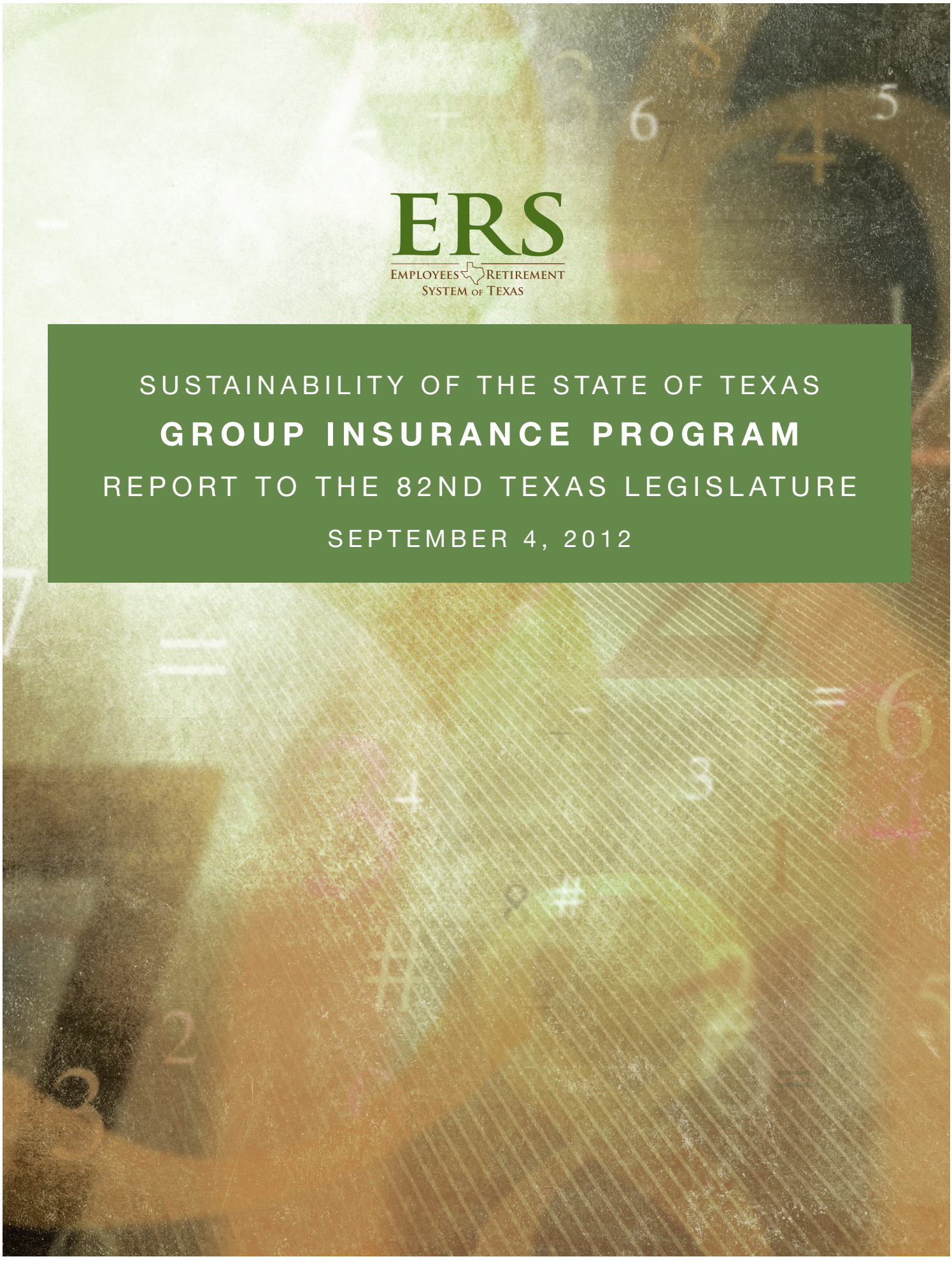



SUSTAINABILITY OF THE STATE OF TEXAS

# GROUP INSURANCE PROGRAM

REPORT TO THE 82ND TEXAS LEGISLATURE

SEPTEMBER 4, 2012

## MISSION

ERS supports the state workforce by offering competitive benefits at a reasonable cost.



Published
September 4, 2012

## CONTENTS OF REPORT

House Bill 1, the appropriations bill for the 82nd Texas Legislature, directed the Employees Retirement System of Texas (ERS) to conduct a study of the long-term sustainability of the Texas Employees Group Benefits Program (GBP), including a review of the current plan design and funding.

**"The GBP covers one in 48 Texans and contributes more than $2 billion a year to the Texas economy through health care provider payments."**

ERS' main goals for the study were to provide an open, inclusive and transparent research process and to present a balanced analysis of a range of options for the Legislature's consideration. The report will refer to the research study as the "Interim Benefits Study" (IBS). The policy framework and methodology for the IBS are outlined in Appendix A.

**Legislative intent for providing health insurance benefits.** The Texas Legislature establishes policy and determines funding for state employee compensation and benefits. The Texas Insurance Code[1] outlines the Legislature's intent for providing health insurance benefits to the state workforce. The GBP was created to:

- provide uniform insurance benefits for all state employees and their dependents,
- recruit and retain competent employees with benefits at least equal to private sector benefits,
- encourage employment and service to the State as a career profession,
- promote and preserve the economic security and good health of employees and dependents,
- foster and develop high standards of employee-employer relationships, and
- recognize long and faithful service and dedication of state officers and employees.

While the intent for providing benefits is clear, state employee and retiree health insurance benefits are not guaranteed in statute. The Legislature sets the funding for the GBP on a pay-as-you-go basis during each legislative session. GBP benefits are subject to change based on the amount of the legislative appropriation.

ERS used legislative directive as its guiding principle when developing a working definition of sustainability and an analytical framework for evaluating the options in the report. It seems clear that providing comparable benefits and controlling plan costs are equally important goals.

**Organization of the report.** This report provides a framework for evaluating potential options for change with the goal of sustainability in mind. The executive summary explores major cost drivers affecting not only the GBP but also other employer-sponsored health plans across the nation. Understanding the most prominent barriers to sustainability is a crucial first step toward finding workable solutions.

Our findings recognize that a "magic bullet" does not exist. The executive summary presents recurrent themes that arose during our research process as a set of guideposts to inform decision-making about the plan. ERS does not make specific recommendations, but instead presents an in-depth analysis of a range of options for the Legislature's consideration. We are mindful that many stakeholders have strong interests in the sustainability of the health plan, and that significant and complex policy questions remain to be answered.

Sections 1-5 of the report review five policy areas that are within the jurisdiction of the Legislature and the ERS Board of Trustees – eligibility, contribution strategy, appropriations, professional management, and plan design (see Figure E1). We evaluated 37 options for their fiscal, legal, policy, administrative, and customer impact. Section 6 presents detailed findings from a benchmarking survey comparing GBP insurance benefits to those of other private and public sector employer-sponsored plans.

***Figure E1: The Legislature and the ERS Board of Trustees share responsibility for establishing policy in five major areas***

| LEGISLATURE | LEGISLATURE | LEGISLATURE | ERS BOARD OF TRUSTEES | LEGISLATURE AND ERS BOARD OF TRUSTEES |
|---|---|---|---|---|
| **Section 1: Eligiblity** Who should be eligible for coverage under the plan? | **Section 2: Contribution strategy** How should the employer and the member share the cost of coverage? | **Section 3: Appropriations** What is the proper funding level? Does the funding process provide flexibility? | **Section 4: Professional management** How do cost management initiatives save the plan money? | **Section 5: Plan design** How can the plan design ensure quality, provide choice, and align incentives with health risks? |

## WHAT IS SUSTAINABILITY?

The rationale behind this study and other reform efforts is the belief that U.S. health care spending is too high and rising too quickly. Whether measured by individual insurance premiums, average spending per person, total national spending, or federal and state government health spending, U.S. health care expenditures are growing faster than inflation, faster than average wages, and faster than the gross domestic product.

**"Sustainability means… managing health care costs to the State, while continuing to offer participants and employers health insurance benefits that are comparable to other large private/public sector employers."**

Achieving long-term sustainability of the GBP will require a complex blend of financial, legal, structural, and operational changes. Long-term success will depend upon coordinated action and commitment from policymakers, providers, and more than half a million people who depend on their GBP benefits.

ERS developed a core set of questions to ask when analyzing the options presented in this report. Figure E2 shows how the sustainability review process worked, using the example of an option ERS evaluated in Section 4 of the report, Accountable Care Organizations. See Appendix B for a complete sustainability review of all the options analyzed in this report.

***Figure E2: Analytical framework for evaluating sustainability***

| OPTION | KEY QUESTIONS ASKED | |
|---|---|---|
| **Accountable Care Organizations (ACOs)**<br>An ACO is a fully-integrated delivery model including primary care doctors, specialists, physician extenders, and hospitals.<br>Providers assume more financial risk, along with the opportunity for financial reward for delivering more effective care at a lower cost. | Does it manage health care costs? | Yes, it has the potential to manage costs, even in the short term. |
| | Does it reduce cost to the employer? | Yes, it has the potential to reduce costs with no increase in administrative cost. |
| | Does it share risk with providers and responsibility with members? | Yes. It moves some risk to providers and rewards them for managing it. Shared savings with providers depend upon reduced cost trend and quality outcomes. |
| | Does it ensure a basic level of comparable benefits? | Yes, alternative payment programs are consistent with national trends. The State of Texas is ahead of the curve with its Patient-Centered Medical Home projects. |
| | Does it encourage behavior change and improve health outcomes? | No direct incentive exists for the member, although the ACO model should improve health outcomes through an intense focus on wellness and better coordination of care. |
| | Do the Legislature and/or ERS have the authority to make the change? | An ACO requires that a hospital be integrated into the spectrum of contracting medical providers. In Texas, this could require legislative changes to the Corporate Practice of Medicine Act, and to the Insurance Code to allow shifting of risk to the provider outside the HMO setting. |
| | Does federal health care reform have an impact? | Yes, the ACO model is now being used in the Medicare program. |
| | Does it affect the projected cost of Other Post-employment Benefits (OPEB)? | It may have a small impact over the long term. |
| | Who is affected and to what extent by this option? | Medical providers would be most affected by this option, as they would have to form partnerships that may not currently exist. Some legal barriers may need to be removed to facilitate these partnerships. |

**The GBP has performed well against the national health care cost trend.** One way of judging how well a plan is controlling costs is the health care cost trend. A plan's core health care cost trend is a complex measure of the annual rate of change in payments to health care providers, including price inflation, the mix of services provided, and changes in health care utilization.[2] On top of this is the impact of changing demographics, plan design changes, state and federal mandates, member cost share leveraging, technological advances, and unhealthy choices. See Appendix C for a more detailed description of the components of the GBP health care benefit cost trend.

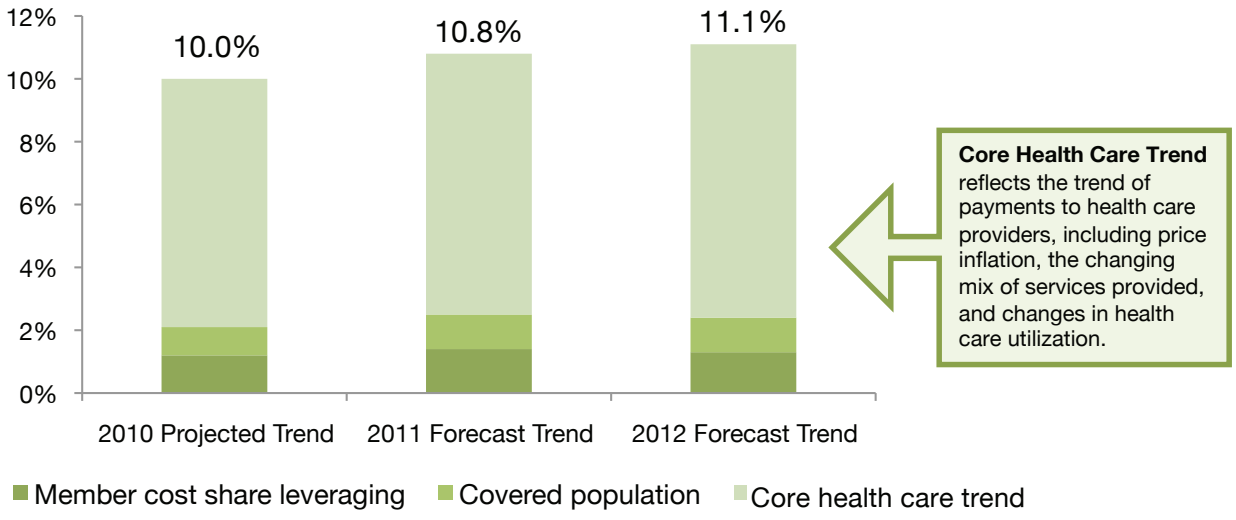
**"At 8%, the underlying GBP health benefit cost trend for FY12 is below the national average."**

In 2011, the health care cost trend fell across the nation due to a slowdown in utilization, reduced capital spending in response to the sluggish economy, and an increased use of generic drugs.[3] At 8%, the GBP underlying health benefit cost trend for FY12 is below the national average. Even so, GBP costs are increasing at a rate more than double that of general inflation.

