

TEXAS EMPLOYEES GROUP BENEFITS PROGRAM  
Cost Management and Fraud Report FY2015



## EMPLOYEES RETIREMENT SYSTEM OF TEXAS

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January 2016

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

# EXECUTIVE SUMMARY

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 employees and retirees 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 competitive, comprehensive health insurance benefits. HealthSelect<sup>SM</sup> 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 \$6.4 billion in FY15 through managing HealthSelect benefit cost trends, increased subsidies for the Medicare prescription drug program, and innovative risk-sharing arrangements with providers.



The GBP spends about **\$8.4 million a day** in health care costs.

**That's \$350,000 an hour...  
\$5,833 a minute...  
\$97 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 FY15, allowing ERS and the State to continue to offer competitive benefits at a reasonable cost.

**97¢**

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

## FY15 HIGHLIGHTS

- Lowered total HealthSelect charges by \$6.4 billion through effective cost management programs.
- The HealthSelect third-party administrator contract is on track to exceed projected administrative savings of \$25 million through FY16.
- Continued to expand the provider network across the state, evidenced by 91% of paid claims in-network in FY15, compared to 89.5% in FY13.
- Maximized the value of medical and prescription drug benefits for Medicare-primary retirees, collecting \$86 million in subsidies and lowering the cost of the HealthSelect Medicare Rx plan.
- The Dependent Eligibility Audit process has produced an 8 to 1 return on investment for the program, with a net savings of \$26 million since 2012.
- After lowering generic copays to \$10 for a 30-day supply, the generic dispensing rate increased to 82.6% in FY15.
- Collected \$14.3 million in additional tobacco premium contributions from more than 39,300 participants.

## HealthSelect has low administrative costs

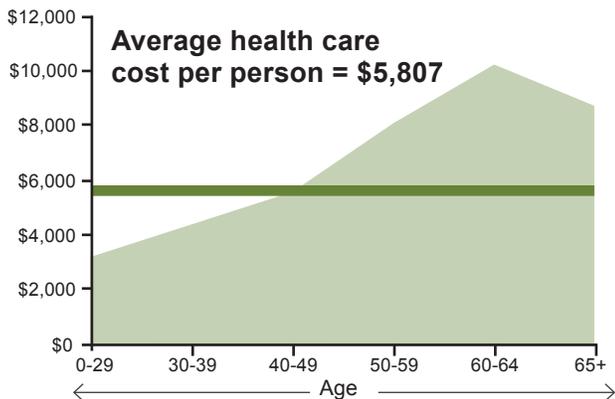
According to federal standards, the GBP is an extremely cost efficient plan. The Affordable Care Act (ACA) requires large employer plans to spend at least 85 cents of every dollar they collect on health care claims. Administrative costs for large, private health plans nationwide are estimated to be about 12 cents per dollar<sup>1</sup>. The HealthSelect program spends only three cents per dollar on administrative costs with the other 97 cents going to pay 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 fund all the health care claims. Therefore, the State and the participants – not an insurance company – assume financial responsibility and bear the risk for paying for all the health care services used.

### Figure 1: ERS averages costs so the plan stays affordable for the group

(HealthSelect average annualized claims cost by age group, medical and pharmacy claims, FY15)



More than 500,000 employees, retirees and their dependents are grouped together in the GBP “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.

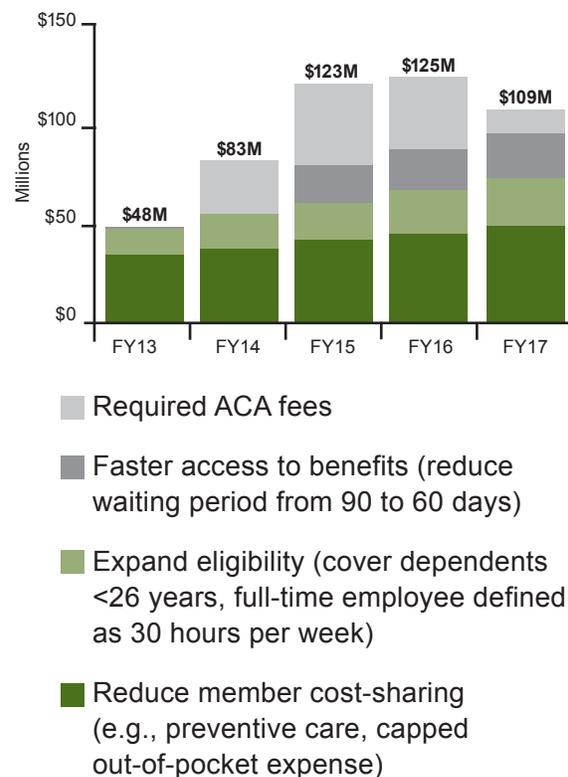
Having a lot of healthy people in the group may lower the average cost, but everyone is different and anyone can have an expensive unforeseen health event. Costs are spread among everyone in the plan so that health insurance never becomes too expensive for people when they need it the most.

## Federal health reform’s cost to the plan increased almost \$40 million in FY15

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. See Appendix A for a detailed projection of the ACA’s impact on the GBP through FY17.

In FY15, the plan spent nearly \$123 million on ACA-related costs; with about two-thirds of that toward increasing benefits and the other one-third toward fees. One of the costliest fees for HealthSelect – the Transitional Reinsurance Program fee – will terminate at the end of calendar year 2016. Pursuant to HR2029, enacted December 18, 2015, the Health Insurance Providers Fee will be suspended for calendar year 2017. As a result, ACA-related fees will be \$18 million lower than they would have been otherwise in FY17.

### Figure 2: ACA-related costs for the GBP will decline in FY17



<sup>1</sup>Source: “Paper Cuts: Reducing Health Care Administrative Costs,” Center for American Progress, June 2012

### HealthSelect enrollment is holding steady

Total HealthSelect enrollment declined in FY12 after ERS added Medicare Advantage (MA) options for Medicare-primary retirees. HealthSelect enrollment is holding steady at 83% of the total GBP population, with 95% of active employees in HealthSelect and 5% in HMOs. About 12% of all GBP participants are enrolled in MA plans.

Medicare Advantage plan enrollment increased nine percent in FY15, to 62,700 Medicare-primary participants. About 69% of Medicare-eligible participants are now enrolled in MA plans. HealthSelect

also has two self-funded pharmacy programs, one for Medicare-primary participants, and one for all other HealthSelect participants.

Because many Medicare-primary participants have enrolled in MA plans in the past few years, year-to-year comparisons of HealthSelect medical costs (and savings) for the Medicare-primary population can be difficult. This report only reflects medical cost data for Medicare-primary participants enrolled in HealthSelect, not those in Medicare Advantage. This report does account for prescription drug spending on the entire HealthSelect and MA populations.

**Figure 3: Enrollment in Medicare Advantage plans has increased 35% since FY12**  
(as of August 31, 2015)

	FY11	FY12	FY13	FY14	FY15
<b>HealthSelect</b>	496,992	437,473	436,012	436,084	<b>436,430</b>
<b>Medicare Advantage</b>	0	46,555	52,335	57,264	<b>62,700</b>
<b>HMOs</b>	29,570	25,866	25,367	24,627	<b>23,949</b>
<b>TOTAL</b>	<b>526,562</b>	<b>509,894</b>	<b>513,714</b>	<b>517,975</b>	<b>523,079</b>

# 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 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 the participants pay in deductibles, copays and coinsurance. For example, starting September 1, 2014, ERS lowered generic drug copays to \$10 for a 30-day supply.
- The “professional management” of the plan includes such things as cost management and fraud control programs, contracting arrangements with providers, and disease management and wellness programs. Third-party administrators (TPAs) are responsible for the day-to-day health care management of the plan.

ERS contracts with a third-party administrator, UnitedHealthcare, to manage HealthSelect medical benefits and with Caremark, a pharmacy benefit manager (PBM) to manage HealthSelect prescription drug benefits. SilverScript, a Caremark subsidiary, provides PBM services for most Medicare-primary participants.

This report focuses on the professional management of HealthSelect – the important ways ERS and the HealthSelect vendors work behind the scenes to control costs. It also focuses on special efforts to address an increasing prescription drug trend, cost-saving initiatives to serve the growing retiree population, and other updates about ERS health insurance contracts and programs.

# COST MANAGEMENT OVERVIEW

## ERS lowered HealthSelect plan charges \$6.4 billion in FY15

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. Total FY15 cost-management reductions for HealthSelect were \$6.4 billion. The individual impact of these savings is significant – without cost-management programs, the FY15 member-only contribution would have been \$1,901 a month, rather than \$535.

## The importance of managing high cost claims

Nationally, as in HealthSelect, there is a high concentration of health care spending among a small percentage of the population. According to the National Institute on Healthcare Management, one percent of the U.S. population accounts for nearly 23 percent of overall health care spending, and five percent are responsible for 50 percent of spending.<sup>2</sup> This pattern of spending is especially pronounced in the HealthSelect drug programs, where 20% of participants incur 90% of plan benefits.

## Negotiating managed care savings

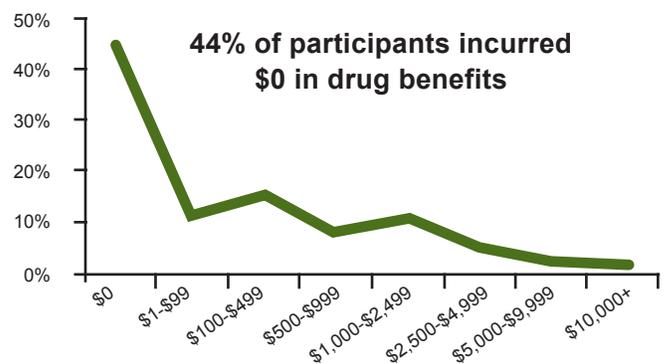
Nearly 70% of all cost management reductions in FY15 – \$4.4 billion – came from HealthSelect's managed care reimbursement arrangement. Managed care reduces costs for the plan through the negotiation of discounted reimbursement rates with providers who agree to participate in the network. The HealthSelect medical TPA continues to expand the network to ensure that participants have access to a broad network of providers across the state. This is evidenced by an increase in the proportion of in-network paid claims from 89.5% of the total in FY13 to 91% in FY15.

