

Major Risk Medical Insurance Program:
Benefit Design Review

Prepared for
The California Managed Risk Medical Insurance Board

Prepared by
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Executive Summary

As health care costs, and insurance premiums, continue to rise in California and across the country, individuals and families are finding it more difficult to obtain and afford coverage. Health plans are trying to lower their costs through increased cost sharing in the form of higher premiums, deductibles and cost sharing, including pharmaceutical benefits management. Health plans also use care and benefits management programs that ensure that patients receive appropriate, cost-effective care when they need it, hopefully reducing the need for more expensive care down the road. To further reduce costs, insurance companies can make it difficult for high risk patients, such as those with preexisting conditions, to obtain affordable health insurance on the individual market.

California, like many states, has a special insurance pool, called the Major Risk Medical Insurance Program (MRMIP), to help provide affordable, meaningful health coverage to these high risk beneficiaries. MRMIP faces the same challenges as high risk pools across the country and the commercial and public insurance markets: high premiums, limited benefits and the mounting need to contain costs while ensuring quality for beneficiaries.

This study is an analysis of the MRMIP participating health plans' practices in containing costs and managing benefits, as well as how they compare to the private group insurance market and selected high risk pools across the country. In addition, this study explores the use of high deductible coverage in state risk pools and the private market, and the extent to which it is appropriate for a high risk pool population.

Key Findings

We found the MRMIP health plans compare well with other high risk pools in terms of offering "value-added" programs such as disease and case management to beneficiaries, and that they are engaged in the same types of cost-containment behaviors such as benefits and pharmaceutical management.

Our key initial finding was that the MRMIP beneficiaries enrolled in two of the four participating health plans, representing nearly half the MRMIP population, did not have access to the clinical benefits of disease management program. This was unlike high risk pools in our target states and California's other insurance markets, which offered disease management programs to all enrollees. Since this study has begun, the two health plans in question have taken steps to ensure that disease management programs are available to MRMIP beneficiaries.

MRMIP varied greatly from both risk pools and the private market in not offering any deductible-based plans.

Key Finding: MRMIP differs significantly from other high risk pools in how it structures and offers benefits to beneficiaries. Although most high risk pools offer between four and six coverage packages to their beneficiaries, those packages are most commonly offered by a single health insurance carrier. MRMIP, with four participating insurance plans, is one of just four of the 34 state risk pools offering insurance plans through more than one carrier.

MRMIP is also the only high risk pool to exclusively offer plans without deductibles. While this means MRMIP beneficiaries have immediate first dollar coverage for needed care, they may pay higher monthly premiums for that benefit. And the low, \$75,000, annual total benefits limit, the most limited benefit package of any high risk pool, means they are without open-ended protection against catastrophic costs.

Key Finding: Case, disease, benefits and pharmaceutical benefits management techniques are widely leveraged by MRMIP contracting plans, as they are in other states. All four participating carriers report that MRMIP beneficiaries have access to case management services, and due to recent program changes all four carriers also offer disease management services to MRMIP beneficiaries. MRMIP plans also engage in similar types of benefits and pharmaceutical management as found in the private market and other high risk pools, including preauthorization requirements for certain services and tiered co-payment schemes for prescription drugs.

Key Finding: While disease and case management programs have been found to improve health status, there is little reliable data on cost savings. Current research suggests that while care management programs provide clinical value and improve health status, there is little evidence they generate cost savings. Health plans report using improved health outcomes and customer satisfaction, rather than cost savings, to measure care management program performance.

Key Finding: Unlike MRMIP, most high risk pool beneficiaries in other states have deductibles. As plans with higher deductibles generally have lower monthly premiums, they are an increasingly attractive option as high risk pools, as well as individuals and families, seek to find affordable coverage. However, there is some evidence that deductibles, particularly high deductibles, may cause some beneficiaries to delay seeking medical care.

Key Recommendations

MRMIP health plans offer similar care and benefits management programs as other high risk pools, making them an unlikely source of cost savings. More research is needed to analyze the possible impacts of new cost sharing and benefit packages for MRMIP beneficiaries:

- MRMIP participating plans use disease, case, pharmaceutical and benefits management techniques which are in line with other state risk pool practices and the commercial market. There is no obvious recommendation to use regarding these programs.
- MRMIP's current annual total benefits package limit, \$75,000, is lower than all other high risk pools. Allowing for a greater annual limit may greatly benefit the less than one percent of MRMIP beneficiaries who accrue higher annual costs and may not require any increase in state appropriations.
- By implementing a high deductible plan alternative, MRMIP enrollees could reduce premium costs and even with cost increases in the deductible payment may see a net savings. But under the state's risk sharing agreement with the MRMIP contractors, the lost premium dollars become a cost to the state. The critical question then becomes how to manage those lost premiums, and whether relatively healthy individuals who would have previously declined MRMIP would take up and add their premium dollars to the pool.

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Introduction

Those purchasing health coverage on the individual market typically face significant barriers. In addition to higher premium prices, individuals are also subject to a rigorous screening process for preexisting conditions. Without being part of an employer group where risk can be shared, many individuals find that insurers reject them based on health status in order to limit the company's risk. This may mean that the individual is "uninsurable" because insurers are unwilling to sell them coverage – or that what coverage is available is unaffordable. As a result, the very individuals most in need of health insurance are often the least able to secure it.

One way state governments have tried to address this problem is by requiring insurers to sell to all of those who wish to purchase coverage, but this solution does not necessarily address affordability concerns. Since Connecticut established the first pool in the nation in the mid-1970s, 34 states have created high risk pools to offer the uninsurable an alternative to purchase health coverage. The idea is simple, providing relatively affordable, commercial insurance to those who do not qualify for public insurance programs and who have been denied coverage on the private market.

However, the problems of the individual market are typically duplicated in high risk pools. While high risk pools offer insurance, high premiums for individuals, limited benefits, and waiting lists (common in California but rare in other state high risk pools) can all continue to be barriers to coverage. It is possible to see these challenges in the sixteen-year history of California's program, the Major Risk Medical Insurance Program (MRMIP) operated by the Managed Risk Medical Insurance Board (MRMIB).

In an effort to better understand and investigate possible methods of improving the California program, MRMIB contracted with Harbage Consulting to review MRMIP's benefits and cost-sharing. The broad question asked of Harbage Consulting is the same asked by any health care payer: is it possible to implement cost-containment measures while protecting access to quality care? If it is possible to reduce costs, such changes could enable more Californians to have access to higher quality care. More specifically, Harbage Consulting was asked to explore issues around disease management programs, case management programs, benefits management, pharmaceutical management and high deductible health plans.

The first and best way to help MRMIP enrollees is by passing comprehensive health reform as is under discussion among the state's political leaders. By creating a more rational and efficient health care market, the need for a high risk pool would likely be eliminated altogether. Short of comprehensive reform, the findings of this study make it clear that there are a number of steps that can be taken by MRMIB to improve the care of MRMIP enrollees and to give them more coverage options. While some of these changes would likely require additional funding from the state for the high risk pool, MRMIP enrollees could benefit from participating carriers continuing to expand access to disease management programs and further exploration of issues surrounding high deductible health plans (HDHPs).

Study Design and Purpose

There is a long history in the United States of trying to balance the need to contain costs with the need to provide access to quality care. In the 1990s, managed care companies became much more aggressive in their efforts to contain costs. Risk was managed and controlled through a variety of gate-keeping activities, including utilization review and prior authorization requirements. This ultimately led to a backlash against aggressive restrictions on health care utilization. Current cost-containment efforts have focused on increasing patients' responsibilities for their health, medical care and costs and include assistive programs, such as disease and case management, and high-deductible, lower-premium plans.

For this study, Harbage Consulting was asked to provide MRMIB an analysis of the range of cost-containment options and better understanding of:

- The use of care management tools within MRMIP, as compared to other high risk pools, including:
 - Disease Management,
 - Case Management,
 - Benefits Management, and
 - Pharmaceutical Benefits Management.
- The role deductible plans play in providing a more affordable option within the high risk market in other states, including an assessment of the extent to which high deductible coverage is appropriate for a high risk pool population.

To do this, Harbage Consulting worked with experts from across the country to develop this analysis, including (Please see biographies section at the end of the paper.):

- Dr. Robert Berenson, of the Urban Institute, for analysis and a national perspective on the impact of disease and case management. He was commissioned to write a full paper, which is at Appendix A. His thoughts and conclusions appear in the main body of the paper as well.
- Bruce Abbe, of Abbe Communications, conducted interviews with high risk pools around the country and offered his thoughts on high risk pool operations.

Sandi Hunt, of PriceWaterhouseCoopers, provides actuarial services to MRMIB and was asked by MRMIB's Executive Director to provide assistance on this project.

In addition to interviewing all four MRMIP plans, in-depth interviews were conducted with eight other high risk pools. The methodology for the interviews, as well as the rationale for the selection of the other states, is provided at Appendices B, F and J.

Background: California's Unique High Risk Pool

Since 1991, MRMIP has provided comprehensive health benefits to individuals who could not obtain insurance on the private market, either because of preexisting conditions. While the high risk pool in California operates much like those in other states, there are some important differences.

Finding: States typically have multiple products, but virtually none have multiple carriers. California contracts with four major plans. Blue Cross is the largest carrier in the program, covering 49.2 percent of MRMIP beneficiaries, and is the only plan available statewide. Kaiser Permanente covers the next largest segment of beneficiaries – 46.7 percent across 46 counties. Blue Shield covers only 3.5 percent of beneficiaries across 27 counties. The fourth carrier, Contra Costa Health Plan, operates only within Contra Costa County, and serves just 52 individuals, or 0.7 percent of the MRMIP population.¹

In contrast, other pools generally offer multiple plan options through one carrier. This has the effect of concentrating all of the risk in one plan and easing administration. In contrast, other pools typically offer between four and six coverage packages through one carrier. There are a few exceptions to this approach:

- Connecticut also uses two carriers, but both are managed through one administrator.
- Idaho offers multiple carriers, but as a unique high risk reinsurance pool (not a traditional risk pool) it requires participation by all carriers in the market.
- Alabama uses two carriers, but was not studied in this report.

All the states interviewed in our survey reported their pools were administered by a third party administrator (TPA) and overseen by a board. Some pools also had dedicated state staff, generally depending on the number of pool enrollees.

Finding: MRMIP is the only high risk pool to offer first dollar coverage exclusively. California's high risk pool is the only pool in the nation that only offers health plans without deductibles. This is due in part to the popularity of managed care, which typically features zero-deductible plans, in California compared to the rest of the nation. Benefits structured in this way help eliminate potential financial barriers that may otherwise keep the sickest population in the individual market from seeking necessary care.

Only three other states, Connecticut, Maryland and Alabama, also offer managed care plans without deductibles, but these non-deductible plans are just one option alongside a number of fee-for-service plans with a range of deductibles. All other states only offer plans with deductibles, and sometimes plans with high deductibles, much like options commonly available in the private individual coverage market.

Finding: Unlike many other state pools, MRMIP is funded by a subsidy limited to \$40 million from the state general fund. Although high risk pools generally require higher premiums than

¹ State of California, Managed Risk Medical Insurance Board, *MRMIP Subscriber and Health Plan Data: April 2007 Summary* (April 2007).

found in the individual market (often set at a certain percent of the typical equivalent premium), they also require additional funding to remain solvent. Of the states in this study, four fund their high risk pools through assessments or taxes on insurance carriers (Minnesota, Oregon, and Connecticut) or hospitals (Maryland). High risk pools funded by a combination of assessments or taxes on insurance carriers and state funding (through tax credits or dedicated state funding) include Idaho and Colorado. Only Utah reported funding their pool, like California, through direct state appropriations and premium payments. However, unlike California, Utah has received extra funding appropriate from the state to prevent capping program enrollment.

Finding: MRMIP offers the most limited total benefit package of any high risk pool. A lack of deductibles makes MRMIP’s benefits generous when beneficiaries first seek care, but its annual \$75,000 limit means the total care beneficiaries can receive is highly restricted. Approximately one percent of MRMIP enrollees reach that cap each year. While MRMIP technically has a \$750,000 lifetime cap, its Guaranteed Issue Pilot Program (GIP) requires members to move out of the program after three years. While the GIP is in effect through the end of 2007, this translates to an actual overall maximum of \$225,000 per enrollee – far below the \$750,000 technically available over a beneficiary’s lifetime.

Only five of the 34 state high risk pools have annual maximum benefits. Of these, the limit set by MRMIP is the lowest; this limit is also lower than those generally found in California’s private market. Some examples:

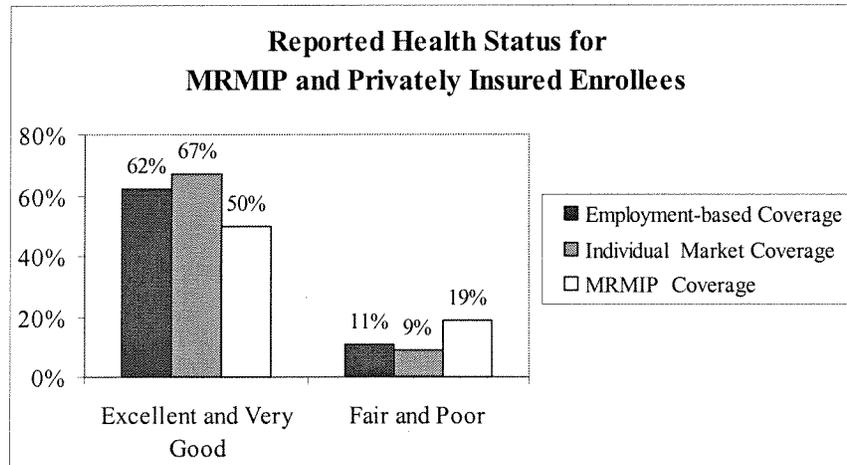
| High Risk Pool Annual and Lifetime Limits | | |
|---|---|---|
| State | Annual Limit | Lifetime Limit |
| California | \$75,000 | Set at \$750,000, though effectively capped by the annual limit and GIP program |
| Mississippi | \$100,000 (prescription drug limit only) | \$500,000 |
| Louisiana | \$100,000 | \$500,000 |
| Utah* | \$300,000 | \$1 million |
| West Virginia | \$200,000 | \$1 million |
| Colorado | -- | \$1 million |
| Maryland | -- | \$2 million |
| Oregon | -- | \$2 million |
| Minnesota | -- | \$5 million** |

*Utah lawmakers recently raised annual maximums from \$250,000, and the lifetime cap will increase to \$1.5 million effective July 2007.

**Minnesota Legislature recently raised lifetime maximum to \$5 million from \$2.8 million.

Finding: MRMIP subscribers generally self-identify health as “excellent” or “very good,” but at lower rates than the commercial market. Despite reporting slightly worse health status than individuals in the private market, MRMIP enrollees claim patterns do not appear to differ greatly from that of the general population. Just 50 percent of MRMIP enrollees report being in excellent or very good health, compared to more than 60 percent of the privately insured

population.^{2,3} In 2004, about 83 percent of the MRMIP population had annual claims totaling less than \$5,000 and 19 percent had no medical claims at all.⁴ This is consistent with the general population, where 80 percent of the population consumed less than \$5,000 in annual health benefits.⁵



Source: MRMIP and the California Health Interview Survey.

Section One: Disease Management

As health insurance premiums continue to rise dramatically, policymakers across America are looking for ways to help contain costs without denying patients needed care or threatening health outcomes. Disease management programs, as well as case management programs, are widely perceived as programs that improve patient care and may help lower costs.

Disease and case management programs also make sense in light of how most health care dollars are spent: a small percentage of health insurance beneficiaries are responsible for a disproportionately high percentage of spending. This holds true for both public insurance programs and private, and for health care spending over time. In 2001, five percent of Medicare beneficiaries were responsible for 43 percent of spending.⁶ In 1996, five percent of the general population was responsible for 55 percent of total health care spending.⁷ This indicates that there exists a relatively small group of high cost beneficiaries, many of whom likely have chronic

² State of California, Managed Risk Medical Insurance Board, *California Major Risk Medical Insurance Program 2006 Fact Book* (March 2006) VII-61.

