



ERS
EMPLOYEES RETIREMENT
SYSTEM OF TEXAS

FY2012

**TEXAS EMPLOYEES GROUP BENEFITS PROGRAM
COST MANAGEMENT AND FRAUD REPORT**



ERS enhances the lives of our participants
through the delivery of quality benefits at a reasonable cost.

EMPLOYEES RETIREMENT SYSTEM OF TEXAS

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FY12 COST MANAGEMENT AND FRAUD REPORT

Texas Employees Group Benefits Program

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 to ensure that strong measures are in place to prevent fraud and abuse. ERS has managed health insurance benefits for the State since 1976.

Employee health insurance is a significant expense for the State of Texas, so it is important to get the most out of every health care dollar. A cost-efficient plan creates value for the State by avoiding billions of dollars in payments and helping employers to continue to offer, and employees to afford, reasonable health benefits at a lower than average cost.

In FY12, ERS and its vendors lowered charges for HealthSelect of TexasSM by \$6.7 billion through tough cost-management practices, including:

- negotiating provider discounts,
- monitoring cost and utilization,
- leveraging outside sources of funds,
- developing innovative payment systems,
- preventing fraud, and
- sharing costs with participants through plan design.

See [Appendix A](#) for a detailed account of the history of cost-containment activities for the HealthSelect program.

HealthSelect has low administrative costs.

HealthSelect is a self-funded point-of-service insurance plan administered by ERS. In a self-funded plan everyone—employer and employee—pays for the plan and bears the risk that the revenue collected will be enough to pay all health care claims during the year. This means that the State and the participants share

FY12 HIGHLIGHTS

Lowered total HealthSelect charges by \$6.7 billion through cost management programs.

Implemented a Medicare Advantage plan (\$15.3 million in premium contribution savings for enrolled Medicare-eligible retirees with dependents).

Collected \$5.2 million in additional premium contributions from more than 26,000 tobacco users.

Obtained reimbursement from the Early Retiree Reinsurance Program (\$70.9 million in total funding received during FY11 and FY12).

Conducted a 100% dependent eligibility audit, resulting in 5% of dependents being removed from the plan (\$12.2 million in net savings for FY12.)

Negotiated a new HealthSelect third-party administrator (TPA) contract (\$25 million savings for FY13-FY16) as compared to other administrative proposals.

Continued to build upon the success of three Patient-Centered Medical Home programs (realized \$11 million in FY11 savings; FY12 savings not yet available).

Negotiated a pharmacy benefit manager (PBM) contract extension, reducing guaranteed plan costs \$41 million for FY13 and FY14 combined.

Invoked Most Favored Nations clause in the PBM contract (\$20 million savings).

Awarded a contract to reopen past Retiree Drug Subsidy claims for reconciliation and potential savings.

Contracted for an Employer Group Waiver Program + Wraparound (EGWP + Wrap) for Medicare retiree drug coverage as of January 1, 2013 (\$27 million savings for calendar year 2013).

in the savings from reduced plan costs and must pay more when plan costs increase.

The recent federal health care reform bill requires insurers of large plans to spend 85 cents of every health insurance dollar on health care costs. HealthSelect far exceeds this standard with about 97 cents of every HealthSelect dollar going toward health care costs.

Most GBP participants (86%) are enrolled in HealthSelect medical benefits while about 95% of GBP participants are enrolled in HealthSelect pharmacy benefits. The rest enroll in fully insured HMOs or Medicare Advantage plans. This report covers only HealthSelect medical and pharmacy cost management programs.

FY12 cost containment savings for the HealthSelect program are not directly comparable to FY11, because 46,884 Medicare-

primary participants were enrolled in Medicare Advantage as of August 31, 2012. Medicare Advantage was not available to GBP participants in FY11.

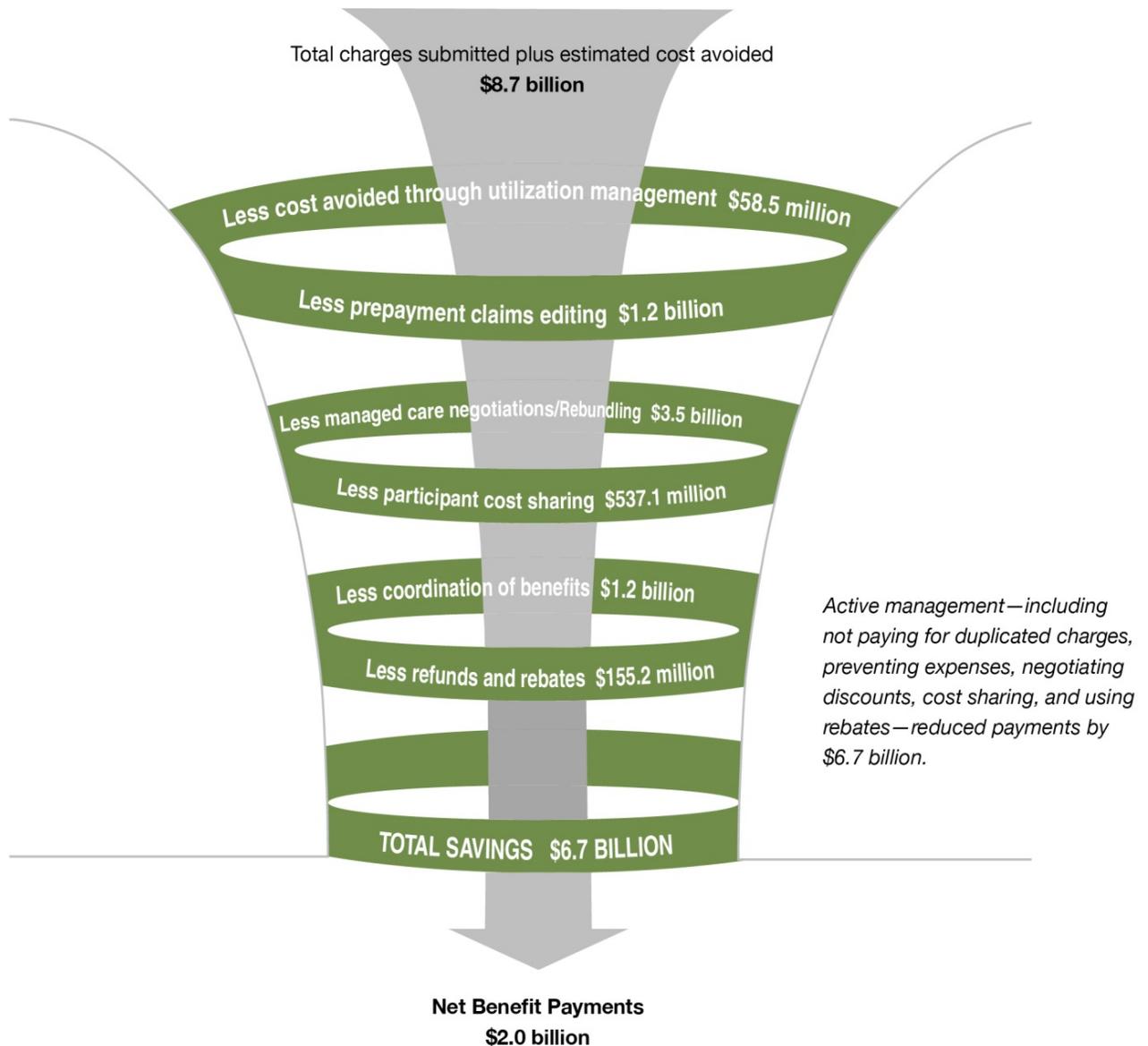
Scope of the Report

The FY12 Cost Management and Fraud report discusses important ways that ERS works behind the scenes to control costs for HealthSelect. We also provide a special focus on new initiatives designed to manage costs for the growing GBP retiree population. Finally, we discuss a few of the cost containment options highlighted in the Professional Management section of our *Study of the Sustainability of the GBP* produced during the interim legislative session and submitted for the Legislature's consideration September 4, 2012.

