



Texas Employees Group Benefits Program

Cost Management and Fraud Report FY2013



EMPLOYEES RETIREMENT SYSTEM OF TEXAS

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**ERS SUPPORTS THE STATE WORKFORCE
BY OFFERING COMPETITIVE BENEFITS
AT A REASONABLE COST.**

EXECUTIVE SUMMARY

Texas Employees Group Benefits Program FY13 Cost Management Report

The Employees Retirement System of Texas (ERS) sets and enforces high performance standards for the Texas Employees Group Benefits Program (GBP) to slow the benefit cost trend and ensure that strong measures are in place to prevent fraud and abuse. ERS has managed health insurance benefits for the State since 1976.

The GBP is a cost-efficient plan that provides more than half a million public employees, retirees and their families with health insurance at an annual cost that is nearly \$2,000 less per person than other large employer-sponsored plans¹. HealthSelectSM of Texas (HealthSelect) is the basic health plan offered to GBP participants since 1992 and the focus of this report.

ERS is known for implementing best practice solutions and taking a proactive approach to managing costs. The HealthSelect program reduced plan charges by \$5.5 billion in FY13 due to better provider discounts, tighter management of HealthSelect benefits, and a new prescription drug program for Medicare-primary participants.



HealthSelect spends about \$6 million a day in health care claims.

That's \$250,000 an hour...
\$4,200 a minute...
\$69 a second...

Employee health insurance is a significant expense for the State of Texas, so it's important to get the most out of every dollar. Professional management and legislative support kept the GBP on a path of fiscal sustainability in FY13, allowing ERS to rebuild the contingency fund and avoid unnecessary benefit changes.

97¢

HealthSelect spends more than 97 cents of every dollar on health care claims.

FY13 HIGHLIGHTS

Lowered total HealthSelect charges by \$5.5 billion through cost management programs.

Implemented a new HealthSelect third-party administrator contract, saving the state \$6.5 million in administrative fees the first year.

The contract is on track to exceed projected savings of \$25 million through FY16 (compared to other administrative proposals).

The new TPA had better provider discounts, saving the plan \$15 million.

Renewed the Medicare Advantage (MA) plans (\$25.8 million savings for enrolled Medicare-primary retirees in dependent premium contributions).

Implemented new Medicare-primary retiree drug coverage as of January 1, 2013, which is expected to save \$27 million for calendar year 2013.

Reopened past Retiree Drug Subsidy claims for reconciliation with net savings of \$7 million.

Collected \$9.7 million in additional tobacco premium contributions in FY13 from more than 27,000 participants; projecting \$14.7 million in FY14 from 41,000 participants.

Added a new Patient-Centered Medical Home in Austin, with another contract under negotiation.

Implemented the pharmacy benefit manager (PBM) contract extension, which is expected to save \$41 million for FY13 and FY14 combined.

Contracted with an outside independent auditor to review medical claims processing accuracy for FY12.

¹ 2012 Mercer National Survey of Employer Sponsored Plans, page 22.

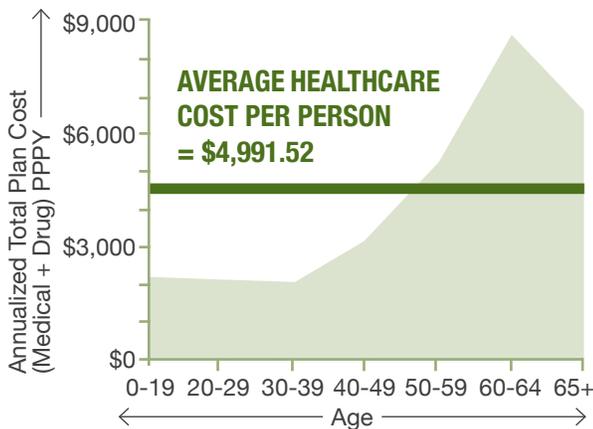
HEALTHSELECT HAS LOW ADMINISTRATIVE COSTS. According to new federal standards, the GBP is an extremely cost-efficient plan. The Affordable Care Act (ACA) requires large employer plans to spend at least 85 cents of every dollar they collect on health care claims. The HealthSelect program spends more than 97 cents of every dollar on health care claims.

THE SELF-FUNDED PLAN BENEFITS FROM A LARGE RISK POOL. HealthSelect is a self-funded insurance plan, meaning that member and state contributions pay for all the health care claims. Through the plan, the State and the members – not an insurance company – assume responsibility and bear the risk for paying for all the health care services used.

More than 400,000 employees, retirees and their dependents are grouped together in the HealthSelect “risk pool,” sharing in savings when costs go down and paying more when costs go up. The size of the group brings predictability to budgeting, creates economies of scale, and ensures that one catastrophic illness does not dramatically change the average cost of coverage for the year.

Having a lot of healthy people in the group may lower the average cost, but everyone is different and anyone can have an expensive unforeseen health event. Costs are spread among everyone in the plan so that health insurance never becomes too expensive for people when they need it the most.

FIGURE 1: ERS averages costs so the plan stays affordable for the group (HealthSelect average annualized claims cost by age group, all medical and pharmacy claims, FY13)



MOST OF FEDERAL HEALTH CARE REFORM’S COST IS RELATED TO PREVENTIVE CARE. The Texas Legislature amended state law in 2011 and 2013 to bring the GBP into compliance with the ACA. ERS has implemented all ACA-required changes to date.

FIGURE 2: HealthSelect spent more than half of ACA-related costs in FY13 on providing preventive care at no cost to the participant (millions)



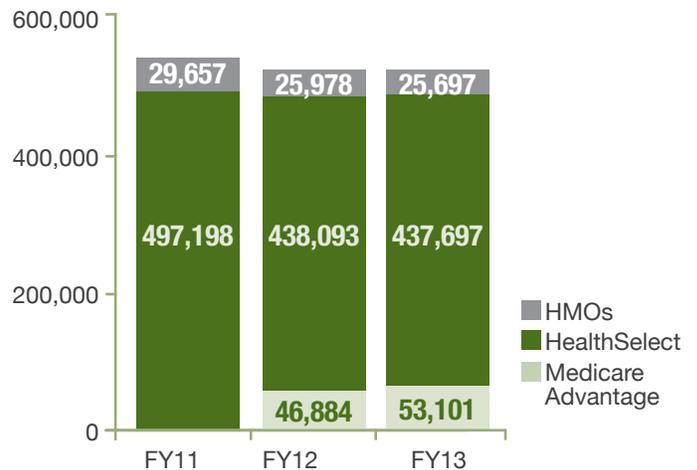
In FY13, the plan spent \$49.3 million on ACA-related costs, of which about 57% went toward providing preventive care at no cost to the participant. See Appendix A for a projection of the impact of the ACA on the GBP over the period FY11-15.

HEALTHSELECT ENROLLMENT IS DOWN. HealthSelect enrollment has declined since FY12, but it still represents 85% of the GBP population. About 53,000 Medicare-primary retirees (two-thirds of those eligible) moved to Medicare Advantage (MA) plans. The rest enrolled in HMOs.

HealthSelect also has two self-funded pharmacy programs, one for Medicare-primary participants, and one for everyone else in HealthSelect.

FIGURE 3: More than 53,000 Medicare-primary GBP participants have enrolled in Medicare Advantage plans since January 1, 2012

TOTAL GBP ENROLLMENT IS MORE THAN 516,000



FY13 cost containment savings for the HealthSelect program are not directly comparable to the past two years, because of the migration to MA plans.

SCOPE OF THE REPORT

ERS manages HealthSelect costs so the state can continue to offer the program within budgeted funds. The ERS Board of Trustees controls insurance costs in two primary ways: the plan design and the professional management of the program.

- The “plan design” is most visible to the people who rely on the plan. It determines what is covered and how much they pay in deductibles, co-pays, and co-insurance. No plan design changes were made in FY13.
- The “professional management” of the plan includes such things as cost containment and fraud control programs, contracting arrangements with providers, and disease management and wellness programs. Vendors are responsible for the day-to-day management of the plan.

ERS contracts with a third-party administrator (TPA) to manage HealthSelect medical benefits and a pharmacy benefit manager (PBM) to manage prescription drug benefits. UnitedHealthcare is the medical TPA. and Caremark provides PBM services for most of the HealthSelect population. SilverScript, a Caremark subsidiary, provides PBM services for most Medicare-primary participants. These contracts are bid and renegotiated regularly.

This report focuses on the professional management of HealthSelect – the important ways that ERS and its vendors work behind the scenes to control costs. It also provides a focus on cost-saving initiatives to serve the growing retiree population, and the expansion of our Patient-Centered Medical Home project.

“ The half million Texans in the GBP would fill the University of Texas at Austin football stadium five times over. ”



COST MANAGEMENT

ERS lowered HealthSelect plan charges \$5.5 billion in FY13

ERS and its vendors proactively manage plan costs to reduce the impact of cost increases on the state and its workforce as much as possible. It's a balancing act to maintain a high level of benefits while also controlling costs.

To put the importance of these efforts in context – without cost-management programs, the FY13 member-only contribution would have been \$1,654 a month, rather than \$468. Total cost-management reductions for HealthSelect in FY13 equaled \$5.5 billion.

NEGOTIATING MANAGED CARE SAVINGS. Two-thirds of all cost management reductions in FY13 – \$3.6 billion – came from HealthSelect's managed care reimbursement arrangement. Managed care reduces costs for the plan through the negotiation of discounted reimbursement rates with providers who agree to participate in the network. The HealthSelect TPA produced an extra \$15 million in managed care savings in FY13 by adding more providers to the network at larger discounts.

AVOIDING CHARGES THROUGH UTILIZATION MANAGEMENT. Nationally, as in HealthSelect, about 20% of the population is responsible for 80% of health care costs². This is even more pronounced in the HealthSelect drug programs,

where 20% of participants incur 90% of plan benefits. On the other hand, 44% of participants incurred \$0 in prescription drug benefits in FY13.

For this reason, utilization management is an important process that highlights cost drivers, identifies people eligible for clinical management programs, and encourages coordination of care. HealthSelect stepped up its utilization management efforts this year to ensure that primary care doctors are more involved in treatment decisions and prescribed services align with best-practice standards. Utilization management saved \$84.3 million in FY13.

ELIMINATING INELIGIBLE CHARGES THROUGH PREPAYMENT CLAIMS EDITING. Prepayment claims editing is the process of screening submitted charges for duplicate claims or late fees, non-covered services or facilities, or services that are not medically necessary. This added checkpoint for accuracy in the claims process eliminated \$947 million in unnecessary charges in FY13.

COORDINATING BENEFITS WITH OTHER INSURERS AND PAYERS. Coordination of benefits (COB) divides health care expenses among responsible payers, ensuring that HealthSelect doesn't pay claims that may be covered elsewhere. For example, Medicare pays first on claims for Medicare-primary participants, then ERS coordinates with Medicare to pay the remaining eligible balance. COB saved the plan more than \$282 million in FY13.