³ University of California, Los Angeles Center for Health Policy Research, *2005 California Health Interview Survey* (2005).

⁴ State of California, Managed Risk Medical Insurance Board, *California Major Risk Medical Insurance Program 2006 Fact Book* (March 2006) VII-61.

⁵ Arthur Baldwin, *The Price of Illness* (California HealthCare Foundation, September 2005).

⁶ United States, Congressional Budget Office, *High Cost Medicare Beneficiaries* (Washington, DC: Congressional Budget Office, 2004).

⁷ M.L. Berk and A.C. Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, 2001: 20(2): 9-18.

conditions. These beneficiaries may be effectively targeted with intervention programs like disease and case management to better manage their care.

Disease management programs typically focus on one-on-one outreach and education to help patients manage a specific medical condition, as well as health monitoring and care coordination to ensure patients receive all appropriate medical services. In practice, the programs can vary greatly in terms of scope and intensity from 24-hour support services for patients to simply providing educational materials, depending on the targeted disease and available resources. (Dr. Berenson's paper in Appendix A offers a definition in greater detail.)

The "top five" conditions for which disease management is used are heart disease, diabetes, chronic obstructive pulmonary disease, congestive heart failure, and asthma. Other conditions commonly targeted are: pregnancy, coronary artery disease, cancer, lower back pain, and depression.

The goal of disease management is to help identify and treat medical conditions before they become severe. This approach improves health for patients, reducing their need for expensive and invasive care and, thus, high, long-term health care costs. However, there is little published research to demonstrate that disease management programs also reduce costs. In part, this stems from a lack of good, comprehensive and available information on the care patients receive, and the total cost of that care, to both establish a baseline and measure progress. Additionally, disease management programs require considerable administrative overhead, which means that even if the programs demonstrate improved care or health outcomes, it may come at an increased cost.⁸

Disease management programs emphasize coordination of care, and one-on-one patient outreach, the types of activities that are generally easier to reimburse within managed care networks than in fee-for-service or preferred provider organization (PPO) health insurance plans, which are common across the country. This is why many of the 26 of the 34 state high risk pools that offer some level of disease management services to their members run their programs either through their health plans, who can negotiate reimbursements directly with providers, or through specially contracted disease management programs. These special programs are paid by the pool, or the health plans, to employ the nurses and care coordinators and directly provide other disease management services to patients without dramatically changing existing provider payment processes for participating carriers.

Disease Management in the Group Market

***Finding:** Disease management plays a significant and growing role in the group market, despite uncertainty of cost savings outcomes.* A survey conducted by the California HealthCare Foundation reports that disease management is becoming much more prevalent. In California, 29 percent of all firms offered a disease management program as a part of their largest health insurance plan in 2006. That percentage rises with the number of employees: disease management programs were offered by 50 percent of all businesses with more than 200 workers

⁸ Bruce Fireman, et al, "Can Disease Management Reduce Health Care Costs By Improving Quality," *Health Affairs*, 2004: 23(6): 63-75.

and 62 percent of firms with more than 1,000 employees. Fifty-two percent of employers surveyed believe they are somewhat or very effective in containing costs.⁹

Practices in MRMIP

Finding: Due to recent program changes, all four participating plans offer disease management services to MRMIP subscribers. While all four health plans participating in California's high risk pool offer some type of disease management programs in their commercial products, until recently, only two plans, Kaiser Permanente and Contra Costa Health Plan, have made those programs available to MRMIP beneficiaries. Blue Cross of California and Blue Shield of California are currently implementing changes to give the approximately 52.7 percent of MRMIP beneficiaries they serve access to disease management services.

Kaiser Permanente, which serves 46.7 percent of MRMIP beneficiaries, has offered disease management programs for an extensive range of conditions including asthma, cancer, cardiac diseases, diabetes, pregnancy and HIV/AIDS. The HMO identifies patients with these medical conditions through their clinical information systems and automatically enrolls them in the programs, which rely heavily on care coordination by primary care physicians. Contra Costa Health Plan, which serves only 0.7 percent of MRMIP beneficiaries, only offers voluntary disease management programs for asthma and diabetes. The asthma program is nurse-run, and involves both in-home visits and some care coordination with physicians.

Blue Cross of California has disease management programs which provide educational materials, health classes, and a 24-hour nurse line as well as help for patients in scheduling and keeping doctor's appointments. These programs are available for four conditions: asthma, diabetes, pregnancy and some cardiovascular diseases. The MRMIP beneficiaries with these conditions who are already enrolled in Blue Cross's case management system, generally the sickest of the Blue Cross MRMIP population, have recently been given access to those disease management services. Blue Cross has also made changes to their claims processing and review system to identify and automatically enroll other eligible MRMIP beneficiaries in the programs. With these changes in place, MRMIP beneficiaries enrolled in Blue Cross have access to disease management services if they need them.

Blue Shield of California also offers disease management services for diabetes, asthma and cardiovascular disease patients, which will soon be available to the MRMIP beneficiaries they serve. These programs assign patients to nurses who teach self-management techniques.

Finding: Plans reported measuring success based on patients' health outcomes, and that cost-savings data are largely unavailable. All four plans indicated they track health outcomes for disease management programs, but none had data available on cost-savings from those programs. Blue Cross saw a 50 percent drop in asthma inpatient admits, and a 47 percent drop in asthma ER visits between 2004 and 2005. Contra Costa reported that hospital inpatient stays and emergency department visits both have remained stable.

⁹ California HealthCare Foundation, *California Employer Health Benefits Survey* (November 2006).

For a chart comparing disease management programs offered by health plans serving MRMIP beneficiaries, see Appendix C.

Lessons from Other States

***Finding:** All five states surveyed provide disease management services to their members, though each offers different approaches.* We found that while the five states surveyed had individual approaches to providing disease management services, there were also commonalities between their programs.

Administrative Structure. We found three typical ways that high risk pools deliver disease management services: through participating insurers (like MRMIP’s current approach), programs operated by pool staff, or specially contracted disease management programs. The participating insurers and pools will often work through third-party, specialized disease management programs where there is a need and a better chance for positive results. This may be because the participating health plans operate using the fee-for-service model that does not lend itself easily to the care coordination services of disease and case management programs.

- ***Insurer-Driven,*** Connecticut, Maryland, and Minnesota: These high risk pools offer disease management programs through their participating health plans, much like MRMIP. Often, the carrier will contract with a separate, outside disease management vendor firm.
- ***Pool-Driven,*** Indiana: This state offers its high risk pool members disease management services both through its participating insurer and an in-house program, with the latter focused only on hemophilia and cardiovascular disease.
- ***Outside Contractor,*** Colorado: This program differs from these other states and California in that while it does target patients with specific chronic diseases, it was specifically designed to provide full case management services for the high risk pool population. The program is operated by a third-party medical management firm (created specifically for this program) in coordination with, but independently of, the participating insurer, just for the high risk pool’s members.

Member Identification, Outreach and Enrollment. To be effective, disease management programs must be able to identify patients with chronic medical conditions, then inform them of available services and enroll them in the appropriate program.

- There are three primary methods of identifying patients. Connecticut relies primarily on reviewing medical claims data, although all states used claims data as at least one part of their identification processes. Minnesota uses both claims data and referrals from either doctors or patients. Indiana, Maryland and Colorado also use health history information collected in enrollment applications. Colorado and Connecticut both report using state-of-the-art “predictive modeling” software to identify health condition risks and special needs.
- States with both mandatory (Colorado and Indiana) and voluntary (Maryland, Connecticut, Minnesota) programs reported using phone calls, letters, and/or other mailed materials as their method of establishing first contact with members identified as potentially eligible for a disease management program.

- Minnesota’s program is voluntary, but members must opt-out. Combined with their on-going print and web-based outreach efforts, this may account for their 98 percent participation rate among eligible members in common chronic illness disease management programs.
- Indiana’s mandatory disease management program requires new members to go through an orientation process where they learn about the programs and services available.
- Although both Colorado and Indiana described their programs as “mandatory” for eligible enrollees, only Colorado reported an enforcement mechanism: the risk pool maintains the right to not pay claims if the individual does not participate. Colorado’s pool has not yet had to deny claims for this reason, but has successfully engaged with enrollees who were out of compliance.

Targeted Diseases. The three most common conditions targeted by disease management programs in the five states surveyed were asthma, diabetes and heart diseases. States varied in the number of disease management programs offered from Connecticut, which only targets diabetes, asthma and heart disease, to Minnesota, which offers one program for more than 30 common chronic illnesses and a second program for 15 rare diseases such as multiple sclerosis, Parkinson’s disease and lupus.

Services Offered. Disease management services vary by both type and severity of a condition and the sophistication of the program. The five states surveyed reported a range of services offered, from proactive telephonic services and coordinated care management by dedicated staff to targeted informational mailings.

For a chart comparing the disease management programs offered by these states, see Appendix G.

Finding: Data on cost-savings resulting from disease management programs in high risk pools in other states is not well established. Current research suggests that there is not much evidence of health plans achieving cost savings from disease management programs, in part due to their slightly higher administrative costs. Like the health plans participating in California’s high risk pools, other pools surveyed generally reported focusing on tracking improved health outcomes and customer satisfaction, rather than cost savings, in measuring the performance of their disease management programs. While several states, such as Colorado and Connecticut, expressed general skepticism regarding the reliability of cost savings accounting provided by disease management vendors, other states reported positive return-on-investment (ROI) data. Maryland’s disease management program reported an ROI of 1.25 to 1 for diabetes, 4.93 to 1 for asthma and 8.66 to 1 for heart failure patients, but that data has not been independently audited. Minnesota requires its participating health plan operate its disease management programs on at least a 1 to 1 ROI, and its carrier currently reports a 1.3 to 1 ROI. The state pool is also implementing customer satisfaction surveys to ensure patients are receiving the care and treatment they need. Indiana has worked extensively on developing realistic ROI methods with their vendor and while staff did not provide data, they did report seeing “improved outcomes, reduced costs, and were getting close to accurate numbers.”

Recommendation

While there is no concrete evidence of cost savings from disease management programs, our survey and research found they provide clinical value for improving health status to participants. For this reason, MRMIP should ensure all participating health plans continue to offer disease management services to all eligible MRMIP members with the hope of improving their health status. With the announcement of program changes by Blue Cross and Blue Shield, this should be achieved, although follow-up by MRMIB will be needed. However, there should be no expectation that these programs will reduce costs.

This recommendation is consistent with the analysis offered by Dr. Berenson for this project (see Appendix A). In his scan of existing research, Dr. Berenson found that health plans in recent years have widely expanded their health promotion and wellness activities. Often, physicians are not compensated for coordinating patient care, particularly for patients with one or more complex, chronic medical conditions, and disease management programs have been developed to fill this void for patients. By monitoring a patient's condition to encourage increased preventative care or early medical intervention, and helping patients self-manage their conditions, disease management can improve health status and outcomes. These programs also can reduce inappropriate, late-stage, or expensive care, and may ultimately reduce the prevalence of chronic conditions by changing patient behaviors. However, they have not yet consistently demonstrated a short-term effect on health care spending. MRMIB may want to work further with MRMIP health plans to understand the precise impact of these programs on MRMIP enrollees.

Section Two: Case Management

Where disease management is designed to coordinate care for patient populations with specific medical conditions, case management is designed to support the individual as a whole and is often targeted at higher-risk populations. These populations, often with multiple and interacting medical conditions or conditions of greater severity, need patient-specific case management that takes into account not just their health, but their functional, social and emotional conditions. While there is limited information on the rate and type of co-morbidities in the MRMIP population, it is reasonable to assume that the co-morbidities are high relative to the general population.

Practices in MRMIP

Finding: All health plans participating in MRMIP offer case management services to MRMIP beneficiaries. All four health plans participating in MRMIP offer case management programs to all eligible enrollees, regardless of payer source. Like disease management programs, the case management programs for MRMIP beneficiaries are offered and managed by the participating health plans. The programs vary slightly in member identification, outreach and enrollment processes, covered medical conditions and specific services offered, but all share the goal of seeking to improve care delivery and health outcomes for their sickest beneficiaries.

Member Identification, Outreach and Enrollment. The four case management programs have similarities and differences in how they identify eligible beneficiaries, then educate and enroll them into their program.

- Most plans use claims data or clinical information systems to identify patients at high risk or with co-morbidities, but other methods are used as well. Blue Shield of California considers admission to an acute or long-term care facility a trigger for eligibility and the Contra Costa Health Plan automatically enrolls any beneficiary once they reach \$50,000 worth of claims.
- Contra Costa Health Plan, Blue Cross of California and Kaiser Permanente automatically enroll identified patients in their case management programs. Blue Shield of California's program is the only plan where members must voluntarily opt-in to the program.
- Phone calls, letters and mailed materials are the most common method of outreach to identified beneficiaries. Kaiser Permanente, however, conducts most of its outreach at medical centers designed specifically for members with chronic conditions.

Targeted Conditions. Although case management is a patient-centered, rather than disease-specific approach, some MRMIP plans target patients with certain medical conditions. Several of the programs target both physical and mental medical conditions.

- Blue Cross of California covers diabetes, asthma, cardiovascular disease, obesity, pain management, and transplant patients.
- Blue Shield of California targets patients with diabetes, hypertension, cystic fibrosis, morbid obesity, complications from surgery, cardiac myopathy, traumatic brain injury, and depression and anxiety (as co-morbidities).
- Contra Costa Health Plan offers case management programs for both mental and physical health, including asthma, diabetes and co-morbid conditions.
- Kaiser Permanente offers case management programs for its geriatric population and patients with co-morbidities.

Services Offered. The level of services offered by the different case management programs varies, but all are generally targeted at ensuring that patients have access to the care they need and are empowered to help manage their medical conditions.

- The Blue Cross of California program provides member education, care coordination and assistance for beneficiaries in adhering to treatment plans.
- The Blue Shield of California case management program receive regular communications from nurses to ensure they are closely following their personal care plan. Blue Shield recently conducted research on a type of enhanced case management for very ill members called patient-centered management, which includes end-of-life management, in-home visits, provider coordination and patient advocacy.
- The Contra Costa Health Plan programs focus on improving collaboration between patients' care providers to help ensure the patients move smoothly through the health care system.
- Kaiser Permanente's case management programs target both patients and care providers. Patients receive care coordination services, and are taught self-management for their medical conditions, as well as general healthy living skills. Providers have access to integrated decision support tools, are encouraged to implement evidence-based care guidelines and participate in care management steering committees.

For a chart comparing case management programs offered by health plans serving MRMIP beneficiaries, see Appendix D.

Lessons from Other States

Finding: Other state pools see case management, like disease management, as a way to help members improve their health. Like in California, many other states' case management programs are operated in coordination with disease management programs, and so are similarly administrated and structured.

Administrative Structure. We found case management services were delivered in two of the same ways as disease management programs: through participating insurers (like MRMIP's current approach or through a specialized management program.

- Connecticut, Maryland and Minnesota's high risk pools offer case management programs through their participating health plans.
- Colorado is unique in offering just one case management program for its high risk pool members, rather than segmenting members into separate disease and case management programs. This comprehensive program is operated by a new type of specialized case management firm designed to meet the specific needs of high risk pool populations.
- Indiana also uses a third party vendor outside of its health plan administrator for disease and case management services, but unlike Colorado focuses more on disease-specific than on overall case management.

Member Identification, Outreach and Enrollment. The states surveyed reported using the same identification, outreach and enrollment processes for their case management as for their disease management programs. See the previous section for more detail on these processes.

Targeted Diseases. In the states surveyed, case management is most commonly targeted at populations with multiple, interacting medical conditions, and this was also true for the case management programs offered by the state high risk pools surveyed.

Services Offered. The high risk pool case management programs in the states surveyed offered a range of services comparable to the range of services available to MRMIP beneficiaries.