Figure 1: Texas Employees Group Benefits Program enrollment changes

Program Enrollment Changed from FY11 to FY12 due to the new Medicare Advantage Program (enrollment based on fiscal year end numbers)								
	HealthSelect Point of Service		Medicare Advantage		Health Maintenance Organizations		Total	
	FY11	FY12	FY11	FY12	FY11	FY12	FY11	FY12
Employees	202,346	197,477	0	0	12,023	10,781	214,369	208,258
COBRA	1,634	1,445	0	0	56	39	1,690	1,484
Retirees	79,266	49,792	0	35,124	4,473	4,187	83,739	89,103
Survivors	3,693	1,500	0	2,275	93	57	3,786	3,832
Dependents	210,259	187,879	0	9,485	13,012	10,914	223,271	208,278
Total	497,198	438,093	0	46,884	29,657	25,978	526,855	510,955
Percentage	94.4%	85.7%	0%	9.2%	5.6%	5.1%	100%	100%

Figure 2: Texas Employees Group Benefits Program savings, HealthSelect FY12



COST MANAGEMENT
Lowering HealthSelect plan charges \$6.7 billion in FY12

ERS and its vendors proactively manage plan costs to reduce the impact of cost increases on employers and participants as much as possible. Total cost-management reductions for the HealthSelect program in FY12 equaled \$6.7 billion. Nearly half this amount came from negotiated discount rates with providers who

agreed to participate in the managed care network.

Without cost-management programs, the FY12 member-only contribution would have been \$1,886.42 a month, rather than \$436.08. See Figure 3 for a financial summary of HealthSelect Cost Management Reporting for FY12.

Avoiding charges through utilization management. It is well known that nationally about 20% of the population is responsible for

80% of health care costs.¹ In HealthSelect, the distribution of health care expenditures is similar. It is important then to focus attention on those with higher health costs, such as those with chronic conditions. Utilization management is a forward-looking process that helps ensure that the services being prescribed and used are aligned with the “best practice” standards for certain illnesses. Utilization management can identify when cost trends are growing for certain services and helps the plan identify people who are eligible for case management and disease management programs.

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 \$1.5 billion in unnecessary charges in FY12.

Coordinating benefits with other insurers and payers. Coordination of benefits (COB) is the practice of dividing health care expenses among responsible payers. For example, when participants become eligible for Medicare at age 65, then Medicare starts paying their health care claims, and the GBP coordinates with Medicare for the payment of any leftover amount. This saves money for the plan because Medicare picks up most of the bill. Coordination of benefits saved the plan \$1.2 billion in FY12.

Maximizing refunds, rebates, and subsidies. These strategies are designed to leverage outside resources to maximize collections for the plan. For example, the Medicare Part D retiree drug subsidy (RDS) has refunded \$235.5 million in Medicare retiree drug costs since FY06. ERS has also taken advantage of a federal incentive

program that is part of the Affordable Care Act (ACA). The program, called the Early Retiree Reinsurance Program (ERRP), provides subsidies to employers that continue health coverage for pre-65 retirees. HealthSelect collected \$40.7 million in ERRP reimbursements in FY12. We do not expect to receive more money from the program, as federal funding appears to be exhausted.

Another way the plan saves money is through the 100% pass-through of all drug manufacturer rebates collected by the HealthSelect pharmacy benefit manager. During FY12, ERS received about \$63.8 million in rebates. We recently conducted an audit to confirm that the plan was properly paid 100% of all rebates.

Claims audits. The Pharmacy Audit Program recouped more than \$646,000 in FY12 through a sophisticated set of programs and procedures to ensure participating pharmacies’ compliance with program guidelines and to protect against provider abuse. The audit protects the financial integrity of the provider network and the prescription drug plan, deterring fraudulent claims and educating participating pharmacies in the correct administrative procedures and guidelines for the program.

Eligibility audits. ERS recently conducted a full dependent eligibility audit that asked all plan members who have added spouses and children to the plan to provide proof of their eligibility for coverage. All told, about 5% of dependents were removed from the plan. The audit produced \$12.2 million in net savings for FY12.

Cost sharing. Sharing costs with participants is also a large part of controlling costs for the plan. In FY12, employees, retirees, and their dependents paid \$537 million of the total cost of their medical expenses – through coinsurance, deductibles, and medical and prescription drug copays.

¹ Kaiser Family Foundation, “Health Care Costs: A Primer. Key Information on Health Care Costs and Their Impact,” March 2009, p. 5.

**Figure 3: Texas Employees Group Benefits Program
HealthSelect, FY12*
Cost Management and Cost Containment**

1	Considered Charges plus Estimated Cost Avoided**		\$8,691,395,934
2	Estimated Cost Avoided		
	a. Medical	(\$32,577,856)	
	b. Pharmacy	(25,943,642)	(58,521,498)
3	Considered Charges		\$8,632,874,436
4	Less Ineligible Charges		(1,198,348,097)
5	Eligible Charges		\$7,434,526,339
6	Less Reductions to Eligible Charges		
	a. PDP Charge Reductions	(\$557,341,995)	
	b. Hospital Claim Reductions	(787,910,671)	
	c. Charges Exceeding Professional Allowed Charges	(1,291,762,426)	
	d. Other Facility and Professional Discounts and Reductions	(899,578,845)	
	e. Rebundling	(6,452,067)	
	f. Medical Copayments and Deductibles	(130,553,655)	
	g. Medical Coinsurance	(224,486,156)	
	h. PDP Cost Sharing	(182,048,095)	
	i. Coordination of Benefits - Medical - Non-Medicare	(19,035,473)	
	j. Coordination of Benefits - Medical - Medicare	(1,169,728,462)	
	k. Coordination of Benefits - PDP	(1,289,984)	(5,270,187,829)
7	Gross Benefit Payments		\$2,164,338,510
8	Refunds, Rebates, and Guarantees		
	a. PDP Rebates	(\$63,762,977)	
	b. Medicare Part D Retiree Drug Subsidy	(39,612,208)	
	c. Early Retiree Reinsurance Program	(40,724,003)	
	d. Subrogation	(7,505,758)	
	e. Pharmacy Audit Refunds	(646,454)	
	f. PBM Audit Refunds	(942,576)	
	g. Hospital Audit Refunds	(1,984,549)	(155,178,525)
9	Net Benefit Payments		\$2,009,159,985

*Amounts taken from:

- (1) Annual Statistical Review by Blue Cross Blue Shield of Texas
- (2) Annual Experience Accounting prepared by Caremark,
- (3) HealthSelect Prescription Drug Plan data, and
- (4) ERS FY12 CAFR (Medicare Part D Retiree Drug Subsidy and ERRP revenue).

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

Increased cost sharing encourages participants to use less expensive services. It also influences the total number of health care services used. The key is to discourage people from seeking unnecessary care while continuing to provide access to needed preventive, acute, and chronic care.

Components of the cost management financial chart

Starting at the top of the financial chart on the previous page, the following section provides a detailed explanation for each line item.

Screening for Ineligible Charges

Line 2. Utilization management

Medical and prescription drug utilization management programs helped the plan avoid an estimated \$58.5 million in charges in FY12. Utilization management is a forward-looking process that helps ensure that services are aligned with “best practice” standards. This process identifies potentially high-cost claims that could be handled in a more appropriate way, and it identifies high-risk patients who would benefit from case management.

1. Total charges submitted plus estimated cost avoided through utilization management	\$8,691,395,934
2. Estimated cost avoided due to utilization management	(58,521,498)
4. Less charges eliminated through prepayment claims editing (see detail below)	(1,198,348,097)

Line 4. Prepayment claims editing

HealthSelect further trims costs by screening for ineligible charges through prepayment claims editing, a process that lowered plan

costs about \$1.2 billion. This process screens charges considered for payment for duplicate claims, late charges, charges for non-covered services or facilities, or charges for services that are not medically necessary.

Detailed savings from prepayment claims edits	
Duplicate charges	\$677,112,966
Late charges	246,889,874
Non-covered charges	129,730,382
Ineligible members	13,804,271
Incomplete claim documentation	123,448,371
Other adjustments	7,362,233
Total	\$1,198,348,097

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 processing personnel, the medical review unit, and/or the Special Investigations Division (operated by the third-party administrator (TPA) for HealthSelect medical benefits). The independent auditor tests the 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 remaining eligible charges. Managed care, rebundling, participant cost sharing, and coordination of benefits saved the GBP almost \$5.3 billion or about 71% of the remaining eligible charges of \$7.4 billion in FY12.