**Federal health reform impact on health care cost trend.** Cost shifting to insurance plans from federal discount payers such as Medicare and Medicaid and mandates from federal health care reform legislation also increase costs for insurance plans.[4] For example, federally required provisions of the Affordable Care Act (ACA) are projected to cost the plan $82.8 million in the FY12-13 biennium.

Additional costs due to the ACA were offset somewhat by $70.9 million in federal government subsidies in FY11-12 from the Early Retiree Reinsurance Program (ERRP), which was 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 ended during the FY12 plan year, two years earlier than originally established because federal funding for this program was exhausted. See Appendix D for more details about the impact of the ACA on the plan.

***Figure E3: Components of national health care cost trend***
*(Aon Hewitt survey of 60 leading health care vendors, average for all health plans, 2011)*



## BARRIERS TO SUSTAINABILITY

Across the nation, public and private sector employers are facing a similar dilemma: how to continue offering competitive benefits while stemming the tide of rising benefit costs. The best employer-sponsored plans are not just shifting costs to employees; they are making serious efforts to understand why the system is unsustainable, then using that information to design strategic, targeted solutions.

**Success is contingent upon many complex intervening forces.** The health care system is suffering from an excess of complexity – in payment systems, regulation and bureaucracy, expensive technology, uncontrollable demand, cost shifting among payers, and unhealthy behaviors – all beyond the scope of ERS', or oftentimes, the Legislature's control.

By necessity, this report focuses on the areas where we can make an impact, but it's important to note that sustainability is, and will be, a product of many environmental factors. ERS can manage costs and encourage change through plan design, but we can't control other factors.

All of the options presented in this report respond directly to one or more of the five major cost drivers identified in the executive summary: the aging population, the inefficient reimbursement system, unsustainable hospital costs, insufficient member responsibility for their health, and cost and utilization of prescription drugs. See Appendix E for a summary table of cost drivers and proposed solutions for the GBP.

### COST DRIVER: The aging workforce increases costs for employer-sponsored plans

It's no surprise that the aging workforce increases costs for employer-sponsored health insurance plans. The GBP membership has grown older right along with the Baby Boomers. Enrollment data shows that three out of four adults in HealthSelect, the self-funded point-of-service (POS) plan are now older than 40. The proportion of plan membership age 50 years and older has increased from 34% in FY96 to 55% in FY11, while the proportion of plan membership younger than 30 decreased from 16% to 9%.

The average age of enrolled employees and retirees (not including dependents) is 51.8 years old.

**Plan membership will continue to grow, especially the retiree population**, and with that growth will come increasing costs for future retiree health insurance. Aging has a real and measurable impact on plan costs. As participants age, they have higher medical costs. Over the past 10 years, the changing demographics of the GBP enrollment have added an average of 1% per year to the health plan cost trend.

**The highest plan costs occur among GBP participants aged 50-64.** Plan costs decrease when a participant turns 65 and qualifies for Medicare, because at that point Medicare becomes primary and starts picking up the bulk of their costs.

A shared concern among employer-sponsored health plans that still provide retiree health insurance coverage is funding the cost of future retiree benefits. ERS reports the projected cost of Other Post-Employment Benefits (OPEBs) for current and future retirees in the Comprehensive Annual Financial Report for the State of Texas. States do not have to fund OPEB projections, only report them. See Appendix F for more information about OPEB costs and the GBP.

**Wise management of retiree health insurance costs is essential.** ERS uses plan design, coordination of benefits, and leveraging of federal subsidies and manufacturer rebates to make retiree health insurance coverage more affordable for retirees and for the

***Figure E5: Plan costs are highest for participants age 50-64***
*(PPPM adjusted average benefit cost, FY11)*

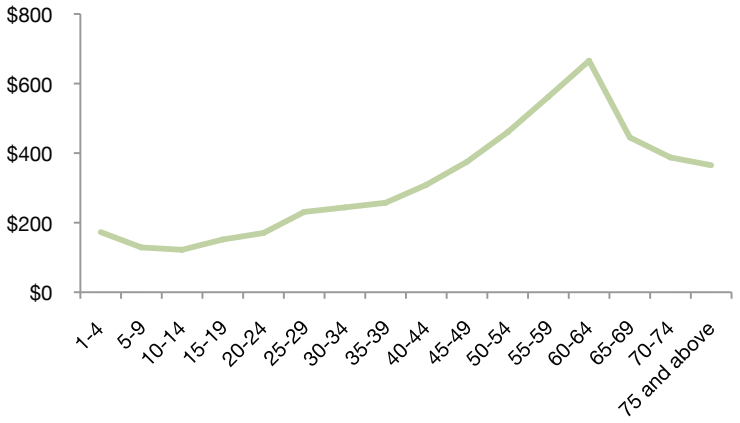
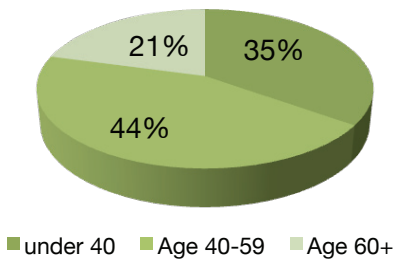
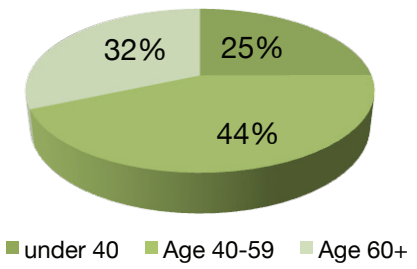



***Figure E4a: FY2000 Age distribution of the GBP membership***
*(enrolled employees and retirees)*




**Since FY00, the proportion of GBP members younger than age 40 has dropped from 35% to 25%.**

***Figure E4b: FY2011Age distribution of the GBP membership***
*(enrolled employees and retirees)*

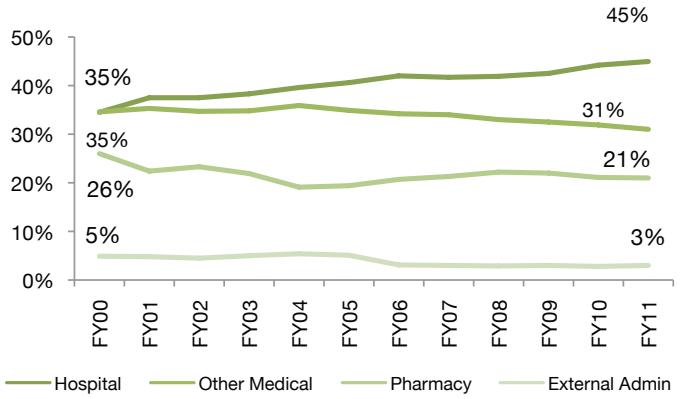


State. For example, the implementation of the Medicare Advantage PPO in January 2012 is expected to reduce plan cost by $30 million in FY13 and will lower the estimated future cost of covering retirees (the OPEB amount) by 6.7%.

**COST DRIVER: Hospital cost increases are unsustainable.**

Plan spending for hospital services in the GBP has increased at an annual rate of about 9% over the past five years, faster than spending for pharmacy or professional services.

***Figure E6 Hospital costs have grown from 35% to 45% of total plan expenditures since FY00***
*(Plan costs as a % of total, FY00-FY11)*




In FY11, hospital expenditures for the HealthSelect plan topped $973 million. Increases in hospital expenditures have the greatest impact on the plan because they represent 45% of total expenditures. According to Segal, price inflation for inpatient hospital services is the largest component of the overall plan cost trend nationwide.[5]

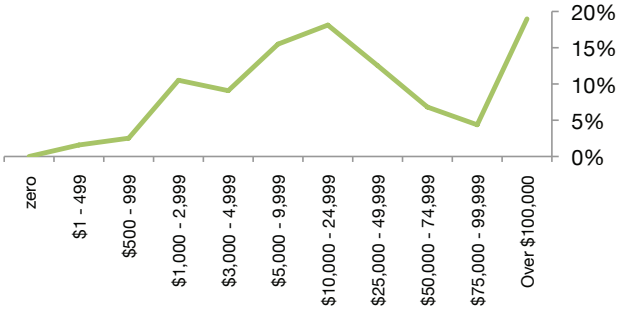
Although ERS does not contract directly with hospitals, we carefully monitor and will react to excessive hospital rate increases. When necessary, ERS has chosen to suppress a hospital from the HealthSelect network when rate increase requests were too high.

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.

**Physician-owned hospitals in Texas increase costs.** The nature of the Texas hospital market also increases costs. Texas is home to fully one quarter of the United States' physician-owned hospitals (POHs). While supporters of the institutions cite better outcomes and higher rates of patient satisfaction, opponents say that economic incentives for physicians to profit from ordering unnecessary tests or procedures create a conflict of interest. Further, most POHs tend to focus on money-making specialties like cardiology and orthopedic surgery, allowing them to draw patients for these services away from community hospitals that need those more profitable procedures to help subsidize the high cost of emergency room, obstetrics, and mental health services used by their uninsured and Medicaid patients.[6]

**Reduced competition due to large hospital consolidations.** Another concern is the trend toward large hospital systems buying up small hospitals in rural areas. Experience in Texas and other regions has shown that when a large hospital system dominates the market, it increases prices and may engage in anticompetitive behavior. Supporters of consolidation say that it leads to greater efficiency and cost-effectiveness.[7] However, a 2011 Department of Justice investigation found that a Wichita Falls-based hospital system – with a 90% market share of general acute-care inpatient services and 65% share of outpatient surgical services – engaged in anticompetitive practices leading to average inpatient rates that were 70% higher than its closest competitors.[8] Texas' many rural hospitals are prime targets for buyouts by big hospital systems, which makes the State—and the GBP, which must provide access to services for members statewide – especially susceptible to cost increases due to this issue.

***Figure E7: Almost 20% of plan costs are attributed to claims over $100,000***
*(distribution of spending on FY11 HealthSelect medical and pharmacy benefits)*




**High-cost claimants are more likely to have a hospital admission.** A Congressional Budget Office (CBO) study found that high-cost Medicare beneficiaries ("those in the top 25% in terms of their spending") accounted for 85% of annual expenditures for the program.[9] A similar pattern exists in the HealthSelect population: participants in the top 23% in terms of spending account for 85% of plan expenditures.

The CBO also found that 78% of high-cost Medicare beneficiaries had at least one short-term hospital stay during the year and 63% had two or more emergency room visits. This compares to 2% of low-cost claimants with a hospital stay and 14% of low-cost claimants with an emergency room visit.[10]

Many insurance plans are now negotiating hospital contracts based on "quality metrics." This might require the hospital to reduce rates of hospital-acquired infections and reduced hospital readmissions. ERS evaluates this option in Section 4 of the report.

**Serious chronic conditions drive hospital costs.** The increased usage of hospital services for musculoskeletal disease is seen in plans across the nation. Nearly half of American adults report a

musculoskeletal condition such as arthritis, chronic joint symptoms, and neck and back pain lasting more than three months.[11] In the CBO study, 78% of high-cost claimants had a chronic health condition, and nearly half (48%) had multiple chronic conditions.[12]

What's more, increased hospital utilization due to cancer results in part from new medical treatments that turn many cancers into chronic, rather than acute, conditions. For example, mortality is decreasing for colorectal cancer, the second leading cause of cancer deaths in the United States, but incidence in men and women under 50 years of age is increasing.[13]

While many expensive hospital admissions may be due to unpreventable circumstances, the statistics speak to a need for increased engagement in wellness and disease management programs for participants with multiple chronic illnesses. ERS explores plan design options that encourage participants to make healthier choices in Section 5 of the report.

### COST DRIVER: The fee-for-service reimbursement system is inefficient and costly.

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 and every service they provide 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.[14] These concerns are compounded by the trend toward doctors having ownership in for-profit facilities, such as labs or free-standing radiology centers.

**Sharing risk with providers may reduce costs and improve quality of care.** Other types of payment systems are believed to create incentives to keep costs down. For example, some Health Maintenance Organizations (HMOs) pay providers a fixed ("capitated") fee per patient, rather than a fee for service. Criticism has been aimed at HMOs as they are perceived to give insurance companies too much power over medical decision-making.[15] In Canadian and European systems, doctors are paid on a salaried basis, which removes the incentive to overprescribe, but may not create a balancing incentive to improve outcomes.

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 ACOs have accelerated payment reform based on performance measures.[16]

The Texas Legislature has 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. During our stakeholder meetings, medical provider groups also expressed qualified support for this idea. ERS has already piloted three successful Patient-Centered Medical Homes (PCMH) in response to initiatives by the Texas Legislature.[17] A more detailed analysis of the PCMH initiative can be found in Section 4 of the report.