- Maryland's case management program relies heavily on phone call check-ins for patients, and the occasional in-person visit, to monitor health and ensure members are receiving all the care they need.
- Minnesota's program offers services designed both to improve patient care and to coordinate benefits utilization: case management to integrate and coordinate care, social-related care consulting, financial assistance consulting, prior authorization for some services, and managed referrals for specialists and high-cost claims.
- Members participating in Connecticut's case management program are assigned a care coordinator who uses best clinical practices to help keep patients from experiencing further medical complications.

- Colorado’s high risk pool case management program also assigns beneficiaries to care coordinators who are available 24 hours a day, approve all major medical decisions, and help “coach” patients on how to take responsibility for their health care.

For a chart comparing case management programs offered by these states, see Appendix H.

Finding: While case management programs are considered important to health status, there is little data to support their effect on costs. As is the case with disease management programs, plans generally report that health outcomes are their primary consideration in performance measures, and that reliable ROI data is not easily available.

Recommendation

MRMIP plans should continue to offer case management services as they do today. Our analysis indicates that health plans apply at least the same, and sometimes more comprehensive, case management benefits standards for MRMIP beneficiaries as they do to the rest of their enrollees. These practices also seem in line with industry standards. However, as the existence of co-morbidities in the MRMIP populations is not well understood, MRMIP should undertake a study of the rate and type of co-morbidities.

In his analysis, Dr. Berenson found that while there is an inherent logic to believing case management programs, like disease management programs, will improve health outcomes and reduce costs, it is difficult to clearly understand their costs and benefits due to the sheer number of different programs and the lack of standardization in measuring outcomes. The greater challenge is in determining costs of the program, as Dr. Berenson found studies which did show improvement in the quality of care for case management program beneficiaries. MRMIB may want to work further with the MRMIP plans to better understand the precise impact of these programs on enrollees.

Section Three: Benefits and Pharmaceutical Benefits Management

The premise behind managed care is that coordinating patient care can improve health outcomes and encourage a more efficient use of health care resources. Original managed care practices relied heavily on cost containment practices and utilization restrictions; current disease, case, and benefit (or utilization) management programs are in part a reaction to those practices.

Health care payers are also changing the philosophy of their cost containment practices, increasing the use of incentives and decreasing penalties or restrictions on benefits. The old method of capitated payments placed the financial risk of high levels of care utilization onto providers by paying them per beneficiary rather than by the volume of services provided. This was used to provide a financial incentive for providers to control care utilization. Many health plans now are trying to “pay for performance” to reward providers who are ensuring their patients are getting the right care at the right time, and avoiding overuse, underuse and misuse of care, by following evidence-based care guidelines. Benefits management practices such as

requiring preauthorization for certain medical services, e.g., outpatient or imaging services, are also increasing in popularity.¹⁰

In addition to these efforts to improve provider performance, health plans and employers also employ increased cost-sharing as a form of benefits management. This is the form of benefits management most often studied and tracked.

Management of pharmaceutical benefits is another method health plans are using to find cost savings, primarily through the use of formularies, tiered cost-sharing and pre-authorization for high-cost medications like biologics, injectable drugs and blood factor products to encourage members to use cost-effective treatments.

Benefits and Pharmaceutical Benefits Management in the Group Market

Finding: *Benefits and pharmaceutical benefits management are common in the group market.* While data on benefits management across health plans and employers is limited, there is evidence that most, if not all, are engaging in increased cost-sharing to help contain costs. This includes increases in premium contributions, deductibles and prescription co-payments. A Kaiser Family Foundation study found that 64 percent of companies with more than 200 employees and 50 percent of companies with fewer than 200 employees believed that increased cost sharing with employees was a somewhat or very effective method of containing costs.¹¹ In California, that number drops to 42 percent for all companies.¹²

Possibly because of California's increased familiarity with managed care, 50 percent of employers here view tighter managed care networks – which may employ stricter benefit utilization controls – as a somewhat or very effective method of controlling costs¹³ compared to 46 percent of employers nationwide.¹⁴

Increased cost-sharing is on the rise in California and across the country. Nationwide, 75 percent of larger companies, and 48 percent of smaller companies, were somewhat or very likely to increase the amount their employees pay for health insurance.¹⁵ In California, 69 percent of employers reported being somewhat or very likely to increase employee premium contributions.

One area where the insured are particularly likely to see benefits management employed is mental health services. For example, 57 percent California employees with mental health coverage face annual limits of 20 or fewer outpatient visits and 63 percent were allowed 30 or

¹⁰ S. Felt-Lisk and G.P. Mays, "To the Drawing Board: New Directions in Health Plans' Care Management Strategies," *Health Affairs*, 2002: 21(5): 210-217.

¹¹ The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2006 Annual Survey* (2006).

¹² California HealthCare Foundation, *California Employer Health Benefits Survey* (November 2006).

¹³ *Ibid.*

¹⁴ The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2006 Annual Survey* (2006).

¹⁵ *Ibid.*

fewer inpatient days for conditions not considered “serious mental illnesses” under state insurance law.¹⁶

The majority of workers with health insurance are also facing increases in their co-payments for prescription drugs, particularly for non-generic or non-preferred medications. Ninety percent of insured employees in America and 87 percent of California employees¹⁷ face a tiered cost-sharing formula for their medications. Tiered cost-sharing is generally based on a formulary, where health plans determine which medications they prefer members to receive based on cost and/or effectiveness. Generic drugs are generally least expensive for patients, followed by preferred brand name and then off-formulary brand name drugs.

Co-payments for off-formulary brand name drugs have increased the most in recent years. For generics, the rise to \$10.23 per prescription in 2006 is a nearly 38 percent increase since 2001. Preferred drug co-payments have increased nearly 62 percent, and non-preferred drugs have nearly doubled, increasing more than 94 percent since 2001.¹⁸ A recent innovation in tiered cost-sharing for prescriptions is the fourth tier, with even higher co-payments for “lifestyle drugs” (such as Viagra) or biologics.

Practices in MRMIP

Finding: All four health plans reported using their group market benefits management practices with their MRMIP beneficiaries. The MRMIP participating health plans have made benefits management a common practice for all beneficiaries. Several examples include:

- Blue Shield of California uses an enhanced utilization management approach, which includes 15 on-site care managers in 40 hospitals throughout the state who oversee claims submitted by local physician groups. The plan also looks to manage benefits by conducting facilities planning on a regional level to ensure local, cost-effective access to care.
- Contra Costa Health Plan uses a number of medical management and cost containment practices including prior authorization, benefit utilization monitoring, advice nurses to triage patient needs over the telephone, disease management and pharmaceutical benefits management.

Three of the plans, Blue Cross of California, Blue Shield of California and Contra Costa Health Plan, also reported the \$75,000 annual benefits limit as a specific challenge in managing care for MRMIP members, despite our findings that less than one percent of the population reaches that cap. One health plan reported that MRMIP beneficiaries who reach the maximum benefit generally do so because they have not used their coverage appropriately, and so need more help managing their benefits.

- Managed care has long been a common practice in California, so it is unsurprising that those practices also apply in the high risk pool, and that

¹⁶ California HealthCare Foundation, *California Employer Health Benefits Survey* (November 2006).

¹⁷ Ibid.

¹⁸ Ibid.

Finding: All plans participating in MRMIP use prescription drug management to contain costs, and all promote generics whenever possible. The three health plans that provided information on their prescription drug management programs reported administrating their plans internally using plan staff. Committees of physicians and/or pharmacists help set formularies for preferred pharmaceuticals for all three plans. Kaiser Permanente uses a regional model, meaning that southern and northern California committees adopt different formularies for their beneficiaries as deemed appropriate. All plans reported encouraging the use of generics. Blue Shield of California requires preauthorization for non-formulary drugs. The plan also performs daily claims audits and employs a system that alerts pharmacists and physicians if members are over-utilizing controlled substances and alters dosing to follow federal Food and Drug Administration guidelines.

For a chart comparing benefits and pharmaceutical benefits management approaches used by health plans serving MRMIP beneficiaries, see Appendix E.

Lessons from Other States

Finding: High risk pools use benefits management and pharmaceutical benefits management techniques to contain costs. All states reported several common benefits management practices including requiring preauthorization for hospitalizations, some specific procedures and advanced imaging services like MRIs, and reviewing continued hospital stays. The states also reported using formularies for generic and prescription drugs, with most using tiered pricing to steer members to generics or preferred brand name drugs. Many of the states also used their pharmacy and benefits management guidelines in coordination with case managers. Case managers in Colorado and Minnesota are involved in authorizing care and prescriptions, and streamlining care referrals. Case management nurses in Maryland and Colorado monitor pharmaceutical use for duplication, over-use or misapplication. The chart at Appendix I shows the full range of activities taken by other states.

For a chart comparing benefits and pharmaceutical benefits management approaches used by these state risk pools, see Appendix I.

Recommendation

MRMIP health plans should continue to apply the same benefits and pharmacy cost containment techniques to MRMIP members as to their other beneficiaries. Based on the best available information through our health plan survey, there is no indication that more aggressive cost-containment steps would be of material benefit to MRMIP subscribers. More research would be needed, and plans would likely oppose a separate program.

Section Four: The Use of Deductibles in High Risk Pools: More Opinion than Fact

Ten years ago, many employers offered plans without deductibles. But in the face of skyrocketing costs, deductibles have become a common technique for the insured to reduce

monthly premiums by accepting greater risk for potential costs. In recent years, growth in the use of high deductibles (generally defined as a policy with a deductible of more than \$1,000) also has become more common. While high risk pools nationally have followed the high deductible trend, California's MRMIP does not offer any plans with deductibles to MRMIP beneficiaries through any of its four carriers, let alone plans with high deductibles.

This section will follow a different format than earlier in the paper and addresses a complex question: Should the MRMIP offer a high deductible health plan (HDHP) option? While other states have deductible options, and some have seen an increase in HDHP enrollment, there is little specifically known on the impact of the plans on risk pool enrollees. Focusing on the high deductible approach, this section will discuss:

- The general argument in favor of HDHPs;
- The general argument against HDHPs;
- Theories as to why MRMIP should consider offering an HDHP; and,
- Critical questions that would need to be addressed before implementation of HDHPs can occur in MRMIP.

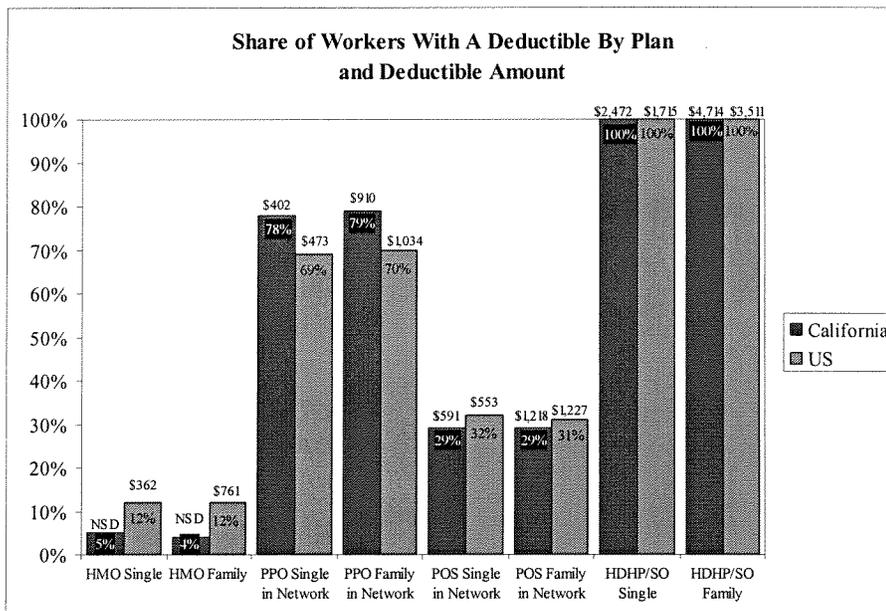
At this time, the HDHP option for MRMIP requires further research before a recommendation could be made on implementation.

Background: Health Plan Deductibles, Variations by Plan and Size

As compared to the rest of the country, California's commercial market has relatively low-level of enrollment in plans with deductibles due to the high-level of managed care penetration and managed care's aversion to using deductibles. About 50 percent of Californian's insured population is in managed care, with another 34 percent in PPOs.

Nationally, only 20 percent of the insured are enrolled in an HMO, while 60 percent are in a PPO.¹⁹

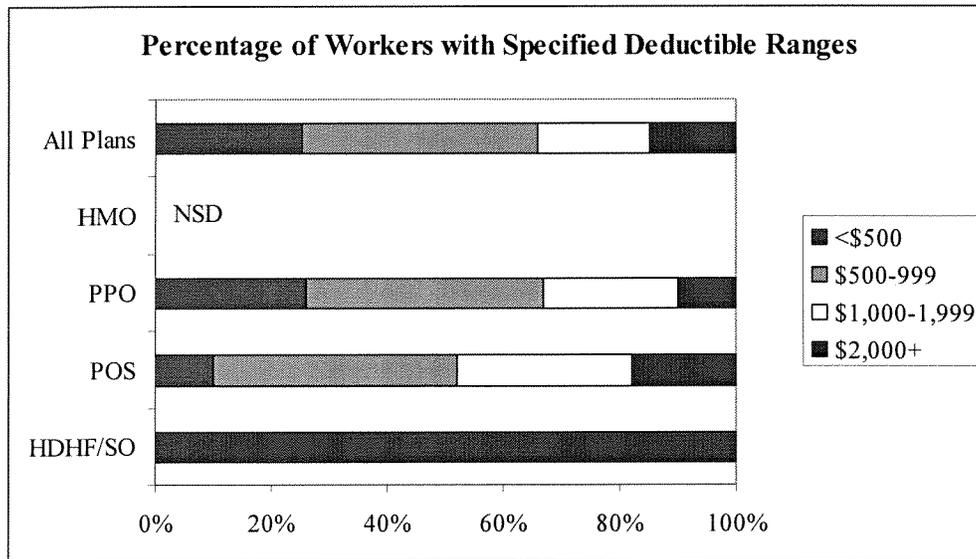
California's largest HMO, Kaiser Permanente, has only recently offered a deductible model on the individual market.



Source: Taken Directly From: California HealthCare Foundation, *California Health Care Benefits Survey* (November 2006).

¹⁹ California HealthCare Foundation, *California Employer Health Benefits Survey* (November 2006).

Also according to the California Health Benefits Survey, 66 percent of California workers with deductibles had a deductible below \$1,000, with only 15 percent of policies with a deductible greater than \$2,000 annually.²⁰



Source: Taken Directly From: California HealthCare Foundation, *California Health Care Benefits Survey* (November 2006).

Growth in HDHPs

The number of American employees enrolled in HDHP plans appears to be stalling, having only increased from 2.4 million in 2005 to 2.7 million in 2006. Despite an initial rapid increase in HDHP usage, employers are reporting that only small percentages of their workers are choosing the plans. For example, just 50,000 of the 8 million members in the Federal Employees Health Benefits Program have taken up higher deductible, consumer-directed plans, which have been available for several years. Overall, only an estimated 19 percent of employees who have HDHP plans as an option choose them. Some companies have been able to boost enrollment in those plans, but generally by making benefits richer and more like traditional health plans: covering preventative services and treatments and increasing employer contributions to cover deductibles.²¹

HDHPs and HSAs

HDHPs can be coupled with Health Savings Accounts (HSAs), which are used to help save funds to cover deductible costs. Signed into law in 2003 by President Bush, four of the five states interviewed for this report offer HSA options as part of their high risk pool. HSAs are only available to adults under certain circumstances, such as enrollment in an HDHP with a minimum deductible of \$1,100 for individuals and \$2,200 for a family (rates increase annually,

²⁰ California HealthCare Foundation, *California Employer Health Benefits Survey* (November 2006).

²¹ Vanessa Fuhrmans, "Health Savings Plans Start to Falter," *Wall Street Journal*, 12 June 2007.

these numbers are for 2007). Money in an HSA is available for investment and rolled-over to future years if it is unspent.