Lines 6a-6d. Managed care savings

Nearly \$3.5 billion in cost reductions came from HealthSelect’s managed care reimbursement arrangement. Managed care reduces costs for the plan through the TPA’s negotiation of discounted reimbursement rates with providers.

6a. Prescription drug program (PDP) charge reductions	\$557,341,995
6b. Hospital claim reductions	787,910,671
6c. Charges exceeding professional allowed charges	1,291,762,426
6d. Other facility and professional discounts and reductions	899,578,845

The GBP is able to leverage the negotiating power of its medical TPA in the health care marketplace because of the large number of participants covered by the TPA. This allows the State, the GBP, and the participants access to discounted reimbursement rates.

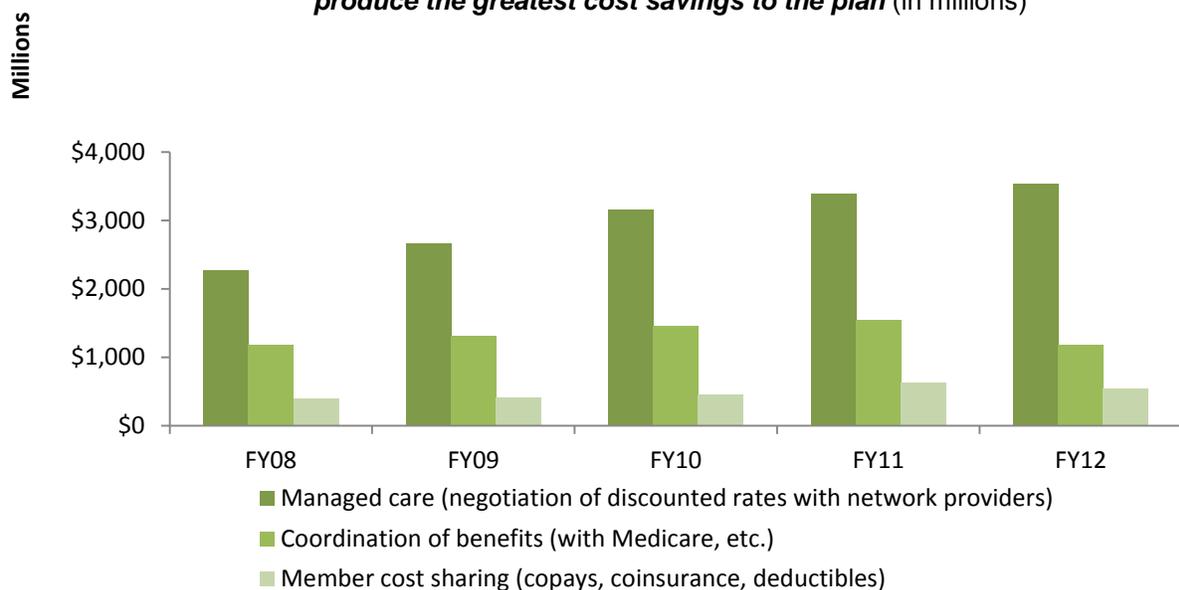
The \$3.5 billion in reduced charges represents the discount taken off the “retail” prices that doctors, hospitals, pharmacies, and other facilities would have charged the GBP and its participants had they not been covered by a managed care network. Managed care savings reduced eligible charges by about 48%.

Line 6e. Rebundling

The HealthSelect program “rebundles” charges as a cost savings measure. Rebundling combines related charges that were originally billed separately. Combining these charges so they are paid in the most cost-effective manner saved the GBP approximately \$6.5 million in FY12.

6e. Rebundling - combining related procedures into one bill for more cost-effective payment processing	\$6,452,067
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Figure 4: Negotiated provider discounts continue to produce the greatest cost savings to the plan (in millions)



Lines 6f-6h. Participant cost sharing

Cost sharing by participants reduces HealthSelect plan costs. Participants using health care services in FY12 paid about 7.2% of eligible charges (\$537 million) through coinsurance, deductibles, and medical and prescription drug copays.

6f. Medical copayments and deductibles	\$130,553,655
6g. Medical coinsurance	224,486,156
6h. PDP cost sharing	182,048,095

Total participant cost sharing for HealthSelect decreased in FY12 because nearly 47,000 Medicare-primary participants moved from HealthSelect to the Medicare Advantage Preferred Provider Organization (MA-PPO) that was implemented on January 1, 2012.

Increases in participant cost sharing not only reduce the amounts that otherwise would be paid by the plan, they also affect the demand for health care services.

Cost sharing encourages participants to use less expensive services. One cost management feature of the HealthSelect prescription drug program is the use of a “three-tier” copay structure.

The participant prescription drug cost share is based on the drug’s tier. There are three tiers of prescription drugs in the HealthSelect PDP. Under this structure, generic drugs are in the first tier with the lowest cost, lower-cost brand name drugs are in the second tier with mid-level cost, and higher-cost brand name and specialty drugs are in the third tier with the highest cost. Lower costs for generic drugs should encourage people to ask their doctors for alternatives to expensive brand-name drugs.

Cost sharing also influences how many health care services are used. The key is to discourage participants from seeking unnecessary care, while still providing needed care. Changes in plan design in FY03 and FY11 showed how shifting costs to participants could reduce utilization and moderate the benefit cost trend.

Unless the plan continues to increase the participant cost share at the same rate that eligible charges increase – either by increasing fixed copays and deductibles, or by switching to a flat percentage (coinsurance) – the proportion of eligible charges paid by participants will decline as costs continue to increase. This phenomenon, called member cost share

Figure 5: HealthSelect total participant cost sharing fell after nearly 47,000 Medicare-primary participants enrolled in the Medicare Advantage PPO in January 2012 (in millions)



leveraging, combines with increasing prices and rising utilization to generate higher health plan costs.

Lines 6i-6k. Coordination of benefits

The second largest reduction to eligible HealthSelect charges comes from coordinating the payment of claims with other health care payers, most notably Medicare. When participants reach age 65 and become eligible for Medicare, GBP health benefits become secondary, which means that the plan only pays eligible health care expenses after the Medicare program has processed the claim. In FY12, coordination with the Medicare program saved the GBP about \$1.2 billion, while coordination with other health insurance programs saved another \$20 million. This amount also decreased in FY12 with the enrollment of Medicare eligible participants in Medicare Advantage plans.

6i. Coordination of benefits - Medical - non-Medicare	\$19,035,473
6j. Coordination of benefits - Medical - Medicare	1,169,728,462
6k. Coordination of Benefits - PDP	1,289,984

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 FY12, ERS received about \$64 million in rebates. ERS annually conducts an audit to confirm that 100% of all rebates were paid to the plan.

8a. PDP rebates	\$63,762,977
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Line 8b. Medicare Part D Retiree Drug Subsidy (RDS)

Beginning January 1, 2006, Medicare-eligible individuals could choose to enroll in the Medicare Part D prescription drug program

that is funded in part by the federal government. ERS chose to continue the prescription drug coverage for retirees offered as part of the GBP and offset the cost through receipt of the RDS offered by the federal government under Medicare Part D. As part of this program, the federal government pays ERS a subsidy for eligible retirees who do not enroll in Medicare Part D and who remain enrolled in GBP drug plan coverage.

ERS began collecting the RDS during FY06. Since FY08, the Legislature has established the GBP appropriation for group insurance in anticipation of the RDS that the GBP would collect during each biennium. During FY12, ERS collected subsidies of about \$39.6 million for prescription drug claims incurred by Medicare-eligible retirees. ERS has collected total subsidies of about \$235.5 million over the seven-year period since the inception of the RDS.

8b. Medicare Part D Retiree Drug Subsidy	\$39,612,208
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Line 8c. Early Retiree Reinsurance Program (ERRP)

The ERRP began providing temporary supplemental revenue to help cover the expenses incurred by pre-Medicare retirees starting in FY10. During FY12, ERS applied for and received reimbursement of about \$40.7 million under the ERRP. In total, ERS has received \$70.9 million in ERRP funding.

8c. Early Retiree Reinsurance Program	\$40,724,003
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Line 8d. 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 \$7.5 million in FY12.