## Conducting audits.

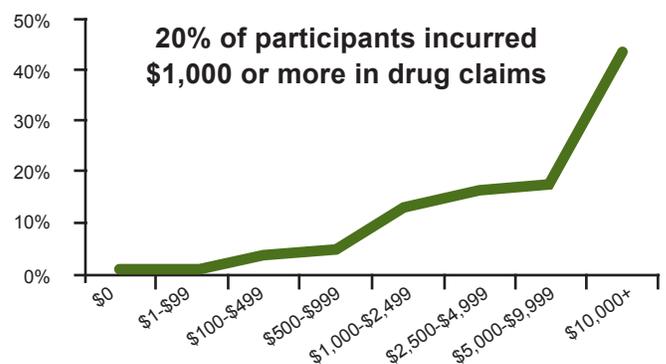
As fiduciaries of the insurance program, ERS is also responsible for ensuring that the plan operates efficiently and delivers the best value to the state. Pharmacy and

PBM Audits protect 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 network pharmacies comply with HealthSelect guidelines. These programs recouped about \$2.8 million in FY15. ERS also saved \$5.5 million in FY15 audits through its ongoing dependent eligibility audit process in FY15.

**Figure 4: 44% of participants did not make a prescription drug claim in FY15**

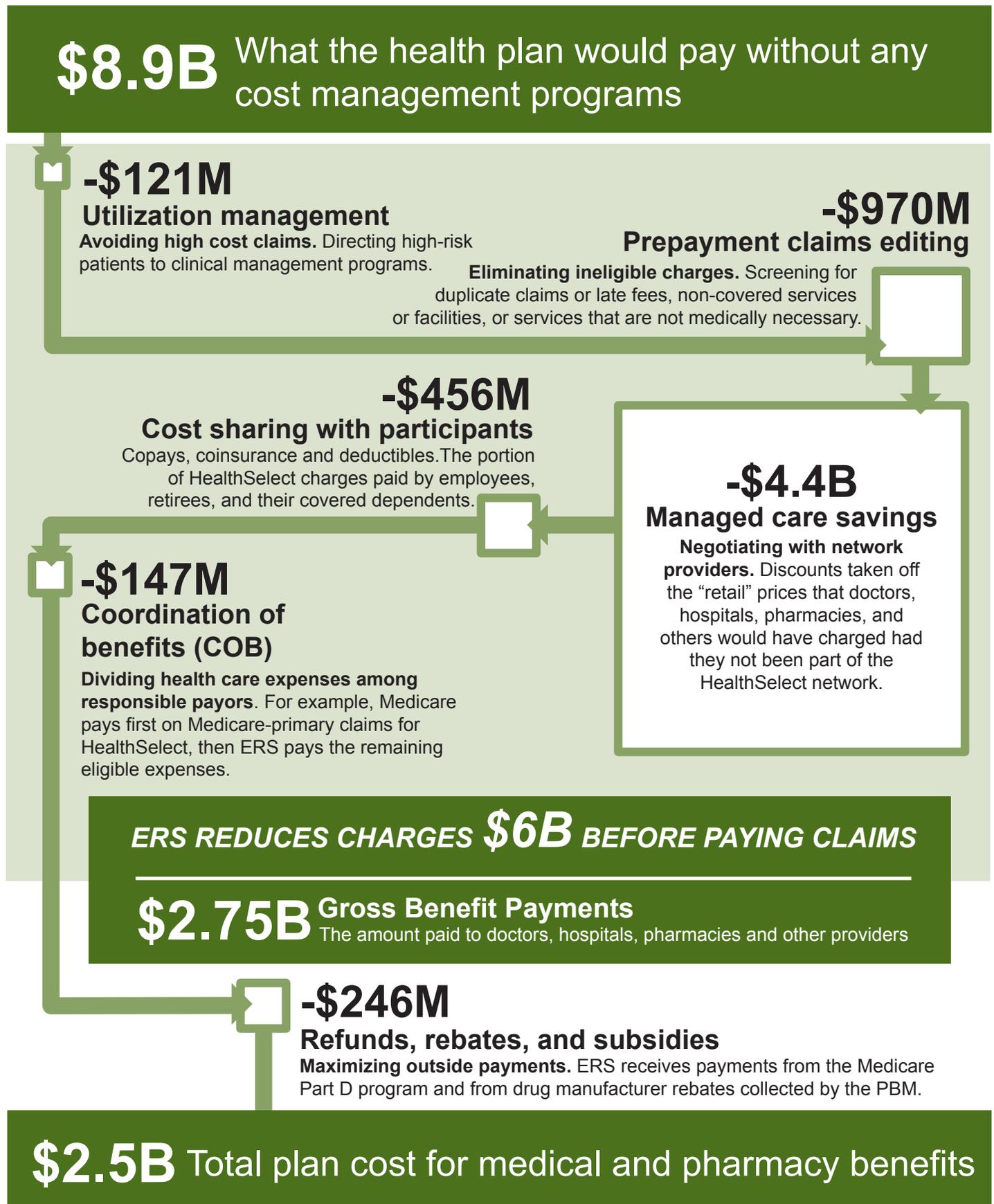


**Figure 5: 20% of HealthSelect participants received 90% of the prescription drug benefits**



<sup>2</sup> National Institute on Health Care Management, "Healthcare's 1%: The Extreme Concentration of Healthcare Spending," November, 2014.

Figure 6: High-level overview of the process followed to reduce HealthSelect charges by \$6.4 billion in FY15



**Figure 7: Texas Employees Group Benefits Program, HealthSelect Cost Management Charge Reductions, FY15\***

1. Considered Charges plus Estimated Cost Avoided			\$8,875,409,368
2. Estimated Cost Avoided			
a. Medical	(76,918,597)		
b. Pharmacy	(43,794,149)	(120,712,746)	
3. Considered Charges			\$8,754,696,623
4. Less Ineligible Charges			(969,984,265)
5. Eligible Charges			\$7,784,712,358
6. Less Reductions to Eligible Charges			
a. PDP Charge Reductions	\$ 855,806,293		
b. Provider Discounts and Reductions	3,580,738,623		
c. Medical Copayments and Deductibles	120,392,264		
d. Medical Coinsurance	202,011,585		
e. PDP Cost Sharing	133,558,835		
f. Coordination of Benefits - Medical - Regular	19,847,870		
g. Coordination of Benefits - Medical - Medicare	125,826,427		
h. Coordination of Benefits - PDP	1,381,982	5,039,563,879	
7. Gross Benefit Payments			\$2,745,148,479
8. Refunds, Rebates and Guarantees**			
a. PDP Rebates	\$ 151,890,411		
b. Federal Revenue - Medicare Part D	86,053,570		
c. Subrogation	5,067,879		
d. Pharmacy Audit Refunds	1,474,138		
e. PBM Audit Refunds	1,316,235	245,802,233	
9. Net Benefit Payments			\$2,499,346,246

\*Amounts taken from:

- (1) Annual Statistical Review prepared by UnitedHealthcare,
- (2) Annual Experience Accounting prepared by Caremark and SilverScript,
- (3) HealthSelect Prescription Drug Plan data, and
- (4) ERS FY15 CAFR (Federal Revenues).

# COST MANAGEMENT FINANCIAL CHART

## Components of the Cost Management Financial Chart

Pages 12-21 provide a detailed explanation for each line item in the financial chart on page 11.

### Screening for Ineligible Charges

#### Line 2. Utilization Management

Medical and pharmacy utilization management programs helped the plan avoid an estimated \$120.7 million in charges in FY15. 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. One example is the redirection of transplant surgeries to Centers of Excellence.

#### Line 4. Prepayment Claims Editing

HealthSelect further trims costs by screening for ineligible charges through prepayment claims editing, a process that weeds out duplicate claims, eliminates charges that exceed benefit limits, and ensures that HealthSelect doesn't pay for services that are not medically necessary. In FY15, this lowered plan costs about \$970 million.

Prepayment claims editing is an essential part of the GBP's fraud, waste, and abuse program, as it also prevents the payment of potentially fraudulent or abusive claims. Any claims that fail the editing process are individually reviewed 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.

<b>1. Considered charges plus estimated cost avoided</b>	<b>\$8,875,409,368</b>
2. Estimated cost avoided due to utilization management	(120,712,746)
<b>3. Considered charges</b>	<b>\$8,754,696,623</b>
4. Less charges eliminated through prepayment claims editing	(969,984,265)
<b>5. Eligible charges</b>	<b>\$7,784,712,358</b>

## Reductions to eligible charges

After eliminating ineligible charges, the plan applies a series of cost management strategies to the \$7.8 billion in remaining eligible charges. Managed care, participant cost sharing, and coordination of benefits saved the GBP \$5 billion of the remaining eligible charges in FY15.

### Lines 6a-6b. Managed care savings

More than \$4.4 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.

<b>6a.</b> Prescription drug program charge reductions	\$855,806,293
<b>6b.</b> Medical provider discounts and reductions	\$3,580,738,623

The TPA and PBM leverage their negotiating power in the Texas health care marketplace to reduce medical and pharmacy costs for participants and the plan. The \$4.4 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.

What is most impressive about the continued growth in HealthSelect managed care savings is that more than 62,000 HealthSelect participants have moved to Medicare Advantage plans since January 1, 2012. This change is reflected in HealthSelect’s continued decrease in savings from coordination of benefits with Medicare.

### Lines 6c-6e. Participant cost-sharing

Sharing costs with participants reduces charges that would otherwise be paid by the plan. In FY15, employees, retirees, and dependents paid \$456 million in out-of-pocket costs through coinsurance, deductibles, and medical and prescription drug copays.

