IMMEDIATE ATTENTION

EB/CAP/00/1

April 13, 2000

To: Members of the Committee on Administrative Policies

From: The Committee Secretary

Subject: **Finances of the Medical Benefits Plan**

Attached for consideration by the Committee is a paper on the finances of the Medical Benefits Plan. Mr. K. Craig (ext. 38212) and Mr. Nicoson (ext. 38223) are available to answer any technical or factual questions relating to this paper.

In the absence of a request to the Committee Secretary by noon on Thursday, April 20, 2000 that this matter be taken up by the Committee, the proposed recommendation that appears on page 9 will be deemed approved by the Committee for transmittal to the Executive Board.

Att. (1)

Other Distribution:
Members of the Executive Board

INTERNATIONAL MONETARY FUND

Human Resources Department

Finances of the Medical Benefits Plan

Prepared by the Human Resources Department

Approved by Margaret R. Kelly

April 13, 2000

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I. Introduction

1. The purpose of this paper is to propose that the Committee on Administrative Policies recommend to the Executive Board the approval of two changes in the Medical Benefits Plan (MBP) as follows: (i) a 15 percent increase in contributions to the MBP for enrollees and the Fund with effect from May 1, 2000; and (ii) a change in the cost-sharing arrangements in the MBP mail order prescription drug plan.

2. In 1994 (EBM/94/63, July 14, 1994), the Executive Board agreed that the staff would annually review MBP finances to determine the appropriate scale of contributions, taking into account the best estimates of future income and expenditure.[1] On March 6, 1998 the Executive Board approved a recommendation that the stabilization reserve be raised to a level of 20 percent of total projected expenses.[2] The Executive Board also approved a 15 percent increase in contributions effective May 1, 1998.

3. This paper is organized as follows: Section II describes financial developments with respect to the MBP from 1997 to 1999; Section III reviews the impact of the new Preferred Provider Organization (PPO) on claims expenditures; Section IV recommends an increase in contribution rates with effect from May 1, 2000; Section V describes a change in the design of the MBP mail order prescription drug plan; and Section VI provides a proposed recommendation by the Committee on Administrative Policies to the Executive Board.

II. MBP Financial Developments 1997–1999

4. In 1997, the MBP experienced the largest escalation in costs since the early 1990s. Expenditures rose by 20 percent mainly owing to an unusually high number of large claims. Consequently, the MBP reserve fell from 27 percent of claims expenditure in May 1997 to 13 percent by December 1997. To correct the continuing financial deficit and to protect against future risk, three major changes were made to the MBP effective May 1, 1998: first, contributions by both staff and the Fund were increased by 15 percent; second, the stop-loss insurance coverage for large claims was increased;[3] and third, the target level for the reserves was raised from 12 percent of estimated annual claims costs to 20 percent of total projected expenses.[4]

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[1]See EBAP/94/51 (7/11/94).

[2]See EBAP/98/19 (2/20/98), and Sup. 1 (2/26/98).

[3]Stop-loss insurance provides protection against large individual member claims that exceed a specific amount in a given calendar year. The individual claim threshold for this coverage was lowered from $250,000 to $150,000 on May 1, 1998.

[4]An interest bearing reserve was established in 1992 to reduce the need for frequent adjustments of the contribution schedule and/or temporary advances by the Fund to cover MBP deficits pending implementation of such adjustments.

MBP Financial Developments, CY 1997–2000
(In U.S. dollars)

	Actual			Projected
	1997	1998	1999	2000
Total expenditure 1/ 2/	22,947,760	21,590,938	28,102,095	29,279,667
Medical 3/	17,275,197	15,237,825	21,299,718	n/a
Prescription drug 3/	1,782,197	2,131,918	2,700,844	n/a
Dental 3/	2,951,139	3,099,417	2,987,537	n/a
Total income 1/ 2/	20,046,743	23,148,952	26,490,531	27,929,558
Surplus (deficit) 1/	-2,901,017	1,558,014	-1,611,564	-1,350,109
End of year reserve After surplus (deficit) applied 1/	2,939,446	4,497,460	2,885,896	1,535,787
Reserves as percentage of Total expenditure 1/	13	21	10	5

1/ Reported by TRE based on the actual payments made.
2/ The projections of total expenditures and total income in 2000 are based on the averages of the last six months of 1999 and include estimated Preferred Provider Organization savings.
3/ These figures are reported by CHS Ingenix based on data provided by CareFirst Administrators, J. Van Breda & Co. Intl., Pharmacare, and MetLife. These figures are based on the date on which claims are authorized and therefore vary slightly from the total expenditure data provided by the Treasurer's Department.