### COST DRIVER: Higher prices for brand-name drugs increase plan costs.

In FY11, the plan spent about $100 million on the Top 10 most utilized drugs, or 22% of the total plan cost for prescription drug coverage. Because members pay flat copays for their drugs, the more expensive the drug, the more the plan pays. For example, the plan pays about two-thirds of the cost for a drug like Lipitor, but for a specialty drug like Enbrel, the plan pays 98% of the cost. Ten percent of HealthSelect participants incur prescription drug claims of $10,000 or more a year.

***Figure E8: Five of the Top 10 most utilized drugs go generic by 2013***

*(HealthSelect reporting period = Feb '11 – Jan '12)*

| Rank | Drug name | Primarily used for | Generic launch | Plan spending |
|---|---|---|---|---|
| 1 | Lipitor | High Cholesterol | Q4-2011 | $13.3 million |
| 2 | Plavix | Blood Agent | Q2-2012 | $12.3 million |
| 3 | Enbrel | Anti-Inflammatory | Specialty drug[18] | $12.2 million |
| 4 | Humira | Anti-Inflammatory | Specialty drug | $11.9 million |
| 5 | Crestor | High Cholesterol | N/A | $10.0 million |
| 6 | Nexium | Ulcer Drug | N/A | $ 9.5 million |
| 7 | Cymbalta | Anti-depressant | Q4-2013 | $ 8.7 million |
| 8 | Actos | Diabetes | Q3-2012 | $ 8.2 million |
| 9 | Copaxone | Multiple Sclerosis | Specialty drug | $ 7.5 million |
| 10 | Singulair | Asthma | Q3-2012 | $ 7.1 million |

Five of the top 10 HealthSelect drugs will have generic alternatives by 2014. For example, Lipitor—the most utilized drug and long-time cost leader for the plan—went generic in November 2011, with a projected savings to the plan of $4.4 million in the first year. After a brand-name drug goes generic, it takes some time before the plan realizes savings, because marketing of the generic alternative is limited to a single manufacturer until six months after the brand-name drug's patent expires.

**Substituting generic drugs for brand-name drugs can save the plan and the member money.** Increasing the generic dispensing rate (GDR) by one point reduces total prescription drug costs by more than 2.5%, saving about $11 million dollars for the plan in

FY11. In the first quarter of FY12, the HealthSelect GDR increased to 74.1%, up from 66.6% two years ago. ERS has made great strides on increasing the GDR, but "best-in-class" plans are still in front, achieving GDRs of up to 82%.[19] Some options for increasing the use of generics are presented in Section 5 of this report.

**COST DRIVER: Members need to take more responsibility for their health.**

Increased participation in wellness and disease management programs is an important goal. Considering the extensive outreach efforts by the plan, participation in the voluntary wellness program is still very low.

***Figure E9: More than half of HealthSelect members over age 50 have high blood pressure***

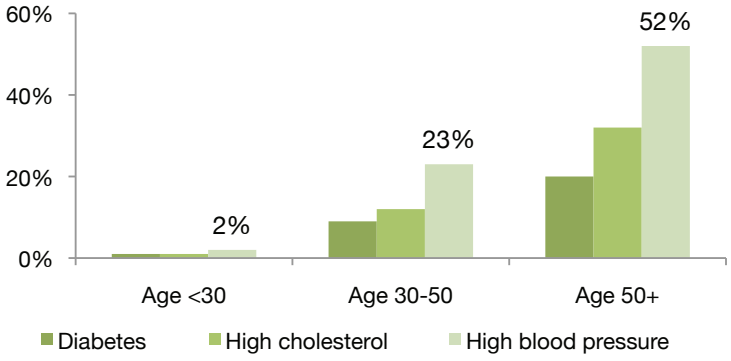
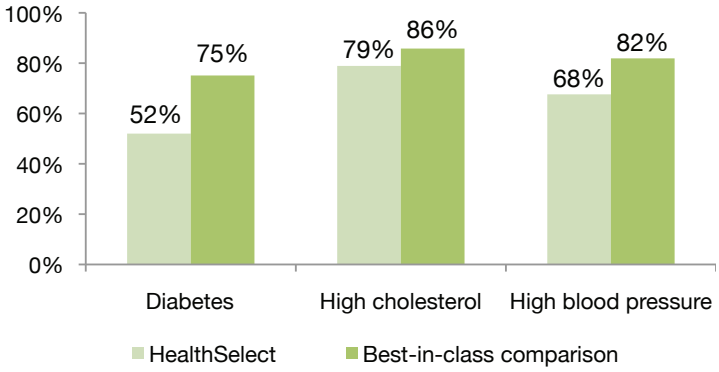



***Figure E10: Too many people do not take their medication as prescribed***




Voluntary participation in disease management is low. Of 70,000 people with high-risk and moderate conditions who were contacted by the disease management program in FY11, only 18% ultimately enrolled. Most people do not respond to repeated efforts to contact them, including personal phone calls and written correspondence. This lack of participation is believed to increase costs to the plan, since effective management of high-risk conditions saves the plan money over the long term, as well as increasing the member's quality of life.

Claims analysis shows that as we age, the risk of having a chronic disease such as diabetes or high blood pressure increases dramatically. More than half of all HealthSelect participants over the age of 50 have high blood pressure.[20] Of greater concern is the fact that many people are not following their doctors' advice. For example, HealthSelect data shows that only about half of HealthSelect participants with diabetes are taking their medication as prescribed. This number may be low, as some participants reportedly fill their medications outside the plan through retail pharmacy discount generic programs.

Members agree there should be financial incentives for wellness. In an FY10 survey of GBP health plan members, 71% of 45,000 respondents expressed a willingness to consider charging higher fees to eligible participants who don't use disease management programs when appropriate. The Legislature—or even employers—could approve financial incentives to encourage members to participate in wellness programs. ERS can also change the plan design to incentivize healthy behavior and responsible use of health benefits.

## REPORT FINDINGS

All businesses face complicated external factors in the current environment – the slow recovery from an extended economic downturn, fewer employees to do more work, and increased budget pressures. High health care cost inflation and federal health reform legislation further complicate the difficult benefits decisions that employers have to make.

This report finds that without action, the cost of health insurance coverage will continue to rise—both for the plan and for its members. During the planning, research, and writing phases of this study, a number of common themes emerged.

### FINDING: Health insurance benefits are key to attracting and retaining qualified employees.

The Legislature provides funding for benefit programs to ensure that state and higher education employers can compete in the marketplace for the most qualified and efficient workforce to deliver essential services.

Health insurance benefits are just one part of the total compensation package, but a crucial one. State agency and higher education employers told us that because employee pay is lower, they depend heavily on benefits to help them attract and retain a skilled workforce.

ERS surveyed and met with state and higher education employers to get their opinions on the importance of the benefit package in their hiring decisions. Across the board, employers said that health insurance benefits were an extremely important factor in attracting the best talent and retaining institutional knowledge. See Common Appendix II for a summary of their comments.

We also conducted a benchmarking study to compare GBP benefits to other large public sector plans and to our approximation of a "typical private sector plan." Detailed findings are reported in Section 6 of this report. See Appendix G for a short overview of how ERS compared GBP benefits to a "typical private sector plan.

**Benefits matter because public sector salaries are lower.** According to the National Institute on Retirement Security (NIRS), public sector employee benefits are more generous and secure than most private sector employee benefits. Factoring in the value of benefits reduces but does not eliminate the gap between state employees and their private sector counterparts.

The average value of state employees' total compensation nationally (wages plus benefits) is 6.8% lower on average than for their private sector counterparts in comparable jobs. When state compensation levels were compared to large employers (100+ employees), the differential was even higher—state compensation was 10.4% lower. [21]

### ARE GBP BENEFITS COMPARABLE?

Recently, the cost and structure of state benefit programs have come under increased public scrutiny. As part of this report's research, ERS conducted a benchmarking study to compare the current state offering with a "typical private sector plan." The value of the HealthSelect plan design (i.e., how much members pay out of pocket for health services) is comparable to the typical private sector plan.

Most private sector plans have a deductible. HealthSelect does not, but GBP participants generally pay more for their prescription drug coverage.

The 100% state contribution for employee-only and retiree-only coverage is outside of the norm.

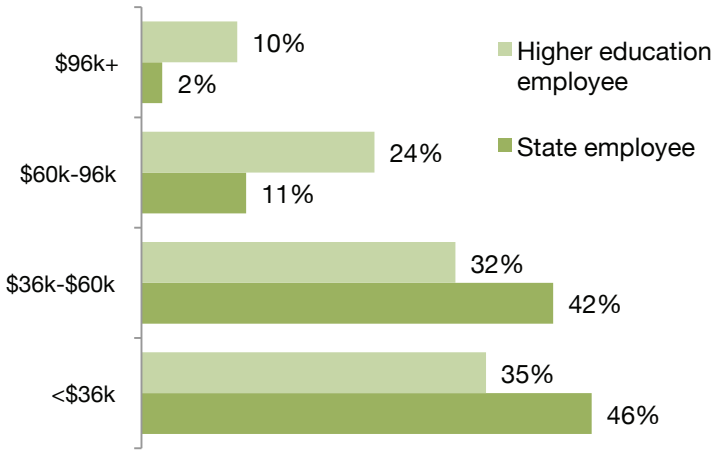
- Private sector employees are typically expected to contribute around 20% of the premium for employee-only coverage.
- In 2011, only five states (including Texas) made 100% employer contributions for employee-only coverage. The average employee contribution among other states is 13%.
- About half (49%) of the largest private sector firms (5,000+ employees) still offer retiree coverage. When they do, most retirees are expected to pay for some or all of their monthly premiums.
- Most states still provide retiree health insurance coverage with a range in cost to the retiree that varies widely (from 0% to 100%). Eligibility is frequently based on a formula that combines age and number of years of service.

When monthly contributions and plan design (copays, coinsurance, etc.) are counted toward the total value of insurance coverage, we found the following:

- Member coverage with the GBP has a 22-28% higher value than the typical private sector plan.
- Member and family coverage with the GBP has a 2-7% lower value than the typical private sector plan.

The principal difference between HealthSelect and "typical private sector plans" is the contribution strategy. The state contribution is more generous for employee-only coverage and less generous for employee and family coverage.

***Figure E11: Higher education employees in the GBP earn more than state employees***
*GBP data, state and higher education employee insurance salary, Aug 2012*




Percent of employees earning within salary range
(numbers may not add to 100% due to rounding)

**When it comes to public sector plan decision-making, context matters.** A big-picture analysis can mute the ways in which important factors—such as employer size, enrollment numbers, member population characteristics, and member attitudes about change—can influence plan decision-making. Stepping back to assess general health plan characteristics also does not take into account the political climate and legislative environment within which public sector plan decisions must be made.

Any changes to existing benefits must be considered for their impact to the state workforce. Employees care a great deal about their health insurance benefits. According to a 2010 workplace study by Mercer, 90% of employees with employer-based health benefits say their health benefits are just as important as salary.[22] In a 2006 ERS survey of more than 10,000 State of Texas employees and retirees, a majority chose health insurance as their most valued benefit.[23]

The Legislature encourages and recognizes career state service by providing health insurance for eligible retirees. The average state employee gives 23 years of service to the state, and upon retirement earns an annuity of $18,000 a year. Retiree health and pension benefits have always been and will continue to be great motivators for employees to dedicate their careers to state service.

**The Legislature decides who is eligible for health insurance benefits.** The Texas Legislature defines eligibility requirements for GBP coverage for more than half a million public employees, retirees, and their dependents.[24] This report examines the impact of policies that would change insurance eligibility, including limiting, or even discontinuing health insurance coverage for some or all participants covered under the plan. ERS examined the potential impact of (a) terminating the GBP health plan and sending all participants to the federal health exchange under the ACA, and (b) ending health insurance coverage for the retiree population.

The State's decision to remove any group of participants from the plan would generate substantial savings for the State both now and in the future, but at what cost? Decisions about employee and retiree health benefits must be made with the knowledge that changing one benefit program could have a significant financial effect on another.

**"The average state employee gives 23 years of service to the state, and when they retire they earn an annuity of about $18,000 a year."**

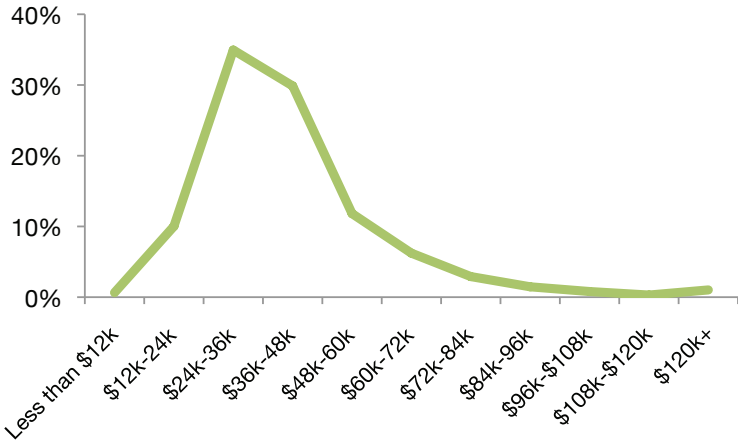
Policies that encourage employees to continue working and contributing toward their retirement until age 65 will have a positive effect on the pension plan. On the other hand, discouraging retirement until 65 introduces an offsetting concern about workforce quality and capacity challenges. For example, younger employees could be discouraged by policies that prevent opportunities for advancement.