8d. Subrogation - recovery against a third party responsible for injury or negligence	\$7,505,758
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Preventing and Investigating Program 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. A transaction that results in unnecessary cost to the program could be defined as “abuse.” In the case of a provider, abuse could result in reimbursement for services that are not medically necessary or that fail to meet professionally recognized health care standards. Abuse of the system by a participant may not be illegal. For example, a participant with a minor health problem using the emergency room instead of going to his or her primary care

provider may be defined as abuse, but it is not considered fraud.

Methods used by ERS and its providers to detect fraud and abuse include internal and external audits, fraud hotlines, prescription drug high utilization analyses, a Special Investigations Division (run by the TPA), and in cases where fraud is detected or suspected, referral 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. This collaborative process results in added savings for HealthSelect. 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 potential misrepresentation on “evidence of insurability” applications;
- 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.

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 saves money in contributions and claims costs.

In calendar year 2011, ERS conducted a full dependent eligibility audit that asked all plan members who choose to cover spouses and children under the plan to provide appropriate documentation proving their eligibility for coverage. All told, about 5% of dependents were removed from the plan. After taking into account the cost of the audit, it saved the plan \$12.2 million in FY12. Savings will continue in future years.

Line 8e-8g. Audit refunds

The Retail Pharmacy Audit Program includes a sophisticated set of programs and procedures to ensure participating pharmacies' compliance with program guidelines and to protect against provider abuse. The Pharmacy Audit Program provides several significant benefits to the GBP. These benefits include protecting the financial integrity of the provider network and the PDP, deterring fraudulent claim submissions among participating pharmacies, and educating participating pharmacies about the correct procedures and program guidelines in the administration of the prescription drug program.

8e. Pharmacy audit refunds	\$646,454
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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 claims processed at retail pharmacies and through mail order. 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

ENHANCED SAFETY AND QUALITY MONITORING IN THE PRESCRIPTION DRUG PROGRAM

Caremark, the PBM for HealthSelect, uses advanced active management techniques to identify questionable claims and doctor prescribing activity. In the core monitoring program, pharmacists will flag inappropriate profiles and authorize intervention, which includes notifying prescribers of a patient's usage history and referring cases to a client investigative unit for follow-up.

As part of the negotiated contract extension, Caremark implemented an Enhanced Safety and Quality Monitoring program to address more complex cases. In addition to core monitoring and follow-up, the PBM provides aggressive communications with prescribers and pharmacies in suspicious cases, intervenes with support services, coordinates with other entities, and ensures ongoing monitoring for the member.

For example, a suspicious pattern appears when a patient presents to multiple doctors and emergency rooms for minor injuries or pain management, cancels follow-up appointments, then fills prescriptions at multiple pharmacies, all within a short time period. In one situation, a patient had controlled substance prescriptions from 12 different prescribers and five different pharmacies over a three-month period.

In a case like this, the patient might be "locked down" to a single pharmacy. All prescribers would be notified of the patient's usage history and diagnoses. The participant may receive medication therapy counseling and could be subjected to a comprehensive investigation through a special investigations unit. The PBM coordinates with the third-party administrator to review medical and prescription drug claims for the participant, and follows up with law enforcement if necessary.

In appropriate circumstances, ERS may seek further remedies from the member by obtaining reimbursement of claims paid for treatment found to be unnecessary, and, if evidence of member fraud is found, expulsion from the GBP.

This type of hands-on intervention is just one effective method of identifying, preventing, and intervening when fraud, waste, or abuse is suspected in the program. Most important, it seeks to identify a suspicious pattern early in the process, so as to prevent and mitigate program losses.

pharmaceutical manufacturers, and (b) ERS receives 100% of all rebate dollars paid to the PBM based on our claims experience.

8f. PBM audit results	\$942,576
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Audits are also done on hospital claims and compliance with billing requirements.

8g. Hospital audit refunds	\$1,984,549
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BOOSTING PARTICIPATION IN WELLNESS AND DISEASE MANAGEMENT

Management is key to a sustainable health plan

The State of Texas provides insurance so that its workers are present and productive on the job. Program participants lead much happier lives when they are healthy. Chronic disease costs the plan, and participant's money and time. As participants age they use more health services and prescription drugs.

The GBP offers many wellness programs to participants to improve their quality of life and productivity, and affect the high cost of health care for chronic conditions.

We make sure employees have wellness benefits through the health insurance plans. HealthSelect and the HMOs all have extensive wellness offerings available to employees, retirees, and their families.

We conduct research on patterns of chronic illness. We look at how many participants are taking their medications for chronic illnesses, and where they are going to get their care – 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

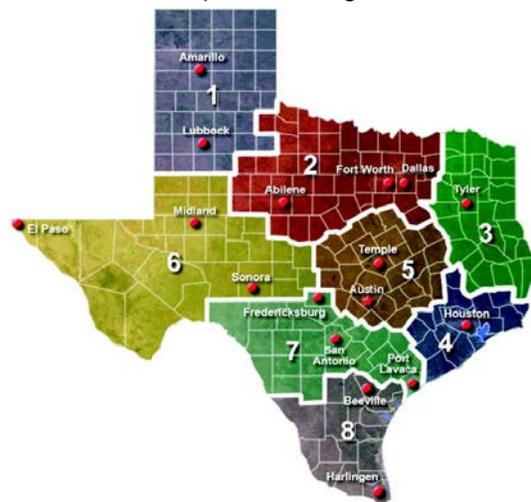
care is available at no cost to participants. The program also keeps generic drug costs and primary care copays low to make sure everyone can afford to go to the doctor and take the medications they need.

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.

We also provide tools for wellness coordinators to focus their wellness efforts at the agency level. In FY09, ERS launched an interactive regional health map on the ERS website, which maps out the incidence of the top six chronic conditions by state region, to help wellness coordinators target conditions for educational seminars and programs at their agency.

The regional health information also helps the health plan target its disease management and wellness efforts. Disease management programs are designed to help participants better manage their chronic conditions.

In addition, participants have 24-hour access to a nurse hotline to speak to a registered nurse.



In FY12, 75% of symptomatic calls to the nurse hotline were redirected to a more appropriate level of care.

Finally, ERS and HealthSelect are active with the State Worksite Wellness Advisory Board, and are helping the State Wellness Coordinator identify opportunities to encourage and engage state employees, wellness coordinators, and state agencies. We work with the Statewide Wellness Advisory Council to plan statewide wellness activities and events that come up during the year.

Participation in HealthSelect Wellness Programs

Because the HealthSelect population is older and with a higher-risk health status than other private- and public-sector plans, increased participation in wellness and disease management programs is an important goal.

Considering the extensive outreach efforts by the plan, participation in the voluntary program is still very low. Of 60,104 participants identified for condition management and contacted by the program in FY12, 9,385 (or 16%) were actively engaged and enrolled in the program. Most people do not respond to repeated efforts to contact them, including personal phone calls and written correspondence. Engagement helps the participant manage his or her complex or chronic condition through individualized support. Effective management of high-risk conditions saves the plan money.

On a positive note, 70% of those participants who do make successful contact with a HealthSelect advisor enroll in the program and experience positive outcomes from the experience. 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 5,840 participants completed health risk assessments in FY12, but this still represents less than 2% of the HealthSelect population.

Participants who complete health risk assessments get a report of potential health risks, allowing them to seek interventional health care, hopefully at an early stage of a condition or potential condition.

HealthSelect also offers discounts to Jenny Craig, Jazzercise, fitness clubs, acupuncture, massage therapy, chiropractic care, nutrition counseling, and more. These discounts are not part of the negotiated benefits package. Instead, they are an “added value” service available to any HealthSelect participant who chooses to take advantage of them.

Of the 1,885 participants who enrolled in the voluntary weight management program in FY12, 65% completed the program during the reporting period, and 52% improved their Body Mass Index (BMI) values.

Financial Incentives Encourage Behavioral Change

After two ERS surveys showed overwhelming support from members for increased premium contributions for tobacco users, the 82nd Legislature enacted a tobacco cessation wellness incentive that took effect January 1, 2012. On that date, tobacco users began to pay \$30 a month more for their health insurance, up to \$90 per household. During FY12, ERS collected additional premium contributions of \$5.2 million from more than 26,000 self-certified tobacco users.