FIGURE 4: 44% of participants did not make a prescription drug claim in FY13 (This group incurred \$0 in drug benefits for the plan in FY13)

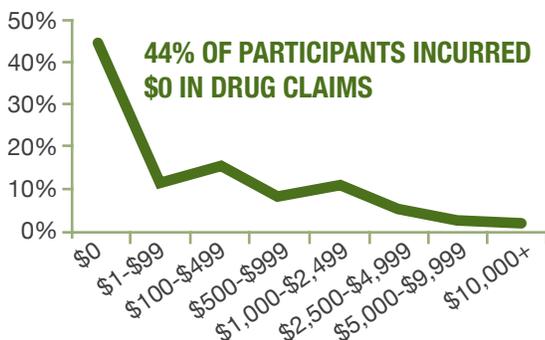
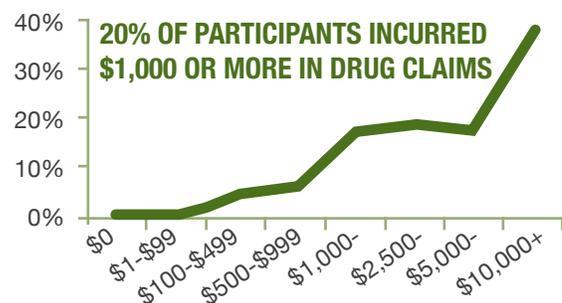


FIGURE 5: 20% of the HealthSelect population received 90% of the prescription drug benefits in FY13 (This group includes all those with at least \$1,000 in drug benefits for FY13)



² Kaiser Family Foundation, "Health Care Costs: A Primer. Key Information on Health Care Costs and Their Impact," March 2009, p. 5.

MAXIMIZING REFUNDS, REBATES, AND SUBSIDIES. These strategies leverage outside resources to maximize collections for the plan. From FY06 to FY13, the federal Medicare Part D retiree drug subsidy (RDS) refunded \$249.1 million in Medicare retiree drug costs. In FY13, ERS contracted with a vendor to reopen past RDS claims for reconciliation. As a result, ERS will net an additional \$7 million in subsidies in FY14.

ERS replaced the RDS for most participants in January 2013 with a new Medicare drug strategy, discussed in more detail on page 23 of this report. ERS also received \$53.6 million in FY13 from the 100% pass-through of all drug manufacturer rebates collected by the PBM. We contract with an independent auditor to conduct an annual audit to confirm that the plan is properly paid 100% of all drug manufacturer rebates.

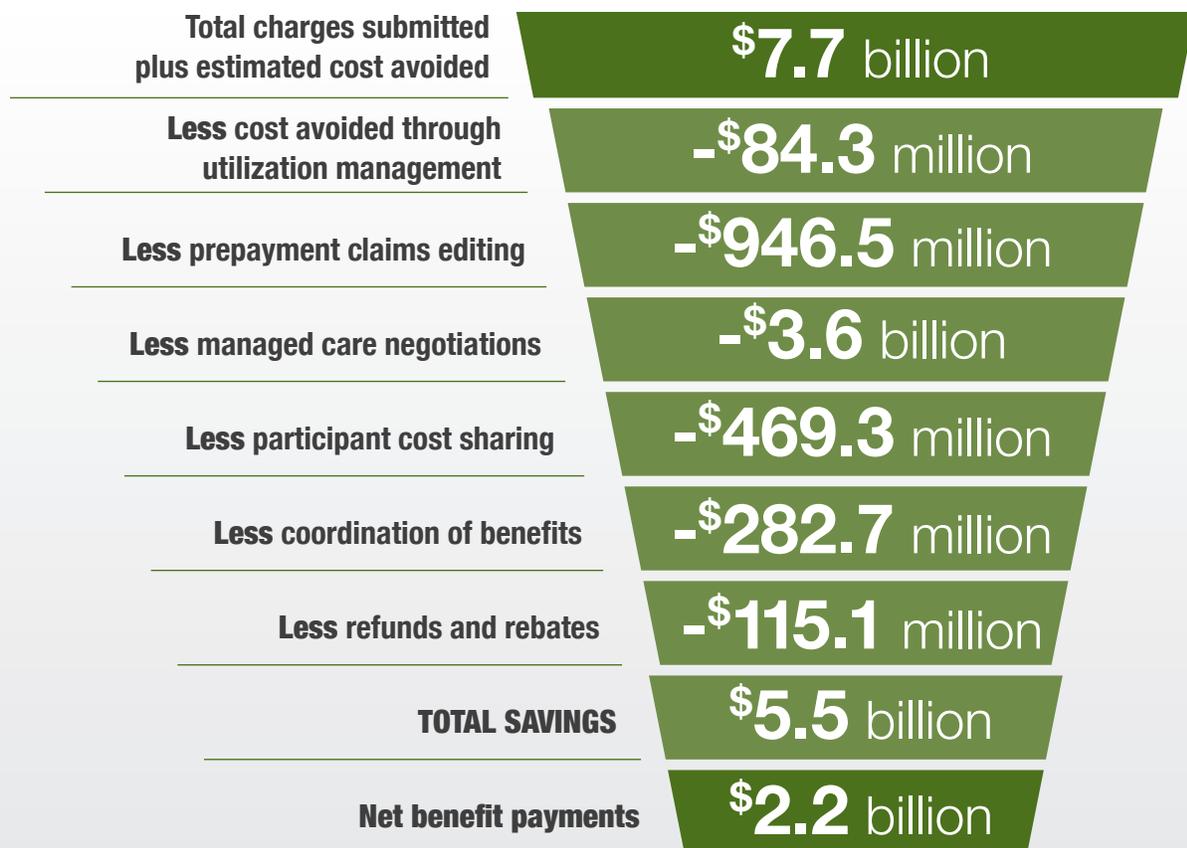
CONDUCTING AUDITS. The Pharmacy Audit Program protects the financial integrity of the provider network and the plan through a sophisticated set of programs and procedures to deter fraudulent claims, protect against provider abuse, and ensure that network pharmacies comply with HealthSelect guidelines. This program recouped about \$1.2 million in FY13.

A successful dependent eligibility audit (DEA) in FY12 removed 5% of dependents from the plan and produced \$12.2 million in net savings. Going forward, ERS will continue to audit all new dependents as they are added to the plan.

SHARING COSTS WITH PARTICIPANTS. HealthSelect participants all belong to the group, and every time they make a choice about their health, it affects the entire group. Increased cost sharing should encourage people to use less expensive services. It should also influence the total number of health care services used. The goal is to encourage people to get necessary care, while taking an increased role in managing their own health and their costs.

In FY13, employees, retirees, and their dependents in HealthSelect paid \$469.3 million of the total cost of their medical and prescription drug expenses – through coinsurance, deductibles, and copays. HealthSelect spent \$28 million in FY13 to ensure that preventive care services were available at no cost to the participants, as required under the ACA.

FIGURE 6: Texas Employees Group Benefits Program savings, HealthSelect FY13



COST MANAGEMENT FINANCIAL CHART

COMPONENTS OF THE COST MANAGEMENT FINANCIAL CHART

Pages 10-19 provide a detailed explanation for each line item in the financial chart starting on the next page.

Screening for Ineligible Charges

LINE 2. UTILIZATION MANAGEMENT

Medical and pharmacy utilization management programs helped the plan avoid an estimated \$84.3 million in charges in FY13. Utilization management is a forward-looking process that identifies potentially high-cost claims that could be handled in a more appropriate way, and directs high-risk patients to clinical management programs. This process ensures that prescribed services align with best practice standards.

1. Total charges submitted plus estimated cost avoided through utilization management	\$ 7,720,820,411
2. Estimated cost avoided due to utilization management	(84,269,857)
4. Less charges eliminated through prepayment claims editing	(946,537,903)

LINE 4. PREPAYMENT CLAIMS EDITING

HealthSelect further trims costs by screening for ineligible charges through prepayment claims editing. This process lowered plan costs about \$946.5 million by weeding out duplicate claims and eliminating charges that exceed benefit limits or the reasonable and customary amount. Medical claims review ensures that the plan does not pay for services that are not medically necessary.

Prepayment claims editing is an essential part of the GBP's fraud, waste, and abuse program, as it is designed to prevent the payment of potentially fraudulent or abusive claims.

When claims data fail to meet the requirements of these and other edits, the plan holds claims for individual review by claims processors, the medical review unit, and/or the TPA's Fraud, Waste and Abuse Division.

The independent auditor tests prepayment edits as part of the annual claims audit and verifies that the edits are applied appropriately.

REDUCTIONS TO ELIGIBLE CHARGES

After eliminating ineligible charges, the plan applies a series of cost management strategies to the \$6.7 billion in remaining eligible charges. Managed care, participant cost sharing, and coordination of benefits saved the GBP almost \$4.4 billion of the remaining eligible charges in FY13.

FIGURE 7: Texas Employees Group Benefits Program, HealthSelect FY13 Cost Management*

1. Considered Charges plus Estimated Cost Avoided**		\$7,720,820,411
2. Estimated Cost Avoided (Utilization Management)		
a. Medical	(\$56,359,082)	
b. Pharmacy	(27,910,775)	(84,269,857)
3. Considered Charges		\$7,636,550,554
4. Less Ineligible Charges (Prepayment Claims Editing)		
		(946,537,903)
5. Eligible Charges		
		\$6,690,012,651
6. Less Reductions to Eligible Charges		
a. PDP Charge Reductions	(\$660,442,527)	
b. Provider Discounts and Reductions	(2,978,631,857)	
c. Medical Copayments and Deductibles	(119,441,848)	
d. Medical Coinsurance	(185,321,419)	
e. PDP Cost Sharing	(164,518,131)	
f. Coordination of Benefits - Medical - Regular	(47,332,285)	
g. Coordination of Benefits - Medical - Medicare	(233,685,380)	
h. Coordination of Benefits - PDP	(1,696,301)	(4,391,069,748)
7. Gross Benefit Payments		\$2,298,942,903
8. Refunds, Rebates, and Guarantees		
a. PDP Rebates	(\$53,580,191)	
b. Federal Revenue - Medicare Part D	(50,874,160)	
c. Subrogation	(7,791,629)	
d. Pharmacy Audit Refunds	(715,576)	
e. PBM Audit Refunds	(149,653)	
f. Hospital Audit Refunds	(2,006,183)	(115,117,392)
9. Net Benefit Payments		\$2,183,825,511

*Amounts taken from:

- (1) Annual Statistical Review by UnitedHealthcare and Blue Cross
- (2) Annual Experience Accounting prepared by Caremark and SilverScript,
- (3) HealthSelect Prescription Drug Plan data, and
- (4) ERS FY13 CAFR (Medicare Part D Retiree Drug Subsidy).

** The estimated cost that did not occur due to health care management programs and interventions, such as disease management

LINES 6A-6B. MANAGED CARE SAVINGS

More than \$3.6 billion in cost reductions came from HealthSelect’s managed care reimbursement arrangement. Managed care reduces costs for the plan through the TPA’s and PBM’s negotiation of discounted reimbursement rates with providers.

6a. Prescription drug program charge reductions	\$ 660,442,527
6b. Provider discounts and reductions	2,978,631,857

The medical TPA leverages its negotiating power in the Texas healthcare marketplace to give the State, the GBP, and the participants access to better rates.

The \$3.6 billion in reduced charges represents the discount taken off the “retail” prices that doctors, hospitals, pharmacies, and other facilities would have charged the GBP and its participants had they not been covered by a managed care network.

Figure 8 shows how managed care continues to be the greatest source of savings for the plan.

LINES 6C-6E. PARTICIPANT COST SHARING

Sharing costs with participants reduces costs that would otherwise be paid by the plan. In FY13, employees, retirees, and dependents who used health care services paid \$469 million through coinsurance, deductibles, and medical and prescription drug copays.

6c. Medical copayments and deductibles	\$ 119,441,848
6d. Medical coinsurance	185,321,419
6e. PDP cost sharing	164,518,131

Cost sharing should affect the amount of health care services used by reducing demand. The goal is to encourage people to get needed care, while taking an increased role in managing their own health and their out-of-pocket costs. HealthSelect covers all preventive services at no cost to the member.