<b>6c.</b> Medical copayments and deductibles	\$120,392,264
<b>6d.</b> Medical coinsurance	\$202,011,585
<b>6e.</b> PDP cost-sharing	\$133,558,835

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 are the greatest source of cost savings to the plan (HealthSelect FY12-FY15, in millions)**



## Member cost-share leveraging

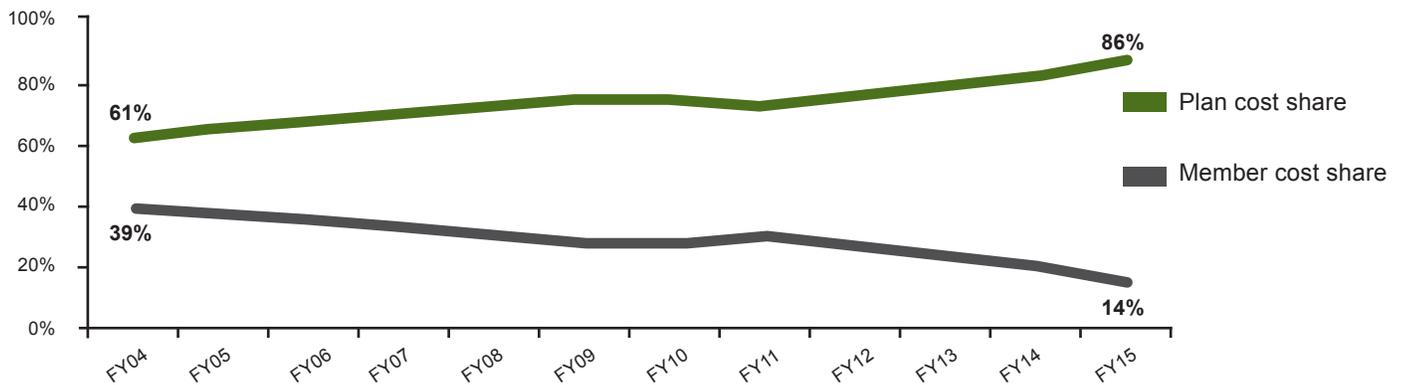
Because HealthSelect participant copays for prescriptions and doctor visits remain flat, as total charges for these services increase participants end up paying a smaller

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 9: HealthSelect participants had lower out-of-pocket costs in FY15, mainly due to reduced generic drug copays (in millions)**



**Figure 10: Member cost share for prescriptions is less than half what it was 10 years ago (member and plan share as a percent of total HealthSelect drug cost, FY04-FY15)**



In past years, drug costs were primarily driven by “blockbuster” brand-name drugs, such as Lipitor, Nexium, and Cymbalta. As generic alternatives for these drugs have become available, specialty drugs have risen to the top of the list.

Specialty drugs are expensive medications prescribed for complex chronic and/or life threatening conditions. They often require special storage, handling and administration, and they involve a significant degree of patient education, monitoring and management.

In FY14, compound drugs were a top cost driver for the plan. However, a mid-year plan design change reduced plan expenditures on compound drugs from \$35.7 million in FY14 to \$1.2 million in FY15.<sup>3</sup>

<sup>3</sup> On July 1, 2014, ERS suspended coverage of non-FDA approved bulk chemicals in compound drugs, and began to require pre-authorization for all compound drugs costing \$300 or more. None of the compound drugs were critical life-saving medications.

Figure 11 shows the exponential increase in the plan cost attributable to specialty drugs in HealthSelect. The plan paid \$248 million in FY15 for more than 57,000 specialty claims. Specialty drug spending in FY15 represented 31% of total drug plan cost, compared to 2.7% in FY01.

### Hepatitis C is a top cost driver for the prescription drug plan

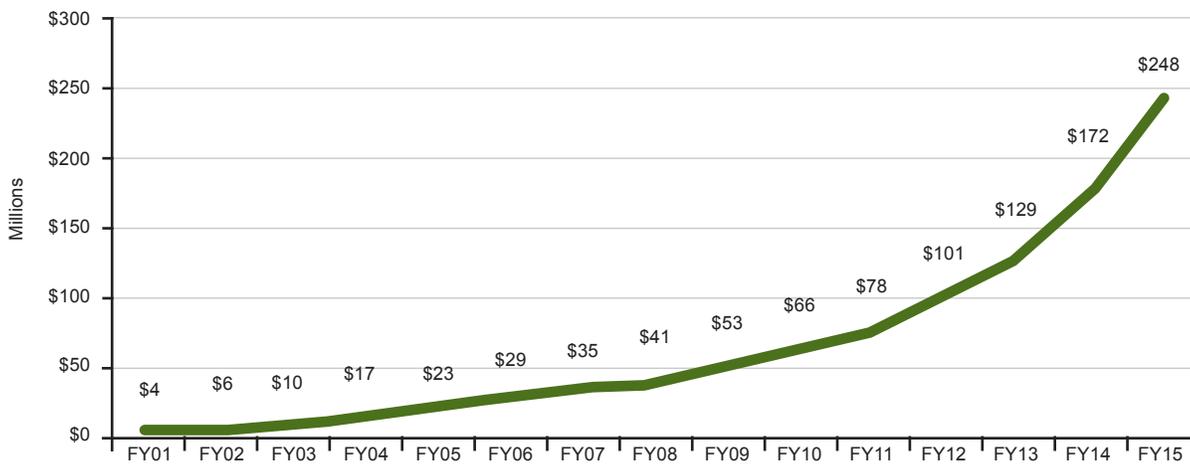
In FY16, the projected annual pharmacy trend is expected to increase once again, from 14% in FY15 to 16%, in part due to the release of new antiviral specialty drugs for the treatment of Hepatitis C.

The Centers for Disease Control (CDC) warns that Hepatitis C is a hidden epidemic for the Baby Boomer

population, predicting that people born between 1945 and 1965 are five times more likely than other adults to be infected. Hepatitis C is a liver disease resulting from a viral infection, causing serious health problems like liver damage and cirrhosis. It is a leading cause of liver cancer and the leading reason for liver transplants. The CDC believes that one-time testing for this group would find an estimated 800,000 undiagnosed cases.<sup>4</sup>

Harvoni – an antiviral drug for Hepatitis C – rose to number one on the Top 10 costliest drug list in FY15. However, this drug has a potential 95% cure rate for appropriate candidates. For example an \$85,000 treatment could prevent a costly liver transplant down the line. In this case, the benefits for members who need to take the drugs would outweigh the plan cost associated with covering those drugs.

**Figure 11: HealthSelect plan spending on specialty drugs has grown exponentially**  
Annual plan cost for specialty drugs, FY01-FY15 (in millions)



<sup>4</sup> Centers for Disease Control, "Hepatitis C Testing for Anyone Born During 1945-1965: New CDC Recommendations".

**Figure 12: Top 10 Costliest Drugs for HealthSelect in FY15 (in millions)**

Drug Name	Type	Therapeutic Use	Plan Cost in Millions FY15	Plan Cost in Millions FY14
1. Harvoni 	Specialty	Hepatitis C	\$30.6	\$0
2. Humira 	Specialty	Rheumatoid Arthritis	\$29.4	\$21.2
3. Lantus 	Brand	Diabetes	\$23.4	\$18.2
4. Enbrel 	Specialty	Rheumatoid Arthritis	\$22.5	\$19.6
5. Novolog 	Brand	Diabetes	\$20.6	\$15.4
6. Victoza 	Brand	Diabetes	\$14.1	\$10.8
7. Crestor 	Brand	High Cholesterol	\$13.2	\$16.6
8. Nexium 	Brand	Gastric Reflux	\$12.9	\$12.1
9. Duloxetine 	Generic	Depression	\$12.2	\$9.8
10. Lyrica 	Brand	Seizures	\$11.0	\$8.6

HealthSelect manages costs in the prescription drug program with a “three-tier” copay structure. A 30-day prescription for a generic drug is least expensive (\$10); a preferred brand-name drug is in the middle (\$35), and a non-preferred brand-name drug costs the most (\$60).

Generic dispensing rate up to 82.6%

Generic copays down to \$10

### Generic drug incentives work

On September 1, 2014, ERS reduced the price of a 30-day supply of generic medication from \$15 to \$10, bringing the GBP more in line with other plans and encouraging the use of generic drugs.<sup>5</sup> Over the next year, HealthSelect’s generic dispensing rate rose to 82.6%. However, new and improved drug therapies are released every day, and as the population ages, demand will continue to grow for more effective treatments for complex chronic health conditions.

Figure 13 shows the dramatic cost savings of using a generic cholesterol-lowering drug rather than a brand-name or specialty drug. Many doctors do try a course

of “step therapy” – testing the effectiveness of a generic drug first before graduating their patients to more expensive brand-name or specialty drugs. In some situations, the more expensive medications may deliver better results, but they also may expose patients to health risks, and the cost impact to the plan is evident.

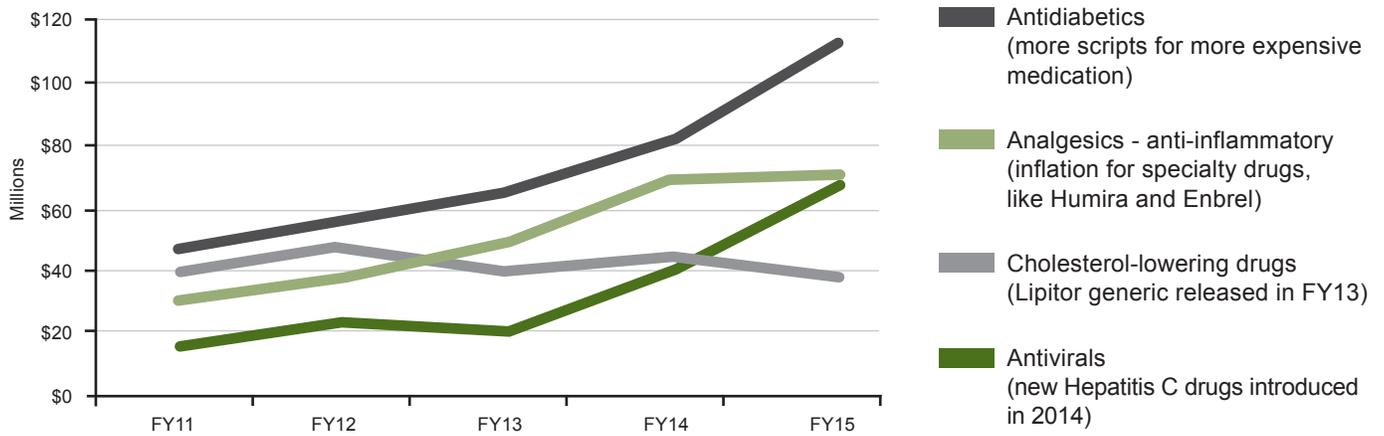
In FY15, HealthSelect began to require step therapy for certain therapeutic classes of drugs, such as anti-inflammatories and medications that reduce high blood pressure.