The General Argument for HDHPs

The proponents of HDHPs coupled with HSAs argue that the approach provides an opportunity to squeeze inefficiencies from the current health care system, thereby lowering health care costs. These plans differ from traditional health insurance, which conceals from consumers the true cost of care, because HDHP plans make individuals responsible for the initial cost of care.

When consumers pay directly for their care, they have an incentive to ask for more cost-effective and higher quality care. Moreover, lower monthly premiums that accompany HDHPs make them an affordable option for individuals and small businesses, helping to reduce the number of uninsured. Proponents believe that HSAs and HDHPs will streamline and improve the health care system by:

- *Allowing for lower premiums will help lower the number of uninsured.* Lower premiums enable more people to afford coverage or to continue to have comprehensive coverage at a time when rising premiums are pricing more people out of coverage all together.²²
- *Encouraging consumers to evaluate the financial costs of a treatment versus the medical benefit.* HDHPs with HSAs bring consumerism to health care by allowing an individual or family to put tax-free dollars in a savings account, and then requiring them to use it to pay for care until after they have reached their deductible, and their insurance coverage kicks in. Consumers are less likely to want unnecessary care if they know they have to pay for it, and more likely to want to purchase cost-effective care when they do need it. Recent studies show that people with HDHPs are in fact less likely to seek unnecessary care and so have lower health care costs.²³ Critics say there is little peer-reviewed, published data to support that HDHPs lower costs and reduce inefficiencies, but a RAND study that experimented with increased cost-sharing found that higher cost-sharing reduced utilization without reducing health status.²⁴
- *Encouraging consumers to identify and use providers with the highest quality and lowest costs.* Making consumers responsible for the “first dollar” of medical care costs encourages them to consider the price and quality of the care they need, demand accurate information to make those decisions, and then seek the highest quality providers.²⁵ Under the HSA model, consumers will shop prudently for their health care, and providers will have to compete for patient business. Consumers will demand both price and quality

²²Grace-Marie Turner, President of the Galen Institute, “Op-ed: Health Savings Accounts: It's all good,” *The Orange County Register*, 6 April 2006.

²³M Beeuwkes Buntin, et al., “Consumer Directed Health Care: Early Evidence About Effects on Cost and Quality,” *Health Affairs*, Nov./Dec. 2006: 25(6): w516-530.

²⁴Jonathan Gruber, *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond* (Kaiser Family Foundation, Oct. 2006).

²⁵David Hogberg, *Washington State Barriers to Health Savings Accounts* (Washington Policy Center, July 2006).

transparency, which will affect quality of care and spur innovation. Providers will find ways to make health care both less expensive and more convenient for the patient.²⁶

- ***Incentivizing good health by allowing consumers to put pre-tax dollars into HSAs and rolling them over year after year.*** Healthy people use less health care. If people know they will be spending their own money to pay for preventable health problems, they will be more inclined to stay healthy by not smoking, eating nutritious foods and exercising.
- ***Helping future retirees subsidize Medicare costs.*** Employees can start contributing to their tax-free HSA-eligible HDHP plans early in their careers and build significant capital to offset future Medicare costs. HSAs are good for the long term, and ultimately they will form a national trust of health care dollars that are family, rather than employer, based.²⁷

The General Argument Against High-Deductible Health Plans (HDHPs)

At the same time, many have expressed concerns that deductibles prevent patients, particularly those with lower-incomes, from seeking care when it is truly needed, and that those delays may worsen a patient's health and lead to greater medical costs when they finally do seek treatment.^{28, 29, 30} When patients are not seeking the care they need to get or stay healthy because of HDHPs, overall health status can be reduced.

HDHPs may:

- ***Require patients to make medical decisions with limited information and limited ability to understand health information.*** A key argument used by proponents of HDHPs is that if given the incentive of saving money, consumers will both seek cost-effective care and avoid unnecessary care. This would seem flawed as American health care consumers generally lack access to adequate information on the cost or quality of treatments and providers. It is easier to find quality information on new cars than hospitals or other providers.³¹ Not only have the needed tools for collecting and providing cost and quality information to consumers never been developed,³² there is no history or culture of patients being required to interpret or understand such information.³³ Participants in consumer directed, high deductible plans have reported to their health insurance plans that they lack the information they need to make decisions about costs and provider

²⁶ David Hogberg, *Washington State Barriers to Health Savings Accounts* (Washington Policy Center, July 2006).

²⁷ David Lenihan, CEO, CareGain Inc, "Health Savings Accounts: An Idea Whose Time Has Come" (AARP, April 2006).

²⁸ FamiliesUSA, *Six Reasons to be Wary of High-Deductible HSA Plans* (December 2006).

²⁹ State of California, Department of Insurance, *Dangerous Prescription* (January 2006).

³⁰ Vanessa Fuhrmans, "Health Savings Plans Start to Falter," *Wall Street Journal*, 12 June 2007.

³¹ Dale Shaller, et al., "Consumers and Quality-Driven Health Care: A Call to Action," *Health Affairs*, March/April 2003: 22(2): 95-101.

³² Judith Hibbard, et al., "Increasing the Impact of Health Plan Report Cards by Addressing Consumers' Concerns," *Health Affairs* 19(5): 138-143, 2000; Joyce Dubow, *In Brief: Decision Making in Consumer-Directed Health Plans* (AARP Public Policy Institute, Issue Paper #2003-05, May 2003); State of California, Department of Insurance, *Priced-Out: State of California Health Care* (2005).

³³ Institute of Medicine, *Health Literacy: A Prescription to End Confusion* (April 2004).

quality.³⁴ An independent study showed that they also have low levels of trust in the information that is provided by health plans.³⁵

- **Cause delays in seeking care.** When patients know that any trip to the doctor's office will mean an unavoidable medical bill, they have been shown to be less likely to seek both necessary and unnecessary care.³⁶ A 2005 survey showed that 31 percent of those in HDHPs self-reported delaying care compared to only 17 percent of those in traditional health plans.³⁷ To the extent that this care is preventative or for a chronic condition, delays in care can cause unnecessarily higher future health costs. Low-income persons and those with health problems are particularly more likely to forgo needed care as costs increase.³⁸
- **Cause delays in seeking preventative care.** HDHP plans that fail to offer first dollar coverage for preventative and chronic care keep patients from the services they need to stay healthy, and avoid the costs and hardship of illness.³⁹ This may ultimately drive costs up further, as patients will wait to seek care until their illness is severe and the necessary treatment is more intensive and expensive.
- **Shift higher costs to consumers.** While HDHP plans are supposed to help lower health care costs overall, initial evidence suggests that they may only be shifting costs to patients. At least two 2005 surveys have shown that individuals with HDHP plans are more likely to spend more of their income on health care.⁴⁰ For example, one survey showed that 42 percent of HDHP enrollees spent five percent or more of their income on premiums and other health care costs compared to only 12 percent of those in traditional plans.⁴¹ In the case of low-income families, unexpected or unexpectedly high health care costs can mean garnished wages or even bankruptcy.⁴² Additionally, there is no guarantee that consumers will in fact save for future medical costs by contributing to

³⁴ MB Buntin, et al., *Consumer-Directed Health Care: Early Evidence Shows Lower Costs, Mixed Effects on Quality of Care* (RAND, 2007).

³⁵ Paul Fronstin and Sara R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey* (Employee Benefits Research Institute, Issue Brief, No. 288, December 2005).

³⁶ Joseph Newhouse et. al., *Free for all? Lessons from the Rand Health Insurance Experiment* (Harvard University Press, 1993).

³⁷ Paul Fronstin and Sara R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey* (EBRI Issue Brief, No. 288, December 2005).

³⁸ Melinda Beewkes Buntin et. al., *Consumer-Driven' Health Plans: Implications for Health Care Quality and Cost* (California HealthCare Foundation, June 2005); Paul Fronstin and Sara R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey* (Employee Benefits Research Institute, Issue Brief, No. 288, December 2005).

³⁹ State of California, Department of Insurance, *Dangerous Prescription* (January 2006).

⁴⁰ Karen Davis et al., *How High is Too High? Implications of High-Deductible Health Plans* (The Commonwealth Fund, April 2005).

⁴¹ Paul Fronstin and Sara R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey* (Employee Benefits Research Institute, Issue Brief, No. 288, December 2005).

⁴² Beth Capell, Testimony to the Investigatory Hearing on Cost-Driven Health Products (California Department of Insurance, September 2005).

HSAs. One survey of HDHP participants found only 29 percent had saved money in their accounts.⁴³

- **Segment risk in the market.** Health insurance can only be affordable when it pools both healthy and sick individuals, to spread the cost and risks of paying for care. HDHP plans tend to attract healthier, and wealthier, enrollees than traditional health plans.⁴⁴ If enough healthy people leave the traditional health insurance market, there is a risk of traditional insurance becoming unaffordable for the people who need it, such as the chronically ill.^{45,46}
- **Lower customer satisfaction.** Recent media coverage has suggested HDHP plans may not have staying power in market because they place more pressure on consumers to make complicated decisions without good information on cost and quality while providing poorer benefits packages than traditional plans.⁴⁷ A 2005 study showed that while 63 percent of individuals with comprehensive health insurance are extremely or very satisfied with their plan, only 33 percent of individuals with HDHP plans expressed the same level of satisfaction. Similar numbers reported being likely to stay with their current health plan even if they had the option to change.⁴⁸

Use of a High-Deductible Plan in MRMIP

There are few facts upon which to base a recommendation upon the use of HDHPs by MRMIP. HDHP research is still preliminary, and little research has focused on the impact on those with chronic conditions. Given the concerns expressed about the use of HDHPs in the broader market, it would seem difficult to understand an argument for their application in a high-risk pool. This section outlines the rationale for considering offering HDHPs to MRMIP enrollees.

Theory for Exploring HDHPs: High risk pools nationally have been using deductibles, with many seeing a surge in enrollment, even though little is known about their impact in those states.

Finding: *All other high risk pools offer a high deductible coverage.* State high risk pools generally have been designed to look like the commercial individual insurance market, and so have included fee-for-services plans with a range of deductibles. Today, MRMIP is the only pool not to offer plans with deductibles. Deductible plan options differ between the other 33 high risk pools and deductible amounts range from \$200 to \$10,000. Most pools try to balance

⁴³ Vanessa Fuhrmans, "Health Savings Plans Start to Falter," *Wall Street Journal*, 12 June 2007.

⁴⁴ MB Buntin, et al., *Consumer-Directed Health Care: Early Evidence Shows Lower Costs, Mixed Effects on Quality of Care* (RAND, 2007).

⁴⁵ Edwin Park et. al., *Proposal for New HSA Tax Deduction Found Likely to Increase the Ranks of the Uninsured* (Center on Budget and Policy Priorities, May 2004).

⁴⁶ Edwin Park et. al., *Assessing the HSA Coalition's Coverage Estimates for the Administration's Proposed HSA Tax Deduction* (Center on Budget and Policy Priorities, September 2004).

⁴⁷ Vanessa Fuhrmans, "Health Savings Plans Start to Falter," *Wall Street Journal*, 12 June 2007.

⁴⁸ Paul Fronstin and Sara R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey* (Employee Benefits Research Institute, Issue Brief, No. 288, December 2005).

the financial risk for members by offering lower premiums or coinsurance in plans with higher deductibles.

Finding: Some of the high risk pools surveyed reported a recent trend of members gravitating to higher deductible coverage. Not only do all other states offer plans with deductibles to their high risk pool beneficiaries, but several reported that more and more of those beneficiaries are choosing plans with higher deductibles.

- Minnesota reports more members choosing plans with higher deductibles in recent years, and its \$2,000 deductible plan is the most popular, covering nearly 30 percent of members. However, the \$1,000 and \$500 deductible plans are nearly as popular, covering approximately 27 and 25 percent, respectively.
- While the \$500 deductible plan is most common for Utah's high risk pool members, the introduction of a new \$5,000 deductible plan has spurred a significant shift to higher deductibles. Prior to the new plan, 37 percent of beneficiaries had a \$2,500 deductible and now 45 percent of beneficiaries have a \$2,500 or \$5,000 deductible.
- Idaho saw many people select a high-deductible plan after offering a new \$3,000 deductible option, which now covers approximately 57 percent of beneficiaries. This contrasts sharply with low deductible options. In 2003, nearly 30 percent of beneficiaries selected a plan with a \$500 deductible. During the past year, only 4 percent of beneficiaries were so enrolled.
- Oregon has seen a small shift from their \$500 deductible plan to plans with \$750 or \$1,500 deductibles, which increased from 8 to 12 percent and 13 to 16 percent, respectively.

While increasing in popularity, HDHPs are not universally the most popular plans in high risk pools. In the state high risk pools where there are special subsidy programs for lower income risk pool members, the beneficiaries receiving those subsidies are staying, or are required to stay, in the lowest deductible (or, if available, managed care) plan. Nearly half of Maryland's high risk pool beneficiaries are enrolled in plans with \$500 or less in deductibles and only 6 percent in the \$2,500 high deductible plan. In Oregon's high risk pool, 64 percent of beneficiaries are enrolled in the lowest (\$500) deductible plan. MRMIP may expect similar trends among its beneficiaries, as approximately 40 percent of subscribers have family incomes under 300 percent of poverty.

Finding: Plans generally seem to offer enrollee protections, including first dollar coverage for preventative care. A key concern with higher deductible plans is that they may cause individuals to forgo needed care. This is particularly a concern for high risk pool members who may rely on expensive prescription drugs or need more regular preventative care to maintain health. To help enrollees, pools offer first dollar coverage or lower deductibles for chronic care and wellness services with their high deductible plan. (See Appendix K for a complete list of prescription drug and preventative care benefits not subject to high risk pool deductibles.)

Prescription Drug Benefits. Most high risk pool plans offered pharmacy benefits deductibles in addition to medical care deductibles; the prescription drug deductibles were lower, but plans with higher medical deductibles had proportionately higher drug deductibles. Only Oregon offers

plans without drug deductibles. In Minnesota's plans, the first twenty percent of the overall medical deductible serves as a prescription drug deductible.

Preventative Care Benefits. Maryland, Minnesota and Oregon offered full coverage for well-baby and/or well-child visits, some immunizations and disease and case management before members reached deductible thresholds. Utah offers some immunizations for traditional deductible plans and selected preventative services for HSA plan members.

Finding: Little is known about the impact of HDHPs on pool financing. Also, there was little formal understanding of the impact of HDHPs on pool financing, or whether risk segmentation had occurred, shifting healthier and cheaper beneficiaries from traditional plans to HDHPs. There is a need to follow-up further with the interviewed states to explore these issues, though our belief is that research here is limited due to the newness of the changes.

Finding: There is little formal understanding on the impact of access to care and enrollee health outcomes in other states. Despite the growth in HDHPs, none of the pools we interviewed indicated research had been done on affects of access to care or satisfaction of enrollees. There was a general sense that if there were barriers to care, plan administrators would hear about those concerns.

For an explanation of the methodology in choosing state risk pools for the deductible aspect of this study see Appendix J. For a chart comparing the deductible plan options offered by these states, see Appendix K.

Theory for Exploring HDHPs: Individuals will see their total out-of-pocket costs fall under an HDHP approach because the net risk is shifted to the state.

By law, MRMIP beneficiaries are charged premiums at 125 percent of what that plan would cost an individual if purchased in the private market, with the shortfall in costs covered by state payments to health plans. As HDHP plan premiums are less expensive on the commercial market, they would also be more affordable for MRMIP beneficiaries compared to no or low deductible plan premiums.

To help better understand the possible impact of adding a deductible, PriceWaterhouseCoopers (PwC) was asked to project the likely premium under a range of deductible plans for MRMIP subscribers. Broken down by age, the following chart compares possible charges for three different deductibles, one at \$500, \$2,500, and \$5,000 for Los Angeles, based on the standard Blue Cross Plan (below).

