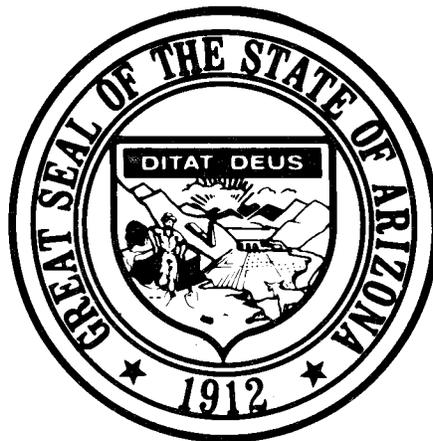


STATE OF ARIZONA
DEPARTMENT OF ADMINISTRATION

EMPLOYEE HEALTH INSURANCE
TASK FORCE REPORT



OCTOBER 1988

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TABLE OF CONTENTS
STATE OF ARIZONA
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TASK FORCE OVERVIEW

| | Page |
|-----------------------------|------|
| Task Force Charge | 1 |
| Membership List | 1 |
| Methodology | 2 |

EXECUTIVE SUMMARY

Major Conclusions and Recommendations of
Task Force:

| | |
|---|---|
| Plan Structure, Funding and Administration. | 3 |
| Employee/Employer Cost Sharing. | 4 |
| Medical Plan and Premiums for Retirees. | 4 |
| Benefit Design. | 5 |

REPORTS

| | |
|---|----|
| Plan Structure, Funding and Administration. | 6 |
| Employee/Employer Cost Sharing. | 14 |
| Medical Plan and Premiums for Retirees. | 17 |
| Benefit Design. | 20 |

TASK FORCE OVERVIEW

STATE OF ARIZONA
EMPLOYEE HEALTH INSURANCE

In August 1988, Catherine R. Eden, Director of the Department of Administration, established a task force to study health insurance for State employees.

Appointed to this task force were benefits experts from the public and private sectors and representatives from the legislature, the retiree's association, and the American Federation of County, State and Municipal Employees. The members were:

Cathy McGonigle, Chairperson of the Task Force
Department of Administration
Assistant Director for Personnel

The Honorable James Meredith
State Representative
House of Representatives

Tom Donovan, Manager
Health Benefits Division
Allied-Signal/Garrett Corporation
Airline Products Division

Dick Palmatier, Coordinator
City of Tucson
Employee Benefits Division

Phil Kundin
Deputy Personnel Director
City of Phoenix

David Parker, Manager
Health Management Programs, Staffing and
Human Resource Development
Honeywell Bull

Bill Hernandez
Senate Staff

Peter Fears, Executive Director
APEA/AFSCME

Noelle Carlier, Manager
Human Resource Development Benefits
Salt River Project
Benefits Division

Susan Gallinger, Director
Department of Insurance

Dave Hunt
Administrator/Clerk
Cochise County

Fred Lange
Associate Director for Human Resources
Arizona Board of Regents

Bill Cook, Vice President
State Retirees Association

Four major issues were addressed by the task force as follows:

- Plan Structure, Funding and Administration
- Employer/Employee Cost Sharing
- Medical Plan and Premiums for Retirees
- Benefit Design

Four subcommittees were formed, with each subcommittee assigned one of the major issues to address. Each subcommittee was asked to answer a specific set of questions relating to the issue it was addressing.

Insurance carriers were invited to make oral and written presentations to the entire task force. In advance of the presentation, the carriers were provided with a complete listing of the issues and questions the task force was going to address. Insurance carriers making presentations were:

CIGNA
EQUICOR
Blue Cross/Blue Shield
Intergroup
Maxicare
Prudential
Metropolitan

The remainder of this report is devoted to the conclusions and recommendations of the task force. The report is divided into an executive summary and four sections corresponding to the four major issues addressed by the task force. The specific questions relating to each issue are listed along with the response of the task force.

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY
MAJOR CONCLUSIONS AND RECOMMENDATIONS
OF THE
EMPLOYEE HEALTH INSURANCE TASK FORCE

I. Plan Structure, Funding and Administration

- The present plan structure is not appropriate and does not meet the objectives of reducing and controlling costs and providing adequate and appropriate coverage to employees.
- Indemnity type coverage, which provides freedom of choice of doctors, should be maintained; however, it does not necessarily need to be maintained in its present form.
- The number of plans is adversely affecting ability to spread risk over a large enough population and is adversely affecting premiums, especially in the indemnity plan.
- The results of the competitive bidding process ultimately will dictate the most cost-effective plan structure and the best course for the State of Arizona.
- The State should solicit bids for three general plan structures and then compare these bids to determine which meets the State's objectives.