**Figure 13: How Does Choosing a Generic Medication Compare to Other Options?**  
*Four Cholesterol-Lowering Medications, 30-day Supply, Retail*



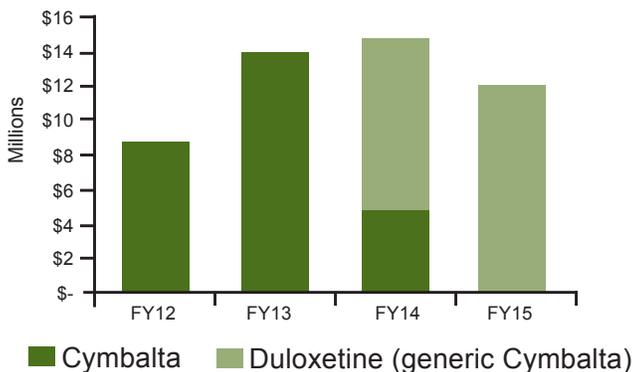
<sup>5</sup> In a 2014 survey of 136,000 GBP-eligible state and higher education employees, 67% of all respondents said they had asked their doctor for a generic medication in the past year.

**Figure 14: Impact on plan costs when a blockbuster drug is released (HealthSelect FY11-FY15, in millions)**



As seen in Figure 14, when the patent for Lipitor – a popular cholesterol-lowering drug – expired in FY12, it had a positive impact on the plan costs for the entire therapeutic class of drugs. In other words, the plan’s total cost for cholesterol-lowering medications was positively affected by the release of one generic drug.

**Figure 15: Cymbalta went off patent in FY14 but plan savings were not realized until FY15**



The “blockbuster gone generic” headline for FY15 was Cymbalta, a popular anti-depressant that is also prescribed “off label” for fibromyalgia, diabetic neuropathy and other reasons. Figure 15 shows the impact to plan costs when Cymbalta lost its patent in December 2013, four months into FY15. A dramatic shift toward generic usage occurred, which had an immediate positive effect on member out-of-pocket costs, but plan savings on Cymbalta were not realized until FY15.

It takes time for a “blockbuster generic” to save money for the plan for two reasons:

- (1) The year before the brand name goes off patent, the manufacturer artificially increases the price, in anticipation of losing money on the generic; and
- (2) For the first six months after the generic is released, the patent-holder has the exclusive right to produce the generic and set the price. After that window expires, competition in the marketplace will drive the cost down.

### Lines 6f-6g. Coordination of benefits

Another way to reduce eligible HealthSelect charges is coordinating the payment of claims with other health care payors. For example, when retired participants become eligible for Medicare, GBP medical benefits become secondary, which means the plan only pays eligible medical expenses after Medicare has processed the claim. In FY15, coordination with the Medicare program saved the GBP about \$126 million. Coordination with other insurance programs saved \$21 million.

6f. Coordination of benefits - Medical - Regular	\$19,847,870
6g. Coordination of benefits - Medical - Medicare	\$125,826,427
6h. Coordination of Benefits - PDP	\$1,381,982

## Refunds, Rebates and Subsidies

### 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 FY15, ERS received nearly \$152 million in rebates, including manufacturer payments received through the Medicare Part D Coverage Gap Discount Program. ERS annually conducts an audit to confirm that 100% of all rebates were paid to the plan.

8b. Federal revenue (subsidy) - Medicare Part D	\$86,053,570
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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 (RDS). Under RDS, the federal government reimbursed ERS for eligible retirees who stayed in the GBP instead of enrolling in Medicare Part D. From FY06-FY15, ERS collected RDS reimbursements of about \$267 million.

Effective January 1, 2013, ERS moved most Medicare-primary participants to a self-funded Employer Group Waiver Program (EGWP) with a wraparound feature, HealthSelect Medicare Rx, administered by SilverScript. In FY15, Medicare Part D subsidies (both RDS and EGWP) reduced plan costs by \$86 million.

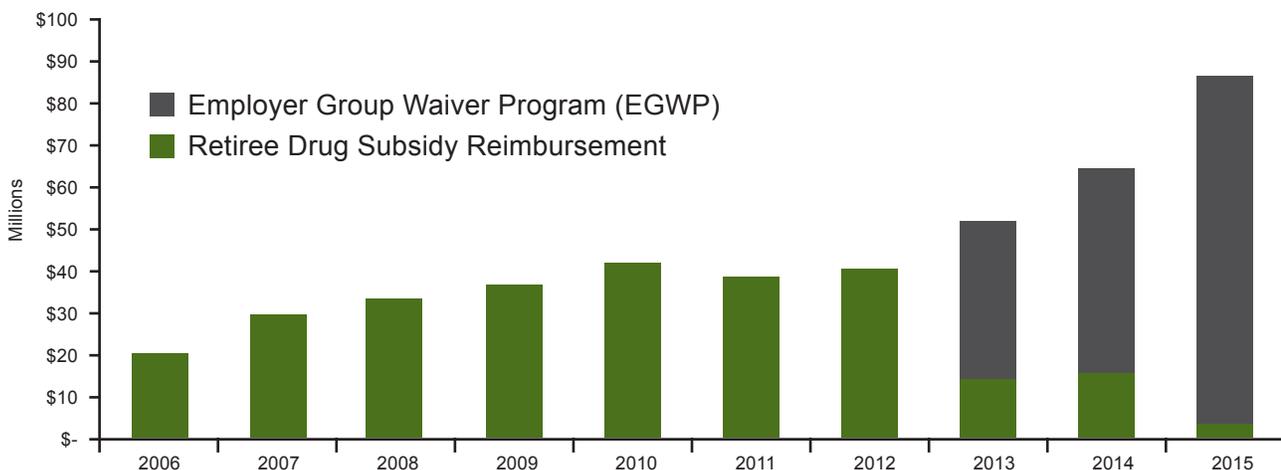
8a. Prescription drug rebates	\$151,890,411
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### Line 8c. Subrogation

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 \$5.1 million in FY15.

8c. Subrogation	\$5,067,879
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**Figure 16: HealthSelect Medicare Rx has more than doubled Medicare Part D subsidies**  
*Medicare Part D revenues for HealthSelect (FY06-FY15) in millions*



# 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 fraud and abuse are prevented or reduced and violators are dealt with appropriately. ERS requires vendors to be diligent in their efforts to prevent, detect, and investigate fraud, abuse, and other improprieties. Fraud and abuse differ in important ways: fraud implies intent, whereas abuse may occur from provider or participant error.

- Fraud is an intentional deception or misrepresentation by a person who knows the deception could result in some unauthorized benefit.
- Abuse is a transaction that results in unnecessary cost to the program, such as when participants regularly use the emergency room for primary care. While this is not fraud, it does direct resources away from true emergencies, and results in expensive and inappropriate charges to the plan.

HealthSelect vendors have fraud, waste, and abuse divisions that investigate and refer 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 in which abuse of certain drug categories is suspected;
- Investigating potentially ineligible dependents through routine eligibility audits; and
- Requiring participants to pay for health care received outside the country before receiving plan reimbursement.

## Figure 17: Fraud investigations are an ongoing concern for all health plans

The Fraud, Waste, Abuse, and Error (FWAE) team for the HealthSelect TPA – investigators, clinical review specialists, nurses, doctors, certified coders and analysts – actively watch claims and investigate fraud and abuse tips from multiple sources, including members, providers, and government agencies, to detect and prevent fraud. Detection identifies suspect providers based on a review of their claims. Prevention safeguards the claims system against potentially abusive providers. Through medical records review, the TPA can deny or recover dollars for non-covered services. The TPA also uses an Advanced Analytics Lab to watch claims pre-and post-payments for suspect activity.

Examples of provider fraud flagged by the FWAE team include:

- In 2015, FWAE identified four surgical centers that were performing “tummy tucks” but masking them as hernia surgeries. Through data analysis, patient interviews, and medical record review the TPA was able to stop significant client dollars from being paid for misrepresented services and/or services billed not rendered.
- FWAE identified pain management providers that may be abusing the system to get paid more through billing errors including duplicate billing, unbundling and billing facet joint injections under anesthesia.
- Some Texas providers are misrepresenting services provided to receive higher reimbursement, especially those who perform spinal manipulations under anesthesia.