Monthly Premiums: Current MRMIP Plan v. Possible Deductible-Based Blue Cross Plans

| Age | Current MRMIP Plan | PPO Share \$500 | Lumenos \$2,500 | Lumenos \$5,000 |
|-------|--------------------|-----------------|-----------------|-----------------|
| 19-29 | \$316 | \$310 | \$235 | \$94 |
| 30-34 | \$429 | \$405 | \$313 | \$131 |
| 35-39 | \$490 | \$455 | \$355 | \$160 |
| 40-44 | \$576 | \$523 | \$398 | \$204 |
| 45-49 | \$658 | \$548 | \$426 | \$254 |
| 50-54 | \$833 | \$704 | \$530 | \$338 |
| 55-59 | \$1,024 | \$866 | \$655 | \$444 |
| 60-64 | \$1,153 | \$1,019 | \$748 | \$524 |

PwC also estimated how enrollees' total out-of-pocket costs change based on the lower premiums but higher deductibles. The sometimes substantial increases in deductible payments offset the premium savings, but for most enrollees there is a net improvement in cost.

Total Out-of-Pocket Costs Changes: Current MRMIP Plan v. Possible Deductible-Based Blue Cross Plans

| Age | PPO Share \$500 | Lumenos \$2,500 | Lumenos \$5,000 |
|-------|-----------------|-----------------|-----------------|
| 19-29 | 28% | 7% | -22% |
| 30-34 | 19% | -1% | -30% |
| 35-39 | 16% | -4% | -31% |
| 40-44 | 9% | -12% | -35% |
| 45-49 | 0% | -18% | -36% |
| 50-54 | -1% | -22% | -38% |
| 55-59 | -4% | -25% | -40% |
| 60-64 | -1% | -25% | -39% |

The concern about this theory is that, while individuals save more money, the only way to make up the shortfall in premium payments is for the state to contribute additional dollars to hold the plan harmless. Additionally, there is no data to support the notion that MRMIP subscribers are going to be more efficient purchasers of care under an HDHP and therefore substantially reduce costs for themselves or the pool.

It is also important to consider out-of-pocket costs as only one factor in determining the quality of coverage benefits, including annual benefits limits and prescription, preventative and wellness coverage.

Theory for Exploring HDHPs: An HDHP approach would increase equity of charges for those in MRMIP who may not have high costs, and may attract a healthier population.

Given changes in the individual market, it is becoming more and more difficult to obtain health coverage, even for those who are healthy. As such, it is at least possible that persons with low or no health costs are being referred to MRMIP. For example, in 2004, almost one out of five persons enrolled in MRMIP had no health claims.

Deductible plan options benefit members of MRMIP who are without significant, ongoing medical care needs and who have the financial ability to self-insure for the deductible. Our analysis has shown that most MRMIP beneficiaries report being in good health, and may benefit from health plan options with lower premiums, deferring greater out-of-pocket costs until necessary.

HDHP Concerns

Further exploration of developing a deductible option could take substantial time. MRMIB may want to consider the following questions before engaging in the actuarial work needed to further explore the deductible questions.

- *How will the financing work?* There are many questions about how to approach the possible use of HDHPs in MRMIP. The primary concern is the loss of premium dollars currently paid by enrollees. Therefore, the key financial question is how to cover the shortfall dollars. One possibility to increase enrollment of healthier people who would have otherwise declined coverage, which would be an appropriate question for the MRMIP's actuaries. The question is critical. Today, about two-thirds of MRMIP's funding source is member premiums, indicating low-cost member premiums are subsidizing high-cost members.
- *Does MRMIP want to reflect the individual or the employer market?* In this study, we examined the increase in take-up rates in deductible coverage, particularly the growth in high deductible health plans. Experts believe this is a result of increasing health care costs, which have made high deductible, lower premium health plans the most affordable option for beneficiaries who don't need high levels of medical care. However, the high risk market offers different challenges. While MRMIP beneficiaries generally report health status and spending levels near those of the general population, many MRMIP enrollees do in fact have high utilization levels.
- *What could a deductible mean to accessing health care? Should disease management and chronic care be carved out of the deductible?* In order to prevent members from avoiding necessary wellness care, the high deductible plans should offer 100 percent coverage of preventative and chronic care services to ensure beneficiaries do not defer needed medical treatment due to cost pressures. This leaves the deductible to cover spending on expensive forms of care, such as inpatient hospital stays and prescription drugs.

- *How can MRMIP beneficiaries be made to better understand the possible impact of a high deductible plan?* If MRMIP decides to offer high deductible options, the pool should consider how best to educate its enrollees about the plan options available to them to facilitate decision-making based on the best financial and health outcomes for the individual. A high deductible necessarily means that the individual is assuming financial risk. While those enrollees with high incomes and assets will be better able to absorb that risk, all enrollees should clearly understand the risk they assume.

Conclusion

Although MRMIP's high risk pool differs in both significant and small ways from other high risk pools and the private market, the pool and its participating health plans are already utilizing most standard approaches to cost containment, including benefits and pharmaceutical management.

The key recommendations of this report cannot guarantee either long- or short-term cost savings, although there are some changes that could be made to MRMIP's benefit package and cost sharing designs to offer better quality care and a greater range of options to beneficiaries.

However, these recommendations may actually require additional funding:

- Disease and case management, while beneficial to members' health outcomes, result in slightly higher administrative costs without certainty in monetary return on investment.
- MRMIP contractors report using the same pharmacy and benefit management techniques with both their MRMIP and commercial populations. There is no obvious recommendation to use regarding these programs.
- MRMIP's current annual total benefits package limit, \$75,000, is lower than all other high risk pools. Allowing for a greater annual limit may greatly benefit the less than one percent of MRMIP beneficiaries who accrue higher annual costs and may not require any increase in state appropriations.
- By implementing a high deductible approach, MRMIP enrollees would generally reduce their premium costs, with cost increases in the deductible payment still resulting in a net savings for most enrollees. But under the state's risk sharing agreement with the MRMIP contractors, the lost premium dollars become a cost to the state. The critical question then becomes how to manage those lost premiums, and whether relatively healthy individuals who would have previously declined MRMIP would take up and add their premium dollars to the pool.

Appendices

Appendix A: The Role of Disease and Case Management in Health Plan Cost Containment Approaches: A National Perspective

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During the 1990s, managed care companies, often operating in very competitive environments, were known for aggressive approaches to containing costs. The approaches, including selective provider networks, provider risk contracting, primary care gatekeeping, and utilization review, which included prior authorization and continued hospital stay monitoring, increased steadily through the decade of the '90s, as did enrollment in health maintenance organizations, the most restrictive form of managed care. (Mays, Claxton and White, 2004). California was noteworthy for its particular reliance on what has been called the “delegated, capitation model,” which lodges financial risk and responsibility in medical groups and independent practice associations. Bearing risk for their own professional services and at times in the past even for hospital care and pharmaceutical spending, these organizations, in turn, administered the same forms of gatekeeper and medical management programs that in other parts of the country typically were performed by health plans directly. (Kerr et al., 1995)

Responding to the backlash to managed care that took place in the late 1990s, health plans discontinued or relaxed many of their cost containment tools in the early part of this decade. (Mays, Claxton, and White, 2004) It was during this period that plans began to emphasize programs that were not perceived as restrictive, but rather were intended to provide and to be perceived as providing value added, in an attempt both to improve care while reducing costs, and to improve health plans' reputations with the public. Disease and case management were the most important such programs and, plausibly, should be able to affect health care spending.

In recent years, plans have expanded these “helpful” additional programs to include health promotion and wellness activities and nurse advice lines. (Draper, 2007) The former encourage enrollees to pursue behaviors, including better eating practices and exercise, that affect their own health and well-being. Although they may have an effect to health care spending in the long run, if the prevalence and progression of common chronic conditions is altered through such life-style changes, there is unlikely to be much short-term effect on spending. Nurse advice lines provide plan enrollees with telephone access to a health plan clinician. Enrollees typically call with a range of issues that can be addressed through education and advice on self-care. They also advise enrollees to help triage particular health problems. Although some of the latter advice may head off unproductive emergency room or other visits, there is little to suggest that nurse advice lines can affect health care costs substantially.

With health insurance premiums again rising at unacceptable rates in the early part of this decade, health plans again looked at “regulatory” approaches to limiting physician autonomy to make medical decisions without oversight. They hoped that they had learned lessons from their prior attempts at utilization review and, to some extent, modified their previous approaches to limiting what they thought might be wasteful and unnecessary spending. Accordingly, some of

the new initiatives have involved carrots rather than sticks, that is, approaches that attempt to improve provider performance by providing them information about their comparative performance, based on provider profiling, sometime accompanied by education for outliers, and even bonuses, in the form of pay-for-performance (P4P) programs. (Felt-Lisk and Mays, 2002). The latter have expanded despite skepticism on the part of physicians and hospitals about health plan motivation. Yet, most P4P programs, especially those targeted to physicians, have focused on improving quality, primarily in the areas of primary and secondary prevention, rather than directly on excessive health care spending. (Rosenthal, et al., 2005)

Some plans have shifted the focus of their prospective review activities from inpatient to outpatient settings, introducing new prior authorization requirements for services such as outpatient and office-based surgery, expensive diagnostic tests, and high-cost pharmaceuticals and biologics such as injectable drugs and blood factor products. (Felt-Lisk and Mays, 2002). More recently, prior authorization has concentrated particularly on the rapid proliferation of advanced imaging services, including CT, MRI and PET scans, which increasingly are owned by physician practices and subject to overuse because of self-referral opportunities created by owner-physicians. (Berenson, Bodenheimer, and Pham, 2006). Health plans report seeing 20-40 percent annual growth increases in such imaging services, and hope that reinstating prior authorization, in this case often administered by third part contractors, would restrain use of such imaging.

So far, there is little data on whether this new wave of ambulatory-based U.R. actually affects physician behavior. Anecdotally, health plan chief medical officers believe that this prior authorization approach to advanced imaging substantially reduces the rate of increase in imaging services, even when there are low denial rates, perhaps through the sentinel effect that reduces the number of requests in the first place. Some also argue that a good third-party imaging utilization vendor can influence the choice of imaging workup, such that more appropriate imaging procedures are performed, thereby reducing redundancy and, in the case of CT and PET, potentially harmful radiation exposure.

Yet, there is concern that the pervasive use of such third-party prior authorization will again either produce a physician-patient backlash or, alternatively, be applied too ineffectively to actually restrain utilization. It is important to note that the most effective approach to restraining use might well be to reduce prices for specific services in order to take away the robust profits associated with particular services, including imaging services, which in turn stimulate physician entrepreneurial activity and resultant inducement to self-referral and resultant overuse. Although there has been a lot of dispute in the health economics literature about the role of relative prices in affecting physician ordering behavior, a strong case can be made that distorted pricing, that is, prices that diverge from the underlying marginal costs of production, can directly affect provider behavior. (Ginsburg and Grossman, 2005)

In short, a potentially reliable and effective approach to restraining utilization of services might be modifying prices paid to providers to change the marginal incentives for providing the services. Yet, health plans that pay physicians on a fee-for-service basis (in California, only PPOs), pay disproportionately more for imaging and other technical services than even Medicare's fee schedule, which has been criticized for continuing to reward technically-oriented

services such as imaging and tests disproportionately high relative to their underlying costs. (Ginsburg and Berenson, 2007). In many markets, health plans simply lack the market power to alter underlying relative values in fees they pay providers. Private plans overall pay higher fees than Medicare does and pay relatively more for the fastest growing services (CBO, 2006) In the face of these utilization pressures, they again are left to adopt prior authorization approaches that seem to have inherent limitations and in the past were poorly executed.

Another broad phenomenon that has occurred in recent years was the introduction of new utilization controls that had been confined to HMOs to preferred provider organization products, spurred on by substantial increases in both the popularity and cost of these looser products, (Felt-Lisk and Mays, 2002) which can be offered to self-funded, ERISA plans, as well as in fully insured products. The result has been a convergence of utilization management practices across products, resulting from some loosening of HMO controls and strengthening of PPO controls (Felt-Lisk and Mays, 2002), although, again, the situation is more complicated in California because of the presence of an integrated group-model HMO – Kaiser-Permanente and the delegated capitation model used routinely by other California HMOs.

Disease Management and Case Management

As noted earlier, health plans for various reasons have given attention to their disease management and case management approaches. A simple reality is that in virtually all health insurance products, whether private and public, a small percentage of beneficiaries make up a highly disproportionate percentage of spending. This phenomenon is not only true in Medicare, in which, in 2001, 5 percent of beneficiaries were responsible for 43 percent of spending, but holds for commercial market enrollees as well. (CBO, 2004b) In fact, health expenditures for the general population are even more concentrated. For example, in 1996, the costliest 5 percent of the U.S. population accounted for 55 percent of total health care spending. (Berk and Monheit, 2001) This pattern of disproportionate spending continues over many years, confirming the role of chronic conditions as a major source of high spending. For example, high cost beneficiaries in Medicare – those in the top 25 percent in terms of spending – accounted for 85 percent of annual expenditures in 2001 and 68 percent of five-year cumulative expenditures from 1997 through 2001. (CBO, 2004b).

The data provide a strong rationale for identifying the relatively small group of potentially high cost beneficiaries and designing effective intervention strategies to reduce their spending. Unfortunately, the culture and structure of medical practice often limit physicians' interest and ability in meeting the complex needs of patients with one or more complex chronic medical conditions. (Berenson, 2006) Busy, frontline physicians are susceptible to the "tyranny of the urgent," focusing their attention on patients with acute, often self-limited problems, rather than engaging in the more time consuming management of usually non-demanding patients with chronic problems. (Wagner et al, 1996). Physicians typically emphasize making diagnoses, "ruling out" serious disease, and recommending curative and symptom-relieving treatments, rather attending to the minutia involved with managing the less urgent, but predictable, needs of patients with chronic illness. Further, physicians in traditional practice lack the time, often the information technology, and certainly the financial incentives to systematically improve the level of case management and care coordination provided to patients with chronic conditions.

While it sounds appealing to at least provide payments to physicians for better care coordination, there are theoretical and practical problems with extending fee-for-service payment methodologies to physician activities related to chronic care management. (Berenson and Horvath, 2003). Accordingly, a disease management industry has developed to fill the vacuum left by lack of physician practice attention to the chronic care management.

According to the Disease Management Association of America (DMAA), comprehensive disease management (DM) programs include all of the following components (DMAA):

- Population identification processes;
- Evidence-based practice guidelines;
- Collaborative practice models to include physician and support-service providers;
- Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance);
- Process and outcome measurement, evaluation, and management;
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers and practice profiling).

Not all of these components have been adopted in all disease management programs, and, indeed, the DMAA considers programs consisting of fewer than all six components to be disease management support services, not a full DM program. In particular, some have suggested that an ongoing barrier faced by DM programs is their inability, or, in some cases, unwillingness to engage practicing physicians, who have the primary responsibility for decision-making about their patient's health care. (Berenson, 2004, Leider, 1999) As noted earlier, for their part physicians may be reluctant to engage with third-party disease management vendors, whether because of lack of appreciation of the value of the services provided or time pressures and lack of compensation even for their time of interacting with DM company nurses or other personnel.

In practice, third-party disease management vendors typically focus on identifying chronically ill patients and communicating frequently with them (usually by phone) to help them self-manage their conditions and head off more serious problems that could result in unnecessary interventions and avoidable hospitalizations. (Villagra, 2004) Sophisticated health plans that offer disease management in-house and disease management companies, use predictive modeling, decision-support software, and remote monitoring devices to complement the core nurse-patient communication approach.

Often targeting different interventions to various subsets of the chronically ill population, these organizations primarily serve a surveillance function—to assure that the patient's treatment plan is being adhered to and to detect any deterioration in clinical status. Some programs also engage patients in self-management education by phone. (Casalino, 2005)

Typical conditions for which disease management is directed include: diabetes mellitus, congestive heart failure, asthma, and pregnancy/ high risk-pregnancy. (Welch, et al, 2002, Felt-Lisk and Mays, 2002). Other conditions sometimes targeted include coronary artery disease, oncology, lower back pain, depression, and chronic obstructive pulmonary disease. The relative

contributions of the various components of comprehensive disease management vary by condition.