These plan structures are:

1. A single carrier that is able to provide a triple option plan or a dual choice plan. A triple option plan would consist of indemnity coverage, a preferred provider option and an HMO. A dual choice plan would consist of an indemnity plan and an HMO. The single carrier would have to:
 - a. combine claims and utilization experience of the indemnity, HMO and preferred provider (as appropriate) plans, so that risk is spread appropriately; and
 - b. charge one premium for the entire program; and
 - c. permit employees to select indemnity, HMO or preferred provider coverage at any time or on a monthly or quarterly basis.
2. Multiple HMOs, each with opt-out provisions permitting employees at any time to receive indemnity coverage.
3. Stand alone indemnity plan with several HMOs, which is the current plan structure.

- Of the three plan structures, the task force felt a single carrier plan or a multiple HMO plan with indemnity opt-out provisions were the two feasible options. However, it was difficult to definitively recommend the best approach without the benefit of bid results. In regard to a single carrier plan, there was much more of a preference for a dual choice plan than a triple option plan.
- The State should not attempt to become self-insured next fiscal year while the program is so unstable. The State would be shouldering all of the risk of the indemnity plan at the worst possible time, that is, at a time when the plan is the weakest and is incurring losses. In addition, there is insufficient time to develop, implement and communicate a self-insured plan.
- The State should solicit bids on both a fully insured and minimum premium plan. With a minimum premium plan, the State would assume responsibility for funding most benefits, and the insurer assumes liability for benefits above a predetermined level.
- Self insurance should be studied further for the future.
- Utilization data should be required and obtained from HMOs.

II. Employee/Employer Cost Sharing

- The State should contribute a flat dollar amount toward insurance coverage for employees and not a percentage of the premium.
- In establishing the flat dollar amount, the State should follow prevailing market practices. Large employers in Maricopa County, as a prevailing practice, tend to pay 100% of the premium for the single employee and up to 80% of the premium for family coverage.
- To remain competitive with the marketplace, the State should consider total compensation including benefits.

III. Medical Plan and Premiums for Retirees

- Adequate and appropriate insurance benefits are provided to retirees.
- A separate plan should not be established for State retirees currently participating in the plan and for newly retiring State employees. However, this issue should be reviewed in future years as more and more employees retire.

- All State retirees, regardless of the retirement system to which they belong, should receive the same subsidy toward health insurance.
- Non-State retirees from other political subdivisions and State retirees who waived insurance benefits upon retirement should not be able to participate in the current plan administered by the Department of Administration. Instead, a separate plan with separate rates should be established. The Attorney General's Office already has provided advice that a separate plan must be established.

IV. Benefit Design

- The State should consider eliminating or reducing those benefits where the deductible does not apply and the reimbursement is 100% of incurred charges; i.e., supplemental accident benefit and outpatient surgery. Outpatient surgery charges should be reimbursed at 80% or 90% rather than 100%.
- If a preferred provider option continues as a part of the program, better contracts with fewer primary care physicians should be negotiated.
- Mental, nervous and chemical dependency benefits should be continued on a short term basis, but adding long term care benefit riders should be explored. The State also should consider eliminating these benefits from the base plan and, instead, negotiating a separate preferred provider contract. The additional cost of these benefits will have to be carefully studied to determine effect on premiums.
- Mandatory second surgical opinions, for all but a few surgeries, should be eliminated. With the majority of the surgeries, the second opinion has merely upheld the first opinion.
- The State's level of benefits generally is in line with other employers' level of benefits.
- The \$600 maximum out-of-pocket expense to employees is too low and should be raised to \$1,000.
- A prescription card service is not recommended.
- A longer waiting period for insurance coverage should not be established for new employees.

REPORTS

I. Plan Structure, Funding and Administration

Objective: Determine how the State's health insurance plan should be structured, administered and funded (self-funded versus fully insured) in order to reduce and control costs and to provide adequate and appropriate coverage to employees.

I.A. Is the present structure (indemnity plan and six HMO plans) appropriate and does it meet the objective?

Response:

No. Multiple plans do not permit the State to consolidate risks and spread risk over the entire population. If one plan absorbs the risk of a generally older and less healthy population, risks increase and premiums increase accordingly. The premium increases drive employees to other plans since employees tend to select insurance coverage on the basis of out-of-pocket costs. The State's indemnity plan has encountered this "adverse selection" placing its existence in jeopardy.

Further, with multiple plans, the State, as a major employer, is unable to take full advantage of its purchasing power and negotiate premiums to the lowest level.

Finally, multiple plans do not permit the most effective administration.