FIGURE 8: *Negotiated provider discounts continue to produce the greatest cost savings to the plan (HealthSelect FY08-FY13, in millions)*

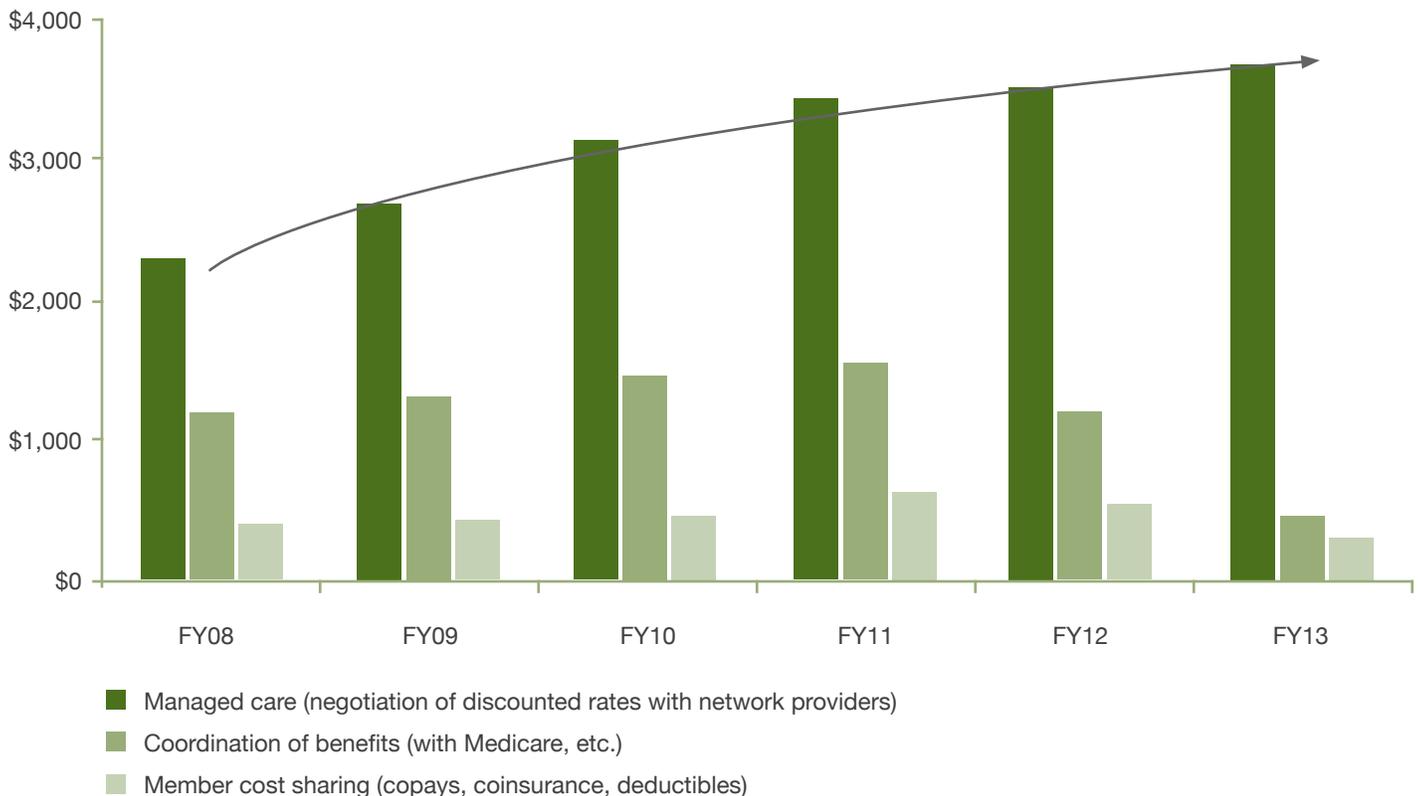


FIGURE 9: HealthSelect total member cost sharing fell after nearly 52,000 Medicare-primary participants enrolled in Medicare Advantage plans (HealthSelect FY13, in millions)

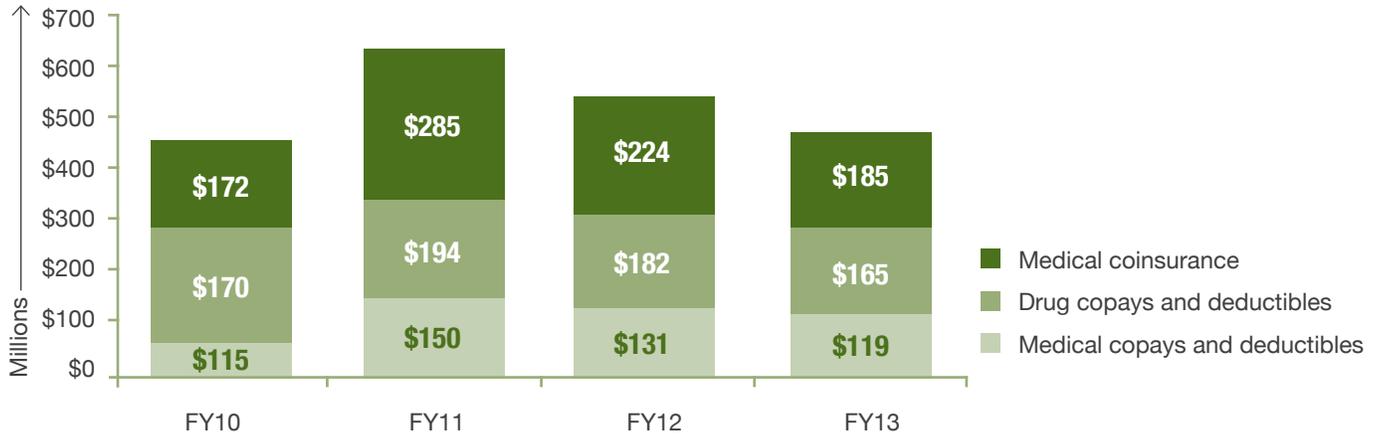
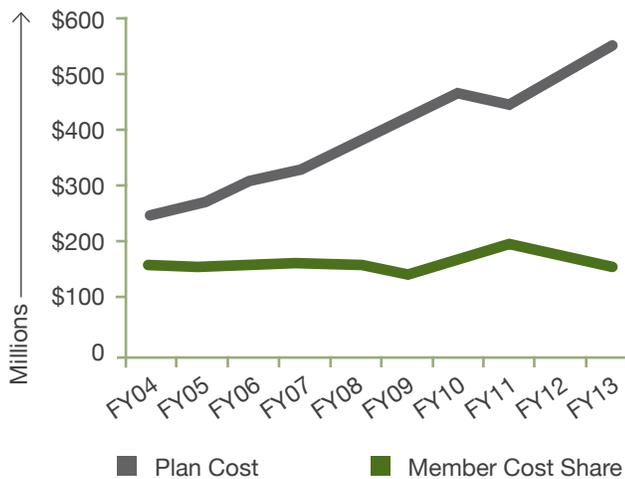


Figure 9 shows the financial impact on HealthSelect members of plan design changes in FY11, and the migration of Medicare-primary participants into MA plans during FY12 and FY13. It's important to remember that HealthSelect data only represents 85% of total GBP enrollment.

MEMBER COST SHARE LEVERAGING.

Because HealthSelect participant copays for prescriptions and doctor visits remain flat, as total charges for these services increase, participants end up paying a smaller and smaller part of the bill. This phenomenon illustrated in Figure 10 is called “member cost-share leveraging”. This is especially clear in the drug program, where price inflation is a major cost driver.

FIGURE 10: Member cost share leveraging in the HealthSelect prescription drug program (in millions, FY04-FY13)



The list of the Top 10 costliest drugs for the program has historically been dominated by brand name drugs, such as the “blockbuster” drug Lipitor. With Lipitor now available in generic form, in FY13, two specialty drugs rose to the top of the list.

FIGURE 11: Top 10 Costliest Drugs for HealthSelect in FY13

Drug name	Type	Therapeutic Use	Plan Cost in Millions
1. HUMIRA®	Specialty	Rheumatoid Arthritis	\$17.1
2. Enbrel® etanercept	Specialty	Rheumatoid Arthritis	\$16.6
3. CRESTOR® rosuvastatin calcium	Brand	High Cholesterol	\$13.7
4. Cymbalta® duloxetine HCl	Brand	Antidepressant	\$13.5
5. LANTUS® insulin glargine	Brand	Diabetes	\$12.6
6. NovoLog® insulin aspart (rDNA origin) injection	Brand	Diabetes	\$11.6
7. Nexium® esomeprazole	Brand	Gastric reflux	\$10.6
8. COPAXONE® (glatiramer acetate injection)	Specialty	Multiple Sclerosis	\$9.3
9. ABILIFY® (aripiprazole)	Brand	Mood Stabilizer	\$8.7
10. VICTOZA® liraglutide injection	Specialty	Diabetes	\$8.4

Figure 12 shows the exponential increase in the cost and utilization of specialty drugs in HealthSelect over the past decade. In FY13, specialty drug spending represented 23% of total drug cost, compared to 2.7% in FY01.

Cost sharing should encourage people to use less expensive services, such as generic drugs. Even though HealthSelect’s 78.4% generic dispensing rate is 5% higher than FY13, the rising cost of specialty drugs has offset much of the financial gain from the increased use of generics.

A THREE-TIERED DRUG COPAY STRUCTURE SHOULD INCENTIVIZE THE USE OF GENERICS. One cost management feature of the HealthSelect prescription drug program is the use of a “three-tier” copay structure. The participant’s cost sharing is based on the drug’s tier, with generics being the least expensive.

Tiered copays should encourage people to ask their doctors for generic alternatives. Figure 13 shows the impact on plan costs when a member chooses a generic osteoporosis drug, rather than a brand name or specialty drug.

FIGURE 12: Plan spending on specialty drugs has increased exponentially over the past decade, HealthSelect FY01-FY13

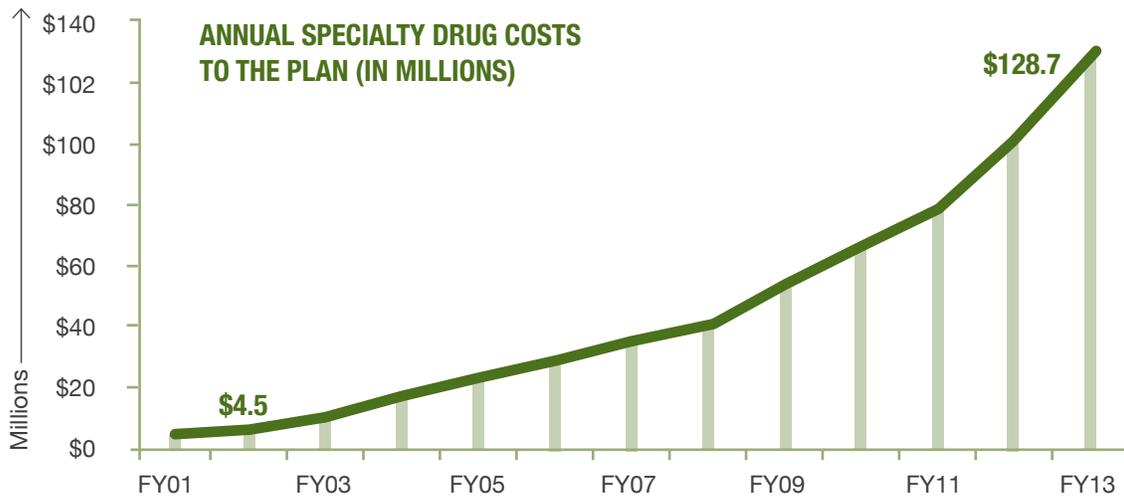


FIGURE 13: How does choosing a generic medication compare to other options?