Also, any change with regard to retiree health benefits would have to be reviewed carefully to ensure that age discrimination is not an issue. Equal Employment Opportunity Commission (EEOC) age discrimination protections apply to everyone over the age of 40.

**Without the GBP, half a million Texans would lose their health coverage.** Few state employees would be able to afford the same quality coverage they receive with the GBP on their own in the marketplace. State employees constitute a large group of primarily middle-income people, all of whom depend heavily on their employer-based health insurance benefits.

Fully 75% of full-time state employees enrolled in the GBP make less than $48,000 a year; only 12% make more than $60,000 a year, and the average retiree earns a pension of less than $20,000 a year.

***Figure E12: 75% of state employees enrolled in the GBP make less than $48,000/year***
*(GBP data, full-time state employee insurance)*



Removing a large group of people from the plan could have the unintended consequence of putting an extra burden on other public programs that support lower-income residents in Texas such as Medicaid.

**FINDING: We all share responsibility for the sustainability of the plan.**

ERS, the Legislature, employees, retirees, covered family members, health care providers, employers, and taxpayers—we all share responsibility for the sustainability of the health plan.

**Many of the options in this report require coordinated action from stakeholders.** When it comes to changing the GBP, ERS and the Legislature have designated responsibilities that control the decision-making framework. Some of the options discussed in this report can be implemented by the ERS Board of Trustees, while others require basic policy changes that only the Legislature can decide. Still others will require coordinated action among stakeholders. For example, responsibility for health decisions and costs should be shared with members and providers.

**The Legislature**

- establishes policy such as determining who receives benefits (eligibility),
- decides the amount of funding for the plan (appropriations),
- sets policy for how cost is shared between employers and the members (contribution strategy),
- requires a basic level of coverage, plus specific health benefit coverages (e.g., bariatric surgery), and
- supports state agency employers with their wellness efforts (Statewide Worksite Wellness Council).

**The ERS Board of Trustees**

- manages the structure of the benefits and how they are delivered within the legislative governance,
- determines what the benefits will cover (plan design), within Legislative parameters and funding,
- oversees program operations and third party administration (contractual arrangements), and
- approves programs to manage costs (cost containment).

**Employees, retirees, and their dependents**

- make lifestyle decisions (weight management, tobacco cessation),
- become informed about their health (taking health risk assessments),
- choose cost-effective services and products (such as generic medications or urgent care centers instead of emergency room care), and
- when an illness occurs, follow their doctor's instructions (taking their medication, getting appropriate screenings).

**State and higher education employers**

- take responsibility for creating an environment of wellness in the workplace,
- encourage use of the GBP's many wellness resources, and
- inform their workforce about benefits, and the value of those benefits, as part of their overall compensation.

**FINDING: A sustainable plan would have predictable rate increases.**

Each biennium, the Legislature decides the level of funding for the plan (appropriations), then ERS manages the plan within the constraints of the appropriation. When revenues are too low or benefit costs are too high, only a few choices are available to the plan: deplete the contingency fund, cut benefits, or shift costs to members.

**The GBP contingency fund was not intended to be a regular source of revenue.** There has been a historical reliance on the contingency fund whenever the appropriation falls short for the year. The statute requires ERS to include in the legislative appropriation request the amount needed to provide a contingency fund equal to 60 days of self-funded expenditures.[25] Twice in the past 10 years, funding shortfalls threatened to drain the contingency fund, resulting in benefit cuts. More than $600 million in costs were shifted to members through two rounds of plan changes on May 1, 2003 and September 1, 2004. In FY11, about $140 million in costs were shifted to members through plan design changes.

**ERS listens to members before making benefit cuts.** Prior to making the FY11 plan design changes, ERS conducted a statewide survey of its membership, listening to the feedback of 45,000 members who responded to the survey and hundreds who attended 11 feedback sessions across Texas. Ultimately, the ERS Board approved a set of changes carefully chosen to have the least impact on members while providing the minimum projected amount required to cover the projected funding gap for FY2011. See Appendix H for a detailed list of plan changes for FY2011.

The survey provided invaluable information on member preferences for cost sharing. The Board used the feedback to guide its decision making in FY11, and survey opinions are cited throughout this analysis.

**Defining the structural elements for sustainability.**
With the exception of a few years, the GBP health benefit cost trend has remained in the single digits over the last 20 years. Over the last 10 years, the HealthSelect benefit cost trend has averaged about 5.5%.

***Figure E13: ERS asked members how they would change the health insurance plan***

| Member Values | Survey Results | Opportunities for change |
|---|---|---|
| State employees and retirees like to budget for their health care expenses. | Members prefer small increases across the board or a small premium of up to $25 per month for member-only coverage – changes that fit into their monthly budget rather than large unpredictable expenses. | Adding a monthly contribution for member-only coverage would require legislative action. Members said a monthly amount over $25 may not be acceptable to most members. |
| Tie benefits to years of service. | Respondents were willing to base the retiree contribution on years of service, but less willing to increase the service needed to qualify for retiree insurance to 20 years. They did not want retirees younger than 65 to pay more for coverage until they reach 65. | A graduated state contribution strategy for retirees such as the one below would require legislative action:<br>• 50% state contribution for 10 years,<br>• 75% state contribution for 15 years, and<br>• 100% state contribution for 20+ years. |
| Members will pay more for provider choices and to protect their doctors' ability to decide what care is appropriate. | Members were willing to have a tiered network for specialists, labs, and prescriptions, but less willing to restrict hospital choices, due to concerns about access and quality. They were also willing to pay more for brand-name drugs when a generic alternative is available. Members would rather pay more for high-tech radiology services to avoid having their doctors subjected to pre-approval. | Value-based incentive design (VBID) encourages members to choose health care services that provide more value for their money.<br><br>A VBID change implemented for FY11 required a $50 copay for choosing an urgent care facility, compared to a $150 copay for choosing the emergency room. Another change was a new $100 copay for high-tech radiology scans, plus 20% coinsurance. |
| Penalize poor lifestyle choices. | Members are willing to charge higher fees to smokers and to people who don't use disease management programs. | The Legislature must approve contribution strategies that incentivize participation in wellness programs or discourage unhealthy behaviors. A tobacco user premium differential was instituted as of January 1, 2012. |

In short, ERS identified the structural elements needed to create and sustain a viable health plan for the long term:

- Rate increases would occur at a predictable, controlled level, providing the State a reliable way to budget for the plan.
- Adequate revenue would allow the GBP to avoid routine reliance on the contingency fund as a substitute for contribution revenue.
- Plan design changes would occur on a predictable basis, allowing GBP members the ability to plan and budget for cost shifts and out-of-pocket increases.

**"Over the last 10 years the HealthSelect benefit cost trend has averaged about 5.5%."**

### FINDING: A flexible approach that offers choice and financial incentives will facilitate behavior change.

Throughout this report, ERS evaluates a number of options that could provide more choices for members. Some of the questions ERS asked employers during the research process include whether a one-size-fits-all benefit plan and contribution strategy still works for all employees. Also, is it possible that a changing workforce may need access to more types and different levels of benefit choices? Employers expressed concern that some employees are unable to afford family coverage, and they are open to having more affordable choices to attract talent to the state workforce. They frequently remarked that changes to the benefit package without a concurrent salary increase would be viewed by employees as a pay cut.

**Choice costs money and adds risk.** Other private and public sector employers tend to offer more plan choices with different levels of benefits. The GBP is limited in its ability to offer more plan choices for two main reasons:

- When the employer pays 100% of the cost for member-only coverage, employees and retirees have no incentive to choose anything but the most generous benefit.
- When multiple plan choices are offered, the risk of adverse selection comes into play, which can drive up costs for members and for the State.

**"…changes to the benefit package without a concurrent salary increase would be viewed by employees as a pay cut."**

A risk adjustment for adverse selection recognizes that people will generally choose in their own best interest. In other words, the youngest, healthiest, and lowest-income individuals will choose the lower-level benefits, and the oldest, sickest, highest-income individuals will choose the higher-level benefits.

Offering members the choice of a lower-level plan won't stop costs from rising. It will just reset the baseline and costs will continue to rise from there.

**"When the employer pays 100% of the cost for member-only coverage, employees and retirees have no incentive to choose anything but the most generous benefit."**

**The importance of the risk pool.** Having one large plan like HealthSelect means most members stay in the same risk pool— everybody belongs to the same group and shares risks across the board for the most expensive claims. Sharing risk keeps costs down for everyone.

Some employer plans have chosen to split the risk pool intentionally as they implement higher- and lower-level benefits, in order to accelerate the process of moving everyone to the lowest-level benefit. When the higher-level plan becomes unaffordable, it goes into a "death spiral" and becomes unattractive to anyone but the most desperately ill people.

**Policy questions to consider.** In short, the question is not whether employers should offer more choice, but how to offer choice in a way that maintains the stability and affordability of the insurance plan. A flat 20% contribution of $90 a month may be fine for some, but it could create a financial burden for lower-income employees, or cause some people to opt out of coverage altogether.

**"…the question is not whether employers should offer more choice, but how to offer choice in a way that maintains the stability and affordability of the insurance plan."**

It has been a long-standing policy of the Texas Legislature to offer the 100% contribution strategy in recognition of the lower salaries of public servants, and as an incentive for recruiting and retaining qualified employees. This could still be done, by offering a 100% contribution for a somewhat lower benefit, with the option for employees to buy up to the current HealthSelect benefit. Keeping everyone in the risk pool would be essential, and it would be advisable to create restrictions on the ability of people to move back and forth between plans when a significant benefit design difference exists.

There are two questions to ask when considering this option:

- Is the higher-level benefit so expensive that it is unaffordable for anyone in the group? This policy may be putting a disproportionate burden on people with expensive health problems such as cancer, who have no choice but to buy the highest-level benefit.
- Is the lowest-level benefit so "bare bones" that having meaningful coverage requires people to buy up? This policy may put a disproportionate burden on the lowest-income employees, who could only afford the lowest-level coverage.

These are complex questions and will require a nuanced approach to ensure access to comparable benefits at a reasonable cost.

**How can the GBP align incentives with health risks?** ERS continues to look for ways to encourage members to make healthy choices. The ERS Board of Trustees can structure the plan design —such as keeping generic copays low—to ensure that people who take maintenance medication for chronic illnesses have affordable choices.

An important way that the GBP differs from private sector employer-sponsored plans is that ERS does not currently have the authority to use GBP funds to motivate, reward, and share savings with members. The Legislature could help in this regard. For example, the appropriations process would ideally give ERS additional flexibility to allocate some portion of GBP funds toward programs to reward member choices.

### FINDING: There's a difference between cost management and cost shifting.

Many of the options discussed throughout the report manage health plan costs by shifting costs to members. Sharing costs appropriately can encourage members to make more responsible decisions, but excessive cost sharing can have an increasingly adverse financial impact on members and discourage them from getting necessary care.

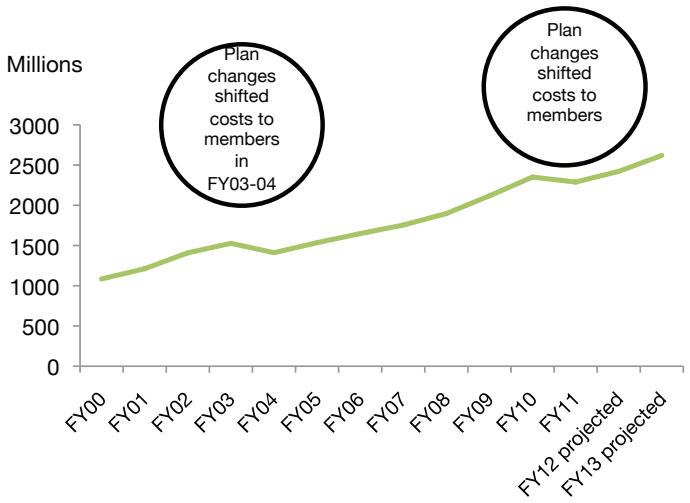
According to Aon Hewitt, "While the GBP has experienced better-than-average health care cost trends and has done less cost shifting than most private sector plans, it is still important to guard against the potential negative consequences of cost shifting."[26]

Health plan benefit cost expenditures fell in FY11 in large part because of significant cost shifting to members through plan design changes that year. The same temporary drop in spending occurred after benefit cuts were made in 2003 and 2004. If no changes are made to the plan, contributions will likely need to increase each year in order to maintain the same level of coverage.