For example, the focus of disease management for congestive heart failure (CHF) is surveillance to detect early deterioration in the patient's clinical state, with intervention at that point. In contrast to CHF, much of the disease management activity associated with diabetes mellitus involves patient education and motivation, rather than disease surveillance, which is performed by the patient's physician based on clinical and laboratory test monitoring.

In the case of CHF, a DM nurse would be empowered, by protocol, to alter the patient's treatment regimen, perhaps by increasing the dosage of diuretics temporarily until the patient has returned to their baseline, stable state. In many cases, however, the lack of relationship with the patient's personal physician requires the DM nurse to urge the patient to contact her own physician with the information gleaned through the nurse's surveillance.

Many health plans and third party disease-management companies have recognized that high-risk and high-cost patients often have multiple conditions that interact with each other, and therefore that it might be more effective to adopt a patient-specific, rather than condition-specific approach to care management. Commonly, plans identify for "case management" a relatively small number of cases in which members incur very high costs. In fact, the term case management has been used for many years by health plans to support care for a particular subset of patients who typically are the most complex. These patients—often categorized as "vulnerable" and "frail"—are at higher risk for being hospitalized and having adverse health outcomes due to a combination of health, functional, and social problems. (Chen, et al, 2002) Because these patients are defined less by their clinical diagnoses than by their functional limitations, case management sometimes involves an approach more customized to the individual needs of particular patients than disease management.

Case management, like disease management, mainly is delivered by telephone. But case management focuses less on the condition and more on functional abilities (such as activities of daily living), social issues (such as caregiver burden and transportation needs), and emotional effects (such as depression and loneliness). (Chen, et al, 2002) It is not uncommon in health plan and vendor-based disease management programs to triage patients from disease management to case management as a patient's condition worsens. Patients in case management usually are at higher risk for unanticipated hospitalizations and other costly care than are patients in disease management. Often, disease management and case management are performed by different professionals but working in the same organization. Occasionally, there may be a sharp separation, such as when a health plan contracts out to a third-party, disease management vendor for DM for specific conditions, while maintaining its own case management services for an array of patients with complex health needs.

What is the Pay-off from Disease and Case Management?

Disease and case management have become ubiquitous in U.S. health care. Yet, because of the heterogeneity of case management interventions tested and outcomes evaluated, it is difficult to analyze overall patient well-being and costs of this approach --despite its inherent logic.

(Ferguson and Weinberger, 1998, Wolff and Boulton, 2005) In fact, there is a remarkably small evidence-base on which to measure the success of these administratively costly approaches, on quality or, especially on cost, even as health plan and independent disease management company officials tout their effectiveness.

Several recent literature reviews have found insufficient evidence to conclude that disease management reduces health-related costs, even for patients whose medical needs are less complex than those of Medicare enrollees who often have five or more chronic conditions. (Ofman et al, 2004, CBO, 2004a). The CBO found a number of problems with the existing research done on the impact of disease management programs.

First, most of the studies did not account for all costs, failing short on capturing administrative costs of the intervention itself and health care spending other than hospital and emergency department spending. Further, studies usually failed to randomize individuals, to an intervention group and to a reference group, thereby introducing a significant bias into any analysis. Perhaps the biggest methodological problem was comparing costs about a disease management program with benchmark costs for the same population in the prior year. Selecting patients based on high spending and then seeing a reduction in costs in subsequent years might simply reflect a statistical phenomenon known as “regression to the mean.” For example, although as noted above there is persistence of high spending among Medicare beneficiaries in subsequent years, the CBO found that only 44 percent of the top quartile of spenders in Medicare’s traditional program in 1997 remained in the top quartile in 1998. (CBO, 2004b)

Demonstrating the methodological and substantive concerns that the CBO identified, researchers at the Permanente Medical Group in Northern California, evaluated the cost impact of their extensive portfolio of disease management programs. Examining quality indicators, utilization, and costs for 1996-2002 for adults with four chronic conditions, researchers found evidence of substantial quality improvement but not cost savings. They concluded that the causal pathway – from improved care to reduced morbidity to cost savings – did not produce sufficient savings to offset the rising costs of improved care. (Fireman et al, 2004)

As often invoked, “the absence of evidence is not proof of absence” of effect. The Medicare Modernization Act in the Section 721 – originally called the Chronic Care Improvement Program and, now, the Medicare Health Support Program (MHSP) -- is piloting disease management for Medicare beneficiaries with severe congestive heart failure and diabetes in a research design that includes beneficiary randomization in an “intent to treat” design. The pilot adopts the approach that is widely used by private plans, which either perform it directly or contract with third-party vendors. An important component of the MHSP pilot is that the contractors are at financial risk for achieving savings overall Medicare spending and could suffer substantial financial losses if they fail.

Although, to date, CMS has not released first year results of the success of the MHSP pilot of disease and case management, a few of the contractors who won awards for particular geographic areas, including Mississippi and Oklahoma, have recently withdrawn from the program strongly implying that they were not able to achieve enough cost savings to justify their own financial commitment to the program. If disease management firms cannot achieve savings in Medicare, working on CHF, a condition associated with substantial rates of avoidable re-

hospitalizations (citation), one must ask whether the broad adoption of third-party disease management by private health plans is justified in the absence of controlled trials of effectiveness and cost-effectiveness.

An alternative approach to improving the care provided to patients with chronic conditions directly involves redesigning the actual practice settings in which these patients receive their primary care. Many of these interventions have been modeled after the Chronic Care Model, developed by Ed Wagner and colleagues at the MacColl Institute at Group Health Cooperative of Puget Sound. (Wagner et al, 1996, Wagner et al 2001, Bodenheimer, Wagner and Grumbach, 2002) Importantly, incompatibility with Medicare and private plan payer approaches have limited the expansion of these models - for the most part they remain fringe programs that seem to be adopted in capitated health plans but may have trouble continuing after research-based funding ends, in predominately fee-for-service environments. (Berenson and Horvath, 2003) Looking at the various approaches to these comprehensive, integrated care models, a recent evaluation concluded that their operating costs are high, their penetration into mainstream health care has been limited, and their ability to improve chronic care or reduce costs remains uncertain. (Wolff and Boulton, 2005)

In short, there is an emerging consensus that a major focus of cost containment efforts should be the relatively small, but growing, proportion of individuals with one or more serious chronic conditions. Yet, to date, there does not appear to be a model of chronic care coordination that has proved to be cost-effective in a fee-for-service payment environment. Recently, the American College of Physicians and American Academy of Family Practice and other specialty societies have developed a proposal for what they are now calling the “patient-centered medical home,” modeled after long-standing approaches used in pediatrics and adopted by some state Medicaid agencies in the so-called Primary Care Case Management (PCCM) model. (American College of Physicians) This approach shares with the Wagner Chronic Care Model the need to substantially redesign how care is delivered in primary and principal care settings.

Indeed, some have argued that the only way to produce a redesign of primary care practices to make it more relevant for the high cost patients with chronic conditions is to fundamentally move away from fee-for-service and to adopt an improved version of primary care capitation. (Goroll, et al, 2007) Interestingly, California already has much more sophisticated form of capitation, appropriately lodging responsibility and risk at the multi-specialty group level, rather than at the individual physician or practice level, as in the new Medical Home models. Indeed, policy analysts increasingly are talking about the need to re-create the delegated, California model, as virtually all other efforts at cost containment, built on a fee-for-service payment platform have proved ineffective.

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Appendix B: High Risk Pool Health Plan Benefits Structure Surveys: Methodology

For this study, it is critical to have a comprehensive understanding of the disease, case and benefits management programs currently in place for the plans contracting with MRMIP. To do this, Harbage Consulting developed a questionnaire to interview all four plans either in person or by phone conference. Results from these interviews are discussed in the findings section of this paper, and complete results can be found in Appendices C, D, and E.

It is also important to know how California's management practices compare to other states. To do this, Harbage Consulting used the same questionnaire to profile five other states. The states, chosen with the help of Bruce Abbe of Abbe Communications, all have chronic care systems in place, though the plans used unique combinations of methods. Results from this survey can be found in Appendices G, H, and I.

The second part of the study focused on the role of deductibles, and high deductibles, in providing health care coverage for high risk pools. California is unique among high risk pools in exclusively offering first dollar coverage. All other states offer a choice of plans that better resemble their state's individual or small-group market. Just as for the benefit management section, Harbage Consulting developed a standardized questionnaire to interview both MRMIP health plans and the high risk pools in other states. Results from these interviews are found in the body of the paper and the following appendices.

Appendix C: High Risk Pool Health Plan Benefits Structure Surveys: Disease Management Benefits in MRMIP

| <i>Disease Management Benefits in MRMIP</i> | | | | |
|---|---|--|--|--|
| Pg. 1 | Blue Cross of California (PPO) | Blue Shield of California (HMO) | Contra Costa Health Plan (HMO) | Kaiser Permanente (HMO) |
| Diseases Covered | Diabetes, asthma, pregnancy and cardiovascular (congestive heart failure and corotid artery disease). | Diabetes, asthma and cardiovascular (congestive heart failure and corotid artery disease). | Asthma (all ages) and diabetes (adults only) | Asthma, breast cancer, cancer, cholesterol management, chronic kidney disease, chronic pain, complex chronic conditions, congestive heart failure (CHF), coronary artery disease, diabetes, elder care, high-risk pregnancy, HIV/AIDS, hyperlipidemia,* hypertension,* pain management, preventive care, and stroke* (* treated as a comorbidity of another condition) |
| Available to MRMIP members? | Newly available for eligible MRMIP beneficiaries both through case management referrals and claims data identification processes. | Eligible MRMIP beneficiaries will have access to these services effective September 1, 2007. | Yes, not based on payer source. | Yes, based on patient need, not payer source. |

| p. 2 | Blue Cross of California (PPO) | Blue Shield of California (HMO) | Contra Costa Health Plan (HMO) | Kaiser Permanente (HMO) |
|-------------------------------|---|---|---|--|
| Member Identification | <ul style="list-style-type: none"> • Medical and pharmacy claims data • Self referral • Physician referral • Take Charge of your Health -- Self-Care Initiative | <ul style="list-style-type: none"> • Claims data: medical, pharmaceutical, laboratory and total monthly • Referrals from case management, physicians, and patient • Johns Hopkins predictive modeling tools, HEDIS data, and high cost and chronic stratification data | <p>Asthma:</p> <ul style="list-style-type: none"> • Claims data • ER visits • Physician referrals <p>Diabetes:</p> <ul style="list-style-type: none"> • Referrals • Patient screening. | <p>Disease-specific case identification protocols through our clinical information systems:</p> <ul style="list-style-type: none"> • Clinical and administrative information from pharmacy, laboratory, outpatient encounters • Hospital discharge data systems. |
| Outreach | <p>Mail and phone calls.</p> <p>If an identified patient has not seen a physician within 12 months, the program follows up.</p> | <p>Members sent one letter and three phone calls to:</p> <ul style="list-style-type: none"> • Invite them into the program • Provide information on the 1-800 helpline and the web education information. | <p>Members receive two phone calls and one mailing seeking their participation in the program and educational material.</p> | <p>Services are integrated in health services.</p> |
| Required Participation | <p>Automatic enrollment.</p> | <p>Automatic enrollment.</p> | <p>Opt-in.</p> | <p>Automatic enrollment.</p> |

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| <p>p. 3</p> | <p>Blue Cross of California (PPO)</p> <ul style="list-style-type: none"> • Educational materials. • Health class enrollment • Assistance in changing primary care physician, if requested. • Help scheduling medical appointments. • Transportation, if needed. • Referrals to Community Resource Centers. • Access to a 24 hour nurse information line. | <p>Blue Shield of California (HMO)</p> <ul style="list-style-type: none"> • Phone contact and access to a disease management nurse • Provide education, support and reinforcement • Overall goal is to improve the member's ability to self manage by identifying their openness or barriers to change and involving them in setting and reaching achievable goals | <p>Contra Costa Health Plan (HMO)</p> <p><u>Asthma Program</u>: Nurse-lead team approach, which includes:</p> <ul style="list-style-type: none"> • In-home visits to identify environmental contributors • Physician collaboration • Education and incentives for self-management <p><u>Diabetes Program</u></p> <ul style="list-style-type: none"> • Self management education • Collaboration with primary care physician • Incentives for getting recommended screenings | <p>Kaiser Permanente (HMO)</p> <p><u>Low to Moderate</u>: Foster self-care and lifestyle changes through condition-specific educational programs, preventive services, and monitoring.</p> <p><u>High</u>: Individual monitoring by clinical case manager and a specialist, who are primary care coordinators.</p> |
| <p>Performance Measurements</p> | <p>Positive health outcomes:</p> <ul style="list-style-type: none"> • Between 2004 and 2005, there was a 50% drop in asthma inpatient admits and a 47% drop in asthma ER visits. • For diabetes, there was a 4% decline in inpatient admits and a 1% drop in ER visits. | <p>Success measured by health outcomes. No ROI information available.</p> | <p>Focuses on health outcomes, measured by quarterly evaluations using HEDIS measures and quality of life surveys. Also tracks hospital inpatient admits per 1000 and ER visits. Admits have decreased and ER visits remain stable.</p> | <p>Clinical data.</p> <ul style="list-style-type: none"> • Use HEDIS reports, which evaluate the effectiveness of care for specific diseases, including asthma and diabetes • Internal clinical measures using regional systems to track pharmacy and lab utilization, and office visits, then measure each program's performance long-term. |

Appendix D: High Risk Pool Health Plan Benefits Structure Surveys: Case Management Benefits in MRMIP

| <i>Case Management Benefits in MRMIP</i> | | | | |
|--|--|--|--|---|
| Pg. 1 | Blue Cross of California (PPO) | Blue Shield of California (HMO) | Contra Costa Health Plan (HMO) | Kaiser Permanente (HMO) |
| Diseases Covered | Diabetes, asthma and cardiovascular (congestive heart failure and corotid artery disease). Also runs programs for obesity pain management, acute rehab, and transplant patients. | Diabetes, hypertension, cystic fibrosis, major depression and anxiety (as a comorbidity), morbid obesity, complications from surgery, cardio myopathy, and traumatic brain injury. | Asthma, diabetes and comorbid conditions. Also offers mental health case management. | Geriatric population, members with comorbidities. |
| Available to MRMIP members? | Yes. | Yes. | Yes. | Yes, benefit is based on patient need, not payer source. |
| Member Identification | <ul style="list-style-type: none"> High-risk patients. Patients with comorbidities. | <ul style="list-style-type: none"> Hospitalization claims data. Authorizations for certain diagnoses. Readmission to an acute care facility. Admission to a long-term care facility. | <ul style="list-style-type: none"> Claims data. Physician or Member Service referrals. Some emergency department patients. MRMIP members with \$50,000 to \$60,000 of paid claims. | <ul style="list-style-type: none"> Clinical information systems: high rates of hospital admission, emergency room use, or medical office use. Patients with Senior Health Assessment high frailty scores. Physician referrals. |

| p. 2 | Blue Cross of California (PPO) | Blue Shield of California (HMO) | Contra Costa Health Plan (HMO) | Kaiser Permanente (HMO) |
|-------------------------------|---|---|---|--|
| Outreach | <p>Mail and phone calls.</p> <p>If an identified patient has not seen a physician within 12 months, the program follows up.</p> | <p>Plan contacts member at least twice and receives verbal and written consent for participation.</p> | <p>Letters, mailings, and phone calls.</p> | <ul style="list-style-type: none"> • Outreach programs at some medical centers designed specifically for members with chronic conditions. • Outreach during member identification process. |
| Required Participation | <p>Identified members are automatically enrolled and must opt-out of program.</p> | <p>Voluntary.</p> | <p>Automatic enrollment.</p> | <p>Automatic enrollment.</p> |
| Services Provided | <ul style="list-style-type: none"> • Screening and specialist referrals. • Assistance with coordination of care and complex needs. • Member education, mentoring and coaching to ensure adherence of treatment plan • Pre- and post-status physical and mental health surveys | <ul style="list-style-type: none"> • Case management nurses generate patient-specific, goal-oriented care plans based on a health evaluation and assessment. • Nurses make periodic phone calls to remind the patient of appointments and necessary tests. • Hospitalized members also are assigned nurses to ensure they are receiving the right level of care after discharge. | <ul style="list-style-type: none"> • Case and disease management nurses collaborate with primary care physicians to guide member through the system and maximize the benefit, for example, coordinating doctor's appointments. • Program also offers mental health and social work support. | <ul style="list-style-type: none"> • Integrated decision support tools for our physicians • Implementation of evidence-based guidelines • Care management steering committees at the medical center level • Skill-building workshops led by peers with same condition to encourage self-management including nutrition, exercise, relaxation, medication usage, communication, and coping with emotions. |