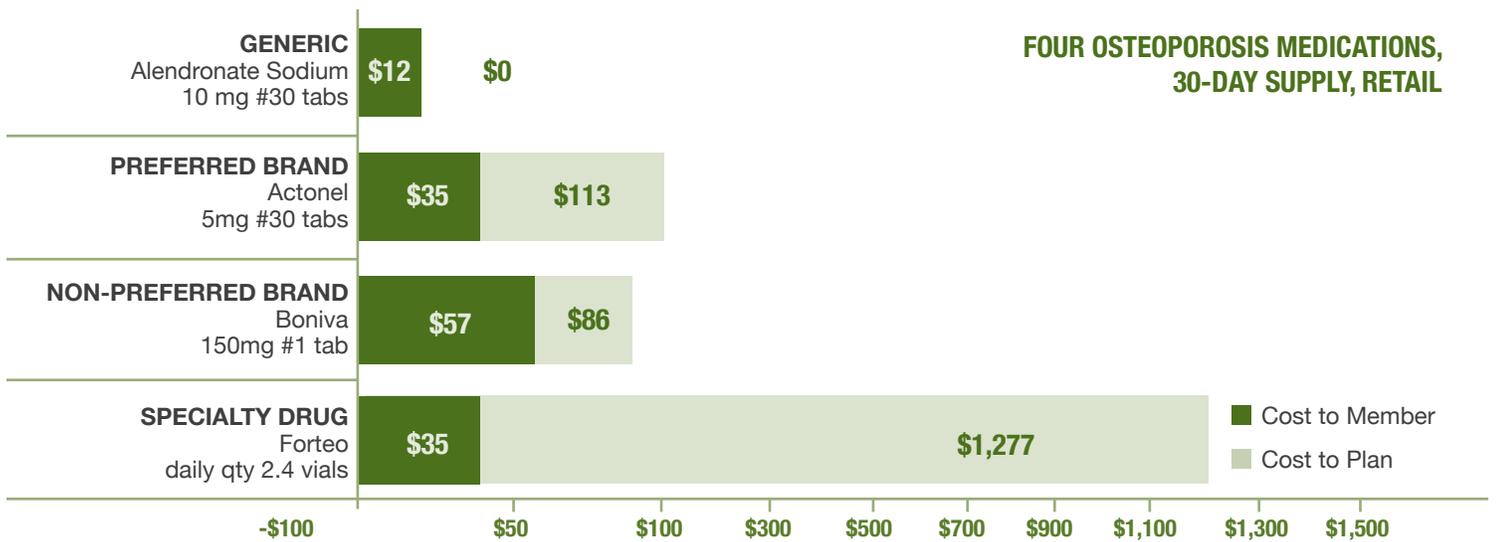
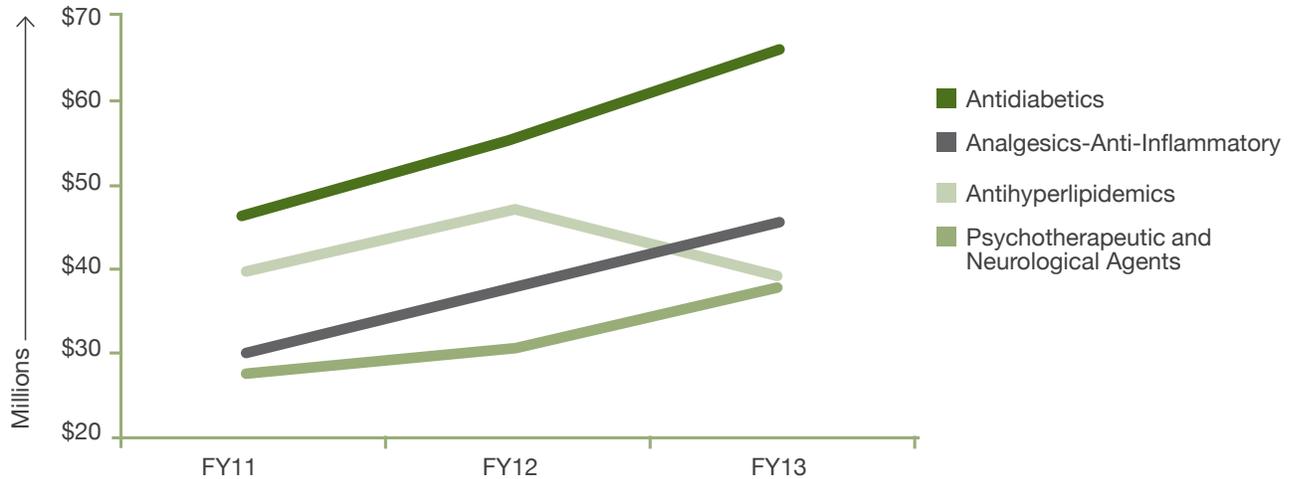


FIGURE 14: After Lipitor went generic, plan spending dropped for the entire therapeutic class, (HealthSelect FY11-FY13, in millions)



LINES 6F-6G. COORDINATION OF BENEFITS

Another way to reduce eligible HealthSelect charges is coordinating the payment of claims with other health care payers. For example, when retired participants become eligible for Medicare, GBP health benefits become secondary, which means that the plan only pays eligible health care expenses after Medicare has processed the claim. In FY13, coordination with the Medicare program saved the GBP about \$234 million. Coordination with other insurance programs saved \$49 million.

6f. Coordination of benefits - Medical - Regular	\$ 47,332,285
6g. Coordination of benefits - Medical - Medicare	233,685,380
6h. Coordination of Benefits - PDP	1,696,301

Refunds and Rebates

LINE 8A. PRESCRIPTION DRUG PROGRAM REBATES

Through arrangements with drug manufacturers, the HealthSelect PBM receives rebates based on the volume of various drugs dispensed under the prescription drug programs it administers. ERS’ PBM contract requires the PBM to return all rebates to the GBP, including a guaranteed minimum. During FY13, ERS received nearly \$54 million in rebates. ERS annually conducts an audit to confirm that 100% of all rebates were paid to the plan.

8a. PDP rebates	\$ 53,580,191
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LINE 8B. FEDERAL REVENUE – MEDICARE PART D. Starting January 1, 2006, Medicare-primary individuals could enroll in a Medicare Part D prescription drug program,

funded in part by the federal government. ERS chose to continue GBP prescription drug coverage for Medicare retirees and offset the cost with federal subsidies received under the Medicare Part D Retiree Drug Subsidy. Under RDS, the federal government reimbursed ERS for eligible retirees who stayed in the GBP instead of enrolling in Medicare Part D. From FY06-FY13, ERS collected RDS reimbursements of about \$249.1 million.

The amount of RDS funds received in FY13 was reduced as ERS moved most Medicare-primary participants to a self-funded Employer Group Waiver Program with a wraparound feature. HealthSelect Medicare Rx, administered by SilverScript (effective January 1, 2013), is expected to save the plan \$27 million in calendar year 2013.

Between the RDS and HealthSelect Medicare Rx, HealthSelect collected nearly \$51 million in Medicare Part D subsidies from the federal government in FY13.

8b. Federal Revenue - Medicare Part D	\$ 50,874,160
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LINE 8C. SUBROGATION

The subrogation program allows the plan to recover certain health-related expenses paid on behalf of a participant who has rights of recovery against a third party for negligence or any willful act resulting in injury or illness to the participant. Typically, such recoveries occur in connection with automobile accidents for which a third party is found liable. Subrogation recoveries saved the GBP \$7.8 million in FY13.

8c. Subrogation - recovery against a third party responsible for injury or negligence	\$ 7,791,629
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LANDMARK EVENTS IN THE HISTORY OF THE GBP

1975 **SB 18 CREATED THE TEXAS EMPLOYEES UNIFORM GROUP INSURANCE ACT**

- ERS was charged with providing health insurance and other optional coverages

1976 **HEALTH INSURANCE COVERAGE BEGAN FOR STATE EMPLOYEES, RETIREES, AND ELIGIBLE DEPENDENTS**

- Three fully-insured indemnity plan choices for employees: a high, medium, and low plan
- Retirees were enrolled in the equivalent of the high plan

LEGISLATURE APPROPRIATED THE SAME AMOUNT OF MONEY TO EVERY MEMBER TO SPEND ON INSURANCE

- The first year, members received \$12.50 a month. If any was left over, they could spend it on dependent coverage.

1978 **TWO HEALTH MAINTENANCE ORGANIZATIONS (HMOs) WERE APPROVED FOR PARTICIPATION IN THE GBP FOR FY79**

1984 **GOVERNOR’S TASK FORCE ON STATE EMPLOYEE HEALTH INSURANCE RECOMMENDED A “SINGLE BENEFIT PLAN”**

- The Task Force found the multiple plan arrangement to be “unsustainable” due to adverse selection

1985 **ERS CONSOLIDATED MULTIPLE PLANS INTO ONE**

- ERS consolidated plans, eliminated open enrollment and established evidence of insurability for late entrants.
- ERS implemented the second surgical opinion, preadmission testing for hospital stays, case management, medical necessity claims review and incentives for outpatient surgery

1987 **FEDERAL LAW AUTHORIZED THE EXTENSION OF COBRA BENEFITS**

1989 **PRESCRIPTION DRUG CARD WAS ADDED**

- Benefits were managed by the health plan administrator, and participants had two levels of copays for their medications

TEXTFLEX FLEXIBLE SPENDING ACCOUNT WAS ESTABLISHED FOR HEALTH CARE EXPENSES

1990 **22 HMOs WERE APPROVED FOR PARTICIPATION IN FY91**

- Benefits were standardized and financial requirements strengthened to reduce adverse selection and ensure that participants were getting similar benefits to the indemnity plan
- By comparison, in FY13, only two non-Medicare HMOs participate in the GBP

FOR THE FIRST TIME, THE LEGISLATURE PROVIDED AN EXPLICIT CONTRIBUTION FOR DEPENDENT HEALTH COVERAGE

1991 **THE LEGISLATURE ADOPTED THE 100% MEMBER-ONLY, 50% DEPENDENT CONTRIBUTION FOR FY92**

1992

HIGHER EDUCATION (EXCEPT THE UNIVERSITY OF TEXAS AND TEXAS A&M) JOINED THE INSURANCE PROGRAM

ERS IMPLEMENTED HEALTHSELECT OF TEXAS

- A self-funded, managed care, point-of-service health benefit plan. Gatekeeper model required members to coordinate care and specialty referrals through their PCP
-

1993

ENROLLMENT INCREASED 39.2% DUE TO INSTITUTIONS OF HIGHER EDUCATION JOINING THE PROGRAM

HEALTHSELECT NETWORK HAD 3,000 PRIMARY CARE DOCTORS AND 8,600 NETWORK SPECIALISTS

- The network started in Austin, Dallas, Houston, and San Antonio, and it took seven years before statewide coverage was available
 - By comparison, today the HealthSelect network has more than 11,000 PCPs and more than 48,000 specialists
-

1996

HEALTHSELECT BEGAN COVERING ANNUAL VISION EXAM

2000

PRESCRIPTION DRUG BENEFIT WAS CARVED OUT

- Medco was the first pharmacy benefit manager (PBM)
-

2001

HEALTHSELECT ADOPTED A THREE-TIERED COPAY STRUCTURE FOR PRESCRIPTION DRUGS

2003

A STATE BUDGETARY CRISIS RESULTED IN MID-YEAR PLAN DESIGN CHANGES

- \$600 million in cost shifting to members
-

2008

IMPLEMENTED TRANSPARENT PBM CONTRACT WITH 100% PASSTHROUGH OF ALL REBATES

- New contract with Caremark saved \$288 million over four years
-

2011

100% DEPENDENT ELIGIBILITY AUDIT

- Removed 5% of dependents and saved \$12.2 million

FUNDING SHORTFALL LED TO FIRST PLAN DESIGN CHANGES IN SIX YEARS

- \$142 million in cost shifting to members.

