech Therapy	0.4%
Total	1.1%

- Capitation referred to in the table excludes CCS, MH, vision and dental
- Removing these services would reduce total HFP managed care expenditures by approximately \$11.0 million total funds annually
 - \$3.9 million in state fund savings using 65% FMAP
- Knox-Keene implications require further discussions

Annual or Lifetime Benefit Maximum

- With the passage of Health Care Reform, lifetime benefit maximum limits are prohibited, as well as “unreasonable annual limits”
- Based on the review by Kelch Associates, Wyoming currently has a \$200,000 annual benefit maximum for the CHIP program
- We analyzed potential savings using a \$200,000 annual limit, as well as a \$50,000 limit for illustrative purposes
- Since CCS services are carved out of the HFP medical contracts, we did the analysis both including and excluding these services to show the dramatic impact that these services have on the calculation

Annual or Lifetime Benefit Maximum (cont'd)

- Note that vision, dental and mental health services were not included in this analysis, although we do not believe they would have a material impact on the results

Annual Benefit Limit	Range of Potential Savings – Including CCS	Range of Potential Savings – Excluding CCS
\$200,000	-0.5% to -2.5%	0.0% to -2.0%
\$50,000	-5.0% to -7.0%	-0.5% to -2.5%

- Savings of 0%–2% translates to approximately \$20.0 million in total funds
 - Roughly \$7.0 million in General Fund savings
- Prior to implementing an annual benefit limit, further discussion with CMS would be necessary to ensure that the limit isn't "unreasonable"
- There may also be further challenges related to Knox-Keene with imposing such a limit

Alternative Benefit Designs

- Alternative benefit designs could include service-specific dollar or utilization limits (i.e., 30-day inpatient annual limit or four scripts per month prescription limit)
- Could be pursued as a secretary-approved coverage
- Kelch Associates found that, in general, most other states do not currently have in place these types of dollar or utilization limits that are service-specific, other than for mental health and substance abuse services.
- Therefore, no cost analysis was performed related to this potential option
- It should also be noted that if such an option were to be pursued in the future for HFP, legislation may be needed regarding a variance from Knox-Keene
- It is also unclear whether imposing these types of limits would comply with the Maintenance of Effort (MOE) requirements contained within the new federal Health Care Reform legislation

Cost Sharing and the 5% CHIP Threshold

- Premiums
 - Want premium so that member shares in financial responsibility but must be affordable
 - Increasing premium too high will drive away healthier members
 - If healthier members leave, the number of enrollees will decline, but the average cost of the remaining children will increase
- Copays
 - Healthy children may be more willing to stay enrolled if copays are increased since they don't use many services
 - For higher utilizers, an increase to copays could become unaffordable, forcing them to forgo necessary services
 - Although a higher physician copay reduces the average net cost per service and lower utilization, it would likely result in some increased hospital and ER costs

Cost Sharing and the 5% CHIP Threshold (cont'd)

- The tables on the following slide show the calculation of the current HFP cost-sharing percentage for both Category B and Category C HFP enrollees
- The analysis was originally developed by MRMIB
- We reviewed the analysis and agree with the results

Cost Sharing and the 5% CHIP Threshold (cont'd)

Category B Enrollees

Family Size	Annual Income of a Single Parent Family @ 150% FPL*	5% Annual Cost-Sharing Ceiling	Current Annual Premium Contribution \$16/month/child \$48/mo. Max	Current HFP Copay Maximum Per Family	Historical Maximum HFP Dental and Vision Copays**	Current HFP Cost-Sharing Percent
1 Child	\$21,865	\$1,093	\$192	\$250	\$235	3.10%
2 Children	\$27,481	\$1,374	\$384	\$250	\$235	3.16%
3 Children	\$33,085	\$1,654	\$576	\$250	\$235	3.21%

Category C Enrollees

Family Size	Annual Income of a Single Parent Family @ 200% FPL*	5% Annual Cost-Sharing Ceiling	Current Annual Premium Contribution \$24/month/child \$72/mo. Max	Current HFP Copay Maximum Per Family	Historical Maximum HFP Dental and Vision Copays**	Current HFP Cost-Sharing Percent
1 Child	\$29,149	\$1,457	\$288	\$250	\$235	2.65%
2 Children	\$36,625	\$1,831	\$576	\$250	\$235	2.90%
3 Children	\$44,101	\$2,205	\$864	\$250	\$235	3.06%

*Dollar amounts are based on the April 1, 2009, FPL.