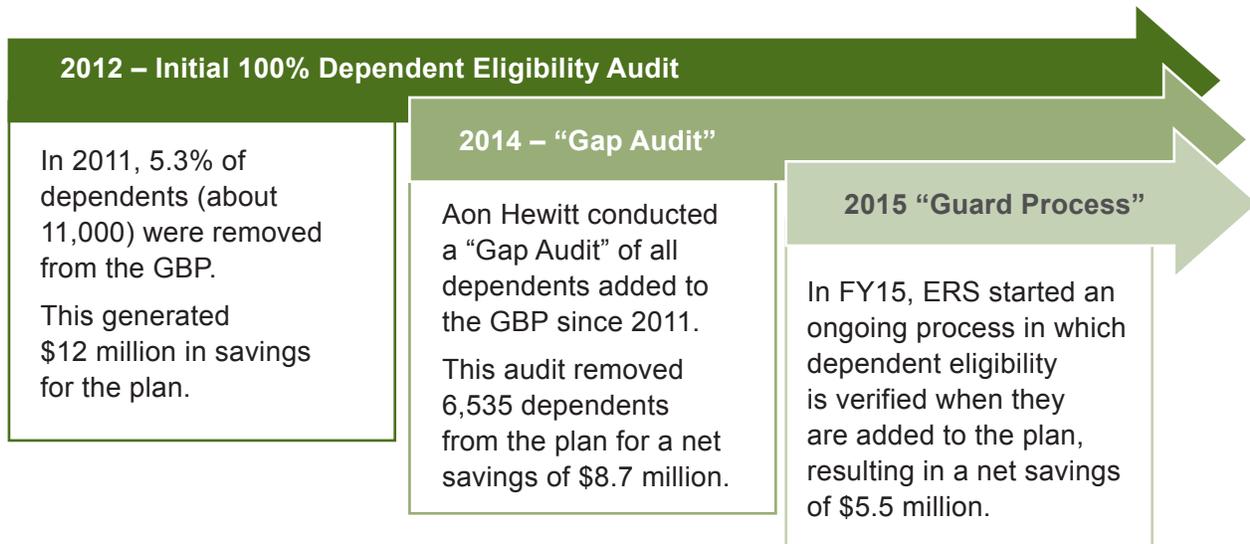
## Dependent Eligibility Audit (DEA)

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 completed a successful 100% dependent eligibility audit in FY12 that asked all plan members who cover

dependents for documentation proving their eligibility for coverage. A second “Gap Audit” was conducted in 2014. Going forward, ERS continues to audit all new dependents as they are added to the plan through an ongoing “Guard Process.” The DEA process has produced significant net savings for the program of \$26 million since 2012, with an 8 to 1 return on investment.

**Figure 18: Dependent eligibility audits saved the plan \$26 million for an 8 to 1 return on investment**



## 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 correct procedures and program guidelines.

8d. Pharmacy audit refunds	\$1,474,138
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In addition to auditing 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 claims experience.

8e. PBM audit refunds	\$1,316,235
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# 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 participants 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

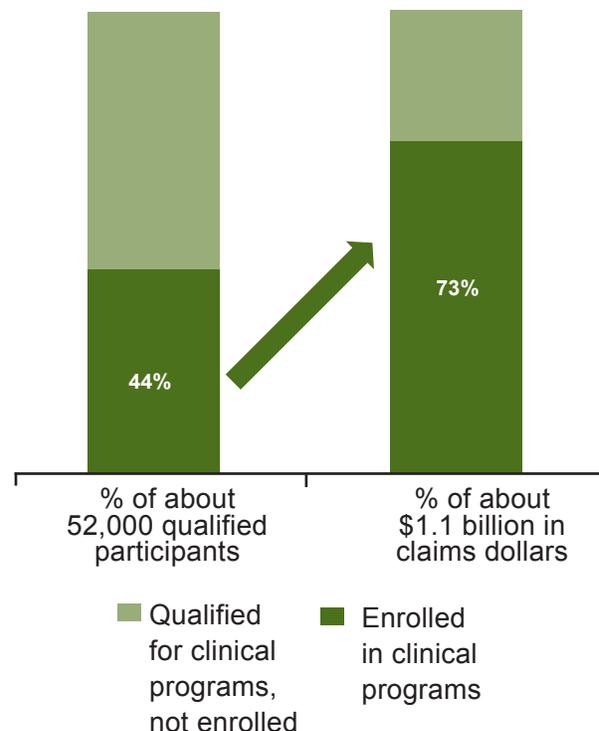
ERS uses multi-channel communications about wellness and the tools that are available to help participants manage their health. These include direct mail, online communications, telephone outreach, face-to-face meetings, and benefit fairs.

## ERS works with employers to promote wellness

Finally, ERS and the HealthSelect TPA work with state and higher education employers to 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.

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.

**Figure 19: HealthSelect successfully targets the highest risk participants for clinical programs**  
(Enrolling the highest risk 44% of qualified participants targets 73% of the claims spend for that group)



## Tobacco premium contributions yielded \$14.3 million in FY15

The 82nd Legislature enacted a 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. Certified tobacco users pay an extra contribution of \$30 a month, up to \$90 per household.

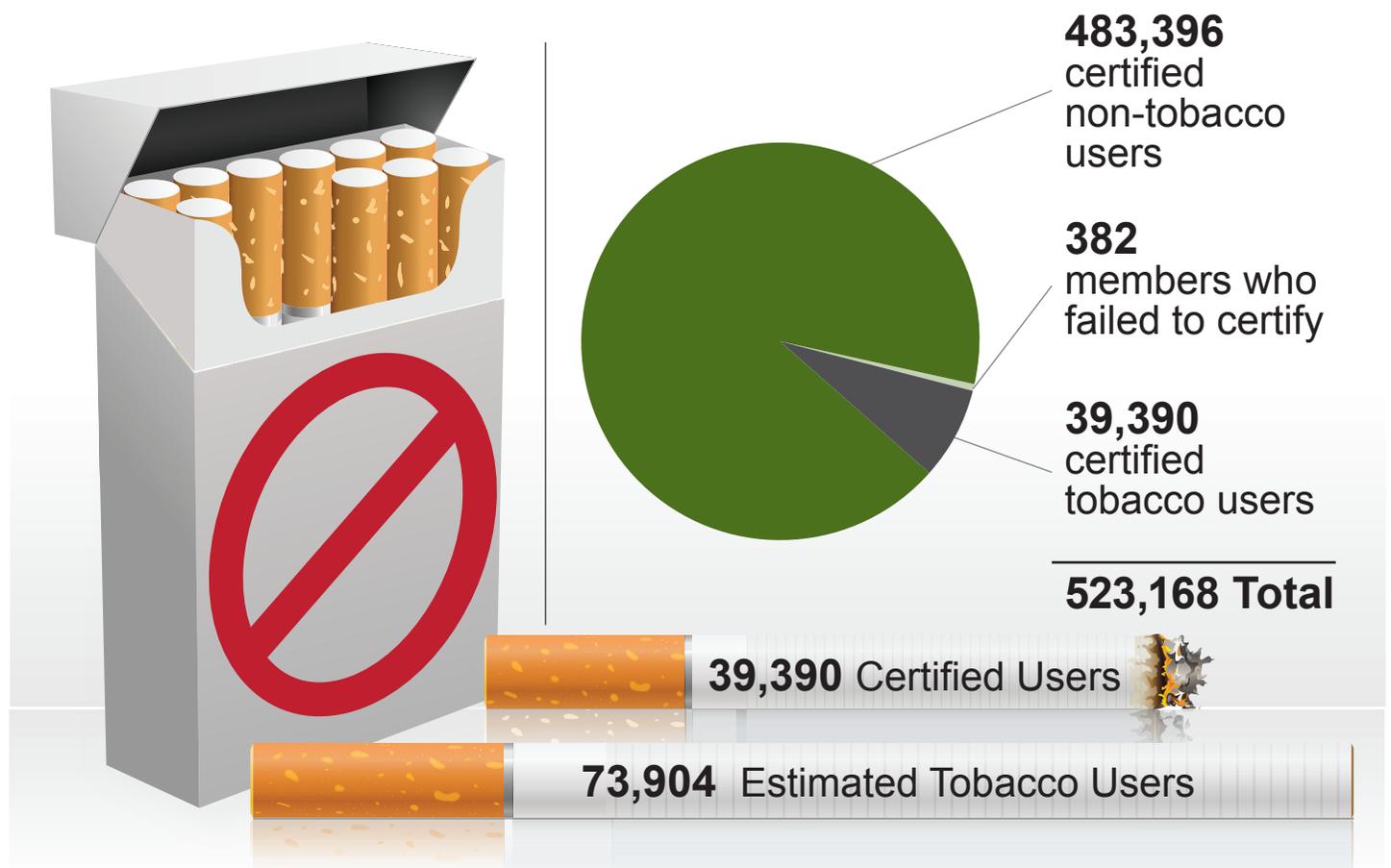
The 83rd Legislature authorized ERS to mandate tobacco certification of all participants starting with FY14 annual enrollment. Those who failed to certify were assumed to be tobacco users and were charged the monthly tobacco premium contributions until they informed ERS they were no longer using tobacco. In FY15, ERS collected \$14.3 million in tobacco premium contributions from more than 39,000 participants who certified as tobacco users, out of an estimated 74,000 potential tobacco users. This means that just over half

of the expected number of adult tobacco users in the GBP have self-certified their tobacco use, based on a national adult prevalence rate of 16.9%.<sup>6</sup>

HealthSelect offers free tobacco cessation coaching programs which have historically attracted extremely low participation. Fewer than 100 participants enrolled in the voluntary HealthSelect tobacco cessation program in FY15.

HealthSelect provides coverage for prescription drugs like Chantix and bupropion, both prescribed to help people quit using tobacco. In FY15, About 2,700 Chantix prescriptions were filled by about 1,500 non-Medicare primary participants, at a net cost to the plan of about \$750,000. However, it takes 12 weeks for Chantix to be effective, and at every 30-day interval, there was a 50% drop in usage. As with any medication, the plan only knows if the prescription was filled, not if it was taken.

**Figure 20: Just over half of the projected tobacco users in the GBP have self-certified to pay the tobacco-user premium contribution of \$30 a month**



<sup>6</sup> Current U.S. prevalence of cigarette smoking status among adults aged 18 and over is 16.9% according to *Summary Health Statistics: National Health Interview Survey, 2014, Table A-12a, page 1 of 9*. There are 437,303 adult participants in the GBP (age 18 or older) as of August 31, 2015.