Costs can be shared with members by increasing the member's share of contributions or through plan design. The ERS Board of Trustees can change the plan design, but only the Legislature can change the contribution strategy.

**The Legislature decides the contribution strategy.** Through the contribution strategy, the Legislature decides how the employer and the member should share the cost for health insurance coverage. Changing the contribution strategy only changes how contributions are shared; it won't control health care costs or lower the plan's expenditures. Reducing health care costs is the only way to reduce the contributions needed to run the plan.

*Figure E14: Expenditures drop briefly after costs are shifted to members*




**The 100% contribution for member-only coverage is outside the norm.** ERS found through its benchmarking study that the GBP contribution strategy for employee- and retiree-only coverage is more generous than other public and private sector plans.

But the Legislature has kept the 100% contribution for employees and retirees intact for years in large part because they recognized that the added value of the insurance benefit made up for lower salaries. Over the course of this study, the question continued to arise: how do we balance the employee's need for quality benefits with the State's need for an affordable, sustainable plan?

**Employers fear the aftermath of a significant benefit cut.** ERS conducted an employer survey and held meetings with many large state agencies and institutions of higher education. Employers all said that if they had to cut benefits without balancing the difference in other parts of the compensation package, their employees would see it as a pay cut. They fear that a major cost shift in benefits could be the "last straw" for many employees, and even more so, they fear that a contribution policy that grandfathers certain groups could create a "mass exodus" of the 13,341 active employees who are currently eligible to retire.

**'...reducing health care cost is the only way to reduce the contributions needed to run the plan."**

Several large employers also noted that many state employees in low-wage, high-stress, high-turnover jobs – such as caregivers at State Supported Living Centers, or entry-level prison guards – do not sign up for dependent coverage because they can't afford it.

**What is the fairest way to share costs?** Some people feel that costs should be spread evenly among the members of a group, so that coverage is affordable for everyone who needs it. An example of this would be the option to raise the member's share of monthly contributions for member-only coverage (legislative decision). If a member-only contribution were enacted, the Legislature may want to consider options to base contributions on salary for employees or longevity for retirees. These choices are analyzed in Section 2 of the report.

Other people believe that those who cost the plan the most should pay more. Options that target expensive groups include raising copays for expensive treatments or specialty drugs (ERS decision). These policies can have ill effects not just on patients, but also on providers. People who can't afford the doctor may wait too long and end up in the emergency room. ER visits cost more and when people can't pay their bills, they leave hospitals with bad debt on the books.

Financial hardship is a reality for many GBP members. Almost 700 ERS annuitants are enrolled in Medicaid. And when the State Kids Insurance Program (SKIP) closed in FY11, more than 13,000 children of low-income state employees became eligible for the federal Children's Health Insurance Program (CHIP).

**"Many state employees in low-wage, high-stress, high turnover jobs do not sign up for dependent coverage because they can't afford it."**

**Cost shifting rarely affects all groups the same way.** The plan's benefit cost trend was down in FY11 for the first time in many years but is expected to rise in FY12 and stay relatively high through the biennium. The main reason for the reduction in the cost of prescription drug coverage: the FY11 plan design changes increased the member's prescription drug cost share to 30%, compared to an industry average of 18%.

Medicare-eligible retirees in the GBP receive drug coverage through the GBP, not through Medicare Part D. Because this group historically has the highest out-of-pocket costs for drugs, when

*Figure E15: GBP drug copays are higher than the typical private sector plan*

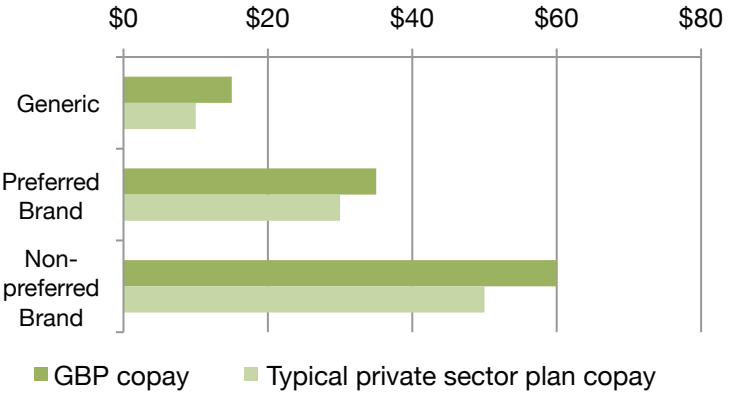
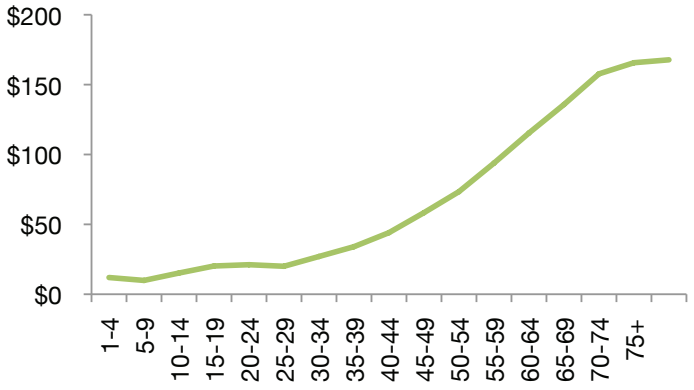


***Figure E16: When GBP drug costs increase, Medicare retirees feel the most impact***

*Average monthly Rx cost by age group*



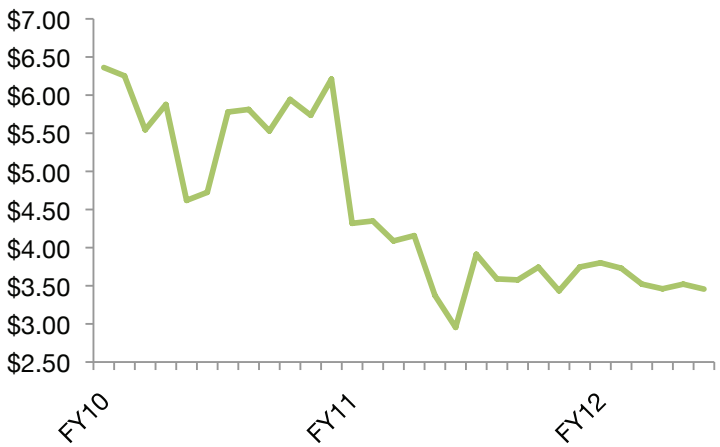

drug copays increase, Medicare retirees are the ones who feel it the most. One positive effect of higher out-of-pocket costs for drugs is that it can encourage more people to find generic alternatives. On the other hand, it could result in some people not taking their medications at all.

**Value-based incentive design (VBID) can lower costs without compromising care.** One area of historically high cost and utilization for the GBP and other insurance plans is that of high-technology imaging. As part of the FY11 plan design changes, ERS added a $100 copay to all high-tech radiology scans, in addition to a 20% coinsurance. In 2012, the American Academy of Family Physicians and Consumer Reports Health teamed up to inform providers and the public about more conservative recommendations for the treatment of nonspecific lower back pain. Their guidelines show that most people with nonspecific lower back pain felt better within a month, whether they got an MRI or not.[27]

The extra out-of-pocket cost plus additional high-profile information in the news about this issue have combined to encourage members to talk to their doctors about screenings before they have them done. ERS also encourages participants to "shop around" for high-cost procedures such as MRIs, because not all facilities charge the same amount. Both usage and plan costs declined and have generally stayed at a lower level for the first 18 months after implementation.

***Figure E17: HealthSelect plan costs for high-tech radiology decreased after a $100 copay was added in FY11***

*(MRI, CT, PET, MRA, and nuclear medicine scans, per member per month)*




**FINDING: ERS provides quality benefits at a lower-than-average cost.**

A basic assumption for this report is that health care costs should be reasonable for the plan and the member. ERS is recognized for providing professional management, resulting in a cost-efficient health insurance plan that provides good value for the State's investment.

**Professional cost management lowered plan charges by $7.3 billion in FY11.** ERS lowered plan charges by $7.3 billion in FY11 through tough cost-management practices, aggressive contract negotiations, avoiding unnecessary costs, and low administrative overhead. See Appendix I for a detailed account of the history of cost containment activities for the HealthSelect program.

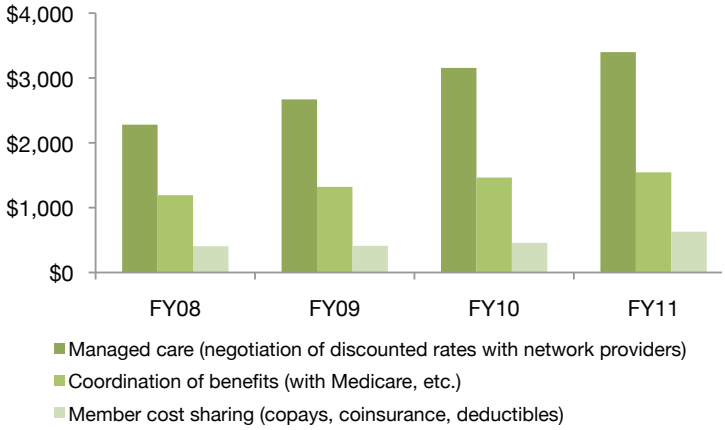
**GBP spending per person is lower than other plans nationally.** Compared to other employer-based plans across the country, the GBP has a much lower average cost per participant. According to a recent Mercer survey, in 2011, the per-employee cost averaged $9,467 for employees enrolled in HMOs and $9,385 for employees enrolled in PPOs."[28] By comparison, the GBP average annual cost per member in FY11 was $7,443. All calculations of average cost (by Mercer and ERS) include the costs for dependents. It is important to note that the average GBP cost-per-member also includes coverage for retirees.

Nearly $3.4 billion in cost reductions in FY11 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 HealthSelect participants 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.

**ERS keeps administrative costs low.** In general, about 97 cents of every HealthSelect dollar is spent directly on health care claims. Between 2004 and 2011, the HealthSelect administrative fee for medical benefits decreased 26%. According to Aon Hewitt, "the GBP currently takes advantage of one of the country's largest risk pools, strong professional management, and economics of scale that can benefit individuals enrolled in a group insurance plan."[29]

**ERS is already implementing best practices and recommendations from the Solution Sessions.** An encouraging finding of this study is that ERS has already adopted many of the best practices

*Figure E18: Negotiated provider discounts proide the greatest cost savings for HealthSelect*
*(in millions)*




being suggested in the marketplace – for example, alternative payment programs, quality-based metrics in hospital contracting, and Surgical Centers of Excellence. ERS has also focused a great deal of energy on managing costs and maximizing funds for the growing GBP retiree population, with positive results.

As a result of the Solution Sessions held in the spring, ERS is pursuing two new options for maximizing the amount of funding the GBP receives from the federal government, including a service to reprocess all of the previously filed Retiree Drug Subsidy claims, and the possible implementation of an Employer Group Waiver Program + Wrap Program, which should help keep the plan's prescription drug costs for Medicare-primary retirees more affordable.

**"About 97 cents of every HealthSelect dollar is spent directly on health care claims."**

ERS will continue to work behind the scenes to manage costs for the plan, for the members and for the taxpayers. We set and enforce high performance standards for the health plan to slow the benefit cost trend and to ensure that fraud and abuse do not occur. Without rigorous management programs to reduce and avoid costs, the FY11 member-only contribution for HealthSelect would have been $1,938 a month, rather than $411.

**FINDING: A long-term view is essential.**

A key goal when designing a sustainable health insurance plan is improving health outcomes while keeping health care costs reasonable and manageable. Careful plan design with the intention of improving health outcomes for the long term can save the plan and the members money. Achieving better outcomes requires the design of thoughtful incentives that address specific health risks.

**Many of the options with the greatest potential for managing costs will not show immediate savings.** Long-term solutions require upfront investments and implementation time. For example, it may be difficult to identify specific savings within a two-year appropriations cycle, but long-term cost trends could be lowered. Many of these savings depend on implementing new systems for rewarding health care providers for managing costs. They also depend on individual members taking an increased role in managing their health outcomes and changing unhealthy behaviors. Without additional funding for targeted strategic initiatives—like focused interventions to increase medication adherence—ERS must put these options on hold or cut other plan benefits.

**Increased member responsibility is a key factor in improving the sustainability of the health plan.** One of the major cost drivers identified for this report is that members need to share more responsibility for their health. GBP participants have low levels of engagement in wellness and disease management programs. Long-term change depends upon individual members taking an increased role in managing their health outcomes and changing unhealthy behaviors.

Where appropriate throughout the report, ERS has explored options that would help the plan manage costs over the long term. These include investing in administrative tools to further our understanding of health risks and attitudes among the GBP population, changing the contribution strategy or plan design to boost participation in disease management, supporting employers through nurse practitioner clinics, and incentivizing participants to take a more active, informed role when making health decisions.