The newly enacted tobacco cessation program also created added support for members and their families trying to quit using tobacco products. Not only does HealthSelect continue to offer free coaching programs, it also now provides coverage for prescription drugs like Chantix and bupropion. About 2,900 participants have filled Chantix prescriptions. The estimated cost to the program of tobacco cessation drugs was \$2.9 million in FY12.

Perhaps in response to the rate changes, HealthSelect enrollment in voluntary tobacco cessation programs more than tripled, from 71 in FY11 to 244 in FY12. Of those who enrolled,

more than half completed the program during the reporting period, and 17.2% quit using tobacco.

Just as with the tobacco cessation incentive, other opportunities exist to encourage participation in wellness programs with financial incentives. For example, some health plans impose financial penalties on those who are eligible for disease management programs yet fail to enroll. In an FY10 survey of GBP health plan members, 71% of 45,000 respondents expressed a willingness to consider charging higher fees to people who don't use disease management programs when available.

RETIREE BENEFITS

Wise management is essential

Most state and local governments offer health insurance benefits to their Medicare retirees. Many private employers do not.² Some employers offer a Medicare Advantage (MA) plan; others give retirees a set amount of money to buy a Medigap or Medicare Supplement policy on the open market. About half of private employers – mostly small businesses – plan to leverage the new federal health insurance exchanges for retiree medical benefits in 2014.³

When GBP retirees and their dependents reach age 65 and become eligible for primary coverage under Medicare, they are now automatically enrolled in the employer-sponsored MA-PPO plan.

Medicare retirees in the GBP are automatically enrolled in the HealthSelect Medicare Advantage Plan. They can opt out of that plan and choose from four other options: HealthSelect, two regional HMOs, or a Houston-area Medicare Advantage HMO. In FY12, about

63% 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 retirees⁴ and Part B premiums start at \$99 a month in 2012, 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 the MA-PPO and HealthSelect plans.

The Medicare Advantage option. When a State of Texas retiree enrolls in one of the MA offerings, traditional Medicare and HealthSelect coverage go away. Retirees with an MA plan do not need – and may not buy – a Medigap policy.

The monthly premiums for the MA-PPO and MA-HMO plans 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 the MA plan are comparable to HealthSelect.

The Early Retiree Reinsurance Program. Early retirees are defined in this federal program as those younger than age 65, who are not eligible for primary coverage under Medicare. Retiree coverage with the GBP is no different from active employee coverage. The State pays 100% of the cost of coverage for qualified retirees, regardless of their Medicare eligibility, and 50% of the cost of coverage for their

² Kaiser and the Health Research & Educational Trust, Employer Health Benefits 2010 Annual Survey, Exhibits 11.3 and 11.4.

³ Hewitt Associates, Employers' Initial Reaction to Health Care Reform: Retiree Strategy Survey, 2010.

⁴ 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.

dependents. Retirees who are not eligible for Medicare have the choice of enrolling in HealthSelect or one of two regional HMOs. More than 90% of choose HealthSelect.

In FY11 and FY12, ERS collected \$70.9 million in funds from the ERRP covering claims incurred in FY10 and FY11. The ERRP is a federal incentive program enacted with the passage of the ACA, designed to encourage employers to continue covering early retirees. The ERRP subsidizes a portion of health care costs for retirees younger than age 65. This is a temporary measure that was scheduled to end on January 1, 2014, but the federal funds are already exhausted for this program. Therefore, ERS does not expect to receive any additional ERRP funding.

Medicare Part D Retiree Drug Subsidy (RDS). The Medicare Modernization Act of 2003 (MMA) established Medicare Part D to provide prescription drug coverage for Medicare-eligible retirees. On January 1, 2006, Medicare beneficiaries became eligible for federally subsidized prescription drug benefits.

*In seven years, the
GBP has collected
\$235.5 million in drug
subsidies for
Medicare-primary
participants.*

COST CONTAINMENT OPTIONS:

Retiree Drug Subsidy Past Claims Reprocessing

During the Solution Sessions held at ERS in January, 2012, a vendor presented an option for reopening HealthSelect's past RDS requests in an effort to identify and reclaim any missed reimbursements. The Centers for Medicare and Medicaid Services (CMS) allows previously reconciled RDS requests to be reopened for up to four years following the final reconciliation, so there is an opportunity to file for reimbursements that were missed the first time around, potentially as far back as 2006.

A contract was executed in the summer and the audit is underway. The RDS claims reprocessing will take 12 to 18 months, so ERS will report on any savings from this measure in FY13 and FY14.

Employer Group Waiver Program + Wraparound (EGWP + Wrap). An EGWP is a basic Medicare Part D program that combines with a wraparound provision to bring the plan design up to par with current employer coverage. A wraparound is necessary with EGWP because HealthSelect prescription drug benefits are more generous than a basic Medicare Part D plan.

In 2009, the Legislative Budget Board recommended in its Government Effectiveness and Efficiency Report (GEER) that the state use an EGWP-only program instead of the RDS.

Until recently, few employers have tried an EGWP due to the administrative complexity and minimal savings. In the Insurance Interim Benefits Study, ERS asked large public-sector plan sponsors how they pay for retiree prescription drug costs. Nine of 13 surveyed currently use the RDS approach. Three use the EGWP approach to obtain federal subsidies for retiree prescription drug coverage.

The federal health reform bill included important changes to the MMA. Generally, these changes improved Part D coverage by reducing retiree costs for certain types of prescription drugs. The changes had the effect of reducing the value of the RDS option for the plan, while increasing the value of the EGWP + Wrap option. Since then, large group plans have begun to replace the RDS option with the EGWP + Wrap option.

The intent of the EGWP + Wrap is to provide the same financial incentives to self-funded plan sponsors that cover Medicare participants as those provided to commercial Medicare Part D plans. Under the EGWP + Wrap, the GBP will qualify for federal subsidies and manufacturer discounts that should yield higher savings for the plan than the RDS arrangement.

ERS considered such a change during the FY12 Insurance Interim Benefits Study. Under the EGWP + Wrap, the GBP would provide standard Part D coverage through a self-funded EGWP

and secondary coverage through a self-funded Wrap arrangement. The Wrap would fill the Part D coverage gap by covering prescription drugs that are not currently covered by Medicare Part D. Together, the two components will match the prescription drug benefits currently provided under HealthSelect.

On April 19, 2012, ERS issued a Request for Proposal (RFP), and after extensive evaluation by staff, the Board awarded the EGWP + Wrap contract to SilverScript Insurance Company. Starting January 1, 2013, prescription drug benefits for Medicare-eligible GBP participants will be available through the new EGWP + Wrap program, called HealthSelect Medicare Rx. This change is expected to save the GBP about \$27 million during FY13.

CONTRACTING

Managed care lowered charges by \$3.5 billion in FY12

ERS contracts with TPAs to process medical and prescription drug claims and build and maintain provider networks. A major part of achieving cost efficiency is negotiating 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 all GBP contracts in the best interests of the participants, the programs, and the State.

Keeping administrative costs low. ERS is not an insurance company. Instead, we contract with TPAs for certain aspects of program administration and management. As of September 1, 2012, HealthSelect medical benefits are administered by a new TPA, UnitedHealthcare. The UnitedHealthcare contract is expected to save the GBP about \$25 million in reduced administrative fees over the next four years. Prescription drug benefits continue to be administered by Caremark, without an increase in administrative fee.

Some of the administrative services provided by HealthSelect TPAs include:

- creating and maintaining provider networks,
- processing claims,
- offering disease management and wellness programs,
- assisting with communications and customer service, and
- providing data analysis, reporting, and actuarial services.

About \$3.5 billion in charge reductions in FY12 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. Because of aggressive contracting strategies by the TPA, physician reimbursement rates have increased more slowly than inflation in recent years.

Controlling costs through limiting the network. HealthSelect is a managed care plan that requires participants to stay “in network” to receive the highest level of benefits. 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 with 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.

Network limitations save the plan money by offering financial incentives for participants to use contracted providers. In a survey

COST CONTAINMENT OPTIONS: HIGH-PERFORMANCE NETWORKS

A high-performance network model generally focuses on specialists rather than PCPs or hospitals. Benefits are split into three tiers, with the high-performing tier having the highest level of benefits:

- Tier 1 consists of high-performing providers,
- Tier 2 consists of the remaining in-network providers, and
- Tier 3 consists of out-of-network providers.