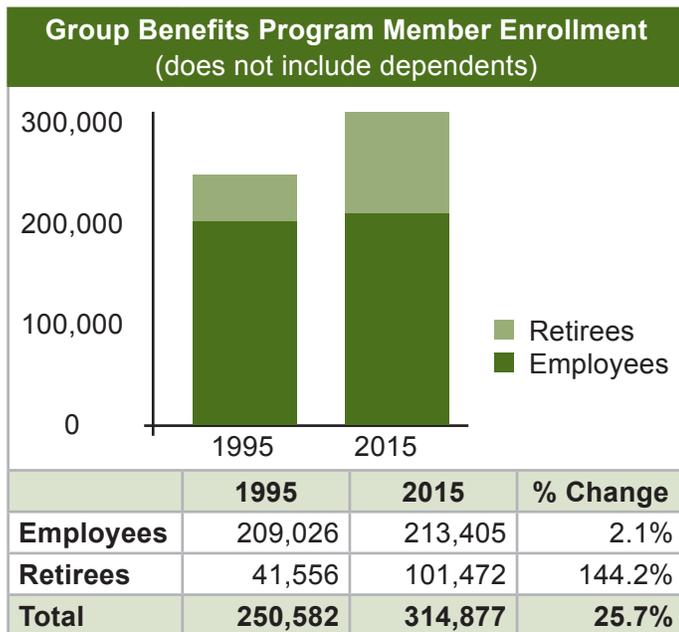
# RETIREE HEALTH INSURANCE

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.<sup>7</sup>

The importance of managing the cost of retiree health benefits cannot be overstated. Figure 21 shows that nearly all of the growth in GBP enrollment since 1995 is due to a 144% increase in the retiree population.

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 21: Increased member enrollment since 1995 is almost entirely due to growth in the retiree population**



## The Medicare Advantage option

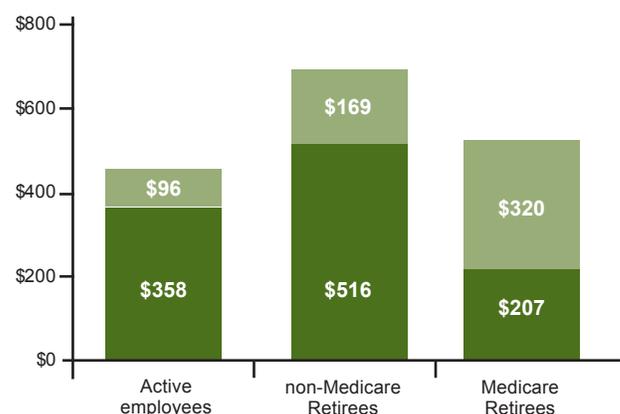
When GBP retirees and their dependents reach age 65 and become eligible for Medicare-primary coverage, they are automatically enrolled in HealthSelect MA. A GBP member enrolled in an MA plan does not have traditional Medicare or HealthSelect coverage. Retirees with an MA plan do not need a Medigap policy.

Medicare-primary participants can opt out of HealthSelect MA and choose among HealthSelect, three regional HMOs, or a Houston-area MA HMO, Kelsey Care. In FY15, about 69% of Medicare-primary retirees and their Medicare-primary spouses remained in the MA plans, while the rest chose HealthSelect or an HMO.

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 participants. The base Part B premium is \$105 a month. Part B premiums increase for retirees with higher incomes.

Figure 22 shows that retirees have higher costs than active employees. Retirees without Medicare have the highest medical costs, and retirees with Medicare have the highest prescription drug costs.

**Figure 22: Medicare retirees have higher drug costs; non-Medicare retirees have higher medical costs (HealthSelect, per participant per month costs, FY15)**



<sup>7</sup> 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.

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.

Benefits offered to GBP retirees under HealthSelect MA are comparable to regular HealthSelect but the MA premiums are less expensive for the State and for the retiree because Medicare subsidizes a large portion of participant medical expenses. MA plan participants continue to receive prescription drug coverage through HealthSelect Medicare Rx.

### **Medicare Part D subsidies**

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-primary participants and offset the cost with federal subsidies received under the Medicare Part D Retiree Drug Subsidy (RDS). Between FY06 and FY15, ERS collected \$267 million in RDS reimbursements from the federal government for Medicare-primary participants who stayed in the GBP.

On January 1, 2013, ERS moved most Medicare-primary participants to a self-funded Employer Group Waiver Program (EGWP) with a wraparound feature called HealthSelect Medicare Rx, administered by SilverScript. In FY15, Medicare Part D subsidies reduced plan costs by \$169 million since FY13.

# CONTRACTING

## Managed care lowered FY15 charges by nearly \$4.4 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 establishing a broad network and by negotiating provider contracts. 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.

The UnitedHealthcare TPA contract remains on track to meet four-year administrative savings projections of \$25 million (compared to other administrative proposals). The prescription drug benefit programs continue to be administered by Caremark and SilverScript, without an increase in administrative fees. About \$4.4 billion in charge reductions in FY15 came from rate negotiations 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.

## Monitoring TPA performance

The ERS account management team in the Benefit Contracts division closely monitors the administrative performance of the HealthSelect TPA and PBM vendors. A customized tool is used to provide monthly status updates on up to 40 vendor performance criteria in the areas of account management, customer service, operations, and systems and data management.

Performance guarantees are formulated during the procurement process, setting expectations for vendor performance during the contract period. A vendor’s failure to meet any requirement stipulated in the contract may result in a monetary performance assessment. The value of a performance assessment is determined by the severity of the violation.

- A Severity 1 “emergency” assessment would be imposed if mission critical systems went down, resulting in a substantial loss or disruption of business services.

- A Severity 2 “critical” assessment would be imposed if a major functionality was severely impaired, but operations could continue in a restricted fashion.
- A Severity 3 “moderate” assessment would be imposed if business operations were adversely impaired in a moderate manner, but an immediate temporary work-around was acceptable to ERS.

## 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. Benefits are designed to save the plan and participants money by offering financial incentives to use contracted providers. The use of network providers continues to rise, with 91% of paid medical claims in-network in FY15, compared to 89.5% in FY13.

HealthSelect provides three levels of coverage:

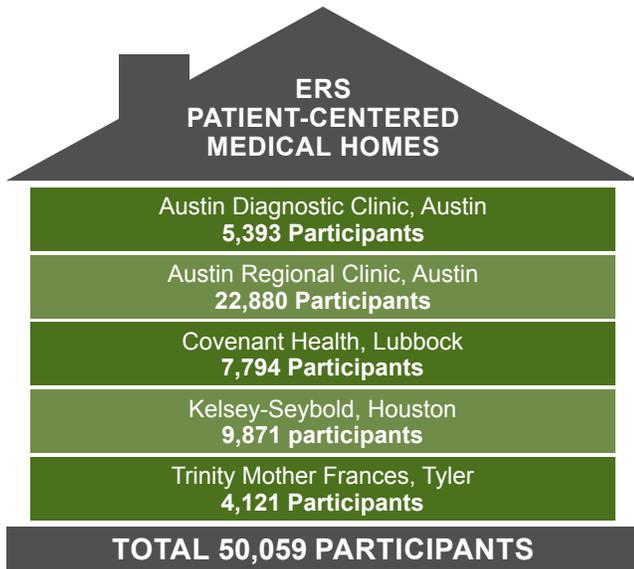
- **Network coverage** means a participant must see a contracted primary care physician (PCP) or “gatekeeper” for specialist referrals or extra services such as lab work, X-rays, or MRIs.
- **Non-network coverage** refers to services provided by non-contracted providers who are outside the direction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

ERS works closely with the TPA to monitor and manage HealthSelect network usage to identify and address gaps in network coverage. If a gap is identified, ERS works to fill those gaps through prioritizing the TPA’s contracting efforts, and, in some cases, contracting directly with the provider.

## Patient-Centered Medical Homes – a blueprint for better care and lower cost.

HealthSelect, like most employer-based plans, has historically paid claims under a “fee-for-service” (FFS) reimbursement strategy. FFS tends to reward doctors who prescribe more diagnostic tests and perform more procedures, not doctors who focus on low-cost preventive care and patient wellness.

**Figure 23: HealthSelect has five Patient-Centered Medical Home projects with more than 50,000 participants**



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

Between 2011 and 2015, ERS partnered with five large clinically integrated physician group practices across the state to create Patient-Centered Medical Home (PCMH) projects, which now treat more than 50,000 HealthSelect participants.

The 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 – such as electronic health records;
- uses evidence-based medicine and clinical decision-support tools to ensure quality standards are met;
- provides enhanced access, such as open scheduling and expanded hours; and
- awards shared-savings payments to the provider group when quality standards and cost targets are met.

### Savings are shared with providers

In addition to its regular FFS payments, HealthSelect pays each PCMH a negotiated monthly capitation payment for those participants who have selected the medical home as their primary care coordinator. The capitation payment incentivizes 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 performance targets.

Through January 2015, the PCMH projects produced a net savings to the state of \$49.5 million. The practices received \$9.7 million in shared savings payments in addition to their reimbursements for medical care. FY15 shared savings payments will be announced in January 2016.

# CONCLUSION

ERS lowered health plan costs by \$6.4 billion in FY15 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 administrative costs represent less than three cents of every health plan dollar. Proactive cost management is an imperative in the face of growing utilization of health care, new technology and more expensive treatments, an aging plan membership, increasing rates of chronic diseases and limited resources.

Successful management and legislative support of the program allowed the GBP to avoid benefit changes for the FY14-15 biennium. But the future will continue to present some difficult challenges for ERS, state lawmakers, and especially for employees, retirees, and their families who count on these health insurance benefits.

## The GBP has a significant impact on the Texas economy

One in 52 Texans – over half a million state and higher education employees, retirees and their families - are currently enrolled in ERS health coverages, in every area of the state. It's important to recognize the economic impact that the plan has on local health providers too.

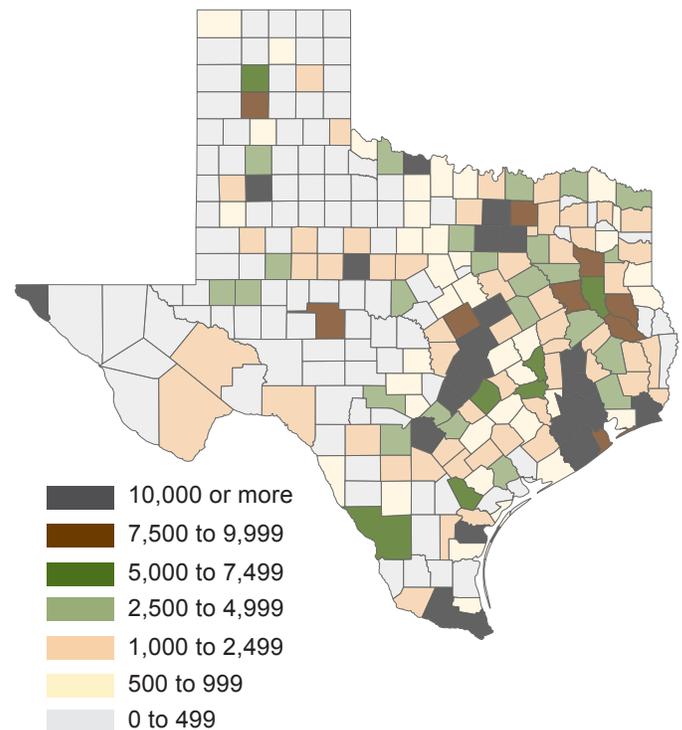
The GBP currently spends about \$8.4 million a day on health care claims. HealthSelect, with 83% of total GBP membership, paid \$2.75 billion in health payments last year to doctors, hospitals, and pharmacies across Texas.