Appendix E: High Risk Pool Health Plan Benefits Structure Surveys: Pharmaceutical and Benefits Management in MRMIP

| <i>Benefits Management in MRMIP</i> | | | | |
|-------------------------------------|---|---|---|--|
| | Blue Cross of California (PPO) | Blue Shield of California (HMO) | Contra Costa Health Plan (HMO) | Kaiser Permanente (HMO) |
| Pg. 1 | | | | |
| Cost Containment Challenges | Helping MRMIP members manage their benefits, in particular helping them stay under the \$75,000 annual limit. | The \$75,000 limit within the MRMIP benefit structure | Managing and monitoring the \$75,000 annual limit is the biggest challenge for high-risk MRMIP members. | Sees part of its core mission as Benefits Management and Utilization Management. |
| Cost Containment Approaches | Steps used for MRMIP are same as in private market. | Steps used for MRMIP are same as in private market. Enhanced utilization management approach: <ul style="list-style-type: none"> • 15 on-site case managers in 40 hospitals throughout the state who oversee both hospital and local physician group claims. • Fraud and abuse unit investigates fraudulent billing practices. • Manages plan through 16 regional network for community-based health and facilities planning. | Steps used for MRMIB are same as in private market. Utilization management controls to covered services. <ul style="list-style-type: none"> • Nurse advice line service. • Provider audits. • Quarterly pharmaceutical benefit reviews. • Reviews hospital stays after release, prior to admission and during a patient's stay. • Prior authorization for hospitalizations, specific procedures and advanced imaging services | Steps used for MRMIB are same as in private market. |

| <i>Pharmaceutical Benefits Management in MRMIP</i> | | | | |
|--|--|--|---------------------------------------|---|
| | Blue Cross of California (PPO) | Blue Shield of California (HMO) | Contra Costa Health Plan (HMO) | Kaiser Permanente (HMO) |
| Pg. 2 | | | | |
| Pharmacy Benefits Manager | Handled internally. | Uses an internal pharmacy benefits manager, but contracts with Argus to process claims data. | Internal staff and PBM-Perform RX | Handled internally. |
| Formulary Development | Developed by a California-based committee made up of relevant experts. | Developed by a California-based committee made up of physicians and pharmacists both internal and external to the network, and from both the community and academia. | Uses one formulary. | Developed by physicians and pharmacists, who evaluate medications by researching relevant medical literature and clinical experiences. Recommendations for formulary additions or deletions are presented to regional pharmacy committees, which meet quarterly to review new drugs and drug information. |

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| <p>Generic Formulary Preferences</p> | <p>Promotes use of generics.</p> | <p>Tiered Payments:</p> <ul style="list-style-type: none"> • Retail and mail order prescriptions charge about \$5 to \$10 less for generics. • Medications off formulary and requiring preauthorization are also priced higher. • 84% of pharmaceuticals are generics and there is a 95% compliance rate to the formulary. | <p>Mandatory generic program. Requires preauthorization for non-generics per doctors orders. Coverage based on medical necessity.</p> | <p>Use generics whenever possible.</p> |
| <p>Other approaches?</p> | <p>None discussed.</p> | <ul style="list-style-type: none"> • Is establishing a real-time preauthorization process for off-formulary medications. • Alerts pharmacists and physicians if members are overutilizing controlled substance drugs. • Makes dosage edits based on FDA guidelines, requires OTC trials before some prescription alternatives. • Daily claims audits. | <p>Pharmacist committee reviews research on drugs.</p> | <p>Established regional pharmaceutical management teams composed of physicians and pharmacists who examine drug utilization. Teams review clinical literature to help physicians develop and implement pharmacy guidelines.</p> |

Appendix F: High Risk Pool Health Plan Benefits Structure Surveys: States Chosen for Disease and Chronic Care Management Study

For the disease and case management survey, we chose five programs that have among the most extensive disease management programs in use by state high risk pools

Methodology - To conduct the survey, Harbage Consulting and its co-researcher Bruce Abbe, of Abbe Communications, forwarded a detailed list of questions and discussion subjects on disease and case management that were developed in conjunction with the MRMIB staff. We then conducted in-depth telephone interviews, each lasting between 1 ½ to 2 hours, with participants in each of the states. Two people from the consulting study team participated on each call, which were recorded with the understanding that it was for internal accuracy purposes only. The state participants included the executive director/president in all five states, along with two additional senior program managers in two states.

The states chosen for the disease and case management study were:

- CoverColorado*: Colorado's state risk pool, CoverColorado, has been on leading-edge of high risk pools for several years in adopting disease management programs and delivering integrated case management programs for its members. CoverColorado now serves approximately 5,600 members. Recently CoverColorado transitioned from using separate outside vendor companies for disease management and case/utilization management to a new start-up company that is delivering integrated case management for members statewide. CoverColorado also uses some of the most sophisticated predictive modeling software and tracking programs for its case management programs. While its disease management services are provided through a vendor, CoverColorado has played a very integral role in the development of the service model provided by the new company.
- Minnesota Comprehensive Health Association (MCHA)*: MCHA has been the largest high risk pool in America, serving approximately 30,000 people, for many years. It is also one of the two oldest state programs, dating back to 1977. Through its third party administrator, one of the largest health plans serving the state, MCHA offers disease management services covering 33 chronic conditions. With assistance from an additional outside provider, MCHA also offers disease management for 14 rare diseases. We hoped to learn about outcomes and service delivery from the largest pool with the most extensive list of diseases served.
- Indiana Comprehensive Health Insurance Association (ICHIA)*: Similar to Minnesota, the Indiana state high risk pool offers an extensive list of disease management services to its members. ICHIA's services have been provided through an outside vendor system that covered 15 rare diseases. Later this year, ICHIA will be changing to a new vendor that will focus on six common diseases – asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), and back pain issues. ICHIA has also developed its own, internal coordinated care management program for hemophilia, perhaps the most

costly of diseases. It now is working to develop another internal program focusing on cardiovascular care.

- *Connecticut Health Reinsurance Association*: Connecticut's state high risk pool, the Connecticut Health Reinsurance Association (HRA) is the oldest state high risk pool, having been passed just ahead of Minnesota's state risk pool in 1976 and beginning operations in 1977. Connecticut offers one managed care plan through the HealthNet health maintenance organization; a PPO plan administered by United Health Care. It also runs a Special Health Plan for low-income residents that benefits from lower reimbursement to providers, also administered by United. HRA offers disease management services to its members for diabetes, heart disease, asthma and other chronic diseases. HRA's disease management systems use predictive modeling to identify individual members to rank their chronic illness risk level and, when necessary, provide integrated services to address multiple diseases.
- *Maryland Health Insurance Plan (MHIP)*: Begun in 2003, MHIP is one of the newer state risk pools, but has grown rapidly and now serves nearly 10,000 members. MHIP offers disease management services covering diabetes type I and II, pediatric and adult asthma, COPD and heart failure. MHIP offers an exclusive provider organization (EPO) managed care plan similar to an HMO, along with PPO plans with different deductibles. MHIP's disease management services are provided through its third party administrator, although they are changing firms later this year.

Appendix G: High Risk Pool Health Plan Benefits Structure Surveys: Disease Management in Other States

| <i>Disease Management Benefits in Other States</i> | | | | | |
|--|--|---|---|--|---|
| | Colorado: Cover Colorado | Connecticut: Health Reinsurance Association | Indiana: Comprehensive Health Insurance Association | Maryland: Maryland Health Insurance Plan | Minnesota: Comprehensive Health Association |
| Diseases Covered | Colorado uses a case management model that does not stratify members by disease. | Diabetes, asthma and heart disease. | Asthma, diabetes, congestive heart failure, back pain, chronic obstructive pulmonary disease, hemophilia and cardiovascular disease. Adding HIV/AIDS by 2008. | Diabetes I and II, chronic obstructive pulmonary disease, pediatric and adult asthma, and heart failure. May expand to: end stage renal failure, major depression and high-risk pregnancy. | Covers more than 45 common and rare conditions including: diabetes, hypertension, coronary artery disease, rheumatoid arthritis, multiple sclerosis, lupus and Parkinson's disease. |
| Triggers or Eligibility | <ul style="list-style-type: none"> Review of new members health history forms. Monthly review of paid claims, prescription drug utilization and preexisting condition information data. Also uses advanced modeling for better identification from claims data. | <ul style="list-style-type: none"> Medical claims information. Also uses advanced predictive modeling for better identification from claims data. | <ul style="list-style-type: none"> Member health history reporting in application process. Also uses referrals and utilization data. | <ul style="list-style-type: none"> Voluntary health status survey at time of enrollment. Claims tracking. | <ul style="list-style-type: none"> Self-reporting and referrals. Claims data. Physician referrals. |
| Outreach | Every new member is contacted by their nurse case manager by phone, email or letter within 30 days of enrollment. | Identified at-risk members are referred to care coordinators. Those members also receive letters and phone calls. | Through a member orientation process, patients are targeted according to their disease. | Follow-up questionnaires and phone calls to members identified through voluntary survey. | Identified members receive written information on how to access available services. |

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|-------------------------------|--|--|--|---|---|
| Pg. 2 | Colorado: Cover Colorado | Connecticut: Health Reinsurance Association | Indiana: Comprehensive Health Insurance Association | Maryland: Maryland Health Insurance Plan | Minnesota: Comprehensive Health Association |
| Required Participation | Yes, as a condition of their eligibility in the program. | Voluntary. | Mandatory participation. | Voluntary. | Voluntary, but members must opt out of program. Eligible members participate at rates of 95-98%, depending on the program. |
| Services Provided | Nurse case managers guide participating members through the system and provide disease-specific information. | Varies by vendor, but all follow best practices in their market. | Member education at townhall meetings and through website. | <ul style="list-style-type: none"> • Phone calls consultations for participating members. • Education programs promote patient self-management. | <p>Services are stratified according to the level of severity of the disease, but services include:</p> <ul style="list-style-type: none"> • Websites with program and disease information. • Educational newsletters. • Telephone risk assessments. • Depression screening. • Physician treatment plan follow-up. |

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| <p>Pg. 3</p> <p>Performance Measurement</p> | <p>Colorado: Cover Colorado</p> <p>Rewards vendors based on certain performance criteria, but does not believe there is credible return-on-investment information, and believes patients, not providers, are responsible for health outcomes.</p> | <p>Connecticut: Health Reinsurance Association</p> <p>Does track information such as length of hospital stays and related network cost savings, but generally believes this particular population needs new and different benchmarks than the general population, and is more focused on providing better care than cost savings.</p> | <p>Indiana: Comprehensive Health Insurance Association</p> <p>Reviews health outcomes as well as individual and group reduced costs.</p> | <p>Maryland: Maryland Health Insurance Plan</p> <p>The administering health plan provides return on investment data, but that information is not independently audited.</p> | <p>Minnesota: Comprehensive Health Association</p> <p>Developing their own custom return-on-investment system with program administrators and independent actuarial firm. Will measure both cost savings and customer satisfaction.</p> |
| <p>Third Party Vendor</p> | <p>Newly formed Common Sense Medical Management (CSM2) created to serve Care Colorado's case management needs.</p> | <p>Each health plan provides its own service.</p> | <p>Uses third-party disease management vendor in addition to internal programs.</p> | <p>Participating health plan runs program in-house.</p> | <p>Programs administered by pool, third-party health plan administrator and outside disease management companies.</p> |

Appendix H: High Risk Pool Health Plan Benefits Structure Surveys: Case Management in Other States

| <i>Case Management Benefits in Other States</i> | | | | | |
|---|--|--|--|--|--|
| | Colorado: Cover Colorado | Connecticut: Health Reinsurance Association | Indiana: Comprehensive Health Insurance Association | Maryland: Maryland Health Insurance Plan | Minnesota: Comprehensive Health Association |
| Triggers or Eligibility | All members with two or more comorbidities are provided case management. Eligible members are identified through claims. | At the discretion of each plan. Uses predictive modeling to identify candidates. | <ul style="list-style-type: none"> Member health history reporting in application process. Also uses referrals and utilization data. | <ul style="list-style-type: none"> Voluntary health status survey at time of enrollment. Claims tracking. | <ul style="list-style-type: none"> Self-reporting and referrals. Claims data. Physician referrals. |
| Outreach | The surveyed state pools use the same outreach and enrollment process in their case management programs as they do in their disease management programs. Please see Appendix G for more details. | | | | |
| Required Participation | The surveyed state pools have the same participation requirements in their case management programs as they do in their disease management programs. Please see Appendix G for more details. | | | | |
| Services Provided | Enrollees are assigned care coordinators who are available 24 hours a day to help navigate the system: <ul style="list-style-type: none"> Ensure members attend appointments, receive tests, etc. Arrange follow-up care. Approve all major decisions, seeking preauthorization for care outside of contract. Help "coach" patients. | Participating members are assigned care coordinators who use best clinical practices to help patients from experiencing further medical complications. | Specific outreach programs per disease. Specialists are hand picked. | Use evidence-based resources and best practices manual to deal with each case. Care coordinators provide phone call check-ins for patients, and the occasional in-person visit, to monitor health and ensure members are receiving all the care they need. | Provides services designed to improve patient care and to coordinate benefits utilization: <ul style="list-style-type: none"> Case management to integrate and coordinate care. Social-related care consulting. Financial assistance consulting. Managing referrals to specialists. Managing high-costs claims and preauthorization requests. |

| Pg. 2 | Colorado: Cover Colorado | Connecticut: Health Reinsurance Association | Indiana: Comprehensive Health Insurance Association | Maryland: Maryland Health Insurance Plan | Minnesota: Comprehensive Health Association |
|---------------------------------|---|---|--|---|---|
| Performance Measurements | Surveyed state pools reported using the same performance measurements for their case management programs as they do for their disease management programs. Please see Appendix G for more details. | | | | |
| Third Party Vendor | <p>Colorado's is unique in offering just one case management program for its high risk pool members, rather than segmenting members into separate disease and case management programs. This comprehensive case management program is operated by a new type of third-party case management firm designed to meet the specific needs of high risk pool populations.</p> | <p>The pool's participating carriers administrate case management programs.</p> | <p>A third party vendor outside of the pool's health plan administrator provides disease and case management services.</p> | <p>In-house case management programs are offered to members through the pool's participating health plan.</p> | <p>The pool's participating carrier administrates case management programs.</p> |

Appendix I: High Risk Pool Health Plan Benefits Structure Surveys: Benefits and Pharmaceutical Management in Other States

| <i>Benefits Management in Other States</i> | | | | | |
|--|---|--|---|--|--|
| | Colorado: Cover Colorado | Connecticut: Health Reinsurance Association | Indiana: Comprehensive Health Insurance Association | Maryland: Maryland Health Insurance Plan | Minnesota: Comprehensive Health Association |
| Pg. 1 | | | | | |
| Cost Containment Challenges | Of the pool's 5,000 members, 200 incur 70 percent of costs. Of those 200, roughly one third have cancer, one third are orthopedic cases and one third have other chronic illnesses. | None Highlighted | Some members have particularly costly diseases, which must be managed. | Between 15 and 20 percent of members are significantly more costly than the rest. Five percent of members have HIV/AIDS and are covered under Ryan White, and with their significant medical care and pharmaceutical costs cause higher loss ratios. | Nearly 13 percent of the pool's population has chosen to participate in a care management program. Staff reports the biggest challenge is to get people with chronic conditions involved in their health care. |
| Cost Containment Approaches | <ul style="list-style-type: none"> Cost containment stems from case management practices that ensure patients receive the appropriate care when they need it. The pool does not use restricting services as a method of containing costs. | Both participating health plans use best clinical practices. | <ul style="list-style-type: none"> Provides case management for members with high cost diseases. There are some lifetime maximums. Eliminates cost for preventive care. No co-pays for maintenance drugs and some vaccinations. | Take a lifelong cost management approach, requiring prior authorization for 25 conditions. | Case management is closely tied to utilization management, and involve prior authorization and management of high cost claims to help control costs. Their third party administrator has focused on managing high technology imaging services, and that management has resulted an approximate 15 percent decrease in radiology costs. |