I.B. Should an indemnity plan be retained in some form?

Response:

Yes. Indemnity type coverage should be maintained; however, it does not necessarily need to be maintained in its same form. About 35% of the State's active employees and about 90% of State retirees currently participate in the indemnity plan. The indemnity plan, unlike HMOs, provides freedom of choice of doctors, which is important to a large segment of the population. Further, many employees do not like an HMO type of operation and would be unwilling to use these services as designed. Full out-of-area medical coverage is an important element of indemnity coverage that is not provided by HMOs. This is especially important to university personnel, retirees, and other employees who travel/reside out-of-state or the country.

I.C. If the indemnity plan should not be retained, what is the impact on other HMOs and employees and how does the State address these?

Response:

As stated above, the indemnity plan should be retained in some form. However, if not retained, there would be an impact on HMOs. The HMOs would have to absorb the present indemnity population with its inherent risk. Premiums for the HMOs probably would increase accordingly. In addition, certain HMOs may face "adverse selection" if their premiums drive employees to other HMOs. The impact on the financial ability of the HMOs also should be reviewed. If an indemnity plan was eliminated, it is possible that there are not enough HMOs currently under contract with the State to service the entire State population. It may be necessary to contract with other HMOs. Employees and retirees in certain rural areas and out-of-state would not have coverage available to them if indemnity coverage in some form did not exist.

Finally, the State and the HMOs would have to deal with a large segment of dissatisfied employees and retirees who are unable or unwilling to use HMO services.

- I.D. Are the number of plans adversely affecting premiums, and adversely affecting carriers' (especially the indemnity carrier's) ability to spread risk over a large population?

Response:

As indicated in I.A. above, the number of plans is adversely affecting ability to spread risk over a large enough population and is adversely affecting premiums, especially in the indemnity plan.

- I.E. The following six questions were addressed. A combined response to these questions is appropriate.

Should a triple option plan be adopted?

Should a dual choice plan be adopted?

If a triple option or dual choice plan should be adopted, should only a single carrier provide coverage for all State employees or should additional carriers be considered? Why?

What should be the general design of a triple option or dual choice plan?

Should there be varying levels of an indemnity plan?

Is there some, more appropriate structure for the State's health insurance plan? Identify the general design.

Response:

Three general plan structures will be discussed as follows and will be described in more detail later:

1. A single carrier, triple option or dual choice plan with point of service, permitting employees to select indemnity type, HMO, or PPO (preferred provider) coverage at any time. A variation of this structure would be to allow employees to change coverage on a monthly or possibly quarterly basis.
2. Multiple HMOs, each with indemnity opt-out provisions, permitting employees at any time to receive indemnity coverage.
3. A stand-alone indemnity plan with several HMOS (the State's current system).

Before proceeding further, although recommendations on plan structure are being made in this report, the results of the competitive bidding process ultimately will dictate the best course for the State of Arizona. The State should solicit bids on all three plan structures to enable it to compare coverage and costs of the different structures and to determine what is most cost effective for the State.

It also should be recognized that any major change in plan structure will cause disruption and dissatisfaction of a certain segment of the employee population. This will be impossible to avoid if the State takes a major step to control its costs.

The components of the three general plan structures are described below. Of the three structures, the task force felt a single carrier plan or a multiple HMO plan with indemnity opt-out provisions were the two feasible options. However, it was difficult to definitively recommend the best approach without the benefit of bid results. In regard to a single carrier plan, there was much more of a preference for a dual choice plan than a triple option plan.

1. TRIPLE OPTION/DUAL CHOICE PLAN WITH POINT OF SERVICE

A triple option or dual choice plan would have the following components:

- A single carrier would provide service to the State of Arizona.

- The single carrier must be able to provide coverage through an indemnity plan, an HMO, and a preferred provider option (if a triple option plan is selected). If a dual choice plan is selected, a single carrier must be able to provide indemnity coverage and HMO coverage.

- Experience from all parts of the program must be combined, and only one premium charged accordingly for the program. Combining experience of the indemnity, HMO and PPO plans will enable the carrier to spread its risk appropriately, and costs should be better controlled.

- There must be strong utilization review of and financial reporting from all portions of the program.

It should be a point of service plan permitting employees to select indemnity, HMO or PPO coverage at any time. This provision eliminates the need for an annual open enrollment. A variation of this structure would be to allow employees to change coverage on a monthly or possibly quarterly basis.

-General plan design:

It generally is recognized that costs are managed best in an HMO environment; therefore, the intent of a triple option or dual choice plan is to encourage employees to use an HMO network in order to control costs. An indemnity plan is made available to those employees who really want to use it, however, at additional cost to the employees in the form of deductibles and co-insurance since an indemnity plan is the more costly program. Accordingly, the following general plan design is recommended for the indemnity plan.