## Without cost management, the state's insurance contribution would more than triple

In FY15, the member-only contribution rate was \$535.44 per month. Figure 25 demonstrates the financial impact that cost management programs had on the monthly contribution rate for member-only coverage during FY15. Without cost-management programs, the monthly contribution rate for member-only coverage would have been \$1,901.41.

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

*Number of ERS participants in GBP insurance by county, FY15*



## Legislative Updates

Several initiatives from the 84th Legislative session will affect the GBP and its participants in the FY16-17 biennium.

### Consumer-directed health plan to be offered September 1, 2016

With the passage of HB 966, ERS is moving forward with the design and implementation of a high-deductible health plan (HDHP) with a health savings account (HSA) for employees and pre-Medicare retirees for FY16. To meet that deadline, the HDHP will be added as an option within the existing HealthSelect TPA contract for the first year, and the HSA account administrator contract will be bid separately through a Request for Proposal (RFP) process.

**Figure 25: Texas Employees Group Benefits Program, HealthSelect FY15, Cost Containment Impact on the Member Only Rate**

	Annual Amount		Required Monthly Revenue for Member-only Coverage		
1 Considered Charges plus Estimated Cost Avoided		\$8,875,409,368		\$1,901.41	
<b>2 Estimated Cost Avoided</b>					
a. Medical		(\$76,918,597)		(\$16.48)	
b. Pharmacy		(43,794,149)	(120,712,746)	(9.38)	(25.86)
4 Ineligible Charges		(969,984,265)		(\$207.80)	
<b>6 Reductions to Eligible Charges</b>					
a. PDP Charge Reductions		(\$855,806,293)		(\$183.34)	
b. Other Facility & Professional Discounts & Reductions		(3,580,738,623)		(767.11)	
c. Medical Copayments and Deductibles		(120,392,264)		(25.79)	
d. Medical Coinsurance		(202,011,585)		(43.28)	
e. PDP Cost Sharing		(133,558,835)		(28.61)	
f. Coordination of Benefits – Regular		(19,847,870)		(4.25)	
g. Coordination of Benefits – Medicare		(125,826,427)		(26.96)	
h. Coordination of Benefits - PDP		(1,381,982)	(5,039,563,879)	(0.30)	(1,079.64)
<b>8 Refunds, Rebates and Guarantees</b>					
a. PDP Rebates		(\$151,890,411)		(\$32.54)	
b. Federal Revenue - Medicare Part D		(86,053,570)		(18.44)	
c. Subrogation		(5,067,879)		(1.09)	
d. Pharmacy Audit Refunds		(1,474,138)		(0.32)	
e. PBM Audit Refunds		(1,316,235)	(245,802,233)	(0.28)	(52.67)
9 Net Benefit Payments		\$2,499,346,245		\$535.44	\$535.44
					Monthly Member Rate

## Contracting activities in response to SB20

The 84th Legislature also enacted SB20, which, in addition to the General Appropriations Act, added new contracting requirements applicable to many state agencies, including ERS. ERS is complying with all procurement-specific requirements, including enhanced reporting to the Legislative Budget Board and timely compliance with new HUB reporting requirements. The HealthSelect medical third-party administrator contract will be rebid in FY16, with a continued focus on providing the best value for the state and participants.

## Type 2 diabetes prevention study

HB1, Rider 14 directed ERS to conduct an interim study on the costs and benefits of offering a Type II diabetes prevention program to state employees. ERS is working with the HealthSelect TPA and the Texas Diabetes Council to estimate the prevalence of pre-diabetes among the state employee population and analyze the costs and benefits of providing an evidence-based diabetes Type 2 prevention program.

Diabetes is a growing problem in the United States and in the state employee population, and ERS is evaluating online programs and “brick and mortar” programs to raise awareness of prediabetes to help employees across the state prevent the onset of Type 2 diabetes. The results of the analysis and action taken by ERS will be included in a report to the Legislature and Governor by August 31, 2016.

## Looking Ahead

### Prescription drug costs are an ongoing challenge in light of expensive new treatments

ERS will continue to monitor the impact of specialty drug claims on plan costs, looking at who is at risk in the population that uses those drugs, and the unintended consequences on patient health of not using the drugs. The plan’s options for addressing prescription drug price inflation are limited. However, the HealthSelect plan is large enough in Texas to move market share to some extent, by adding more competitively priced drugs to the formulary. HealthSelect could remove particularly pricey medications from the formulary when a less expensive equivalent drug of similar efficacy is available.

## ERS will continue to proactively manage retiree costs

While the number of active employees in the GBP is holding steady, the retiree population has more than doubled since 1995. In fact, a 26% growth in GBP membership over two decades is due entirely to the growing retiree population. Managing costs for an aging health plan is paramount. In the past several years, ERS has successfully implemented new medical and pharmacy plans for Medicare-primary participants. These initiatives continue to produce savings for the plan, and they reduce contributions for members with dependents enrolled in the Medicare Advantage plans.

### Affordable Care Act costs are primarily due to fees and reducing member cost sharing

The cost of ACA-related fees peaked in FY15, then will taper off as one of the costliest fees for HealthSelect – the Transitional Reinsurance Program fee – is terminated. Total plan costs for FY16 are projected to cost the plan about \$125 million. Pursuant to federal action on December 18, 2015, the Health Insurance Provider fee will be suspended for calendar year 2017, which will lower ACA-related costs by \$18 million in FY17. HealthSelect spent \$32 million in FY15 to ensure that preventive care services were available at no cost to the participants, as required under the ACA.

Another FY15 development was a new ACA-imposed maximum cap on member out-of-pocket health care costs. Starting January 1, 2015, once an individual spent \$6,350 or a family spent \$12,700 on medical costs, the plan picked up the rest of the tab. Starting January 1, 2016, the caps are \$6,550 for an individual and \$13,100 for families, which includes both medical and pharmacy costs. While most participants never come close to spending this much money on their health care in a year, for some of the very sickest people who rely on the health plan, it will provide some financial relief.

ERS continues to work ahead of the curve to maintain competitive, comprehensive benefits at a reasonable cost. However, the program needs coordinated action to make further inroads on reducing plan costs. Attracting and retaining a qualified state workforce is a prime objective in a total compensation philosophy. When asked, employees consistently name health insurance as their most valued benefit. We look forward to working with the Legislature to find cost effective ways to continue offering a benefit that not only provides a competitive advantage to state employers, but also shows that the State of Texas values a healthy productive workforce.

## 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.

Since FY13, ACA-related costs have increased annually. The cost of ACA-related fees will peak in FY16, then will taper off as one of the costliest fees for HealthSelect – the Transitional Reinsurance Program fee – is terminated. Pursuant to federal action on December 18, 2015 the Health Insurance Provider fee will be suspended for calendar year 2017, which will lower ACA-related costs in FY17.

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.

### Projected Additional Plan Cost FY13 - FY17 Related to the Affordable Care Act<sup>1</sup> (Revised January 2016)

	Projected Plan Cost (\$millions) <sup>2</sup>				
	FY13	FY14	FY15	FY16	FY17
1. Eliminate Lifetime Maximum for Out-of-Network Services	\$0.3	\$0.3	\$0.3	\$0.4	\$0.4
2. Expand Coverage to Dependents to Age 26	\$12.4	\$13.4	\$15.4	\$17.2	\$19.0
3. Cover Preventive Care at 100%	\$26.4	\$28.2	\$31.7	\$34.1	\$36.8
4. Cover Contraceptives at 100%	\$8.1	\$8.9	\$9.7	\$10.5	\$11.6
5. Reduce Waiting Period	\$0.0	\$0.0	\$19.3	\$20.9	\$22.9
6. Implement Maximum Member Cost Sharing	\$0.0	\$0.0	\$0.1	\$4.6	\$4.9
7. Change Definition of Full Time Employee from 40 to 30 Hours per Week <sup>3</sup>	\$0.0	\$4.0	\$4.2	\$1.0	\$1.1
8. Patient Centered Outcomes Research Trust (PCORT) Fee <sup>4</sup>	\$0.5	\$0.9	\$1.0	\$1.0	\$1.1
9. Transitional Reinsurance Program Fee <sup>5</sup>	\$0.0	\$18.5	\$22.1	\$14.3	\$4.0
10. Health Insurance Provider Fee <sup>6</sup>	\$0.0	\$8.8	\$19.1	\$21.8	\$7.4
<b>Total</b>	<b>\$47.7</b>	<b>\$83.0</b>	<b>\$122.9</b>	<b>\$125.2</b>	<b>\$108.5</b>

<sup>1</sup> Projected additional Plan Cost to the GBP for all employers and members.

<sup>2</sup> Projected Plan Cost represents costs incurred in fiscal year.

<sup>3</sup> Amounts shown are projected additional employer contributions.

<sup>4</sup> The PCORT fee helps fund the Patient Centered Outcomes Research Institute's research on the comparative effectiveness of medical treatments

<sup>5</sup> The Transitional Reinsurance Program Fee is designed to spread financial risk across insurers to assist plans that attract individuals at risk for high claims costs. This fee does not affect the Medicare Advantage plans. It terminates after December 31, 2016.