LAUNCHED PATIENT-CENTERED MEDICAL HOME PILOT PROJECTS

2012

LEGISLATURE IMPOSED AN EXTRA \$30 PER MONTH CONTRIBUTION FOR TOBACCO USERS

IMPLEMENTED MEDICARE ADVANTAGE PPO AND HMO FOR MEDICARE-ELIGIBLE PARTICIPANTS

2013

AWARDED THE HEALTHSELECT TPA CONTRACT TO A NEW CARRIER FOR THE FIRST TIME IN 30 YEARS

- Projected to save \$25 million in administrative fees over four years

IMPLEMENTED HEALTHSELECT MEDICARE RxD RUG BENEFIT FOR MEDICARE-PRIMARY PARTICIPANTS

PREVENTING AND INVESTIGATING FRAUD

Fraud prevention, detection, and investigation are integral components of the overall GBP cost management strategy. ERS takes the necessary steps to ensure that fraud and abuse of the program are prevented or reduced, and that violators are dealt with appropriately.

ERS requires vendors to be diligent in their efforts to prevent, detect, and investigate fraud, abuse, and other improprieties. Although fraud and abuse may be confused with each other, fraud implies intent, whereas abuse may occur from provider or participant error.

- Fraud is an intentional deception or misrepresentation by a person who knows that the deception could result in some unauthorized benefit.
- Abuse is a transaction that results in unnecessary cost to the program. For example, providers may bill the plan for services that are not medically necessary. Participants may be abusing the system when they go to the emergency room with minor health problems instead of to their primary care doctor, but they are not committing fraud.

The TPA has a Fraud, Waste and Abuse Division that investigates and refers suspected fraud cases to the proper criminal authorities and to ERS to enforce administrative penalties.

When law enforcement intervention is not necessary, the TPA engages providers in a collaborative process to speed the recovery of overpayments. Examples of anti-fraud and abuse methods include:

- annual auditing of provider claims for incorrect coding, double-billing, or falsified data;
- identifying and intervening in cases where abuse of certain drug categories is suspected;
- investigating potentially ineligible dependents through routine eligibility audits; and
- requiring that participants pay for all health care received outside the United States prior to receiving plan reimbursement.

Figure 15: *Provider tip leads to successful fraud investigation*



UnitedHealthcare received a call from a physician's office indicating they suspected a HealthSelect plan participant of a fraudulent practice known as 'member ID card sharing'. An investigator from UnitedHealthcare's Fraud, Waste, and Abuse division was assigned to initiate a case and the participant's record

was flagged to pend payment for any incoming claims. The investigator interviewed the physician and office staff and was able to obtain important information about the patient's

behavior and statements made in the office. The physician's office provided copies of the HealthSelect plan ID card and the Driver's License submitted by the patient, and other important evidence.

After several weeks of investigation, it was determined that there was a high probability that the participant in question knowingly provided their HealthSelect plan ID card and Driver's License to their uninsured family member so that they could seek care for an illness. The efforts of this investigation resulted in the referral of the case to local law enforcement for prosecution as well as to the Texas Department of Insurance.

DEPENDENT ELIGIBILITY AUDIT (DEA)

ERS has a fiduciary responsibility to manage health care costs and control fraud. Ineligible dependents increase the cost of health care to the State; therefore, removing ineligible dependents from the GBP reduces state contributions and plan costs.

ERS conducted a 100% dependent eligibility audit that asked all plan members who cover dependents for documentation proving their eligibility for coverage. About 5.3% of dependents were removed from the plan at a net savings to the plan of \$12.2 million in FY12. Going forward, ERS will continue to verify eligibility of all new dependents as they are added to the plan.

LINE 8D-8F. AUDIT REFUNDS

The Retail Pharmacy Audit Program includes a sophisticated set of programs and procedures to:

- ensure participating pharmacies’ compliance with program guidelines,
- protect the financial integrity of the provider network and the PDP,
- deter fraudulent claim submissions, and
- educate participating pharmacies about the correct procedures and program guidelines.

In addition to auditing the specific retail pharmacies, ERS contracts with an independent auditor to review claims and administrative services to ensure compliance with the PBM contract. This audit reviews all retail pharmacy and mail order claims.

As part of ERS’ transparent contract with the PBM, the independent auditor examines the rebate contracts between the PBM and pharmaceutical manufacturers to ensure that (a) 100% of all claims are billed to the pharmaceutical manufacturers, and (b) ERS receives 100% of all rebate dollars paid to the PBM based on our claims experience.

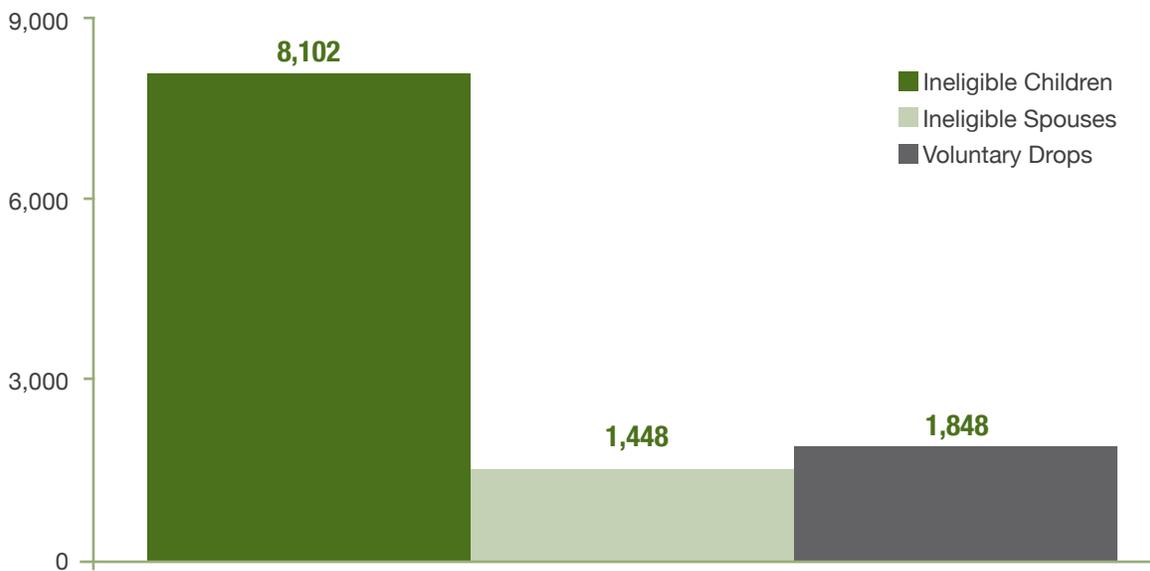
8e. PBM audit results	\$ 149,653
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Audits are also done on hospital claims and compliance with billing requirements.

8f. Hospital audit refunds	\$ 2,006,183
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8d. Pharmacy audit refunds	\$ 715,576
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FIGURE 16: *Dependent audit removes >11,000 ineligible dependents and saves \$12.2 million*



WELLNESS AND DISEASE MANAGEMENT PROGRAMS

The State of Texas provides health insurance so that its workers are healthy, present and productive on the job. Poor health costs both employers and employees time and money. The GBP offers many voluntary wellness programs to help participants improve their quality of life and hopefully slow the growing cost of health care benefits. ERS supports and promotes wellness in many ways.

WE MAKE SURE EMPLOYEES HAVE WELLNESS BENEFITS THROUGH THE HEALTH INSURANCE PLANS. HealthSelect, HealthSelect MA, and the HMOs all have extensive wellness offerings available to employees, retirees, and their families.

WE CONDUCT RESEARCH ON PATTERNS OF CHRONIC ILLNESS. We study whether people are taking their medications for chronic illnesses, and where they are getting care – for example, do they go to the emergency room when they have an asthma attack, or are they going to their primary care doctor first, before it is an emergency?

WE FOCUS OUR PLAN DESIGN TO ENCOURAGE PEOPLE TO GET THE CARE THEY NEED. Preventive care is available at no cost to participants. The program also keeps generic drug costs and primary care copays low to make sure everyone can afford to go to the doctor and take the medications they need. HealthSelect participants also have 24-hour hotline access to a registered nurse.

WE EDUCATE EMPLOYEES AND RETIREES ON AVAILABLE WELLNESS PROGRAMS. ERS provides multi-channel communications about wellness and the tools that are available to help participants to manage their health. We use direct mail, online communications, telephone outreach, face-to-face meetings, and benefit fairs.

ERS WORKS WITH OTHER AGENCIES TO PROMOTE WELLNESS. Finally, ERS and the HealthSelect TPA are active with the State Worksite Wellness Advisory Council, and are helping identify opportunities to encourage and engage state employees, wellness coordinators, and state agencies. We also help plan statewide wellness activities and events that come up during the year.

ENGAGEMENT IN HEALTHSELECT CLINICAL MANAGEMENT PROGRAMS DOUBLED. Increased participation in disease management and case management programs is an important part of controlling costs.

FIGURE 17: *Clinical Program engagement doubled from 16% to 35% of identified at-risk members*



HealthSelect significantly increased engagement in clinical management programs in FY13, providing engaged participants individualized telephone support with a nurse.

Engaging in a clinical management program helps a participant better manage his or her complex or chronic condition. For example, enrollees are more likely to manage their illnesses by going to their doctors, monitoring their conditions with appropriate diagnostic tests, and taking their medications. They are also less likely to be hospitalized or go to the emergency room, compared to people with poorly managed health conditions.

The TPA reported that 6,028 participants completed health risk assessments in FY13, a 3.2% increase over FY12. However, this still represents less than 2% of the HealthSelect population. Those who complete the health risk assessment get a free report of their potential health risks, allowing them to seek interventional health care, hopefully at an early stage of a condition or potential condition.