The State will continue to experience budget pressures. Competition for limited funding will always exist. Future decisions must balance the need to cut health plan costs with the goal of maintaining access to affordable, quality benefits. According to Aon Hewitt, "taking an excessively short-term review on health care strategies will unnecessarily close the door on many opportunities that could deliver value to stakeholders."[30]

The study process clarified the reach and scope of the state employee health benefits program. Not only does the GBP provide health insurance benefits to more than half a million people in Texas, it is also a major contributor to the economic wellbeing of the state, paying more than $2 billion in claims to thousands of local health providers across Texas last year.[31]

## SUMMARY OF FINDINGS

"Sustainability means managing health care costs to the State, while continuing to offer participants and employers health insurance benefits that are comparable to other large private/public sector employers. See Appendix J for a county-level analysis of the economic impace of HealthSelect in Texas.

**Health insurance benefits are key to attracting and retaining qualified employees.**

- The HealthSelect plan design (i.e., how much members pay out-of-pocket for health services) is comparable to the typical private sector plan.
- When monthly contributions and out-of-pocket costs are counted, employee-only coverage is more generous than other plans, and employee and family coverage is less generous than other plans.
- Benefits matter because public sector salaries are lower than the private sector.
- Without the GBP, half a million Texans would lose their health coverage.

**We all share responsibility for the sustainability of the plan.**

- ERS, the Legislature, employees, retirees, covered family members, health care providers, employers, and taxpayers—we all have a role to play in ensuring that high-quality, comparable benefits are available to the state workforce.

**A sustainable plan would have predictable rate increases.**

- Rate increases would occur at a predictable, controlled level, providing the State a reliable way to budget for the plan.
- Adequate revenue would allow the GBP to avoid routine reliance on the contingency fund as a substitute for contribution revenue.
- Plan design changes would occur on a predictable basis, allowing GBP members the ability to plan and budget for cost shifts and out-of-pocket increases.

**A flexible approach that offers choice and financial incentives will facilitate behavior change.**

- The 100% state contribution for employee- and retiree-only coverage is outside the norm.
- When the State pays 100% for member-only coverage, members have no incentive to choose anything but the most generous benefit.
- Choice costs money and adds risk. When multiple plan choices are offered, the risk of adverse selection comes into play.
- Ideally, ERS would be given the flexibility to put some GBP funds toward wellness incentives.

**There's a difference between cost management and cost shifting.**

- Sharing costs can encourage members to make more responsible choices, but excessive cost sharing can discourage them from getting necessary care.
- Reducing health care claims is the only way to reduce the contributions needed to run the plan.
- Employers fear the aftermath of a significant benefit cut.
- Many low-wage state employees do not take family coverage because they can't afford it.

**ERS provides quality benefits at a lower-than-average cost.**

- Professional cost management programs lowered plan charges by $7.3 billion in FY11.
- GBP costs are lower than the national average for other employer-sponsored plans.
- ERS spends 97 cents of every HealthSelect dollar on health care claims.
- ERS is already implementing best practices and recommendations from the Solution Sessions.

**A long-term view is essential.**

- Many of the options with the greatest potential for managing costs will not show immediate savings.
- Long-term solutions require upfront investments, rigorous ongoing management, and time to deliver results.
- Designing systems that share risk with providers and increase member responsibility all take time.
- Lasting change depends upon individual members taking an increased role in managing their health outcomes and changing unhealthy behaviors.

[1]Texas Insurance Code, §1551.002
[2]Aon Hewitt 2011 Health Insurance Trend Driver Survey, p.6.
[3]Aon Hewitt 2011 Health Care Trend Survey, p.4
[4]Ibid, pgs 4-5.
[5]Segal 2012 Health Plan Cost Trend Survey
[6]Texas Tribune, "Texas' physician-owned hospitals may be in danger.",November 20, 2009
[7]Roy, Avik., "Hospital Monopolies: The Biggest Driver of Health Costs That Nobody Talks About," Forbes.com, August 22, 2011.
[8]Healthcare Financial Management Association, "DOJ Settlement Dismantles Texas Hospital's Monopoly," March 2, 2011.
[9]Congressional Budget Office, "High-Cost Medicare Beneficiaries," 2005.
[10]Ibid.
[11]Mackay, Crystal, et al., "Health Care Utilization for Musculoskeletal Disorders," Arthritis Care & Research, Vol. 62, No. 2, February 2010, pp. 161-169, DOI 10.1002/acr.20064
[12]CBO, 2005.
[13]U.S. National Institutes of Health, National Cancer Institute, The 2009 Annual Report to the Nation on the Status of Cancer, 1975-2006.
[14]Catalyst for Payment Reform, "Action Brief: Improving Fee-for-Service Payment," 2012
[15]Millenson, Michael L., "Analysis: ACOs could have the Medicare muscle to transform health system," Kaiser Health News, May 2, 2012.
[16]Schneider, Eric C., et al., "Payment Reform: Analysis of Models and Performance Measure Implications, RAND Health Technical Report, 2011.
[17]Texas Insurance Code, Art. 4, Ch. 848, as enacted by SB7 (Nelson), 82nd Texas Legislature, 2011.
[18]Note: Specialty drugs do not have generic equivalents.
[19]Insights 2012 Connected: Advancing the Science of Pharmacy Care, Caremark, p. 19.
[20]BCBSTX Reporting & Analytics, Blue Insight, FY2011.
[21]National Institute on Retirement Security, Center for State & Local Government Excellence, Out of Balance? Comparing Public and Private Sector Compensation over 20 Years, by Keith A. Bender and John S. Heywood, April 2010. http://www.nirsonline.org/storage/nirs/documents/final_out_of_balance_report_april_2010.pdf; data are from the National Compensation Survey and the associated Employment Cost Index published by the Bureau of Labor Statistics. Large firms are those with 100 or more workers.
[22]Mercer Workplace Survey shows employees highly value health benefits; skeptical about health reform," November 3, 2010.
[23]Saurage Marketing Research, "Member Perception about Managing Health and Health Care Costs," December 2006
[24]Texas Insurance Code, §§1551.101-102
[25]Texas Insurance Code, §1551.211
[26]Aon Hewitt, Commentary on Sustainability of the State of Texas Group Benefits Program Report to the 82nd Texas Legislature, July 31, 2012, p.6.
[27]American Academy of Family Phyisicans and Consumer Reports, "Choosing Wisely: Imaging tests for lower-back pain; when you need them and when you don't," 2012.
[28]Mercer, "2011 National survey of employer-sponsored health plans," p.8
[29]Aon Hewitt, Commentary on Sustainability of the GBP, p.7.
[30]Ibid, p.6.

## SECTION 1: ELIGIBILITY

### Who should be eligible for coverage under the plan?

When developing a sustainable health insurance plan, the Legislature must first decide who should be covered. The Texas Legislature defines eligibility requirements for GBP coverage for more than half a million public employees, retirees, and their dependents.[1] ERS manages enrollment for the plan and it also conducts eligibility audits to ensure that only those eligible for coverage are participating in the plan. See Appendix K for a detailed description of the current eligibility requirements for GBP coverage.

This section of the report examines the impact of policies that would change insurance eligibility, including limiting, or even discontinuing health insurance coverage for some or all participants covered under the plan. For each option, ERS projects potential savings to the State and the effect of eligibility changes on current plan members.

State employee and retiree health insurance benefits are not guaranteed in statute. The Legislature sets the funding for the GBP on a pay-as-you-go basis during each legislative session. GBP benefits are subject to change based on the amount of the legislative appropriation

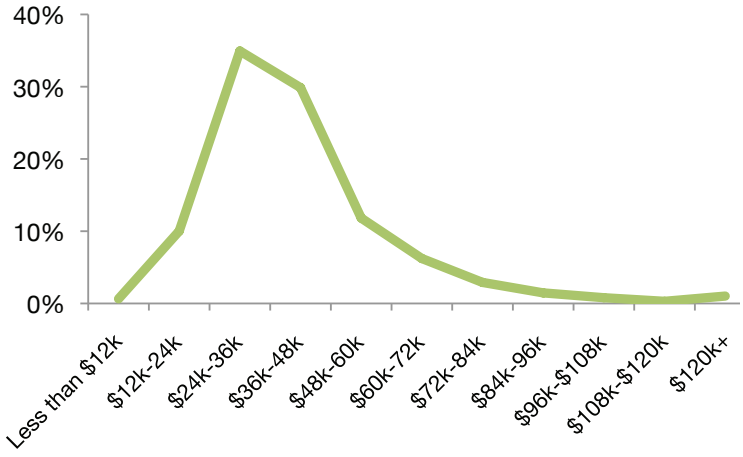
### ELIGIBILITY CHANGES WOULD IMPACT THOUSANDS OF MIDDLE-INCOME TEXANS.

Any changes to existing benefits must be considered for their impact to the state workforce. Employees care a great deal about their health insurance benefits. According to a 2010 workplace study by Mercer, 90% of employees with employer-based health benefits say their health benefits are just as important as salary.[2] In a 2006 ERS survey of more than 10,000 State of Texas employees and retirees, a majority chose health insurance as their most valued benefit.[3] Eliminating health insurance coverage for its workforce would put the State of Texas outside the norm among private and public sector employers.

State employees constitute a large group of primarily middle-income Texans, all of whom depend heavily on their employer-based health insurance benefits. Fully 75% of state employees enrolled in the GBP make less than $48,000 a year; only 12% make more than $60,000 a year.

***Figure 1.1: 75% of state employees enrolled in the GBP make less than $48,000/year***

*(GBP data, full-time state employee insurance salary, Jun 2012)*




Few state employees would be able to afford the same quality coverage they receive with the GBP on their own in the marketplace. Aon Hewitt notes that "the GBP currently takes advantage of one of the country's largest risk pools, strong professional management, and economies of scale that can benefit individuals enrolled in a group insurance plan. In the federal exchange plan, plans will be individually rated, and this creates the possibility that many individuals will pay much more for coverage similar to their current plan."[4]

ERS heard from several large state agency employers that even with the current GBP coverage—many employees in low-wage, high-stress, high-turnover jobs—such as caregivers at State Supported Living Centers, or entry level prison guards—do not sign up for dependent coverage because they can't afford it.

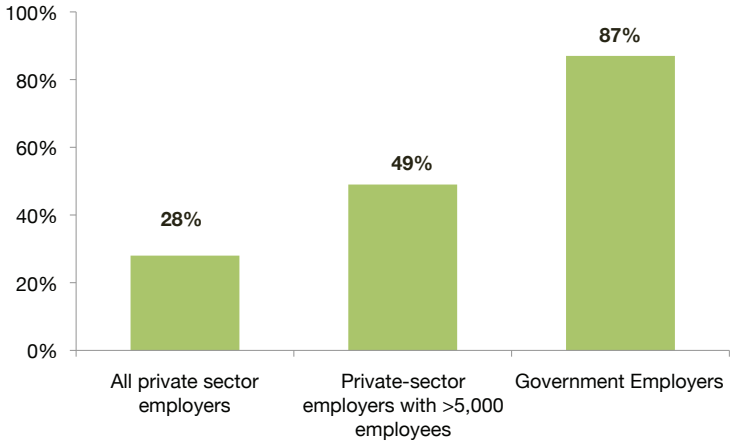
Employers also told ERS that they feared a major change in benefits could be the "last straw" for many employees—and that decisions to grandfather certain groups could create a "mass exodus" of the 13,341 active employees who are currently eligible to retire. From their perspective, eliminating health insurance coverage would affect the State's ability to recruit and retain employees, a key part of the legislative intent for the program.

Policies that encourage employees to continue working and contributing toward their retirement until age 65 will have a positive effect on the pension plan. On the other hand, discouraging retirement until 65 introduces an offsetting concern about workforce quality and capacity challenges. For example, younger employees could be discouraged by policies that prevent opportunities for advancement.

The Texas Legislature currently encourages and recognizes career state service by providing health insurance for eligible retirees. The average state employee earns about $18,000 a year in pension benefits after giving 23 years of service to the state. Retiree health and pension benefits have always been and will continue to be a great motivator for employees to dedicate their careers to state service.

**"The average state employee gives 23 years of service to the state, and when they retire they earn an annuity of about $18,000 a year."**

***Figure 1.2: 87% of government employers offer health insurance to retirees***




Many private sector employers have stopped offering retiree health benefits altogether. As of 2011, only 1 in 4 large private sector firms (>200 employees) still offer retiree health insurance benefits. But nearly half (49%) of the largest employers—those with more than 5,000 employees—continue to offer retiree health insurance coverage.[5]

In contrast, 87% of state and local governments continued to offer retiree health insurance,[6] although at varying extremes. Some states pay 100% of the premium for their retiree health insurance; others only go so far as to make coverage available, while charging the retiree 100% of the premium.[7] Some states end coverage at age 65. All 13 public sector entities surveyed for this report provide retiree coverage.

Clearly, limiting eligibility for state-provided insurance generates substantial savings to the State, but at an enormous cost to the half a million people who rely on the GBP. Removing a large group of people from the plan could have the unintended consequence of putting an extra burden on other public programs that support lower income residents in Texas.