**Amounts from HFP OOP Expenditures Report, November 2009.

Cost Sharing and the 5% CHIP Threshold (cont'd)

- Since the current level of cost sharing for the Category B and Category C groups are no more than 3.2%, clearly there is room to impose additional cost sharing in the HFP program
- The Governor's proposed budget would increase the annual premiums for HFP members in the category B and C enrollment groups
- The tables on the following slide show the impact the increased premiums would have on the cost-sharing calculation

Cost Sharing and the 5% CHIP Threshold (cont'd)

Category B Enrollees

Family Size	Annual Income of a Single Parent Family @ 150% FPL*	5% Annual Cost-Sharing Ceiling	Current Annual Premium Contribution \$30/month/child \$90/mo. max	Current HFP Copay Maximum Per Family	Historical Maximum HFP Dental and Vision Copays**	Governor Proposed HFP Cost-Sharing Percent
1 Child	\$21,865	\$1,093	\$360	\$250	\$235	3.86%
2 Children	\$27,481	\$1,374	\$720	\$250	\$235	4.38%
3 Children	\$33,085	\$1,654	\$1,080	\$250	\$235	4.73%

Category C Enrollees

Family Size	Annual Income of a Single Parent Family @ 200% FPL*	5% Annual Cost-Sharing Ceiling	Current Annual Premium Contribution \$42/month/child \$126/mo. Max	Current HFP Copay Maximum Per Family	Historical Maximum HFP Dental and Vision Copays**	Governor Proposed HFP Cost-Sharing Percent
1 Child	\$29,149	\$1,457	\$504	\$250	\$235	3.39%
2 Children	\$36,625	\$1,831	\$1,008	\$250	\$235	4.08%
3 Children	\$44,101	\$2,205	\$1,512	\$250	\$235	4.53%

*Dollar amounts are based on the April 1, 2009, FPL.

**Amounts from HFP OOP Expenditures Report, November 2009.

Cost Sharing and the 5% CHIP Threshold (cont'd)

- The tables on the previous slide show that the Governor's proposed premium increases would push the HFP cost-sharing percent up just beyond 4.7% on an annual basis for a single parent with three children
- CMS guidance is needed since it is not clear if premium increases are allowed under MOE
- While there is not a lot of room left (if the Governor's proposal is enacted), some savings may still be achievable by increasing the copayments for physician services from the current \$10/visit level to \$15/visit for categories B and C enrollees
- As described earlier, such an increase would likely cause a decrease in physician service utilization, as well as the direct decrease to unit cost
 - There would also likely be a resulting increase in ER and inpatient services

Cost Sharing and the 5% CHIP Threshold (cont'd)

- Mercer projects that this particular change in copays could potentially result in a gross savings of 4.1% of total medical HFP capitation payments (excluding CCS, MH, vision and dental) for the Category B and Category C groups
- This is estimated to be a \$25.0 million total funds savings to the program
 - \$8.8 million in state fund savings
- However, the increase to inpatient and ER costs is more difficult to quantify and will offset the savings captured to some extent from the higher physician copays
- It is unclear whether imposing these types of limits would comply with the MOE requirements contained within the new federal Health Care Reform legislation

Cost Savings Related to Prescription Services

- Pharmacy expenditures have become a more significant portion of health care costs for virtually all health coverage/programs over the past ten years
- Pharmacy costs account for approximately 10.7% of health care expenditures or 9.6% of total HFP managed care expenditures (excludes CCS, MH, vision and dental)
- On an annual basis this amounts to approximately \$96.0 million total funds
- Passage of Health Care Reform could provide Medicaid managed care programs with further potential savings
 - Unfortunately, it does not appear that the new law will directly offer any new pricing or other benefits for CHIP pharmacy

Cost Savings Related to Prescription Services (cont'd)

- Mercer obtained pharmacy pricing and other data from some of the HFP health plans
 - Dispensing fees
 - Contracted discounts off AWP for generic, brand and specialty drugs
 - Whether plans used formulary/preferred drug list
 - Generic utilization
- Based on the pricing data reported by the health plans, they appear to be doing a good job in obtaining fairly aggressive pricing for HFP
- Based on that high level review, the plans appear to be doing a good job managing the pharmacy benefit
- Doesn't appear to be much of a savings opportunity
 - Note that a 10 percent savings in pharmacy would only equate to approximately \$9.6 million in total funds annually

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Healthy Families Benefit Review

▶ Summary

Of the benefit changes studied and analyzed, the following have savings potential:

1. Minimum benefit as benchmark equivalent
2. Annual benefit limit
3. Increases in subscriber cost sharing

Healthy Families Benefit Review

1. Eliminating specific benefits from HFP and covering only services required under federal law does have savings potential, but requires an exemption from Knox–Keene basic benefits, and leaves children uncovered for what are considered basic benefits in the Knox–Keene framework
2. This and other benefit changes modeled (such as an annual benefit limit) may conflict with the federal health reform CHIP maintenance of effort or not be approved by CMS

Healthy Families Benefit Review

▶ Summary

- ▶ Additional increases in enrollee cost sharing, above the level proposed in the Governor's Budget, are possible within the 5% of income limit, and could yield potential savings to HFP as outlined by Mercer
- ▶ It is unclear whether the changes would be approved given the new federal maintenance of effort requirement
- ▶ Cost sharing levels approaching the 5% limit may also require potentially costly administrative changes for plans and MRMIB

Healthy Families Benefit Review

- ▶ Questions and Discussion
- ▶ Next Steps