HIGHER TOBACCO-USER PREMIUM CONTRIBUTIONS YIELDED \$9.7 MILLION IN FY13

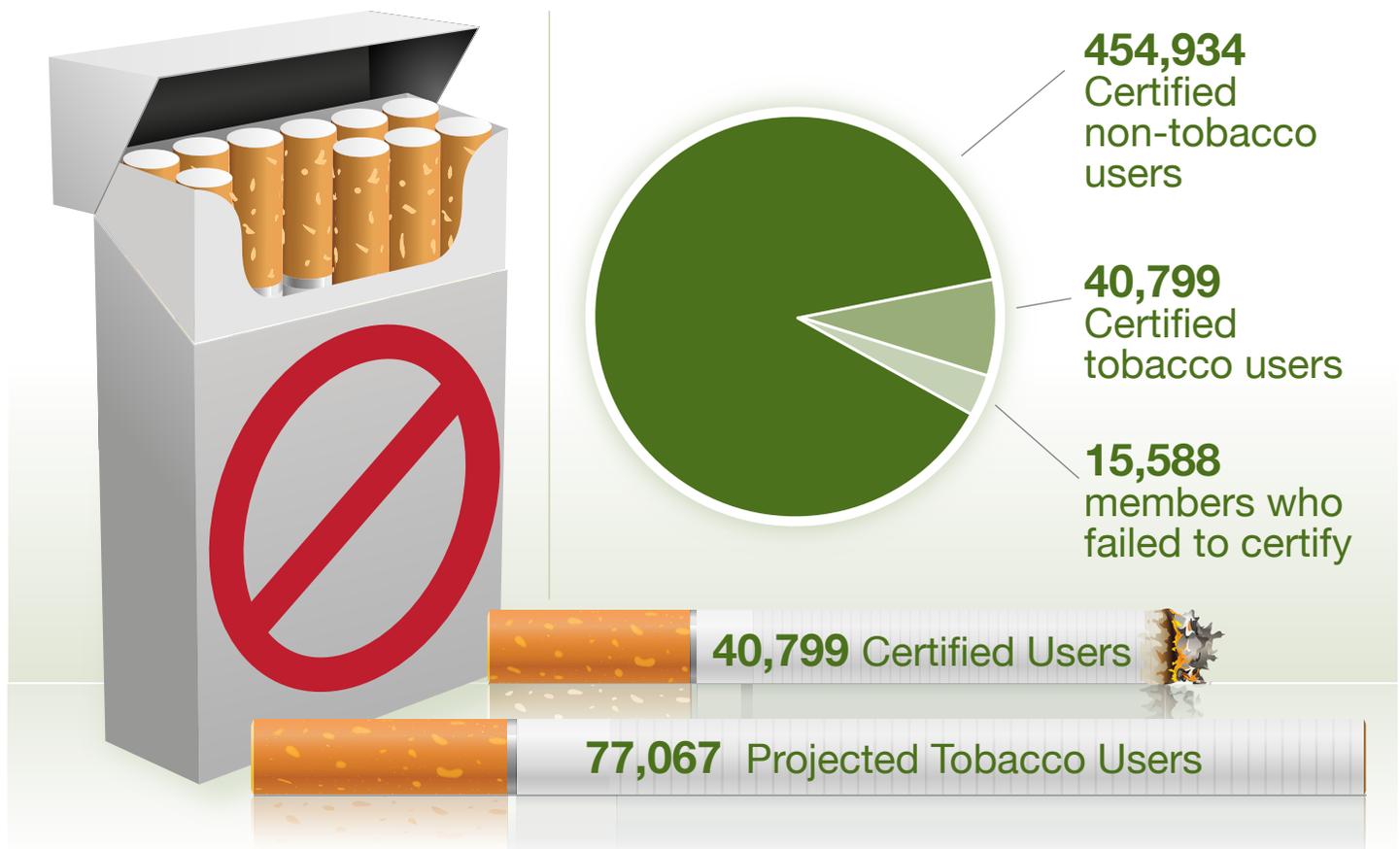
The 82nd Legislature enacted an “opt in” or voluntary tobacco user premium contribution that took effect January 1, 2012. The program was designed to encourage and support people to stop using tobacco, by covering tobacco-cessation medications and offering voluntary tobacco cessation support programs.

In FY13, ERS collected \$9.7 million in additional tobacco contributions from more than 28,000 participants who voluntarily certified their tobacco use. Upon certification,

tobacco users paid an extra contribution of \$30 a month, up to \$90 per household.

In FY14, the Legislature authorized ERS to mandate tobacco certification of all participants during annual enrollment. About 97% of the GBP population self-certified. Those who failed to certify were assumed to be tobacco users and are charged the monthly tobacco premium contributions until they inform us they are no longer using tobacco. In FY14, ERS projects \$14.6 million in tobacco contributions from about 41,000 participants.

FIGURE 18: Just over half of the projected tobacco users in the program have self-certified to pay the tobacco user premium contribution of \$30 a month



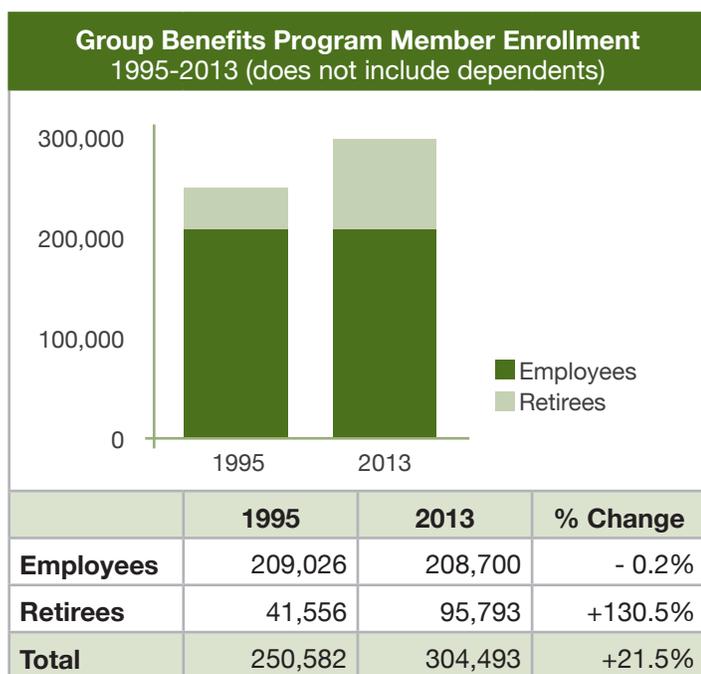
HealthSelect offers free tobacco cessation coaching programs, and it now provides coverage for prescription drugs like Chantix and bupropion. In FY13, About 3,800 participants filled Chantix prescriptions, at an estimated

cost to the plan of about \$550,000. Only 70 participants engaged in the voluntary HealthSelect tobacco cessation program in FY13.

RETIREE BENEFITS

Most state and local government employers offer health insurance benefits to their Medicare-primary retirees. Many private employers do not. Some employers offer a Medicare Advantage plan; others give retirees a set amount of money to buy a Medigap or Medicare Supplement policy on the open market.

FIGURE 19: The entire increase in GBP member enrollment since 1995 is due to the retiree population more than doubling

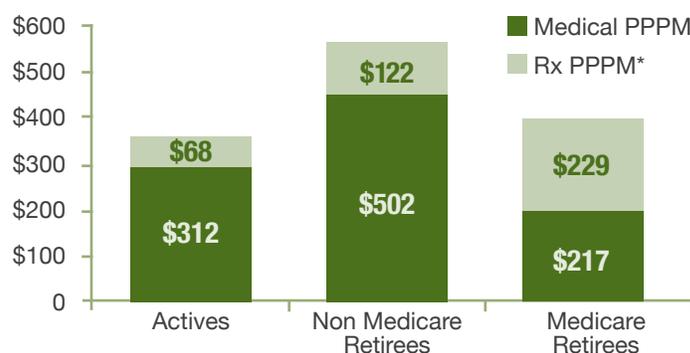


The importance of managing retiree health benefits cannot be overstated. All of the growth in GBP enrollment since 1995 is due to a doubling of the retiree population.

As seen in Figure 20, retirees have higher costs than active employees. Retirees without Medicare have the highest medical costs to the program, and retirees with Medicare have the highest prescription drug costs to the program.

About two-thirds of the Medicare-primary population in the GBP has now moved to a fully-insured HealthSelect MA plan. One-third remain in the HealthSelect self-funded plan. All retiree prescription drug costs are counted in this report, as the HealthSelect Medicare Rx plan is a self-funded drug plan. Not all Medicare-primary medical costs are counted here, as the MA plans are not part of the self-funded HealthSelect benefit.

FIGURE 20: Retirees without Medicare have the highest average medical costs; Retirees with Medicare have the highest average pharmacy costs



*Per participant per month cost by employee status, Health Select FY13)

THE MEDICARE ADVANTAGE OPTION. When GBP retirees and their dependents reach age 65 and become eligible for primary coverage under Medicare, they are automatically enrolled in HealthSelect MA. A GBP member enrolled in an MA plan does not have traditional Medicare or HealthSelect coverage. Retirees with an MA plan do not need a Medigap policy.

Medicare-primary participants can opt out of HealthSelect MA and choose from four other options: HealthSelect, two regional HMOs, or a Houston-area MA HMO, KelseyCare. In FY13, about 65% of Medicare-primary retirees and their Medicare-primary spouses remained in the MA plans, while the rest chose HealthSelect or one of the non-MA HMOs.

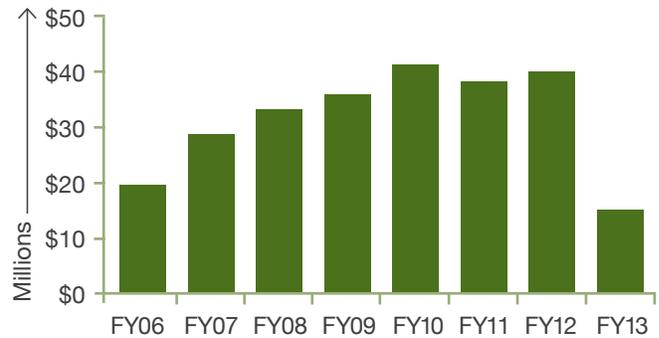
To get the most from their GBP benefits, Medicare-primary participants in all GBP health plans must have Medicare Part A (hospital) and Part B (other medical) coverage. Part A is free for Medicare-primary participants³. Part B premiums started at \$105 a month in 2013, but vary based on the retiree’s income. HealthSelect coordinates benefits with Medicare to pay most expenses not paid by Medicare. When retirees use doctors who accept Medicare, they have very low out-of-pocket costs under both HealthSelect MA and HealthSelect.

GBP monthly premiums for HealthSelect MA and KelseyCare are less expensive for the State and for the retiree because Medicare, as the primary payer, subsidizes a large portion of participant medical expenses. MA plan enrollees continue to receive prescription drug coverage through HealthSelect Medicare Rx. The benefits offered to GBP retirees under HealthSelect MA are comparable to HealthSelect.

MEDICARE PART D RETIREE DRUG SUBSIDY (RDS). January 1, 2006, Medicare retirees became eligible for federally subsidized prescription drug benefits through the federal Medicare Part D program.

The Medicare Modernization Act of 2003 (MMA) created a number of subsidy options to encourage employer-sponsored insurance plans to continue drug coverage for Medicare-primary participants. The most popular of these approaches has been the Retiree Drug Subsidy. Over an eight-year period, HealthSelect collected \$249.1 million in RDS program subsidies.

FIGURE 21: Between FY06 and FY13, HealthSelect offset \$249.1 million in Medicare-participant drug costs with the federal Retiree Drug Subsidy



During an ERS Solution Session in January 2012, a vendor presented an option for reopening HealthSelect’s past RDS filings to identify and reclaim any missed reimbursements as far back as 2006. ERS contracted with a vendor for the reconciliation of past RDS filings, a process that yielded \$7 million in net savings for the plan.

EMPLOYER GROUP WAIVER PROGRAM + WRAPAROUND (EGWP). On January 1, 2013, ERS moved the majority of Medicare-primary participants to an EGWP program called HealthSelect Medicare Rx. This is a basic Medicare Part D program that combines with a wraparound feature to match the prescription drug benefits provided under HealthSelect.

The Legislative Budget Board originally recommended the EGWP option for ERS in its 2009 Government Effectiveness and Efficiency Report. ERS reviewed the option several times and chose not to implement it because the RDS program provided more savings at that time.