Participants have the lowest out-of-pocket costs when they choose a Tier 1 provider, with increasing out-of-pocket expenses for the use of Tiers 2 and 3. Some plans do not tie reimbursement to choosing a preferred provider, but instead use the model only as an informational tool to help participants choose providers based on cost and quality.

Plans most often target specialists for high-performance networks in part because specialists tend to drive hospital admissions. High-performance physicians will often use high-performance hospitals. In addition, a person does not generally choose a hospital, but chooses a physician who in turn drives the hospital selection.

PCPs are excluded from high-performance networks to avoid disruption of established doctor-patient relationships. Across plans, specialists are chosen based on a common set of criteria. To be included, a specialty area must:

- represent a large share of medical spending,
- reflect significant variation in costs and quality,
- generate sufficient claims volume to assess physician- or practice-level efficiency and quality, and
- have established quality measures and/or guidelines to benchmark performance.

The use of high-performance networks has been slow to catch on due to the lack of information about quality standards. Providers and patients have also resisted the idea of restricted networks.

conducted by ERS in 2010, members said they were willing to pay more to have access to the providers of their choice. With this in mind, future changes to the health plan must balance cost with choice and access with quality.

High-performance Networks

ERS explored a number of options that limit provider cost increases through the contracting process. High-performance networks are one way that an insurance plan can steer participants toward quality, cost-efficient care. In this model, the TPA ranks certain types of providers based on cost and quality data, then lets participants choose which doctors they want to see. Participants can choose any doctors they want, but if they choose doctors that are not ranked as high performers, they will have to absorb the extra costs. ERS conducted a survey of its membership in 2010 regarding their health insurance benefits, with 45,000 participants responding. When asked about restricted high-performance networks:

- 70% would support restricted pharmacy networks,
- 69% would support restricted lab and radiology networks, and
- 60% would support restricted specialist networks.

About half were okay with restricting the hospital network, but those in smaller cities and rural areas had strong concerns that any limitation of provider options would negatively affect their situations. Some respondents were fearful that if the insurance plan limited the network too much, they would only be able to choose less experienced or lower-quality doctors.

Negotiating Hospital Savings through the Contracting Process

Plan spending under HealthSelect for hospital services has increased at an annual rate of about 9% per year over the past five years, faster than spending for pharmacy or professional services. Increases in hospital expenditures have the greatest impact on the plan because they represent 46% of total expenditures. According to Segal consulting, price inflation for inpatient hospital services is the largest component of the overall plan cost trend nationwide.⁵

⁵ Segal 2011 Health Plan Cost Trend Survey.

Although ERS does not contract directly with doctors, hospitals, or other health service providers, we participate with our vendors in closely monitoring rate increases. When necessary, we have chosen to suppress a hospital from the HealthSelect network when rate increase requests were unreasonable. Competitive pressure can be used to moderate price increases among urban hospitals, but this approach generally does not work in rural areas where the loss of the only available hospital could affect access for miles around.

Hospitals cite many reasons for rising costs. Hospitals cite many reasons why their costs are increasing: hospital labor shortages, cost shifting for uncompensated care, and credit issues including facility expansions and collection issues.

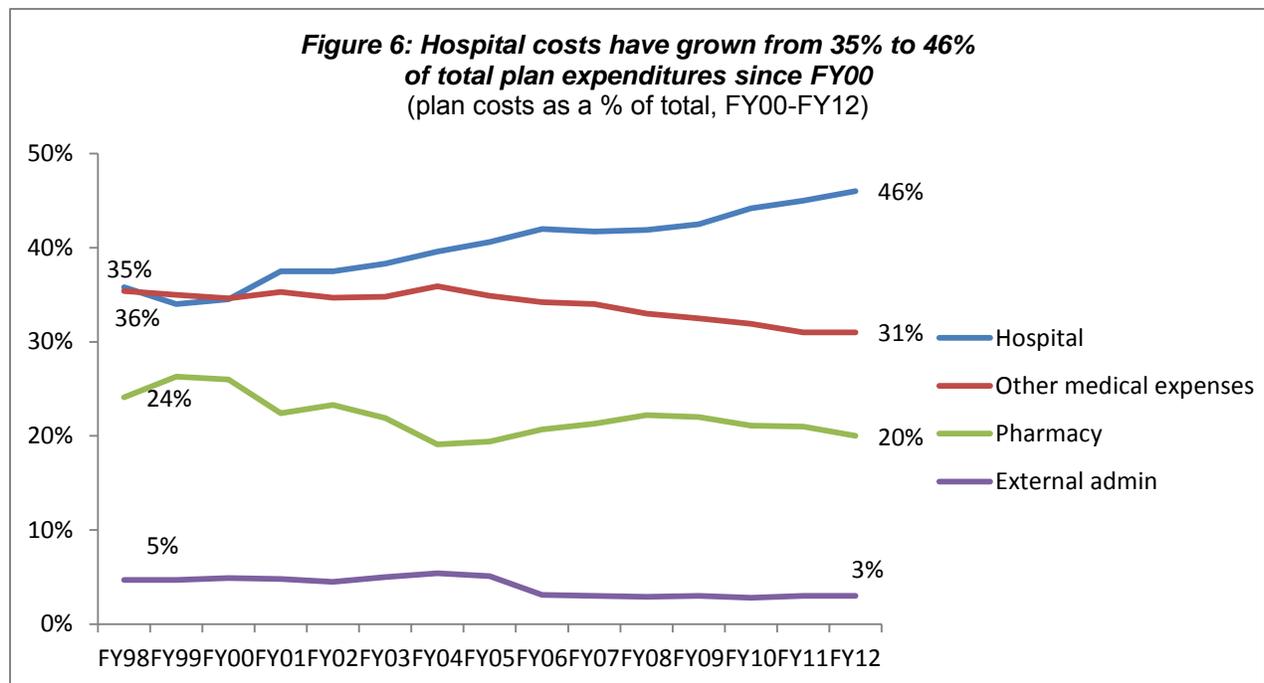
In response to many of these issues, there is a national movement toward shifting more risk to providers and tying payments to high performance and quality care. The FY12 Insurance Interim Benefits Study explored several options for limiting hospital cost increases through the contracting process.

COST CONTAINMENT OPTIONS: HOSPITAL CONTRACTING USING QUALITY METRICS

Results-based hospital contracts fall under the umbrella of “pay for performance,” in that hospitals could receive bonuses on top of their standard reimbursement levels for meeting certain quality metrics. It’s important to remember that the hospitals with the best outcomes are not always the least expensive.

Quality metrics typically include reductions in hospital-acquired infections, “never events” (serious medical errors that are clearly identifiable and preventable), and readmission rates. Savings often result from better discharge planning and rehabilitation services.

Contracting for a provider network is one of the main responsibilities of the TPA. ERS also monitors contracts, performs claims review, and is involved in target-setting and negotiating reimbursement levels. In several instances, the TPA has installed incentive-based compensation metrics in lieu of across-the-board increases in contractual reimbursement rates.



ALTERNATIVE PAYMENT MODELS

Much has been written about the inefficiency of the American “fee-for-service” (FFS) reimbursement system. Many studies have documented how paying providers for each

service they bill creates “perverse incentives” for doctors to overprescribe – more office visits, more lab tests, more X-rays – in order to boost their reimbursement. This system is also faulted for offering greater financial rewards for specialty care, which leads to a shortage of primary care doctors.⁹ These concerns are compounded by the growing number of doctors who have ownership in for-profit facilities, such

COST CONTAINMENT OPTIONS: SHARING RISK WITH PROVIDERS

Delivery system reforms support alternative payment models. Recent state and federal legislative initiatives have encouraged insurers to explore alternative payment systems that reward integrated groups of providers for reducing costs and improving quality outcomes. Medicare’s experiments with Accountable Care Organizations (ACOs) have accelerated payment reform based on performance measures.⁶

The Texas Legislature also endorsed efforts to create Health Care Collaboratives, through which integrated groups of providers can earn financial rewards if they meet certain cost and clinical goals.⁷

Effective January 1, 2011, ERS launched three successful Patient-Centered Medical Homes (PCMHs) in response to initiatives by the Texas Legislature.⁸ These pilot programs reimburse providers based on cutting the cost trend while meeting clinical quality targets. All three projects saved money in the first year and two received shared savings payments for exceeding contract expectations of cost and quality.

as labs or freestanding radiology centers.