Annual deductible \$200 per person and \$400 per family (non-PPO and PPO). Presently: No deductibles for PPO and \$150 per person and \$300 per family for non-PPO.

Co-insurance for office visits, lab charges, hospital and doctor charges, etc.

a. Triple Option Plan

90% paid by insurance carrier and 10% by employee if a preferred provider is used and 80% paid by insurance carrier if a preferred provider is not used. This is present benefit level.

b. Dual Choice Plan

80% paid by insurance carrier and 20% by employee. This is present benefit level.

The State may wish to solicit bids at a lower co-insurance level to determine impact on premiums.

Out-of-pocket costs to employees \$1,000 plus deductibles, and \$3,000 for families. Presently \$600 and \$1,800, respectively.

2. MULTIPLE HMOs WITH INDEMNITY OPT-OUT PROVISIONS

This plan structure would provide for a number of HMOs to provide insurance coverage to State employees and would require each HMO to offer an indemnity opt-out provision. That is, employees would be able to opt at any time to go outside the HMO network and receive indemnity coverage. Again, since costs are managed best in an HMO environment, the intent is to encourage employees to use the HMO network.

With this plan structure, it is mandatory that the HMOs contracting with the State provide the same indemnity type provisions. The indemnity plan design should be the same as listed above for a triple option or dual choice plan.

3. STAND-ALONE INDEMNITY PLAN WITH SEVERAL HMOs

The State's current plan structure consists of a stand-alone indemnity plan with several HMOs. This is not a recommended option in that premium costs are expected to be much higher with this type of structure.

However, the State should solicit bids again this year for a stand-alone indemnity plan and several HMOs to determine if this would be a feasible option.

Varying levels of an indemnity plan are not recommended. This complicates benefit administration and communication. In addition, this encourages more usage of an indemnity plan, which is more costly than usage of HMOs.

I.F. Should the State become self-insured or maintain a fully insured health insurance plan? Identify the advantages and disadvantages of each approach and substantiate how the advantages of recommended approach outweigh disadvantages.

Response:

The State should not attempt to become self-insured next fiscal year while the program is so unstable. The State would be shouldering all of the risk of the indemnity plan at the worst possible time. That is, it would be the risk bearer at the time when the indemnity

plan is at its weakest and is incurring losses. In addition, there is insufficient time to develop, implement and communicate a self-insured plan for next fiscal year. Significant lead time is required to operationally set up and communicate a self-insured plan. This would include negotiations with providers, selection of a third party administrator or awarding of an administrative services only contract, completion of actuarial work to establish premiums, establishment of benefits, development of forms, communication with employees and a myriad of other activities. Without adequate lead time, implementation of a proper self-insured program would be unsuccessful. It is important to note that self-insurance does not solve the State's problems. Implementing a new plan structure such as a triple option or dual choice plan will begin to solve the problems. Self-insurance basically will address how the plan will be funded.

However, there are certain advantages to self-insurance including more flexibility in plan design, cash flow advantages, and elimination of premium taxes. In regard to premium taxes, State governments do not reap the same benefit as the private sector in that the taxes accrue back to the State when paid. Therefore, this is a debatable advantage to state government.

Self-insurance is a subject which deserves further study since it may be beneficial to the State over the long term. The State's current and past insurance consultants have advised the State to ensure the program is stable before going self-insured. Accordingly, stability of the program should be considered during any study of self-insurance. At the present, the State should consider a fully insured plan or a minimum premium plan which will be described below.

I.G. Is there a combined approach whereby the State and the carrier(s) assume a proportionate share of the risk?

Response:

In addition to a fully insured plan, the State should consider a minimum premium plan which, in essence, is a partially self-insured plan. With a minimum premium plan, the State would assume responsibility for funding most benefits, and the insurer assumes liability for benefits above a pre-determined level.

The State should solicit bids on both a fully insured and minimum premium basis. In considering a minimum premium plan, the State should carefully determine the share of the risk it wishes to absorb and prudently establish the level at which it would accept liability.

I.H. What are the pros and cons of the minimum premium payment? What consideration should be given to this concept in the plan design?

Response:

Minimum premium plan

Pros: - Cash flow advantages in establishing reserves and utilizing float.

- Annual liability limit for the State.

- Elimination of premium taxes; however, this is a debatable advantage for State government in that these taxes accrue back to the State. Further, there have been recent court decisions in other States that minimum premium plans are subject to premium taxes.