5. Following the contribution rate increase on May 1, 1998, reserves were rapidly replenished. Two other factors also contributed to the rise in reserves. First, there was a significant drop in large claims. Second, the then-MBP administrator lost about 7,000 claims between April and July 1998, many of which were not processed until 1999.[5] This shifted some expenditures that should have been paid in 1998 to 1999. With reserves slightly exceeding the target level at the end of 1998, no increase in MBP contribution rates was proposed for FY 2000.

6. Total expenditures rose by 30 percent in 1999.[6] Reserves as a percent of total expenditures dropped from the 20 percent target level to approximately 10 percent by the end of 1999. In addition to the lost 1998 claims paid in 1999, higher reimbursements made by a new MBP administrator, more rapid cost increases in the U.S. healthcare industry, and a higher level of large claims accounted for the sharp growth in MBP costs in 1999.

[5]Of the 20,000 claims that would normally be submitted during a four-month period, only 13,000 claims were actually processed by United Health Care (UHC) during this period.

[6]Claims expenditures rose by 26 percent on a per enrollee basis in 1999.

7. With effect from January 1, 1999, the responsibility for the administration of the MBP medical claims was transferred from United Health Care to CareFirst Administrators (formerly, Willse and Associates) and J. Van Breda & Co. International. The decision to replace UHC was made as a result of widespread dissatisfaction of MBP participants with the steady deterioration of claims processing that resulted in lost claims, low and uneven reimbursements, and difficulty in resolving disputes.

8. Each medical claims administrator employs somewhat different methods and guidelines for processing claims, which can significantly affect expenditures. UHC is predominantly a managed care company and tended to apply managed-care protocols to processing MBP claims. This managed-care approach resulted in lower reimbursements and expenditures than should have been provided for under the design of the MBP. The new administrators are reimbursing Fund claims in accordance with MBP provisions. There is also evidence that UHC's database for establishing reasonable and customary charges was lower than that used by indemnity plans such as the MBP. This also resulted in lower reimbursements and contributed to the dissatisfaction of participants. The level of reasonable and customary charges used by CareFirst is somewhat higher than that of UHC.

9. The average rate of cost increase for 1999 in the U.S. healthcare industry nationally for combined employee and retiree health care was approximately 12 percent.[7] Historically, the Fund's MBP expenditure increases have been about 25 percent below the U.S. national trend. The adjusted increase for 1999 would be about nine percent based on this historical relationship.

10. Actual MBP expenditure for 1999 was only moderately higher than would be expected on the basis of historical trends since 1997. Total MBP expenditure in 1997 was around $23 million. Using 1997 as the base year, with a five percent increase in 1998 and a nine percent increase in 1999, the expected 1999 expenditure would have reached around $26 million.[8] The actual total MBP expenditure for 1999 was roughly $28 million. HRD believes that this excess is partly attributable to the higher reimbursement provided by the new administrators in processing medical claims. As the adjustment to the methods of the new administrators has taken place in 1999 and costs stabilized during the last six months of the year, HRD believes that this represents a one-time correction. The MBP costs should be in line with the U.S. healthcare industry trends from 2000 forward.

11. Another factor contributing to the increase in MBP costs in 1999 was a significant increase in large claims. There were 42 claimants with annual claims over $50,000, who were responsible for $6,000,000 or roughly 30 percent of the $21,000,000 in medical claims. One claimant alone was responsible for over $1,000,000 in claims. In 1998, there were only

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[7]Using the *2000 Health Care Cost Survey,* Towers Perrin, January 2000 data, the seven percent increase for 1998 and the 12 percent increase for 1999 were adjusted to five percent and nine percent respectively according to MBP historical trends.