Moving away from FFS requires making different kinds of payments to medical providers. For example, payments can be “bundled” based on a single episode of care. One bundled payment would combine every service provided in a single hospital visit.

Payments can also be made on a “capitated” or “global” basis. A global payment allows an insurer to pay a provider – usually a PCP – a fixed amount per patient. Any of these payments can also be combined with performance-based payments that reward providers for reducing costs while meeting quality standards.¹⁰

Patient-Centered Medical Homes

The Patient-Centered Medical Home (PCMH) model is similar to the Accountable Care Organization (ACO) model, but the provider team is made up of an integrated multi-specialty practice. These models generally:

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

The plan pays the PCMH a monthly capitation payment for those participants who have selected a medical home as their primary care

¹⁰ Catalyst for Payment Reform, “Payment Reform Framework.”

coordinator. The purpose of the flat payment is to incentivize enhanced care coordination not found in the standard FFS practice.

In January of 2011, the GBP launched its PCMH model program, starting with three large multi-specialty practices:

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

In addition to setting performance targets, ERS incorporated a small monthly care coordination payment (between \$1.50 and \$4.00 per participant per month) in addition to the health plan's current FFS payments. The goal is to reduce the cost trend, while meeting quality standards of care.

All three plans reduced the cost trend below the target, saving the GBP an estimated \$11 million in FY12. The GBP issued shared savings payments of \$1.3 million to Austin Regional Clinic and \$1.2 million to Kelsey-Seybold Clinic. Drug therapy costs for all three medical home projects rose, but there were significant decreases in other services, such as inpatient hospital stays.

On December 13, 2012, the National Committee for Quality Assurance announced that Kelsey-Seybold Clinic in Houston is the nation's first NCQA accredited ACO. Ultimately, this will affect anyone who uses Kelsey as a provider through ERS' KelseyCare Advantage plan for Medicare retirees, and other participants using the clinic as part of the PCMH pilot.

ADMINISTRATIVE TOOLS

Better data equals better results

Part of reducing costs for the plan is using data to produce better results. The HealthSelect TPA already uses data-mining tools to flag cost drivers for the plan, such as unusual cost increases for a specific diagnosis or facility. Claims analysis is also used to identify people with very high claims costs, or with multiple chronic illnesses who could benefit from disease management programs. This information is also

used to recommend plan design changes. ERS is very sensitive to maintaining the privacy of plan participants, and enforces strict Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information (PHI) rules when these tools are used.

In 2009, as part of the contract negotiation process, ERS required the medical and pharmacy TPAs to agree to a greater level of data integration for the program. In other words, for the first time, medical and pharmacy data were integrated into one database to identify cost trends from a total claims perspective. This gave the plan the ability to enhance disease management and utilization review, more easily investigate high-cost claims, and prevent, detect, and investigate fraud and abuse.

Several vendors came forward during the FY12 Insurance Interim Benefits Study process to present their ideas for increasing sustainability of the program through sophisticated data-management tools. Many of their recommendations were common-sense business practices that are already underway internally or are under consideration.

Some of the data mining tools proposed by vendors during the study process would require participants to take health risk assessments or biometric screenings. Others vendors provide tools for more intensive data-mining purposes, such as:

- **Group profiling of plan membership** by integrating medical and pharmacy data with attitudes/behaviors surveys, health risk assessments and/or biometric screenings. These diagnostic tools can help the plan understand costly conditions, treatment plans, patient adherence, and clinical outcomes.
- **Forecasting and modeling tools** with user-friendly interface. This would look like a series of customized dashboards to help the plan easily find data to target cost drivers (e.g., demographics, utilization, and cost and use), recommend and model benefit

design changes, flag areas of concern, and provide predictive forecasting.

Incentivizing the participation in assessment tools would require legislative support, as well as close legal consideration of how the information would be used, and the protections required for participants' personal health information.

WITHOUT COST MANAGEMENT, THE STATE'S INSURANCE CONTRIBUTION WOULD INCREASE FOURFOLD

Prior to the beginning of each fiscal year, the ERS Board of Trustees sets HealthSelect contribution rates for the State and the members. In FY12, state and member contributions and investment income from the insurance trust were sufficient to cover the benefits and administrative expenses. The member-only rate for FY12 was \$436.08 per month.

The summary chart on page 24 demonstrates the financial impact that various cost management programs had on the monthly contribution rate for member-only coverage during FY12. In the absence of the cost-management programs, the required monthly revenue for member-only coverage would have been \$1,886.42.

Although the chart focuses on revenue required to provide member-only coverage, the cost-management programs result in proportionate reductions in the revenue required for dependent coverage.

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. Neither a national economic

downturn nor significant cost shifting to participants in FY11 put the brakes on mounting costs in the HealthSelect program. Fortunately no benefit changes were required for FY12, 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 lowered health plan costs by \$6.7 billion in FY12 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 only three cents of every health plan dollar. However, these efforts may not be enough.

The FY12 Insurance Interim Benefits Study on the sustainability of the health plan provides a detailed look at a number of options for increasing the sustainability of the program. The report showed that ERS is already implementing many of the best-practice solutions in the marketplace; however, the program needs coordinated action with lawmakers and plan participants to make further inroads on reducing plan costs. We look forward to working with the Legislature in the coming year to ensure that employers can continue to offer a reasonable benefits package at a lower-than-average cost.

**Figure 7: Texas Employees Group Benefits Program
HealthSelect, FY12
Cost Management and Cost Containment
Impact on the Member Only Rate**

		Annual Amount	Required Monthly Revenue for Member-only Coverage	
1	Considered Charges plus Estimated Cost Avoided	\$8,691,395,934	\$1,886.42	
2	Estimated Cost Avoided			
	a. Medical	(\$32,577,856)	(\$7.07)	
	b. Pharmacy	(25,943,642)	(5.63)	(12.70)
4	Ineligible Charges	(1,198,348,097)	(260.10)	
6	Reductions to Eligible Charges			
	a. PDP Charge Reductions	(\$557,341,995)	(\$120.97)	
	b. Hospital Claim Reductions	(787,910,671)	(171.01)	
	c. Charges Exceeding Professional Allowed Charges	(1,291,762,426)	(280.37)	
	d. Other Facility & Professional Discounts & Reductions	(899,578,845)	(195.25)	
	e. Rebundling	(6,452,067)	(1.40)	
	f. Medical Copayments and Deductibles	(130,553,655)	(28.34)	
	g. Medical Coinsurance	(224,486,156)	(48.72)	
	h. PDP Cost Sharing	(182,048,095)	(39.51)	
	i. Coordination of Benefits – Medical - Non Medicare	(19,035,473)	(4.13)	
	j. Coordination of Benefits – Medical - Medicare	(1,169,728,462)	(253.88)	
	k. Coordination of Benefits - PDP	(1,289,984)	(0.28)	(1,143.86)
8	Refunds, Rebates, and Guarantees			
	a. PDP Rebates	(\$63,762,977)	(\$13.84)	
	b. Medicare Part D Retiree Drug Subsidy	(39,612,208)	(8.60)	
	c. Early Retiree Reinsurance Program	(40,724,003)	(8.84)	
	d. Subrogation	(7,505,758)	(1.63)	
	e. Pharmacy Audit Refunds	(646,454)	(0.14)	
	f. PBM Audit Refunds	(942,576)	(0.20)	
	g. Hospital Audit Refunds	(1,984,549)	(0.43)	(33.68)
9	Net Benefit Payments	\$2,009,159,985	\$436.08	\$436.08
			Monthly Member Rate	