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| <p>Pg. 2</p> <p>Recent Changes In Benefits To Reduce Costs</p> | <p>Colorado: Cover Colorado</p> <p>Co-pays for preventive care, some scheduled benefits and some vaccinations were eliminated to change member incentives.</p> | <p>Connecticut: Health Reinsurance Association</p> <p>Three years ago the pool raised deductibles and co-pays.</p> | <p>Indiana: Comprehensive Health Insurance Association</p> <p>Is considering covering healthy lifestyle programs to address obesity such as weight reduction programs or exercise groups.</p> | <p>Maryland: Maryland Health Insurance Plan</p> <ul style="list-style-type: none"> Increased the out-of-pocket limit from \$2,000 to \$3,000 in the \$500 deductible plan and from \$2500 to \$3500 in the \$1000 deductible plan. Increased co-pays on prescription drugs by \$5 to \$12. Plan has adopted a two-month preexisting condition exclusion for new applicants. | <p>Minnesota: Comprehensive Health Association</p> <p>None.</p> |
| <p>Medical Management Tools</p> | <ul style="list-style-type: none"> Primary care case managers channel and approve referrals. Preauthorization required for hospitalizations, some specific procedures and advanced imaging services. Continued hospital stay review. Use of health technology assessment and cost-effectiveness analysis in coverage and medical necessity decisions. Discharge planning. | <ul style="list-style-type: none"> Primary care case managers channel and approve referrals. Preauthorization required for hospitalizations, some specific procedures and advanced imaging services. Continued hospital stay review. Use of health technology assessment and cost-effectiveness analysis in coverage and medical necessity decisions. | <ul style="list-style-type: none"> Primary care case managers channel and approve referrals. Preauthorization required for hospitalizations, some specific procedures and advanced imaging services. Pay for performance, selective contracting and use of high performance networks. Use of technology assessment and cost-effectiveness analysis in coverage decisions. | <ul style="list-style-type: none"> In July 2007, the HMO plan will include capitation. Primary care case managers channel and approve referrals. Preauthorization required for hospitalizations, some specific procedures and advanced imaging services. Continued hospital stay review. | <ul style="list-style-type: none"> Primary care case managers approve referrals. Preauthorization required for hospitalizations, some procedures. Continued hospital stay review. Use of high performance networks and selective contracting. Use of technology assessment and cost-effectiveness analysis in coverage decisions. |

Pharmaceutical Benefits Management in Other States

| Pg. 3 | Colorado: Cover Colorado | Connecticut: Health Reinsurance Association | Indiana: Comprehensive Health Insurance Association | Maryland: Maryland Health Insurance Plan | Minnesota: Comprehensive Health Association |
|------------------------------|---|--|---|---|---|
| <p>Formulary</p> | <p>Developed through pharmacy benefits manager, Rx Solutions. May be overruled by nurse managers based on need.</p> | <p>Each participating health plan develops their own formulary, but the pool has tried to keep it simple and as similar between the two plans as possible.</p> | <p>Part of Indiana's statewide aggregate purchasing program.</p> | <p>Each plan uses its own formulary.</p> | <p>The pool offers two formularies, one general formulary for most members and a second formulary with deeper discounts for particularly high-cost members in partnership with Walgreens, a pharmacy chain.</p> |
| <p>Tiered Pricing</p> | <p>Yes. Pool covers 80 percent of generic drugs on the formulary, 60 percent for brand name drugs on the formulary, and 40 percent of non-formulary brand name drugs.</p> | <p>Yes. Specifics not provided.</p> | <p>Yes, three tier program with \$12 co-pay for generics, \$24 for preferred brand name drugs, and \$40 for brand name drugs.</p> | <p>Yes, members pay a \$20 co-pay for generics, \$ 27 for preferred brand name drugs, and \$47 for off-formulary brand name drugs. Additionally, members the difference in cost between the generic and brand name drug if they opt for a brand name over an available generic.</p> | <p>There are different prices for generic and brand name medications.</p> |

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| Pg. 4 | <p>Colorado: Cover Colorado</p> <p>Nurse case managers receive monthly, individualized pharmacy reports. This helps them identify overuse and misuse of pharmacy benefits, as well as identify high-risk patients for case management.</p> | <p>Connecticut: Health Reinsurance Association</p> <p>Members are encouraged to use generic drugs.</p> | <p>Indiana: Comprehensive Health Insurance Association</p> <p>None.</p> | <p>Maryland: Maryland Health Insurance Plan</p> <p>Case management nurses and the pharmacy benefits manager track utilization and watch for duplication, overuse or misapplication.</p> | <p>Minnesota: Comprehensive Health Association</p> <p>Uses a prescription drug processing firm (Drug Impact) to administer a mail order system.</p> |
| <p>Other approaches?</p> | <p>Third party, Rx Solutions</p> | <p>Administered by each participating health plan.</p> | <p>Pool uses Indiana's statewide pharmacy benefits manager for state programs.</p> | <p>Yes, no specifics given.</p> | <p>Their third party administrator uses a pharmacy benefits manager and in-house staff.</p> |

Appendix J: High Risk Pool Health Plan Benefits Structure Surveys: States Chosen for Deductible Plan Options Study

For the deductible study, we approached five states we believed would provide a good cross-section of experience and insights into the different deductible plan choices currently available to high risk pool members in other states.

Methodology - To conduct the survey, Harbage Consulting and its co-researcher Bruce Abbe, of Abbe Communications, forwarded a detailed list of questions and discussion subjects on deductibles developed in conjunction with the MRMIB staff. We allowed a few days for participants to review the questions and prepare their thoughts and information, then conducted in-depth telephone interviews, each lasting between 1 ½ to 2 hours. Two people from the consulting study team participated on each call, which were recorded with the understanding that it was for internal accuracy purposes only. The interviewees included the executive director/president in four states, along with two additional senior program managers in two states. In one state, Idaho, which has no full-time pool staff, there were four participants including two members of the board, and representatives from the pool's third party administrator and Idaho State Department of Insurance. In all cases, we interviewed people with the best knowledge of the operations of the state program.

The states chosen for the deductible plan study were:

- *Minnesota Comprehensive Health Association (MCHA)*: The largest, and one of the two oldest, state high risk pools, MCHA has always offered among the most affordable levels of premiums to its members, generally comparable to or below MRMIP levels. MCHA offers six deductible option plans for its regular (non-Medicare) members, including an HSA-eligible plan, and deductible amounts range from \$500 to \$10,000. We hoped the larger size of the pool would provide more reliable trend data compared to what smaller plans could offer.
- *Maryland Health Insurance Plan*: MHIP is one of the newer state risk pools, begun in 2003, but has grown relatively quickly to nearly 10,000 members. This is in part due also to offering comparably more affordable rates compared to other risk pools, including a low-income premium subsidy program. MHIP is one of only three other states that offer its members a zero deductible, first-dollar coverage EPO plan (the others being Connecticut, which did not participate in the deductible study but was in the chronic care management study, and Alabama). MHIP also offers \$500 and \$1,000 deductible PPO plans; a \$2,500 deductible HSA-eligible plan; and a special \$200 deductible plan only for low-income premium subsidy members. We hoped the combination of the zero deductible managed care plan, along with the higher deductible and plans, would provide insights into consumer choices and experience that would be valuable should MRMIB choose to move in the same direction.

- *Oregon Medical Insurance Pool:* OMIP is long-established, comparatively larger pool that now serves approximately 15,000 people. OMIP offers four PPO deductible plan options at \$500, \$750, \$1,000, and \$1,500 deductible levels. These deductibles are in the moderate range among state risk pools, without offering a high-deductible, HAS-eligible coverage plan. OMIP also has a substantial number of lower-income people among its members who receive premium subsidies through another state program. We chose Oregon for its history, larger size, and great mix of lower-and moderate-income members.
- *Utah Comprehensive Health Insurance Pool (HIPUtah):* While HIPUtah is partially financed through dedicated state appropriations, similar to MRMIP, it also serves a smaller population in a much differently-structured individual insurance market than the California high risk pool. Utah's risk pool offers four deductible plans at \$500, \$1,000, \$2,500 and a new \$5,000 high deductible, HSA-eligible health plan. We hoped to learn about trends regarding consumer choices, affordability and premium-setting related to the different plan options.
- *Idaho High Risk Reinsurance Pool:* Idaho's individual high risk pool is technically a reinsurance pool that enrolls high risk individuals in plans all individual market carriers are required to offer on a limited, guarantee issue basis. The Idaho pool is similar to traditional risk pools in using state funds to subsidize losses incurred from offering standardized coverage plans to high risk individuals. Idaho's pool is one of four risk pools offering coverage through more than one carrier; Alabama, Connecticut and California are the other three. Idaho's pool offers coverage through all five individual commercial market carriers, including both major medical and PPO plans with deductibles from \$500 to \$5,000, and an HSA-eligible \$3,000 individual/\$6,000 family deductible plan. We hoped presenting the unique structure of the Idaho High Risk Reinsurance Pool, along with trends and experiences regarding consumer choices among its deductible options, would provide special insights that might be valuable to MRMIP stakeholders.

Appendix K: High Risk Pool Health Plan Benefits Structure Surveys: Deductible Plan Options in Other States

| <i>Deductible Plan Options in Other States</i> | | | | | |
|--|---------------------------|----------------------------------|--|-------------------|-------|
| | Medical Deductible | Pharmaceutical Deductible | Non-Deductible Services | Enrollment | |
| Maryland | \$0* | \$250 | All | 1,489 | 14.6% |
| | \$200** | None | Well-child visits and immunizations; case and disease management | 1,100 | 10.8% |
| | \$500 | \$100 | | 2,406 | 23.6% |
| | \$1,000 | \$250 | | 2,512 | 24.6% |
| | \$2,500 (HSA) | Combined | | 628 | 6.2% |
| Minnesota | \$500 | \$100 | Well-baby visits; well-child immunizations; cancer screenings; mammograms; case and disease management | 7,259 | 25.2% |
| | \$1,000 | \$200 | | 7,946 | 27.6% |
| | \$2,000 | \$400 | | 8,329 | 28.9% |
| | \$5,000 | \$1,000 | | 2,666 | 9.3% |
| | \$10,000 | \$2,000 | | 1,478 | 5.1% |
| | \$2,700 (HSA) | Combined | Above and additional preventive services | 1,756 | 6.1% |
| Oregon | \$500 | \$0 | Immunizations; well-baby and well-child care; preventive services; disease management | 9,920 | 64.0% |
| | \$750 | \$0 | | 1,860 | 12.0% |
| | \$1,000 | \$0 | | 1,240 | 8.0% |
| | \$1,500 | \$1,000 | | 2,480 | 16.0% |
| Utah | \$500 | \$150 | Some immunizations | 1,140 | 34.0% |
| | \$1,000 | \$250 | | 637 | 19.0% |
| | \$2,500 | \$500 | | 939 | 28.0% |
| | \$5,000 (HSA) | Combined | Preventive care services | 570 | 17.0% |
| Idaho | \$500 | \$250, 50% coinsurance | No | 54 | 3.9% |
| | \$1,000 | | | 243 | 17.4% |
| | \$2,000 | \$500, 50% coinsurance | | 221 | 15.8% |
| | \$5,000 | | | 800 | 57.1% |
| | \$3,000 (HAS/0) | | | 79 | 5.6% |

*Exclusive Provider Organization, an HMO-like option.

** Low-Income Subsidized Premium Plan

Biographies of the Harbage Consulting Team and Project Partners

Peter T. Harbage

With more than a decade of experience in health care policy, Peter currently the President of Harbage Consulting, a Sacramento-based health policy consulting firm. Past and present clients include the New America Foundation, the California Department of Insurance, California HealthCare Foundation, and the Blue Shield of California Foundation.

Harbage has previously served as Assistant Secretary of Health for the state of California under Governor Grey Davis. He has also served as Special Assistant to the Administrator of the Health Care Financing Administration. Since 2003, Harbage has been the top health care advisor to Senator John Edwards. Harbage graduated Phi Beta Kappa with High Honors from the University of Michigan, where he also earned his Masters of Public Policy. His first health policy experience was participating on First Lady Hillary Rodham Clinton's Health Care Task Force in 1993.

Harbage has appeared on CNN and NPR, and his work has been cited in the *Los Angeles Times*, the *Washington Post*, and the *San Francisco Chronicle*.

Hilary Haycock

An occasional independent consultant for Harbage Consulting, Haycock has a background in public policy research, and government and public affairs. She also currently manages the day-to-day communications support for an array of corporate, association and non-profit clients at Ziegler Associates, with a particular focus in health care issues in California. Haycock came to Ziegler Associates from the California Institute for County Government, a nonpartisan public policy organization where she examined state policies at the local level, including emergency department usage, disparities in care for Medi-Cal recipients, children's health and the economy and growing population of the Sacramento region. She also served in U.C. Berkeley's Government Affairs Office and the district office of Congresswoman Susan Davis. She graduated with High Honors in Political Science from the University of California, Berkeley.

Bruce Abbe

Consultant/CEO of Abbe Communications and Management Services, Bruce Abbe is a communications, public policy and management consultant focusing on health care, state health insurance access programs, and other fields. He has more than 20 years of experience in government relations, public policy and communications for national non-profit organizations and public affairs agencies.

Previously, Abbe served for twelve years on the board of directors of the National Association of State Comprehensive Health Insurance Plans (NASCHIP), the national organization made up of all of the state high-risk health insurance pools, which provide access to coverage for chronically ill. He also previously edited and produced the last 12 editions of the annual state risk pool directory, "Comprehensive Health Insurance for High-Risk Individuals – A State-By-State Analysis".

In January, 2006, Abbe formed his own consulting service – www.abbecommunications.com -- to provide public affairs and communications, publication management, program development and management consulting services to corporate, government and organizational clients.

Robert Berenson

Robert Berenson, M.D., is a Senior Fellow at the Urban Institute. He is an expert in health care policy, particularly Medicare, with experience practicing medicine, serving in senior positions in two Administrations, and helping organize and manage a successful preferred provider organization.

From 1998 to 2000, he was in charge of Medicare payment policy and managed care contracting in the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). In the Carter Administration, he served as an Assistant Director of the Domestic Policy Staff. He was also National Program Director of IMPACS (Improving Malpractice Prevention and Compensation Systems), a grant program funded by the Robert Wood Johnson Foundation, from 1994 to 1998. Dr. Berenson is a board-certified internist who practiced for 12 years in a Washington, D.C., group practice and is a Fellow of the American College of Physicians.

Dr. Berenson is also adjunct professor at the University of North Carolina School of Public Health and the Fuqua School of Business at Duke University. He is co-author, with Walter Zelman, of *The Managed Care Blues & How to Cure Them*, published in 1998. Dr. Berenson's current research focuses on modernization of the Medicare program to improve efficiency and the quality of care provided to beneficiaries.

Clara Evans

With nearly ten years of policy experience, Evans worked on this paper while she was a Director at Harbage Consulting. Prior to consulting, Evans was a Senior Consultant at the California State Assembly's Committee on Health, where she focused on children's health issues, chronic diseases, and licensing of medical professionals, hospitals and clinics. She was also involved in negotiating SB 2, a play-or-pay health reform measure in 2003. Before working for the California Legislature, Evans spent five years working on Capitol Hill, as the Senior Legislative Assistant to U.S. Representative Howard Berman, where she was focused on health care, education and the budget.