[8]*2000 Health Care Cost Survey.*

24 large claims, responsible for about $2,000,000 of the $14,000,000 paid in medical benefits.

12. Stop-loss coverage provides the Plan with protection for claims exceeding $150,000 in a calendar year with a maximum lifetime benefit set at $1,000,000 per person. In spite of this protection, given our relatively small member population, the MBP remains vulnerable to the effects of large claims owing to the exposure to the first $150,000 for each claimant, the cost of chronic conditions that exceed the $1,000,000 maximum, and increases in the stop-loss premium demanded by the insurer following years in which the insurer incurred losses.

III. PREFERRED PROVIDER ORGANIZATION (PPO)

13. To help address the erosion of the reserves and the increasing medical costs of the MBP, HRD expanded the medical discount arrangements that have been in place for several years with providers in the Washington, D.C. area. Effective January 1, 2000, the MBP joined Private HealthCare Systems (PHCS), a passive Preferred Provider Organization (PPO).

14. A PPO is an organization of providers, such as hospitals and physicians that contract with employers like the Fund to provide services at more competitive rates. It is referred to as passive because members have free choice of physicians and hospitals and are not penalized for using a provider that is not in the system. Because the providers' fees are discounted, their use results in savings to both the Fund and MBP participants.

15. Implementation of the PHCS PPO is conservatively estimated to result in savings of about $2.2 million in 2000, or approximately eight percent of the total projected MBP expenditure of about $31.5 million. The projected annual saving of $2.2 million is an estimate by CareFirst Administrators based on the number of PPO enrolled doctors, hospitals, and other providers currently being used by MBP participants. As a conservative estimate, the projected savings do not assume that any MBP participants will change from their current providers to PPO providers. The cost to the Plan to join the PPO is estimated at $192,000 in 2000.[9] Arrangements have been made to extend the PPO benefits to MBP participants residing outside the United States who come to the United States for treatment to maximize the potential savings.

16. The savings from joining the PPO alone will not be sufficient to bring the MBP reserves back to the target level of 20 percent of total projected expenses. It will, however, reduce the size of the contribution increase needed on May 1, 2000. Based on the PPO savings beginning January 1, 2000, the MBP reserve is now expected to decline to nine percent of total projected expenses by May 1, 2000, instead of approximately six percent without the PPO. Chart 1 shows the level of the reserve projected to December 2001, and the expected effect of the PPO in slowing the decline in reserves.

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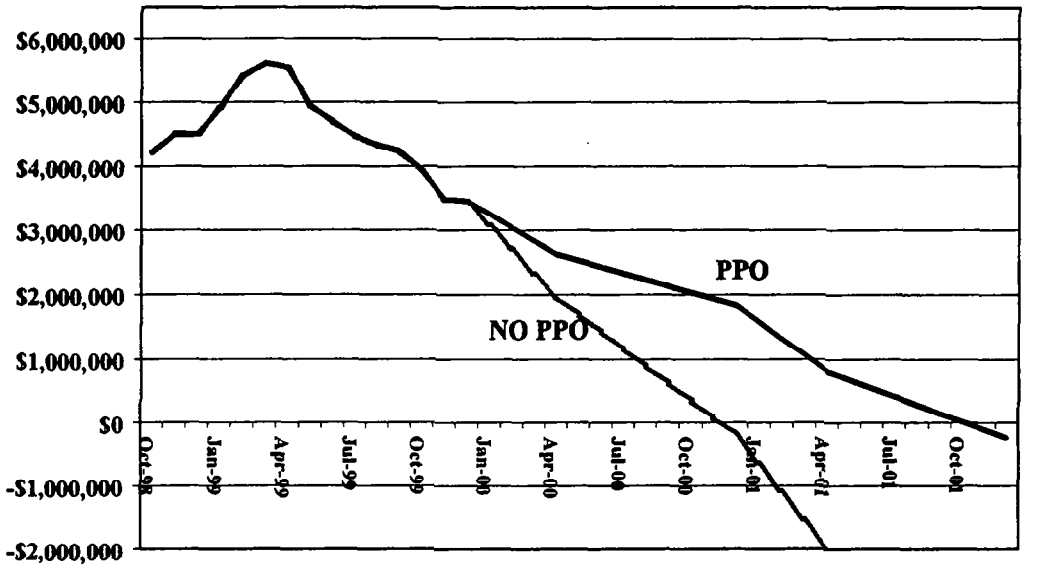
[9]The PHCS PPO subscription charge is $4.95 per staff member/retiree per month.