Cons: - State may shoulder a significant amount of risk depending upon the point at which the insurance carrier assumes liability for claims. In the State's current situation, risk is significant since claims are significantly exceeding premiums.

- If the insurance carrier has a deficit in one year, it will carry forward to the next year.

- Unless alternate arrangements are made, the State would bear the liability for claims runout after a termination of a contract with an insurance carrier.

I.I. Is it possible to reduce administrative claims cost? If so, how can this be best accomplished?

Response:

Performance criteria in claims administration should be a part of the contract. In addition, the State should review the performance of the carrier.

I.J. What consideration should be given to changing the current rating structure? Should only family and single rates (2 tiered structure) be provided? Why?

Response:

At this time, a three or more tiered rating should not be pursued. Changing plan structure will be enough of a change for next fiscal year without complicating it with a tiered rating structure.

I.K. What types of utilization data should be requested from HMOs?

Response:

The same utilization data required by indemnity plans should be required and obtained from HMOs. Requested data should include:

- capitation rates
- types of surgery
- waiting time for appointments
- admissions per 1,000
- surgeries per 1,000
- waiting time for specialists
- all services provided
- prescriptions

I.L. Are there any other overall ways to reduce and/or control costs?

Response:

For a long term goal, the State may wish to study and consider the possibility of joining forces with other public jurisdictions to determine if a more cost-effective plan can be obtained for all entities involved.

In regard to retirees, the State may wish to consider terminating eligibility for health insurance if the retiree obtains employment elsewhere and can obtain continuing and appropriate coverage from the new employer.

II. Employee/Employer Cost Sharing

Objective: Determine whether the current premium cost sharing plan is realistic and feasible in view of both the State revenue and rising health care costs. The following questions should be addressed. Conclusions should be substantiated.

- II.A. Should the State pay a flat dollar amount toward insurance coverage regardless of the plan selected or should the State pay a percentage toward the premium? What method is most cost effective and why?

Response:

This question can only be answered based upon the basic plan design finally chosen. If the State would go to a single carrier and there is only one premium for all employees, then this question is moot. Whether it is a flat dollar amount or based in percent, there is really no difference with only one premium involved. If the State would have a multiple HMO plan with the provision to opt-out of each HMO network for indemnity coverage, the State should establish a flat dollar amount and should follow the prevailing market practice in setting this amount.

If the State would continue with its existing plan structure, before setting either a flat dollar amount or a percentage, the State should first consider the impact the State's contribution will have on the plans. That is, the State must consider whether the state's contribution rate will drive employee away from certain plans to other plans and whether this "adverse selection" against certain plans is tolerable or desirable. Adverse selection may not make it possible to offer a wide range of plans.

- II.B. Should the single and/or family premium contribution by both State and employees be changed? Why and how?

Response:

It is recommended that the State keep in line with the prevailing practices in the marketplace for cost sharing. Staff should keep reviewing this issue as plan design changes in the future. It appears that the percent of cost shared by the employee for family coverage is at the upper end of the marketplace, and therefore should not be seen as a source of increased revenue for next year.

- II.C. Should premiums be indexed to a three tier or more rating structure?

Response:

At this point, the State should not go to a three or more tiered rating structure. A tiered rate plan is a plan with separate rates for the single employee, employee and spouse, employee and one child, etc., with the premiums dependent upon experience in each group. To create a tiered rate plan at this point would create confusion and communication problems for implementation for the first year. It should be noted that no matter how you tier the rates the cost to the State does not change. Tiered rates are only a matter of distribution of employee premiums among employee groups and could put an economic burden on employees with large families who may least be able to afford it. It is recommended that no action in this area be taken until after a new plan design is in place and implemented and the program is stable.

It also should be noted, however, that if the State has a two-tier plan, when other employers have multi-tier plans, it could cause adverse selection in that large families with two working parents who have the option of joining the insurance plan of either company may tend to join the State's insurance plan if the State does not tier rates since their rates would be lower. However, the State should continue to study the multi-tier rating structure for future years. Other cost-sharing issues that would cause serious communication problems and provide few or no cost savings such as the tiered method should be deferred for further study.

II.D. Is there a prevailing practice in premium cost sharing among large employers in Arizona? Identify various practices. What should the State adopt?

Response:

The industrial model for large employers in Maricopa County shows that, as a prevailing practice, these employers tend to pick up 100% of the premium for the single employee and up to 80% of the premium for family coverage. The State should study the cost sharing as it relates to the present plan and again as it relates to the new plan design. In setting the contribution rate, the State should attempt to meet the prevailing practice as much as economically feasible. At present, the State contributes 99% of the employees' cost (single coverage) for both the indemnity and HMO. For family coverage, the State contributes 83% for the indemnity carrier, and from 70% to 84% for the HMOs. Increasing the employee's premium cost could lead to an increased utilization of the plan based upon the thought "I have to get my money's worth".