ERS has made great efforts to communicate to members that GBP benefits are not guaranteed under statute. Even so, many employees and retirees covered by the GBP may still believe that their benefits are a promise from the state, which could create a potential for litigation if the benefit was taken away. See Appendix L for a summary of legal issues effecting the GBP.

For each of the options, policymakers would need to determine who would be affected. The more people who are exempt from the change, or "grandfathered", the less savings for the State. Ten years of service is the minimum required amount of service to qualify for GBP health insurance benefits at retirement. ERS costed the options in this section assuming there would be no grandfathering. Both options in this section present remarkably complicated choices with far-reaching consequences. The potential cost savings cannot be considered in a vacuum.

## OTHER ELIGIBILITY RELATED ISSUES.

**ACA-mandated coverage of children up to age 26 will cost employers.** ERS recently complied with Affordable Care Act (ACA) requirements (and state requirements under SB 1664) to cover children up to age 26, a change estimated to cost employers $20.4 million in the FY12-13 biennium.

**GBP 100% dependent eligibility audit saved $14.8 million.** ERS recently conducted a 100% dependent eligibility audit of the GBP. We have a fiduciary responsibility to manage health care costs and eliminate fraud. Ineligible dependents increase the cost of health care to the State. Removing ineligible dependents from the GBP saves the plan money in contributions and claims costs.

ERS contracted with Hewitt Associates L.L.C. (Hewitt) conducted the dependent audit which provided an initial "amnesty" period allowing members to drop dependents from the plan with no questions asked. After that, 100% of the remaining dependents were subject to legal verification of their eligibility for insurance coverage. All told, about 5% of dependents were removed from the plan, saving employers $14.8 million for FY12.

***Figure 1.3: Actuarial estimates of the impact of eligibility changes to the GBP***

| Estimated savings to the State* | Estimated reduction to the projected OPEB cost | Option |
|---|---|---|
| **HIGH**<br>79.8% | 100% | **1.1.1 Eliminate coverage, send employees to the federal exchange and pay the federal penalty** If the Legislature eliminates employee coverage, then it must pay a federal penalty of $2,000 per person starting in 2014, indexed annually for medical inflation. The penalty is per employee only; no penalty is paid for dependents or retirees. Low-income employees and families could apply to the exchange to receive an additional federal subsidy for their coverage.<br><br>**No grandfathering**<br>**Action required**: Changing eligibility requires legislative action, which would mean revision of the Insurance Code, Ch. 1551 to eliminate coverage for employees and retirees. This would also require substantial statutory revision to abolish the GBP. It would also require authorization in the appropriations bill for the Comptroller's office to pay the federal penalty. |
| **HIGH**<br>38.8% | 100% | **1.1.2 Eliminate coverage, pay the penalty and give the employee the net difference of the current contribution, including payroll tax**. By 2014, ERS estimates that member-only coverage in the GBP will have a value of $6,000 per year. This option assumes that the State would commit $6,000 per employee – of which $2,000 would go to the federal government and the remaining $4,000 to the employee.<br><br>**No grandfathering**<br>**Action required**: Changing eligibility requires legislative action, which would mean revision of the Insurance Code, Ch. 1551 to eliminate coverage for employees and retirees. This would also require substantial statutory revision to abolish the GBP. It would also require authorization in the appropriations bill for the Comptroller's office to pay the federal penalty and allocate the contribution to employees. |
| **HIGH**<br>28.2% | 100% | **1.1.3 Eliminate coverage, pay the penalty and give the employee the full active supplement.** By 2014, ERS estimates that member-only coverage in the GBP will have a value of $6,000 per year. This option assumes that the State would pay the $2,000 penalty to the federal government, and would give the employees the value of the full active supplement, or $6,000 per employee.<br><br>**No grandfathering**<br>**Action required:** Changing eligibility requires legislative action, which would mean revision of the Insurance Code, Ch. 1551 to eliminate coverage for employees and retirees. This would also require substantial statutory revision to abolish the GBP. It would also require authorization in the appropriations bill for the Comptroller's office to pay the federal penalty and allocate the contribution to employees. |
| **HIGH**<br>28.2% | 100% | **Option 1.2 Eliminate coverage for retirees**<br><br>**No grandfathering**<br>**Action required:** Changing eligibility requires legislative action. This requires substantial revision of the Insurance Code to eliminate coverage for retirees. |

*expressed as a percentage of $4.1 billion in projected employer contributions assuming no grandfathering

### OPTION 1.1 Eliminate coverage for all participants and send them to the Federal Exchange in 2014

Under the ACA, employers can eliminate insurance coverage for their employees in 2014 and pay a $2,000 per person penalty to the federal government.[8] The employee could "shop" from a variety of health insurance plans at an insurance exchange. States have the option to develop their own exchange or send people to the federal exchange.

Since the ACA was upheld by the United States Supreme Court and Texas has not taken steps to establish its own exchange, the current assumption is that Texans will be in the federal exchange. The exchange has to offer a guaranteed minimum "essential benefits" package plus several buy-up options. The minimum benefits package should cover "60% of the cost of health care" which will be defined at the state level. The Legislature can eliminate coverage for the state workforce in one of three ways:

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• By cutting insurance benefits and paying the $2,000 penalty per employee, the State would reduce its financial obligation for health insurance benefits by 80%.<br>• Since ACA does not require employers to cover retirees, projected OPEB costs would show a significant decrease if retiree coverage was limited or eliminated.<br>• Even if the State chose to contribute an extra amount above the $2,000 penalty, the State would have much more flexibility for budgeting that amount, as it would no longer be driven by growth in the health care cost trend. The State could limit the impact of new FICA taxes by considering the value of the tax in determining the amount of the supplement paid to the employee.<br>**Impact on members**<br>• Most employees would get a premium credit towards the cost of coverage in the exchange. Subsidies are available for families making up to four times the federal poverty level. | **Budget Issues**<br>• State contributions to the exchange are a less efficient use of health insurance funds because GBP administrative costs are only 3 cents on the dollar, compared to the ACA requirement that administrative costs not exceed 15 cents on the dollar.<br>• Currently the health insurance benefit is tax free to the State and the employee. If an employee goes to the exchange, any amount paid by the State to the employee would be taxed for FICA and federal income tax (FIT) purposes. This means that both the employee and the State would now be paying taxes for a benefit that was formerly tax free.<br>• Capping the excess contribution at $4,000 will not stop health care costs from growing. Not recognizing health care inflation will cause the value of employee health benefits to erode over time.<br>• Could increase the number of uninsured individuals in Texas, or drive additional Medicaid enrollment.<br>**Impact on members**<br>• Health insurance benefits are key to recruiting and retaining a qualified and competent state workforce. Significant benefit cuts could seriously hinder recruitment and retention efforts, as well as health and productivity of the workforce.<br>• Very few large employers are considering this as an option, which would put the State of Texas far outside the norm.<br>• Employees and retirees would be strongly opposed.<br>• Insurance available on the exchange may not be comparable to the GBP benefit in either cost or coverage.<br>**Legal Issues**<br>• GBP benefits are not guaranteed under the Insurance statute, and ERS has made great efforts to communicate this fact to members of the GBP. However, many employees and retirees covered under the GBP may still believe that their benefits are a promise from the State, which could create a potential for litigation if the benefit was taken away.<br>• This option would require significant legal research on the ACA and drafting of amendments to Insurance Code 1551.<br>**Operational issues**<br>• Unclear what the effect would be on the small group of people who get insurance through the GBP but do not receive a state contribution. |

**Income level to qualify for federal subsidy**
(4x the 2012 poverty rate)

| Persons in household | Poverty guidelines |
|---|---|
| 1 | $44,680 |
| 2 | $60,520 |
| 3 | $76,360 |
| 4 | $92,200 |

**Eliminate coverage and pay the federal penalty.** If the State eliminated employee coverage, then the federal government would require GBP participating employers to pay a federal penalty of $2,000 per covered employee starting in 2014, indexed annually for medical inflation. The penalty is per employee only; no penalty is paid for dependents or retirees. Employees would be on their own to purchase coverage through the exchange. Employees with household income between 138% and 400% of poverty would qualify for a sliding scale premium credit based on income.

**Eliminate coverage, pay the penalty, and give the employee the net difference of the current contribution, including payroll tax.** By 2014, ERS estimates that member-only coverage in the GBP will have a value of $6,000 per year. This option assumes that the State would commit $6,000 per employee – of which $2,000 would go to the federal government and the remaining $4,000 to the employee as a salary supplement in lieu of the state provided health insurance benefit. Employees could use the supplement to offset health insurance premium expenses.

**Eliminate coverage, pay the penalty and give the employee the full active supplement.** By 2014, ERS estimates that member-only coverage in the GBP will have an average value of $6,000 per year. This option assumes that the State would pay the $2,000 penalty to the federal government, and would provide a salary supplement equal to the full average value of the coverage of $6,000 per employee. Employees could use the supplement to offset health insurance premium expenses.

**How would this option change the role of ERS and the employer?** Because the penalty is a federal assessment against employers, payment would continue to be an employer responsibility. The assessment would have to be considered in the legislative appropriation just like the insurance cost is currently, since it would be an employment cost. In that case, the higher education assessment would also be subject to the proportionality formula.

If this option were adopted, ERS would no longer have a role in state employee health insurance. The payment procedure would likely change since there would no longer be a reason for ERS to collect employer insurance contributions. Presumably the Comptroller would manage the payment of the federal penalty, the Legislative Budget Board (LBB) would determine the additional state contribution to employees (if any), and payroll officers at individual agencies would handle reporting and contribution payments. The federal government would determine eligibility for low-income subsidies.

**Impact on different coverage categories.** If the Legislature decided to eliminate employee coverage and send active employees to an exchange, then it also would have to decide what to do about retiree and dependent coverage. The ACA does not require employers to cover retirees or dependents. The State must only comply with regulations to cover children up to age 26 if children are eligible for insurance coverage from the State.

Currently, all types of employees – state employees, judges, law enforcement officers, elected state officials – are part of the same health insurance program. Policymakers would need to decide whether to eliminate coverage for all employees. In addition, the State legislatively mandates ERS to allow some designated classes to participate in the GBP – such as wrongfully incarcerated individuals – so the Legislature would also have to consider whether continued access to the program was appropriate if more options (such as participation in an exchange) were available.

**The GBP health insurance benefit is not currently subject to taxation.** Health insurance provided by the State is a pre-tax benefit to the employer and the member. Any salary supplement provided in lieu of the health insurance benefit would be taxed for FICA and federal income tax (FIT) purposes. To limit the State's financial exposure on the tax issue, the value of the State's FICA tax could be considered in determining the amount of the salary supplement.

### OPTION 1.2 Eliminate coverage for all retirees

Employers participating in the GBP provide retiree health insurance benefits at age 65 with 10 years of service, or when a member meets the Rule of 80. This option looks at the potential impact of eliminating coverage for all GBP retirees.

Claims analyses show that retirees in general consume more health care. Pre-65 year old retirees have some of the most expensive health insurance claims and Medicare retirees have the highest drug claims. Eliminating health and prescription drug coverage for all retirees would save employers money and eliminate the estimated OPEB cost of insuring retirees in the future.

**Age discrimination issues should be studied before making major changes to retiree benefits.**

Any option that reduces or eliminates benefits for retirees could raise age discrimination issues. Under the Age Discrimination in Employment Act (ADEA) administered by the Equal Opportunity Commission and the Department of Labor, employers must be careful when making benefit changes that benefit younger members at the expense of older members. (Age 40 is the cutoff). All options relating to retiree coverage must be thoroughly vetted for issues with the ADEA.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Saves the State money since enrollment would be reduced significantly.<br>• Eliminating coverage for all retirees also eliminates the projected OPEB cost.<br>• If the State grandfathers any groups, the projected OPEB cost would not stop growing until the year that the benefit stopped.<br>**Policy Issues**<br>• If the State can discourage people from retiring until they qualify for Medicare at age 65, this will increase retention, lower insurance plan costs, and improve the financial condition of the pension plan. | **Budget Issues**<br>• The GBP receives the full state contribution for retiree-only coverage and uses it to offset costs for all participants. Losing contributions for Medicare-eligible retirees would raise the unit price of health insurance for all plan members.<br>• The GBP benefits from including retirees whose primary coverage is Medicare, since Medicare pays the majority of their medical costs.<br>• Grandfathering eliminates savings in the early years.<br>**Impact on Members**<br>• Retirees will experience a significant and unanticipated financial hardship at a time when they are unable to make up for these types of monetary losses.<br>• Retirees could see this as a violation of a promise from the State for benefits in exchange for their career employment.<br>• Some members (retirees and long-term employees) may be too old to recover from the benefit loss<br>**Policy Issues**<br>• Depending on the grandfathering policy, there could be a “rush to retirement”.<br>• Some of the eliminated retirees could end up on Medicaid, which will shift costs from one public program to another.<br>• This policy could discourage highly skilled employees from dedicating their career to public service, leading to increased turnover and a loss of institutional knowledge.<br>**Legal Issues**<br>• Many retirees covered under the GBP believe that their benefits are a promise from the State, which could create a potential for litigation if the benefit was taken away or if grandfathering was not implemented.<br>• Employers must be careful when making changes that reduce or eliminate benefits for retirees. All options relating to retiree coverage must be thoroughly vetted for issues with the ADEA.<br>**Operational Issues**<br>• Could have impact on whether people choose to retire under ERS or TRS, shifting costs to another retirement system and creating a significant discrepancy. |

[1]Texas Insurance Code, §§1551.101-102
[2]Mercer Workplace Survey shows employees highly value health benefits; skeptical about health reform," November 3, 2010.
[3]Saurage Marketing Research, "Member Perception about Managing Health and Health Care Costs," December 2006
[4]Aon Hewitt Commentary, p.7
[5]Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011
[6]Ibid.
[7]Clark, Robert L., "Will Public Sector Retiree Health Benefit Plans Survive? Economic and Policy Implications of Unfunded Liabilities, Paper presented to Annual meeting of the American Economic Association, January 2009.
[8]The employer penalty for failing to offer insurance coverage is $2,000 per year, regardless of an individual's financial standing. If an employer offers insurance but an employee is entitled to a premium credit based on the 9.5% income qualification, the penalty is $3,000. Since the options ERS examines in this section of the report eliminates all insurance coverage, the assessment would be determined at $2,000 for all employees.