Chart 1
MBP Reserves Projected to December 2001
(With and Without PPO)



IV. CONTRIBUTION RECOMMENDATION FOR FY 2001

17. HRD reviews the MBP's finances each January for the purpose of determining contributions for the upcoming financial year based on attaining the reserve target by the end of the year.[10] Proposed changes in contribution rates are submitted to the Committee on Administrative Policies for consideration. In proposing an increase or decrease in contribution rates, HRD considers the level of the reserve at that time and makes projections of the reserve for the calendar year based on expected revenue and cost estimates. If the reserve level is projected to be above (below) the 20 percent target, the Executive Board may be asked to approve a reduction (increase) in contribution rates in conjunction with the next financial year's Administrative Budget; a refund of contributions or contribution holiday may also be considered by the Board in lieu of, or in addition to, a reduction in the contribution schedule.

18. To reach a reserve target of 20 percent by the end of 2000, the MBP would require a 20 percent increase in contributions on May 1, 2000.[11] HRD believes that the increase in the level of MBP expenditure in 1999 above the expected trend has been caused by the

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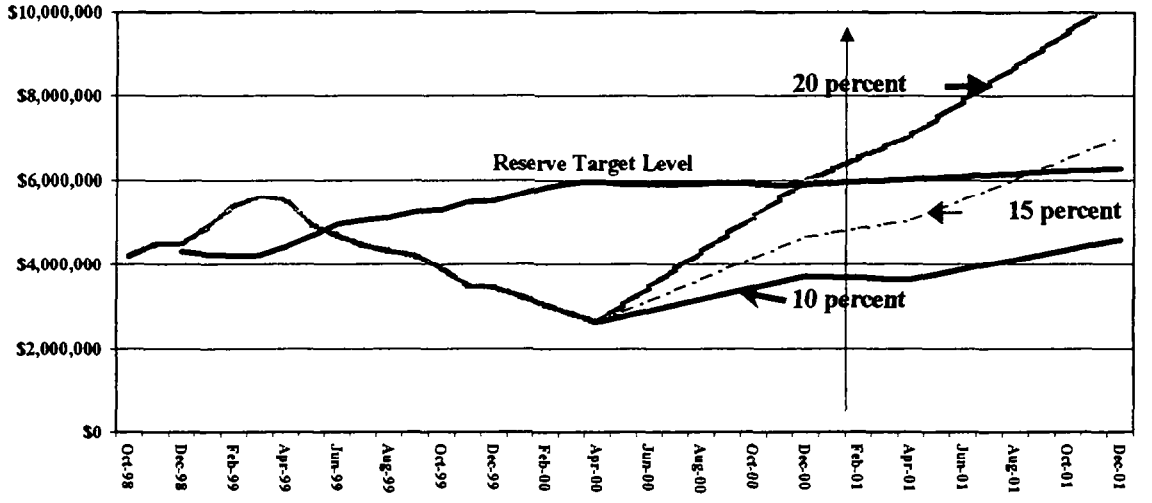
[10]The procedure for the MBP's financial review was modified in 1994. See EBAP/94/51, (7/11/94).

[11]The required percentage increase is based on the following assumptions for 2000: (i) a medical inflation rate of seven percent; (ii) an expected salary increase of close to five percent on May 1, 2000; and (iii) PPO savings of $2.2 million.

exceptional factors described in Section II, which should not continue in 2000. Thus, it is likely that a 20 percent increase in contributions would result in a rapid accumulation of reserves, with reserves exceeding the target level in 2001 and continuing to grow quickly. Therefore, it is recommended that a lower contribution increase be implemented.