It also is recommended that the State look at a total compensation philosophy to remain competitive. This means that not only should salaries be competitive but total compensation, i.e., the non-direct salary benefits should also remain competitive. Therefore, health insurance costs to employees should not be out of line with the market especially when State salaries currently are below the average market wage.

III. Medical Plan and Premiums for Retirees

Objective: Determine whether retirees should continue participation in the active employee insurance plan or whether a separate plan with separate rates for retirees should be established. Determine appropriate and adequate benefits for retirees. The following questions should be answered. Conclusions should be substantiated.

III.A. Are retirees provided with adequate and appropriate benefits? If not, identify changes and how premiums would be affected.

Response:

The present plan does provide appropriate and adequate benefits for our retirees. Long-term care would be an additional benefit that would be helpful to the retiree population; however, the costs are prohibitive. The State may wish to consider making available a supplemental long-term care plan for retirees, of which the premiums would be paid by retirees.

III.B. Does retiree participation in the health plan adversely affect the premiums for active employees?

Response:

Yes, retiree participation in the health insurance plan does raise the overall group premiums. Equicor, our indemnity carrier, has advised the State that they estimate that active employee rates are currently approximately 2% higher due to the presence of the current retirees in the plan.

III.C. Should a separate plan with separate rates be established for retirees? Why or why not?

Response:

It is strongly recommended that current State retirees and newly retiring State employees continue to be a part of the DOA plan. Based on Equicor's estimates, premiums in the indemnity plan are 2% higher with retirees in the plan. Keeping in mind that the State pays the majority of insurance costs, active employees are not paying significantly more with retirees in the plan. It should be noted that the Social Security system works under the concept of working employees contributing to the benefits of those who have retired; this concept is a part of a basic American philosophy, and no reason is seen at this point to change that in regard to retiree insurance as long as there is not an unreasonable level of support. It should be kept in mind that current retirees once were active employees

who were paying their fair share of premiums that were somewhat higher as a result of retiree participation in the plan. This issue should be reviewed in future years as more and more employees retire and become a part of the plan to determine if the premiums for active employees are being significantly affected.

III.D. If a separate plan should be established, should the design plan include a single carrier or multiple carriers? If multiple carriers are determined, what is the adequate number of carriers and why?

Response:

It is felt that a separate plan should not be established for retirees at this time. However, if a separate plan is established, it should be a triple option or a dual choice plan.

III.E. Should the retiree health plan remain the single option or dual or triple option plan?

Response:

It should be the same as for active employees except for those employees with Medicare supplement.

III.F. What deductibles and benefits should be made available to retirees?

Response:

Retirees should be offered the same plan(s) as active employees. Additionally, a catastrophic plan with higher deductibles, higher co-payments, and higher stop loss at a lower premium level should also be considered.

Tiered rates for retirees are not recommended.

III.G. Determine which method of claim payment is most cost effective for the State: Diagnostic related groups or premiums?

Response:

The answer depends on the plan design. A recommendation is unable to be made until plan design is solidified.

III.H. What incentives can be introduced to encourage retirees to use plan services more prudently?

Response:

With a triple option or dual choice plan geared toward encouraging participation in an HMO, that issue would take care of itself. Prudent use of plan services is an issue for all plan participants.

III.I. What elements are required with the new integrated State plan with the Medicare plan that is effective January 1, 1989?

Response:

The new long-term care provisions and maximum out-of-pocket expense provisions need to be integrated with the Medicare supplement plan offered.

III.J. Should the State contribute to its retirees health insurance? At what rate and how?

Response:

The legislature is already taking care of that issue by authorizing subsidies for retired members of the Arizona State Retirement System and the Public Safety Retirement System; however, different subsidies are being provided. It is felt that all retirees of the State of Arizona should receive an equal subsidy. It is noted that over 3,000 retirees of the university system receive no subsidy. There should be some type of subsidy to cover all employees whether they are in the Public Safety System, Arizona State Employees Retirement System, or in the University Optional Retirement Plan.

III.K. What, if any, legal issues exist in providing health benefits for retirees?

Response:

One legal issue exists as to whether non-State retirees can be members of the current DOA-administered plan, and whether these people, in essence, should be further subsidized by higher premiums for active State employees and State retirees. This issue surfaced due to recent legislation which authorized retirees of the Arizona State Retirement System, previously employed by other political subdivisions of the State, to be a part of the DOA-administered retiree health insurance benefit plan. It is felt that non-State retirees and State retirees who waived insurance benefits upon retirement should not be a part of the larger group. We understand that the Attorney General's Office already has indicated that a separate plan with separate rates must be established by DOA. No other legal issues were found at this time.