However, recent changes in federal law resulting from the ACA require drug manufacturers to pay 50% rebates on brand name prescription drugs in the Medicare Part D coverage gap, called “the donut hole.” This made EGWP a more attractive savings option for employers.

Under HealthSelect Medicare Rx, the GBP is expected to save \$27 million for calendar year 2013.

³ Medicare Part A is free at age 65 as long as you have paid into Medicare for at least 40 quarters of your working career. Otherwise, you are charged a monthly premium.

CONTRACTING

MANAGED CARE LOWERED FY13 CHARGES BY \$3.5 BILLION

ERS contracts with vendors to process medical and prescription drug claims and build and maintain provider networks. The plan saves billions of dollars by negotiating provider contracts that save the plan money while improving access and enforcing high standards of care. We do not use standard contracts; rather, we develop and administer customized GBP contracts in the best interests of the participants, the programs, and the State.

In FY13, the administration of HealthSelect medical benefits was successfully transitioned to a new TPA, UnitedHealthcare. The new contract saved the plan \$6.5 million in administrative fees in FY13, and is on track to meet four-year savings projections of \$25 million (compared to other administrative proposals). Both prescription drug benefit programs continue to be administered by Caremark, without an increase in administrative fees.

About \$3.6 billion in charge reductions in FY13 came from the negotiation of discounted reimbursement rates with providers. The savings represent the discounts taken from the “retail” prices that doctors, hospitals, pharmacies, and other providers would have charged the GBP had they not been covered by a managed care network.

CONTROLLING COSTS THROUGH MANAGING THE NETWORK.

HealthSelect is a managed care plan that requires participants to stay “in network” to receive the highest level of benefits. Network limitations save the plan money by offering financial incentives for participants to use contracted providers. Switching to a TPA with more aggressive contracting strategies resulted in more physicians being added to the HealthSelect network at better discount rates, saving the plan \$15 million in FY13.

HEALTHSELECT PROVIDES THREE LEVELS OF COVERAGE:

- **In-network** coverage means a participant must see a network primary care physician (PCP) or “gatekeeper” for specialist referrals or for extra services such as lab work, X-rays, or MRIs.
- **Non-network** coverage refers to services provided by non-contracted providers or outside the direction of a PCP. Participants can go out-of-network, but they pay more.
- **Out-of-area** coverage refers to coverage for those who reside outside of Texas or who are eligible for primary coverage under Medicare. Out-of-area coverage does not require the selection of a PCP or referrals. These services also cost the participants more.

Although ERS does not contract directly with doctors, hospitals, or other health service providers, we participate with our vendors in closely monitoring rate increases. Competitive pressure can be used to moderate price increases.

ALTERNATIVE PAYMENT MODELS

Much has been written about the inefficiency of the American “fee-for-service” (FFS) reimbursement system. The belief is that paying providers for each service they provide creates incentives for doctors to overprescribe – more office visits, more lab tests, more X-rays – to boost their reimbursement.

Moving away from FFS requires paying medical providers in new ways that reward them for reducing costs while continuing to meet quality standards. Recent state and federal legislative initiatives have encouraged insurers to explore alternative payment systems that reward providers for reducing costs and improving quality outcomes.

PATIENT-CENTERED MEDICAL HOMES REDUCE COST AND IMPROVE QUALITY

The Patient-Centered Medical Home (PCMH) model is a provider team made up of an integrated multi-specialty practice. This model generally:

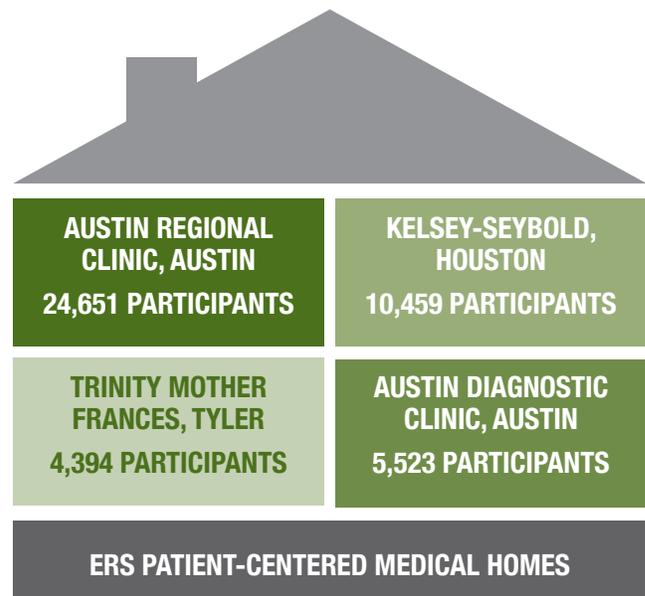
- focuses on wellness and establishing an ongoing relationship with a personal primary care physician;
- uses advanced information technology;
- ensures that quality and safety standards are met through the use of evidence-based medicine and clinical decision-support tools;
- provides enhanced access, such as open scheduling, expanded hours, and new options for communication between provider and participant (e.g., email); and
- awards shared-savings payments to the provider group when quality standards are met and cost targets are achieved.

Since January of 2011, the GBP has implemented four PCMH projects, with large multi-specialty practices in urban areas:

- Austin Regional Clinic in Austin,
- Kelsey-Seybold in Houston,
- Trinity Mother Frances in Tyler, and
- Austin Diagnostic Clinic in Austin.

ERS continues to pursue new PCMH contracts across the state.

FIGURE 22: HealthSelect has four Patient-Centered Medical Home projects with more than 45,000 participants



SAVINGS ARE SHARED WITH PROVIDERS. In addition to its regular FFS payments, HealthSelect pays the PCMH a negotiated monthly capitation payment for those participants who have selected the medical home as their primary care coordinator. The capitation payment is designed to incentivize enhanced care coordination not found in the standard FFS practice.

ERS also sets performance targets, designed to reduce the health benefit cost trend, while meeting quality standards of care. The PCMH projects have successfully reduced the health benefit cost trend below their ERS-prescribed performance targets, saving the GBP an estimated \$11 million in FY12. To date, the GBP has issued shared savings payments of \$1.3 million to Austin Regional Clinic and \$1.2 million to Kelsey-Seybold Clinic. FY13 savings were not available at publication time. In general, drug therapy costs for the HealthSelect PCMH projects rose, but there were significant decreases in other services, such as inpatient hospital stays.

CONCLUSION

Proactive cost management is an imperative in the face of growing utilization of drugs and medical services, higher-cost medical care and drug therapies, an aging plan membership, increasing rates of chronic diseases, and limited resources.

ERS lowered health plan costs by \$5.5 billion in FY13 through tough cost-management practices, aggressive negotiation of contracts, and low administrative overhead. The HealthSelect benefit cost trend is lower than the national trend, and our administrative costs represent less than three cents of every health plan dollar.

Successful management and legislative support of the program allowed the GBP to avoid benefit changes for the FY13-14 biennium. But the future will continue to present some difficult decisions for ERS, state lawmakers, and especially for the employees, retirees, and their families who count on these health insurance benefits.

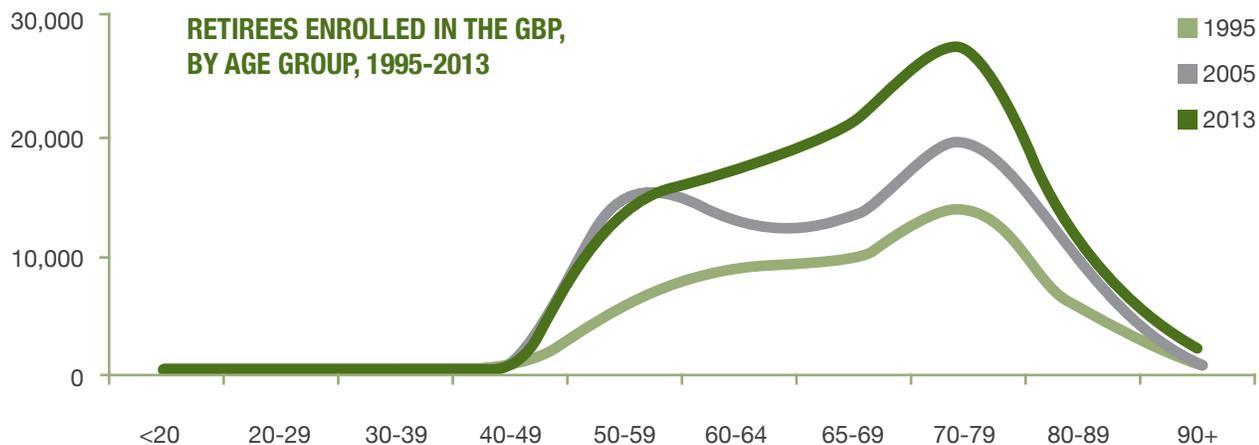
ERS IS IMPLEMENTING BEST PRACTICES. Extensive study and benchmarking research has shown that ERS has already implemented many best practices found in the marketplace. For example, ERS started offering “Solution Sessions” in 2012, a formalized, transparent process for vendors to present cost saving ideas for the GBP.

Since then, 30 vendors have presented at open meetings, held in the ERS auditorium and live-streamed over the internet. As a result, ERS has implemented a number of Solution Session ideas, and has institutionalized an open government approach to gathering new ideas for the program.

ERS IS PROACTIVELY MANAGING RETIREE COSTS. While the number of active employees in the GBP is holding steady, Figure 25 shows how the retiree population has more than doubled since 1995. In fact, a 21% growth in GBP membership over two decades is entirely due to the growing retiree population.

Managing costs for an aging health plan is paramount. In the past two years, ERS has implemented new health and pharmacy plans for the Medicare-primary retiree population. These initiatives have produced savings for the plan, and reduced contributions for members with dependents enrolled in the Medicare Advantage plans.

FIGURE 23: The GBP Retiree Population has doubled, and they have grown older since 1995 (Retirees enrolled in the GBP, 1995 – 2013)



THE GBP HAS A SIGNIFICANT IMPACT ON THE TEXAS ECONOMY.

The GBP provides cost-effective coverage to more than half a million Texans, in every area of the state. It's important to remember the economic impact that the plan has on local health providers too. HealthSelect, with 85% of total GBP membership pays \$2.2 billion in health payments each year to doctors, hospitals, and pharmacies across Texas. See figure 24 for the impact of HealthSelect in Texas.

WITHOUT COST MANAGEMENT, THE STATE'S INSURANCE CONTRIBUTION WOULD INCREASE FOUR-FOLD. In FY13, the member-only contribution rate for FY13 was \$468 per month. Figure 25 on page 28 demonstrates the financial impact that cost management programs had on the monthly contribution rate for member-only coverage during FY13. Without cost-management programs, the monthly contribution rate for member-only coverage would have been \$1,655.

Looking ahead

The 83rd Texas Legislature took a key step to reducing the state's health care costs for the retiree population

by passing a tiered contribution strategy that will require non-grandfathered retirees to have at least 20 years of service to qualify for a 100% member contribution from the State. After September 1, 2014, non-grandfathered employees who retire with 10-15 years will pay 50% of the contribution for their health coverage, and those with 15-20 years will pay 25% of their contribution for their health coverage.

The Legislature also asked ERS to follow up on a finding from the FY12 ERS Interim Benefits Study that lower income employees may be turning down dependent care coverage because they can't afford it. ERS will conduct a member survey in FY14 to test that assumption, and to solicit member preferences for less costly health plans.

ERS continues to work ahead of the curve to maintain quality benefits at a cost significantly lower than the national average. However, the program needs coordinated action to make further inroads on reducing plan costs. We look forward to working with the Legislature to find cost effective ways to continue offering competitive benefits to the state workforce at a reasonable cost.