<sup>6</sup> Projected Health Insurance Provider Fees will fund premium tax subsidies for low-income people and their families who purchase insurance through the exchange. It will be permanent starting in Calendar Year 2014 and is paid by GBP insurers. HealthSelect and Community First HMO are exempt from this fee.

## APPENDIX B: Financial Status of the Group Benefits Program, FY15

Texas Employees Group Benefits Program, Summary of Health Plan Experience All GBP Health Plans Based on Experience through September 2015.			
\$Millions			
	FY14	FY15	Projected FY16
<b>Revenue from State/Members</b>			
Employer contributions for state agencies	\$1,521	\$1,653.1	\$1,808.6
Employer contributions for higher education	643.3	706.9	773.5
Employer contributions – non-state agencies	62.4	67.7	74.1
<b>Employer Contributions – total</b>	<b>2,226.8</b>	<b>2,427.7</b>	<b>2,656.2</b>
Member contributions	435.8	455.1	492.3
Other revenue	179.9	230.0	226.1
<b>TOTAL REVENUE</b>	<b>\$2,842.5</b>	<b>\$3,112.8</b>	<b>\$3,374.6</b>
<b>HEALTH CARE EXPENDITURES</b>	<b>\$2,788.6</b>	<b>\$3,051.6</b>	<b>\$3,409.3</b>
Net Gain/(Loss)	\$53.9	\$61.2	(\$34.7)
<b>Fund Balance</b>	<b>\$379.3</b>	<b>\$440.5</b>	<b>\$405.8</b>
<b>Other Expenses Incurred Outside of the GBP Fund</b>			
Member cost-sharing (copays, coinsurance and deductibles)	\$490.2	\$494.0	\$503.5

### Projected Average Annual Cost Trends for HealthSelect (FY16-17)

Category	Increased Use of Service	Industry Price Increases	Maintenance of Member Cost Share	Total
Hospital	2.3%	4.1%	0.6%	<b>7.0%</b>
Other Medical Expense	0.9%	4.4%	0.2%	<b>5.5%</b>
Pharmacy	3.5%	8.0%	4.5%	<b>16.0%</b>
<b>Total</b>	<b>2.2%</b>	<b>5.2%</b>	<b>1.4%</b>	<b>8.8%</b>

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.

## APPENDIX C: Landmark Events in the History of the GBP

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**1975**

### **SB 18 CREATED THE TEXAS EMPLOYEES UNIFORM GROUP INSURANCE PROGRAM**

- ERS was charged with providing uniform health insurance and other optional coverages for state employees, retirees and eligible dependents
- 

**1976**

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

- Three fully-insured indemnity plan choices for employees: high, medium, and low plans
- 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, each member received \$12.50 a month; if any was left over, it could be spent on dependent coverage
- 

**1978**

### **TWO HEALTH MAINTENANCE ORGANIZATIONS (HMOS) WERE APPROVED FOR PARTICIPATION IN THE GBP FOR FY79**

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**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/incentives for outpatient surgery
- 

**1987**

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

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**1989**

### **PRESCRIPTION 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**

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**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 receiving benefits similar to those provided under the indemnity plan
- By comparison, in FY15, only two non-Medicare HMOs participate in the GBP

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

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**1991**

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

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**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 with a gatekeeper model
  - Members must coordinate care and specialty referrals through their PCP
-

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# 1993

**ENROLLMENT INCREASED 39.2% AFTER INSTITUTIONS OF HIGHER EDUCATION JOINED 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. The network was expanded to all Texas counties over the next seven years.
  - 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**

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# 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**

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# 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% PASS-THROUGH 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**

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# 2012

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

**IMPLEMENTED MEDICARE ADVANTAGE PPO AND HMO FOR MEDICARE-PRIMARY PARTICIPANTS**

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# 2013

**HEALTHSELECT IMPLEMENTED A NEW TPA CONTRACT FOR THE FIRST TIME IN 30 YEARS**

- Projections to save \$25 million in administrative fees over four years are on track

**IMPLEMENTED SILVERSCRIPT, A HEALTHSELECT MEDICARE DRUG BENEFIT FOR MEDICARE-PRIMARY PARTICIPANTS**

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# 2014

**IMPOSED STRICT PAYMENT RULES TO ADDRESS 250% COST INCREASE FOR COMPOUND DRUGS**

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# 2015

**REDUCED COPAYS ON GENERIC DRUGS FROM \$15 TO \$10**

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## APPENDIX D: Glossary of Terms

**Affordable Care Act (ACA):** A federal statute signed into law by President Barack Obama on March 23, 2010, enacting significant regulatory reforms of the U.S. healthcare system.

**Adverse selection:** In health insurance, when multiple plans are offered, adverse selection occurs when people avoid buying higher levels of insurance benefits unless they are sure they will benefit from it.

**Capitation:** A fixed provider payment amount per person regardless of type or amount of health care services used.

**Compound drugs:** Compound drugs are specially formulated combinations of two or more medications made in compounding pharmacies.

**Contingency fund:** The amount of health plan assets that remain in the ERS Insurance Trust after all liabilities have been accounted for. The contingency fund's intended use is to cover unanticipated expenses arising from adverse fluctuations in claim costs or an unforeseen event such as a flu pandemic.

**Contribution rate:** The monthly amount that the employer and member must pay for health insurance coverage (expressed in dollars). The GBP rate, set by the ERS Board of Trustees, divides the actual health plan costs between employers and members based on the contribution strategy established by the Legislature.

**Contribution strategy:** Set by the Legislature; specifies the portion of total health plan costs paid by the employer (expressed as a percentage). Currently, the employer pays 100% of the cost for member-only coverage and 50% of the cost for dependent coverage.

**Coordination of benefits (COB):** Divides health care expenses among responsible payers, ensuring that HealthSelect doesn't pay claims that may be covered elsewhere.

**Employer group waiver plan + WRAP (EGWP):** A basic Medicare Part D program combined with a wraparound provision that brings the plan design up to par with current employer coverage. The EGWP allows plan sponsors to offset prescription drug costs incurred by plan members through federal subsidies.

**Fee for service (FFS) reimbursement:** A payment model in which providers are paid for each service they perform.

**Fully insured plan:** A plan in which the employer contracts with an insurance company to assume financial responsibility for claims and administrative costs.

**Generic dispensing rate (GDR):** The percentage of all filled prescriptions comprised of generic medications.

**Grandfathering:** Application of old rule applies to an existing group of participants (or situation) and a new rule applies to a future group of participants (or situation).

**Health benefit cost trend:** A complex measure of the annual rate of change in per capita payments to health care providers, including price inflation, the mix of services provided, and changes in health care utilization.

**Health Insurance Provider Fee:** ACA-required fee (starting January 1, 2014) that funds premium tax subsidies for low-income people and their families who purchase insurance through the exchange. HealthSelect and Community First HMO are exempt from this fee. Pursuant to federal action on December 18, 2015 the Health Insurance Provider fee will be suspended for calendar year 2017.

**HMO plan:** A pre-paid health program where healthcare services are provided through a closed provider network.

**Health savings account (HSA):** A tax-favored account that individuals use to pay qualified medical expenses; a tax-free way to save for expected health care expenses. HSAs are portable and funds are carried over without limit from year to year.

**Managed care:** A cost management practice that negotiates discounted reimbursement rates with providers who agree to participate in the network. Participants pay less for using network providers; they pay more for using out of network providers.

**Medicare Advantage plan:** A type of insurance plan that is provided by private insurance companies. It provides an option to traditional Medicare and Medicare supplement coverage with a single plan and administration.

**Medicare Part A:** This part of Medicare pertains to hospital insurance.

**Medicare Part B:** This part of Medicare pertains to other medical insurance.

**Medicare Part D:** This part of Medicare is a separate insurance policy just for prescription drugs.

**Member cost share leveraging:** When the benefit design consists of fixed copays, the plan will bear a larger share of cost increases over time, while member copays stay the same.

**Patient Centered Outcomes Research Institute fee:** This ACA-required fee helps fund research on the comparative effectiveness of medical treatments.

**Point-of-Service (POS) plan:** A type of managed care insurance plan where the member chooses a network primary care physician (a “gatekeeper”) who provides and directs all of his medical care, including specialist referrals. Members pay more if they choose out-of-network providers.

**Pre-payment claims editing:** Screening submitted charges for duplicate claims or late fees, non-covered services or facilities, or services that are not medically necessary.

**Retiree drug subsidy (RDS):** A federal program under Medicare Part D that subsidizes a portion of eligible-retiree drug costs. To receive subsidies, the plan sponsor must continue to offer employer-provided drug coverage to retirees who would have otherwise enrolled in Medicare Part D.

**Risk pool:** The total number of participants covered for health insurance through the GBP.

**Risk pooling:** The spreading of financial risks evenly among a large number of contributors to the insurance program.

**Self-funded model:** A model in which the employer and the participants—not an insurance company—assume direct financial responsibility for funding health care claims. Employers and employees pay for the plan and bear the risk that the revenue collected will be enough to pay all care claims during the year.

**Specialty drugs:** Expensive medications prescribed for complex chronic and/or life threatening conditions. They often require special storage, handling and administration, and they involve a significant degree of patient education, monitoring and management.

**Step therapy:** A cost containment policy that requires members to try less expensive drugs before the plan covers a more expensive brand name drug. Also called “Step Protocol.”

**Subrogation:** 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.

**Transitional Reinsurance Program Fee:** An ACA-required fee that is designed to spread financial risk across insurers to assist plans that attract individuals at risk for high claims costs. This fee does not affect the Medicare primary participants including those enrolled in Medicare Advantage plans. It will be terminated December 31, 2016.

**Utilization:** A measure of how often members go to the doctor, get services, or fill prescriptions.

**Utilization management:** A process that highlights cost drivers, identifies plan participants eligible for clinical management programs, and encourages coordination of care by ensuring that primary care doctors are involved in treatment decisions and prescribed services are aligned with best-practice standards.

**Value based incentive design (VBID):** This type of plan design aligns incentives with the clinical value (as opposed to acquisition cost) of the drug or service. Incentives can include monetary rewards, reduced premium shares, or lower deductibles and copays.

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