IV. Benefit Design

Objective: Determine what benefit designs are needed which are cost effective and provide for adequate coverage to employees. The following questions should be addressed taking into consideration that the State will be considering triple option and dual choice plans and self-insurance as well as fully insured options.

IV.A. Are current benefits provided by the indemnity and HMO plan cost effective? Why or why not?

Response:

Relative to the indemnity plan, there are some benefits that are cost effective and some benefits that are not cost effective. From the employee's perspective, the present \$150 per person/\$300 per family calendar year deductible is a good benefit. The same is true relative to the 80/20 co-insurance level in which the carrier pays 80% of the eligible charges and the employee pays 20%. However, from a premium reduction standpoint, consideration should be given to changing deductibles, out-of-pocket expenses, and co-insurance to correspond with any new plan structure. Further, the State should consider eliminating or reducing those benefits where the deductible does not apply and the reimbursement is 100% of incurred charges, i.e., the \$300 supplemental accident benefit and outpatient surgery. Outpatient surgery should no longer be reimbursed at 100% since hospitals have shifted their costs from inpatient to outpatient to offset the lost revenues when companies encouraged use of outpatient surgery. Outpatient charges should be reimbursed at 80% or 90%. In the HMOs, the State should offer well-baby care and annual physicals. The benefits in the current mini-wellness provisions (blood pressure checks, hemocults, urine analysis, and blood glucose screenings) would then be included in the annual physical.

If a preferred provider option (PPO) continues to be a part of the insurance plan, cost effectiveness may be improved by renegotiating PPO contracts. Currently, there are 2,600 preferred providers under contract out of 6,400 in practice, which means about 40% of available providers participate in the State's PPO program. To be more competitive and to achieve lower discounted rates, the carrier should negotiate with fewer primary care physicians (PCPs) but screen for the better ones. Good contracts will include incentives for these providers to change their patterns of behavior and become more cost effective.

The State should continue the mental, nervous, and chemical dependency benefit on a short-term basis, but explore adding long-term care benefit riders. These riders should have caps in either dollars to be paid out or in a maximum number of days that coverage would be provided or a combination of both. The cost of these should be carefully studied since increased coverage means increased premiums. The State should also consider eliminating the mental, nervous, and chemical dependency benefit from the base plan and, instead, negotiate its own PPO arrangement, which should include an employee assistance program (EAP), a tight utilization review (UR), and a good medical case management (MCM) program. A gatekeeper concept should be considered. The PPO arrangement should also include an inpatient/outpatient treatment program and an outpatient detoxification program. However, it should be kept in mind that the negotiated PPO costs could have higher premium costs and caps. Such caps could be set at \$50,000 lifetime benefit, with a \$4,000 annual limit for outpatient care. Negotiated rates can have different arrangements, one such arrangement could be per capita, on a monthly basis, plus, a specific cost per treatment.

If a separate mental, nervous and chemical dependency PPO contract is arranged, an 80/20 or 70/30 co-insurance level should be established for using a preferred provider and a 50/50 co-insurance level if a preferred provider is not used. This type of copayment arrangement definitely would provide an incentive to use the PPO.

Pre-admission review (PAR) and utilization review (UR) can be most cost effective by controlling admission to the hospital and the length of hospital stays per admission.

The mandatory second surgical opinion (MSSO) for all surgeries should be eliminated, except for hysterectomies, tonsillectomies, and appendectomies. For hysterectomies, tonsillectomies and appendectomies, second surgical opinions have been helpful and the second opinion has frequently varied from the first opinion. However, with good UR it is possible to reduce even those frequent procedures. With the majority of other surgeries, the second opinion has merely upheld the first opinion. Therefore, continuing to require second opinions for other surgeries is not cost effective. In regard to maternity claims, every consideration should be given to the hospital packages and birthing center arrangements which are more cost effective.

IV.B. Is an appropriate level of benefits provided to State employees? If not, identify changes.

Response:

Yes. The State's level of benefits generally is in line with other employers' level of benefits. The mental, nervous, and chemical dependency benefit should be reviewed to determine if it is cost effective to increase. Recommendations for changes to benefit levels are illustrated in response to Question IV.A.

IV.C. What level of benefits (including deductibles, co-insurance and stop loss) should be incorporated into the indemnity plan?