APPENDIX A: History of Cost Management Programs

FY02 – FY13

FY2002	<ul style="list-style-type: none"> • Legislative intent rider to grant no rate increases for participating providers • Required prior authorization on certain prescription drugs • Expanded use of quantity limits on prescription drugs • ERS January 2002 restructured contract with Medco and improved contract rates
FY2003	<ul style="list-style-type: none"> • Reduced HealthSelect Plus availability to only major metropolitan areas • Froze enrollment in HealthSelect Plus • Medco takes over as PBM for HealthSelect Plus – better discounts and contract rates, more consistent administration
May 2003	<ul style="list-style-type: none"> • Eliminated HealthSelect Plus • Increased HealthSelect PCP office visit copay from \$15 to \$20 and specialist office visit copay from \$20 to \$30; HMO PCP copay increased from \$20 to \$30 and specialist copay increased from \$30 to \$40 • Mail order copays for 90-day supply increased to three 30-day supply copays • Retail maintenance fee created for maintenance drugs • Generic incentive – member pays the generic copay plus the difference between the cost of a brand-name drug and its generic equivalent when a generic was available but brand-name chosen instead • Standardized retail pharmacy network – removed tiered discounts • Increased emergency room copay from \$50 to \$100 • Increased participants' coinsurance percentages for network from 10% to 20%, non-network from 30% to 40%, out-of-area from 20% to 30% • Implemented \$100-a-day copay for inpatient charges and outpatient surgery, capped at five days for inpatient
FY2004	<ul style="list-style-type: none"> • Implemented 90-day waiting period for new employees • Required retirees to be 65 years old with 10 years of service to qualify for health insurance coverage (10/65 Rule) and subjected them to a 90-day waiting period • Reduced state contribution to part-time rate for employees working less than 40 hours per week • Discontinued board member state contribution • Tightened eligibility for retiree insurance for those not meeting the Rule of 80 or 10/65 Rule (Gap coverage) • Implemented \$50 prescription drug plan year deductible • Reduced payment for specialty pharmacy medications through medical component • Increased out-of-pocket coinsurance maximum to \$1,000 for network, \$3,000 for non-network, and \$1,000 for out-of-area
FY2005	<ul style="list-style-type: none"> • Enhanced management of radiological services • Non-sedating antihistamines moved from Tier 2 to Tier 3 in HealthSelect • Developed additional Prior Authorization programs • Dose Optimization – evaluates the daily dose of a member's medication and encourages using the drug strength that would allow the medication to be used once a day, which leads to cost savings for the PDP • FCR – Formulary Coverage Review – encourages the use of the least expensive drug in the same category • Audit to eliminate non-eligible dependents with ongoing monitoring of dependent eligibility
FY2006	<ul style="list-style-type: none"> • New third-party administrator contract for HealthSelect saves \$79 million over the next three years • New pharmacy benefit manager contract for HealthSelect saves \$48 million over the next three years • Added the BlueCare Connection programs to HealthSelect: <ul style="list-style-type: none"> ♦ 24/7 nurse hotline, ♦ Special Beginnings program, ♦ disease management, ♦ wellness programs, ♦ care and case management, ♦ 100% claims audit (ongoing), and ♦ participation in the Medicare Part D subsidy

FY2007	<ul style="list-style-type: none"> • Personal health manager • Opt-out credit • Continued participation in Medicare Part D subsidy
FY2008	<ul style="list-style-type: none"> • 100% PBM claims audit • Wellness committee established • Continued participation in Medicare part D subsidy
FY2009	<ul style="list-style-type: none"> • New pharmacy benefit manager transparency contract for HealthSelect saves \$288 million in prescription drug costs over the next four years • Continued participation in Medicare Part D subsidy
FY2010	<ul style="list-style-type: none"> • Coordination of benefits with Medicare Part B prescription drugs • Pharmacy re-contracting regarding average wholesale price (AWP) modification saves \$49 million over three years • Unclaimed funds process established • Continued participation in Medicare part D subsidy • Negotiated for costs savings of \$20 million annually from Most Favored Nations (MFN) clause for the PBM contract in FY11 and FY12
FY2011	<ul style="list-style-type: none"> • 100% Dependent Eligibility Audit • Increased HealthSelect PCP office visit copay from \$20 to \$25 and specialist office visit copay from \$30 to \$40; HMO PCP copay decreased from \$30 to \$25 and specialist copay level at \$40 • Ability to fill extended-day prescriptions at retail participating pharmacies • Increased prescription drug copay from \$10 to \$15 for generics, \$25 to \$25 for preferred brand-name drugs, and \$40 to \$60 for non-preferred brand name drugs • Increased annual maximum amount of coinsurance paid by participant from \$1,000 to \$2,000 in-network, \$3,000 to \$7,000 out-of-network, and \$1,000 to \$3,000 out-of-area • Increased emergency room copay from \$100 to \$150; new urgent care copay of \$50 • Implemented \$100-a-day copay for high-tech radiology (MRI, nuclear medicine, CT scan) • Limited annual visits and lower allowable charges for chiropractic care • Received \$30.2 million from Early Retiree Reinsurance Program (ERRP) • Received \$20 million in savings due to FY10 negotiations for the Most Favored Nations (MFN) clause in the PBM contract
FY2012	<ul style="list-style-type: none"> • Realized \$12.2 million in net savings from the 2011 Dependent Eligibility Audit • Implemented tobacco use contribution differential, effective January 1, 2012 • Continued, with the potential to expand, medical home/accountable care practice model pilot programs • Implement Medicare Advantage (MA) programs for Medicare primary participants with same benefits as HealthSelect; the MA-HMO was effective September 1, 2011, and the MA-PPO became effective January 1, 2012 • Received \$20 million in savings due to FY10 negotiations for the Most Favored Nations (MFN) clause in the PBM contract • Received \$40.7 million from the ERRP • Evaluated the use of Employer Group Waiver Plan plus Wraparound (EGWP+Wrap) to replace the Retiree Drug Subside (RDS)
FY2013	<ul style="list-style-type: none"> • Contracted for audit of the RDS reimbursements • Negotiated a two-year extension of the PBM contract, reducing guaranteed plan costs an estimated \$41 million for the two-year period • Contracted with a new third-party administrator, saving the plan \$25 million in administrative expense over four years • Implemented EGWP+Wrap January 1, 2013, for a \$27 million savings to the plan in calendar year 2013 • Continued, with the potential to expand, medical home/accountable care practice model pilot programs

APPENDIX B: FINANCIAL STATUS OF THE STATE EMPLOYEES GROUP BENEFITS PROGRAM
AS OF AUGUST 31, 2012

Texas Employees Group Benefits Program Summary of Health Plan Experience			
Based on Experience through September, 2012			
<i>\$Millions</i>			
	FY11	Projected FY12	Projected FY13
Revenue from State/Members			
State Contribution for State Agencies 1% agencies' payroll contribution	\$1,264.9	\$1,257.5 56.5	\$1,354.8 56.5
State Contribution for Higher Education 1% higher ed's payroll contribution	527.9	514.0 30.7	557.5 30.7
State Contribution – Other ¹	50	46.5	50.0
State Contribution - Total	\$1,842.8	\$1,905.2	\$2,049.5
Member Contribution	394.9	395.6	416.8
Total Contributions	\$2,237.7	\$2,300.8	\$2,466.3
Revenue from Other Funding Sources:			
Refunds, Rebates and Part D Subsidy	\$140.6	\$153.1	\$112.3
Net Investment Income ²	1.6	1.1	(5.2)
Total	\$ 142.22	\$154.2	\$107.1
TOTAL REVENUE³	\$2,379.9	\$2,455.0	\$2,573.4
HEALTH CARE EXPENDITURES³	\$2,288.5	\$2,398.2	\$2,600.6
Net Gain/(Loss)	\$91.4	56.8	(\$27.2)
Fund Balance	\$228.0	\$284.8	\$257.6
Other Expenses Incurred Outside of the GBP Fund			
Member Cost Sharing	\$666.5	\$568.2	\$568.9

¹ Non-state employee groups

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

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

Health Benefit Cost Trend

ERS expects the health plan benefit cost trend to stabilize in FY 2013 to 8% per year. A breakdown of trend by cost category is shown in the following table:

HealthSelect					
<i>Projected annual health benefit cost trends for FY 2013-2015</i>					
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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ERS ENHANCES THE LIVES OF OUR PARTICIPANTS
THROUGH THE DELIVERY OF QUALITY BENEFITS AT A REASONABLE COST.



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