19. HRD has reviewed options for an increase ranging from 10 percent to 20 percent and proposes a 15 percent increase in the contribution schedule with effect from May 1, 2000. This increase is expected to result in an increase in the reserve to the target level of 20 percent of projected expenditures by around July 2001, rather than December 2000. It is estimated that with an increase in MBP contribution rates of only 10 percent, the reserve target would not be reached until early 2002. This implies a delay of over one year in achieving the reserve level required under the Plan.

Chart 2
MBP Reserves with Projected Contribution Increases to December 2001
Using 10, 15 and 20 Percent Contribution Increases on May 1, 2000



V. MAIL ORDER PRESCRIPTION DRUG BENEFIT CHANGE

20. The MBP Mail Order Prescription Drug Benefit, administered by PharmaCare Direct, requires modification to bring this MBP benefit closer to market practice. The benefit allows a participant to purchase up to a three-month supply of medication with a $12 copayment. By comparison, if the same medication was obtained from a retail pharmacy using the PharmaCare card, the participant would pay 20 percent of the prescription cost, and the plan would pay 80 percent. The cost of the mail order program was $375,000 in 1999, accounting for 13.8 percent of the total 1999 prescription drug cost of $2,700,000. The Plan's prescription drug costs have risen by 28 percent since 1998.

21. The current $12 copayment is below the market level. As a result, inequitable treatment occurs between those who use the mail order program and those who use the card program. The mail order benefit was intended to cover maintenance medications generally used for chronic conditions. However, the prescription drug industry has changed and many new, very expensive drugs have come into the marketplace. This was not envisioned when the benefit was established. The Fund does not specify a list of drugs that are covered under this program, as is done with many other plans. Some of the new drugs that have become available in recent years cost more than $1,000 per month. Under the current rules, a member may purchase a three-month supply of these costly medications for only $12 using the mail order service. For example, the actual cost for the new drug *Enbrel* is $2,712 for a three-month supply. A participant would pay only $12, or less than one percent of the actual cost for this three-month supply, while his or her colleague using the card program would pay 20 percent, or $542. On an aggregate basis, the MBP is collecting less than five percent of the actual cost of the mail order prescription drugs being dispensed under this benefit. This arrangement provides no incentive for the member to make the most cost-effective choice when purchasing prescription drugs and is contrary to the intent of the program.

22. As a result, the $12 copayment, which was appropriate when the program was begun in 1992, is now profoundly out of date. Applying a national trend factor for prescription drug plans to the current copayment would yield an adjusted copayment of more than $30.

23. Two revisions to the mail order plan are proposed. First, to increase the copayment to $20 per prescription (for up to a three-month supply of medication) for the first $400 of medication.[12] Second, if the prescription cost exceeds $400 based on a three-month supply, participants will pay 10 percent of any cost above $400. This would bring the mail order program to a level where the cost sharing between the Plan and the participant would be in line with similar plans, while still providing an incentive for participants to use the program.[13] This is expected to change the percentage cost-sharing ratio (MBP/participant) from 95:5 to 88:12 and provide an additional $23,000 of income to the MBP. Periodic adjustments to the copayment will be needed in the future to keep the plan in line with similar plans in the marketplace.

24. The effective date for these changes would be delayed until August 1, 2000 to allow participants with a high level of expenditures to prepare for the additional cost sharing. This delay will also give the administrator a reasonable period of time to modify its systems and procedures to implement these changes.

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[12] An increase to a $30 copayment in one step could be viewed as excessive.

[13] The cost of a prescription filled through the mail order program is lower than if the prescription is filled at a pharmacy, because the drug cost and the dispensing fee are lower. The lower copayment provides an incentive for staff to use this lower-cost program.

VI. PROPOSED RECOMMENDATIONS

It is proposed that the Committee recommend that the Executive Board approve the following decisions:

- that the MBP's contribution schedule and the Fund's contribution to the MBP be increased by 15 percent with effect from May 1, 2000; and

- that the copayment on the Mail Service Prescription Plan of the MBP be increased to $20 with effect from August 1, 2000, and that the copayment apply to the first $400 of the prescription cost. For prescriptions with a total cost in excess of $400, participants will pay a 10 percent coinsurance for the amount above $400.