Response:

The current deductible and copayment are closely aligned with what other employer plans are offering. However, this question needs to be answered after a plan structure is solidified. Regardless of plan structure, it is felt the \$600 maximum out-of-pocket expense to employees is too low.

IV.D. What additional options should be included which will provide adequate coverage relative to both the needs and financial resources of the various salary levels of employees? (Consider co-insurance rates, deductibles and stop loss.)

Response:

There does not appear to be any need to add options to the plan connected with the various salary levels of employees.

IV.E. Is there a way to counteract the hospital's cost shifting from inpatient to outpatient benefits?

Response:

The State may be able to counteract this by eliminating the 100% reimbursement for outpatient surgery and reimbursing at 80% or 90%.

IV.F. What role, expanded or diminished, should the PPO feature play in the design? Is current PPO coverage structured properly?

Response:

As stated in the response to question IV.A, there should be some changes if a preferred provider option continues as a part of any new plan structure.

If so, possibly the basic structure of the PPO could be renegotiated with better contracts to fewer preferred case providers (PCPs), with more incentives to be more cost effective. However, with carriers negotiating these PPO contracts, it could be more difficult to change the physicians' behavior patterns. Employees also need incentives to change their behavior patterns by lowering co-insurance levels if a preferred provider is not used. The State's consultant should be used more to review carrier rates relative to cost-effectiveness. Regarding the mental, nervous, and chemical dependency benefit, as indicated earlier, the State should consider removing these benefits from the base plan and establishing a separate PPO provider arrangement, with tight utilization review (UR) controls. Included would be an employee assistance program (EAP), an inpatient/outpatient treatment program, and outpatient detoxification program. To be cost effective, there must be medical case management (MCM) involved on each case.

IV.G. Determine which method of claim payment is the most cost effective for the State: Diagnostic Related Group (DRG) or per diem?

Response:

There is not enough experience or data with capitated rate to determine whether DRGs or per diems are most cost effective.

IV.H. Should mental health and substance abuse coverage be increased or decreased and how will this affect premiums?

Response:

This issue has been addressed in response to Question IV.A.

IV.I. Should the State consider adding long-term care (LTC) to the substance abuse and mental health coverage? Presently, LTC (treatment beyond 60 days) is not provided. How will this affect premiums?

Response:

As indicated in response to Question IV.A., long-term care should definitely be considered; however, adding riders to extend the care beyond 60 days will do nothing more than raise premium costs. The State should consider removing the mental health and substance abuse benefits from the base plan and negotiating a properly controlled long-term care (LTC) PPO plan. This change may or may not increase premium costs.

IV.J. Should we develop an employee prescription drug program which establishes cost based on prescription volume rather than individual prescriptions? How will this affect premiums?

Response:

It is not recommended that the State put in a prescription card service that charges per employee, per card issued, per month. Most prescription drug plans cost the employee a fee of \$3 out-of-pocket, per prescription. However, it costs the employer about \$6.75, per prescription, to break even. A wholesale, catalog prescription drug plan for retirees could be considered. There may be enough discount in the drug prices and a large enough volume purchased to be cost effective.

IV.K. What incentives can be introduced which encourage employees to use plan services more prudently?

Response:

Since current claim charges include a cost per claim check issued, employees need to be educated in proper filing of claims. Simplifying the claims filing and claim reporting process should be explored. Consideration should be given to using "claims kits," which many carriers provide for distribution to employees. It has been noted by some employers that the greatest misuse of filing claims comes from the more highly compensated employees than from the lower paid employees.

IV.L. Does the proposed benefit design accommodate non-discrimination testing which is effective July 1, 1989.

Response:

Non-discrimination testing is regulated under Section 89 of the Internal Revenue Code. It is designed to check every employer/employee benefit plan to see if it discriminates in favor of the highly compensated. If it does, the value of the benefit is considered income to all highly compensated employees. It is unknown, at present, what problems the non-discrimination testing will cause until final regulations are released. There are several tests which can be done in order to determine whether the plans discriminate or not.

IV.M. Are there any other cost containment features that can be introduced in the indemnity/HMO plans?

Response:

Yes. Premiums negotiated for HMOs should be based on demographics and experience to reflect risk assumed by the HMOs. The State should contribute more toward the plans with the higher risk population. Also, consideration should be given to establishing a coordination of benefits (COB) carveouts, i.e., a policy that does not permit coverage under two different policies for dependents.

IV.N. Should a longer waiting period be introduced before coverage is effective for new employees?

Response:

From a recruiting standpoint, coverage should not change from the State's current practices. Although delaying coverage for 60 or 90 days will save the State premium dollars, this action will affect recruiting of employees, adversely impact lower-paid employees to a greater degree, and adversely impact employee relations.