FIGURE 24: HealthSelect has a significant economic impact on the Texas economy

HEALTHSELECT PAID MEDICAL AND RX CLAIMS \$ IN FY 2013
TOTAL CLAIMS - \$2.2 BILLION
HEALTHSELECT ENROLLMENT - 437,650

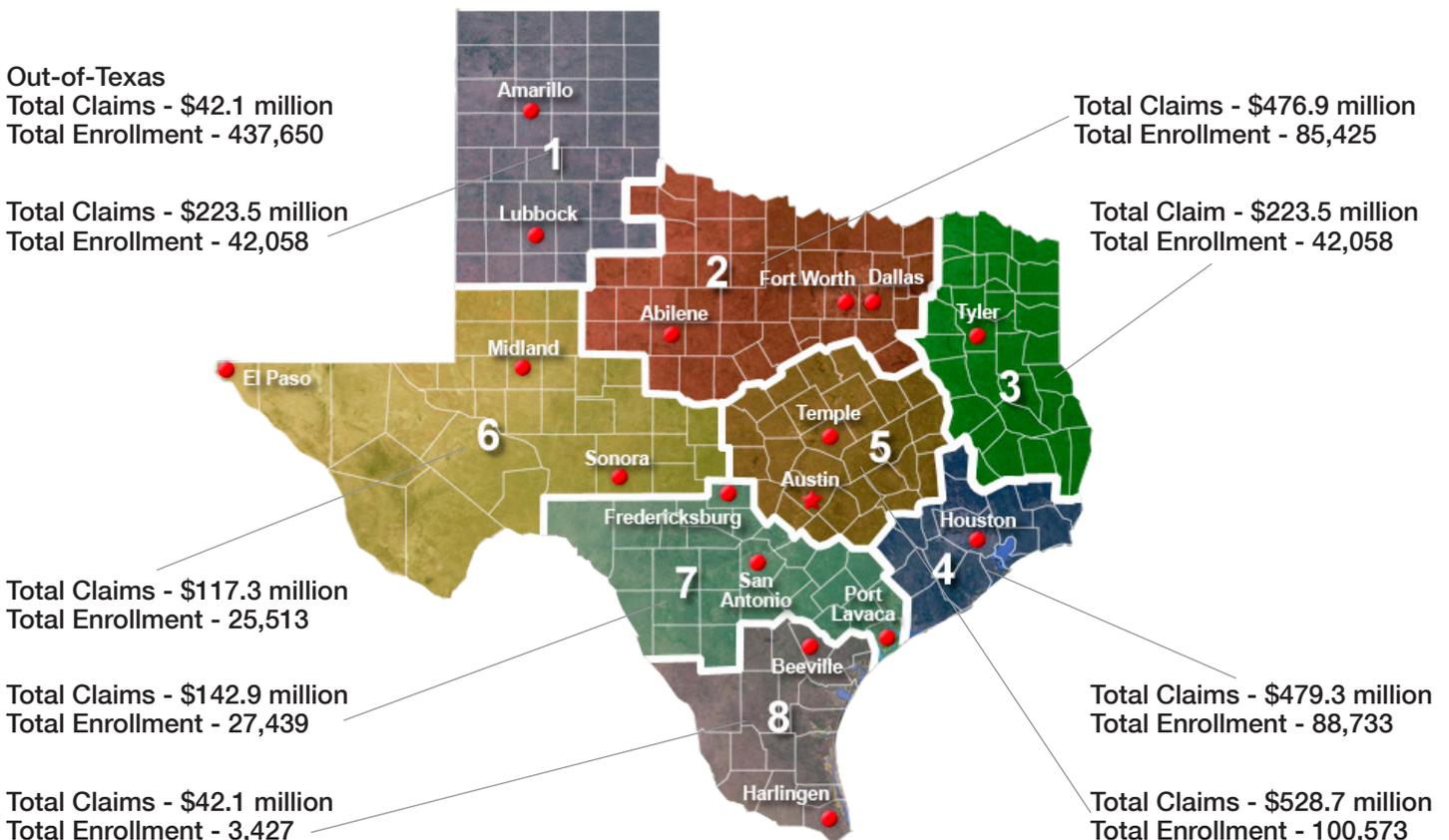


FIGURE 25: Texas Employees Group Benefits Program, HealthSelect FY13, Cost Containment Impact on the Member Only Rate

	Annual Amount		Required Monthly Revenue for Member-only Coverage	
1 Considered Charges plus Estimated Cost Avoided	\$7,720,820,411		\$1,655.17	
2 Estimated Cost Avoided				
a. Medical	(\$56,359,082)		(\$12.08)	
b. Pharmacy	(27,910,775)	(84,269,857)	(5.98)	(18.06)
4 Ineligible Charges	(946,537,903)		(202.92)	
6 Reductions to Eligible Charges				
a. PDP Charge Reductions	(\$660,442,527)		(\$141.58)	
b. Provider Discounts & Reductions	(\$2,978,631,857)		(638.55)	
c. Medical Copayments and Deductibles	(119,441,848)		(25.61)	
d. Medical Coinsurance	(185,321,419)		(39.73)	
e. PDP Cost Sharing	(164,518,131)		(35.27)	
f. Coordination of Benefits – Medical - Non Medicare	(47,332,285)		(10.15)	
g. Coordination of Benefits – Medical - Medicare	(233,685,380)		(50.10)	
h. Coordination of Benefits - PDP	(1,696,301)	(4,391,069,748)	(0.36)	(941.35)
8 Refunds, Rebates, and Guarantees				
a. PDP Rebates	(\$53,580,191)		(\$11.49)	
b. Federal Revenue - Medicare Part D	(50,874,160)		(10.91)	
c. Subrogation	(7,791,629)		(1.67)	
d. Pharmacy Audit Refunds	(715,576)		(0.15)	
e. PBM Audit Refunds	(149,653)		(0.03)	
f. Hospital Audit Refunds	(2,006,183)	(115,117,392)	(0.43)	(24.68)
9 Net Benefit Payments	\$2,183,825,511		\$468.16	\$468.16
				Monthly Member Rate

APPENDIX A: Impact of the Affordable Care Act on the GBP

The Texas Legislature amended state law in 2011 and 2013 to bring the GBP into compliance with the requirements of the Affordable Care Act (ACA). ERS has implemented all required ACA-related changes to date.

The GBP saw a net gain of almost \$38 million to the program in FY11 and FY12 due to the ACA. Starting in FY13, ACA-related costs have increased annually. More than half of the increased costs in FY13 are due to the plan covering 100% of the cost of preventive care services.

About 25% of the increased costs to the GBP projected through FY15 are due to new fees required by the ACA. Only one of the new fees is permanent, and it does not apply to HealthSelect.

According to ACA standards, ERS manages an extremely cost-efficient plan. The ACA requires large employer plans to spend at least 85 cents of every dollar they collect on health care claims. The HealthSelect program spends more than 97 cents of every dollar on health care claims.

EMPLOYEES RETIREMENT SYSTEM GROUP BENEFITS PROGRAM PROJECTED ADDITIONAL PLAN COST/(SAVINGS) FY11 - FY13 RELATED TO THE AFFORDABLE CARE ACT¹ REVISED DECEMBER, 2013

	Projected Plan Cost/(Savings) (\$millions) ²				
	FY11	FY12	FY13	FY14	FY15
1. Early Retiree Reinsurance Program Receipts	(\$30.2) ³	(\$40.7) ³	\$0.0	\$0.0	\$0.0
2. Eliminate lifetime maximum for out-of-network services	\$0.3	\$0.3	\$0.3	\$0.3	\$0.3
3. Expand coverage to dependents to Age 26	\$0.0	\$7.8	\$11.8	\$12.7	\$13.7
4. Cover preventive care at 100%	\$0.0	\$26.1	\$27.9	\$29.9	\$32.0
5. Patient Centered Outcomes Research Trust (PCORT)	\$0.0	\$0.0	\$0.5	\$1.1	\$1.1
6. Cover contraceptives at 100%	\$0.0	\$0.0	\$8.8	\$9.6	\$10.6
7. Reduce Waiting Period	\$0.0	\$0.0	\$0.0	\$0.0	\$19.3
8. Transitional Reinsurance Program Assessments	\$0.0	\$0.0	\$0.0	\$18.6	\$22.2
9. Change Definition of Full Time Employee from 40 to 30 Hours per Week	\$0.0	\$0.0	\$0.0	\$4.1	\$4.4
10. Health Insurer Fee	\$0.0	\$0.0	\$0.0	\$9.1	\$17.6
Total	(\$29.9)⁴	(\$6.5)⁴	\$49.3	\$85.4	\$121.2

¹Projected additional plan cost/(savings) to the GBP for all employers and participants. Estimates updated December, 2013.

²Projected Plan Cost represents costs incurred in fiscal year, except as noted in Footnote 3 below.

³Funds received from the Federal government: \$30.2M received in FY11 based on claims incurred in FY10 and FY11; \$40.7M received in FY12 based on claims incurred in FY11.

⁴Negative amounts denote savings to the GBP.

APPENDIX B: Financial Status of the Group Benefits Program, FY13

Texas Employees Group Benefits Program, Summary of Health Plan Experience Based on Experience through September, 2013			
\$Millions			
	FY12	Projected FY13	Projected FY14
Revenue from State/Members			
State Contribution for State Agencies 1% agencies' payroll contribution	\$1,257.5 56.5	\$1,351.0 56.5	\$1,477.7 56.5
State Contribution for Higher Education 1% higher ed's payroll contribution	514.0 30.7	558.6 30.7	609.3 32.6
Employer Contribution – Other ¹	46.5	57.3	62.4
Employer Contribution - Total	\$1,905.2	\$2,054.1	\$2,237.5
Member Contribution	395.6	415.0	446.2
Total Contributions	\$2,300.8	\$2,469.1	\$2,683.7
Revenue from Other Funding Sources:			
Refunds, Rebates and Part D Subsidy	\$153.1	\$119.9	\$107.9
Net Investment Income ²	1.1	(18.6)	(9.6)
Total	\$154.2	\$101.3	\$98.3
TOTAL REVENUE³	\$2,455.0	\$2,570.4	\$2,782.0
HEALTH CARE EXPENDITURES³	\$2,398.2	\$2,529.8	\$2,802.8
Net Gain/(Loss)	\$56.8	\$40.6	(\$20.2)
Fund Balance	\$284.3	\$325.4	\$304.6
Other Expenses Incurred Outside of the GBP Fund			
Member Cost Sharing	\$568.2	\$554.8	\$565.9

¹Non-state agencies

²Net investment income represents the excess of investment income over ERS insurance operating expenses related to the insurance program

³Reduction in member cost sharing for FY12 reflects transfer of Medicare-primary participants to MA PPO.

HEALTHSELECT PROJECTED ANNUAL HEALTH BENEFIT COST TRENDS FOR FY 2014-2015

Category	Utilization Trend	Cost/Unit Trend	Expenditure Trend	MCS Leverage	Plan Cost Trend
Hospital	2.6%	5.9%	8.5%	1.0%	9.5%
Other Medical Expense	1.9%	2.6%	4.5%	0.5%	5.0%
Pharmacy	2.5%	2.9%	5.4%	3.6%	9.0%
Total	2.4%	4.2%	6.6%	1.4%	8.0%

The rates presented above represent the gross (underlying) health benefit cost trends prior to recognition of benefit, legislative and/or administrative changes that could be expected to impact health benefit cost.

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