## SECTION 2: CONTRIBUTION STRATEGY

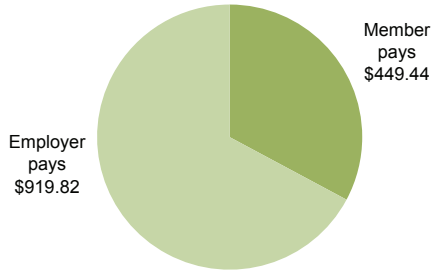
**How should the employer and the member share the cost of coverage?**

Once the state has decided who should be covered under the GBP, the next question is how to pay for them. The contribution strategy, set by the Legislature in a rider in the appropriations bill, determines what percentage of the monthly cost of coverage will be paid by the employer and what percentage will be paid by the employee.

Employers participating in the GBP[1] pay 100% of the cost of member coverage and half of the cost of dependent coverage. This works out to be a 67% employer/ 33% employee contribution for family coverage.[2] See Appendix M for a more detailed description of the types of employers that use the GBP and how they pay for it.

What the State calls the monthly "contribution" is essentially the same as an insurance "premium," and the terms will be used interchangeably when comparing the GBP with other plans.

***Figure 2.1: GBP employers pay 67% of member + family contribution***
*(based on FY13 contribution of #1,369.26)*




## HOW DO GBP CONTRIBUTIONS COMPARE?

According to the National Conference of State Legislatures (NCSL), in 2011, only four other state employers paid 100% of the premium for standard member-only insurance coverage (Iowa, Kentucky, Minnesota, and North Carolina). Ten states paid 100% of the premium for the lowest-cost individual insurance policy option (Delaware, Iowa, Kentucky, Michigan, Minnesota, Mississippi, North Carolina, Texas, Utah, and Wyoming).[3]

According to a survey by Mercer, the majority of private sector employers (92%) expect the employee to contribute to employee-only coverage.[4]

Regarding family coverage, the NCSL reports that just two states paid 100% of the premium for standard family insurance policies (North Dakota and Oregon) and nine states paid 100% of the premium for the lowest-cost family insurance policy option (Alaska, Delaware, Iowa, North Dakota, Oklahoma, Oregon, Pennsylvania, Utah, and Virginia)[5]

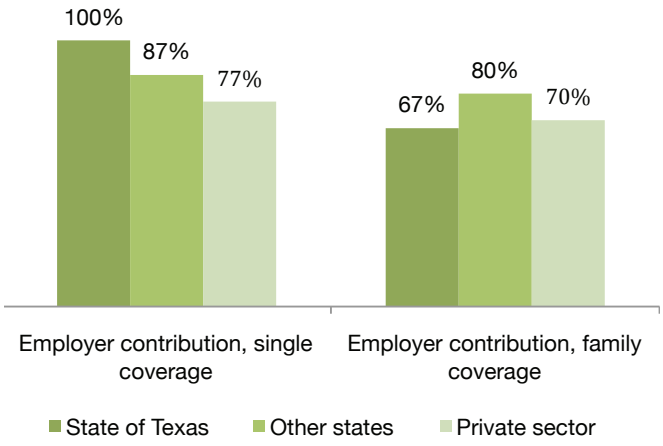
**State of Texas employees contribute less for single coverage, more for family.** The GBP health insurance contribution strategy differs from typical private and public sector plans in two ways:

- **Lower employee cost for single coverage.** For GBP health coverage, employees pay 0% of their member-only contribution, compared to a 13% contribution by public sector employees and 23% by private sector employees.
- **Higher employee cost for member and family coverage.** For GBP health coverage, employees pay 33% of the monthly cost for covering themselves and their families compared to a 20% contribution in the public sector and 30% for the private sector.

During a series of meetings with large Texas state agency employers, ERS heard that people who work in the lowest-paid, highest-turnover jobs—like aides at State-Supported Living Centers or entry-level prison guards—often decline dependent health coverage because they can't afford the cost.

**"Many of the state's lowest paid employees decline dependent health coverage because they can't afford the cost."**

***Figure 2.2: The State contributes more for member coverage, less for families than other employers***




**What to consider when comparing benefit features**. Even though the GBP employer contribution for single employee coverage is more generous than other plans, GBP out-of-pocket drug costs are much higher and salaries are lower. Thus, when viewed from the perspective of the total compensation package, state employee health insurance may not be as generous a benefit as it first appears.

Under state law, the GBP must provide a uniform benefit to all employees and retirees in the plan.[6] This means that HealthSelect, the health maintenance organizations (HMOs), and the Medicare Advantage plans must all offer a similar level of benefits to participants. Every member of the plan—from professor to prison guard—qualifies for the same level of benefits.

Lower paid state employees are likely receiving a more generous compensation package than similarly paid employees in the private sector, while higher paid state employees may be receiving a less generous compensation package than similarly paid private sector employees. Further, many public sector functions have no equivalent job or function in the private sector. For example, many jobs in public safety, higher education, environmental regulation, the judiciary, and more—these require advanced degrees and technical training, have higher pay grades, and offer benefit structures specifically designed to attract and retain workers with specialized skills.[7]

**"Even though the GBP employer contribution for single employee coverage is more generous than other plans, GBP out-of-pocket drug costs are much higher and salaries are lower."**

**Public sector retirees are more likely to have access to employer-based health benefits**. Many private sector employers have stopped offering retiree health benefits altogether. As of 2011, only one in four private sector firms with more than 200 employees still offers retiree health insurance benefits. But among the largest employers—those with more than 5,000 employees—nearly half (49%) offer retiree health insurance coverage. In firms that still offer retiree health insurance, the retiree pays about half the premium cost out-of-pocket, creating affordability issues, especially for those who are living on fixed incomes.[9]

In contrast, 83% of state and local governments continued to offer retiree health insurance, although at varying extremes.[10] Some states pay 100% of the premium for their retiree health insurance; others only go so far as to make coverage available, while charging the retiree 100% of the premium.[11] Some states end all coverage at age 65.

## CHOICE COSTS MONEY AND ADDS RISK.

Other private and public sector employers tend to offer more plan choices with different levels of benefits. The GBP is limited in its ability to offer more plan choices for two main reasons:

- When the employer pays 100% of the cost for member-only coverage, employees have no incentive to choose anything but the most generous benefit.
- When multiple plan choices are offered, the risk of adverse selection comes into play, which can drive up costs for members and for the State.

A risk adjustment for adverse selection recognizes that people will generally choose in their own best interest. In other words, the youngest, healthiest, and lowest-income individuals will choose the lower-level benefits, and the oldest, sickest, highest-income individuals will choose the higher-level benefits.

**"When the employer pays 100% of the cost for member-only coverage, employees have no incentive to choose anything but the most generous benefit."**

Offering members the choice of a lower-level plan won't stop costs from rising. It will just reset the baseline and costs will continue to rise from there.

**The importance of the risk pool.** Having one large plan like HealthSelect means most members stay in the same risk pool – everybody belongs to the same group and shares risks across the board for the most expensive claims. Even with multiple plans, you can still keep everyone in the same risk pool. Sharing risk keeps costs down for everyone.

Some employer-sponsored plans have chosen to split the risk pool intentionally as they implement higher- and lower-level benefits, in order to accelerate the process of moving everyone to the lowest level benefit. When the higher-level plan becomes unaffordable, it goes into a "death spiral" and becomes unattractive to anyone but the most desperately ill people

**Learning from the past.** In the 1980s, the state offered a choice among several insurance plans – a high, medium and low benefit. And even though all participants were kept in the same risk pool, allowing members to switch annually among plans increased costs, as employees and retirees learned that they could enroll in the more generous plan in years that they expected to have higher health care costs, then switch back to the lower plan in other years.

In response to a 1984 Governor's Task Force on State Employee Health Insurance, ERS adopted a single plan because adverse selection among multiple state insurance plans had increased costs to an unsustainable rate. The logic was that requiring all participants to enroll in one plan would increase administrative efficiencies, attract more competitive bids, prevent adverse selection, and ultimately allow ERS to keep cost increases to a manageable level.

**"… the question is not whether employers should offer more choice, but how to offer choice in a way that maintains the stability and affordability of the insurance plan."**

**Policy questions to consider.** In short, the question is not whether employers should offer more choice, but how to offer choice in a

way that maintains the stability and affordability of the insurance plan. A flat 20% contribution of $90 a month may be fine for some, but it could create a financial burden for lower-income employees, or cause some people to opt out of coverage altogether.

It has been a long-standing policy of the Texas Legislature to offer the 100% contribution strategy in recognition of the lower salaries of public servants, and as an incentive for recruiting and retaining qualified employees. This could still be done, by offering a 100% contribution for a somewhat lower benefit, with the option for employees to "buy up" to the current HealthSelect benefit. Keeping everyone in the risk pool would be essential, and it would be advisable to create restrictions on the ability of people to move back and forth between plans.

Two questions to ask when considering this option:

- Is the higher-level benefit so expensive as to be unaffordable for anyone in the group? This policy may be putting a disproportionate burden on people with expensive health problems like cancer, who have no choice but to buy the highest-level benefit.
- Is the lowest-level benefit so "bare bones" that having meaningful coverage requires people to buy up? This policy may be putting a disproportionate burden on the lowest income employees, who could only afford the lowest-level coverage.

These are complex questions and will require a nuanced approach to ensure access to comparable benefits at a reasonable cost.

## HOW DOES ERS SET MONTHLY CONTRIBUTION RATES?

In the State's self-funded health plan, the monthly contribution rate is simply the dollar amount that employers pay for each member's health coverage.

In a self-funded plan, both employers and employees contribute money each month into a fund used to pay for health care.

The contribution rates for each group are estimated to cover the cost of coverage for that group. For example, the member contribution is intended to pay for member costs, not for any other category. Likewise, the contributions for children and spouses are intended to pay the cost of covering those groups. Spouses have the highest claims cost so the spousal premium is the highest.

In years when total costs exceed total contributions, ERS must pay the shortfall with money accumulated in the GBP contingency fund or cut benefits. Statute requires ERS to include in the Legislative Appropriations Request the amount needed to provide a contingency fund equal to 60 days of self-funded expenditures. ERS estimates that 60 days of claims costs will require $489 million as of August 31, 2013.

### WHAT IS THE DIFFERENCE BETWEEN THE "CONTRIBUTION STRATEGY" AND THE "CONTRIBUTION RATE?"

The Legislature sets the "contribution strategy" (expressed as a percentage) for the plan. This strategy tells ERS what portion the employer will pay and what the members will pay for total health plan costs. For example, the State requires the employer to pay 100% for member-only coverage, and 50% for dependent coverage. To determine actual dollar amounts to be paid by the members and the State, ERS sets a "contribution rate." The contribution rate divides the actual health plan costs between the employers and members based on the contribution strategy established by the Legislature.

The contingency fund is intended to provide for unanticipated expenses arising from adverse fluctuations in claim costs or unforeseen events such as a flu pandemic. Anything could happen, and that's why it's important to keep a back-up source of funds.

**Averaging costs across the groups.** The GBP provides health insurance for more than half a million people in the state, or one in 48 Texans. One advantage of joining a large program like the GBP is that everyone shares the cost of their insurance.

With the exception of a few years in the early part of the last decade, trends have remained in the single digits over the last 20 years. The HealthSelect benefit cost trend has averaged about 5.5% over the last 10 years.

Having a lot of healthy people in the group lowers the average cost, but everyone is different and their health care costs vary year to year. Because the group is so big, one person's illness does not dramatically change the average cost for the year.

***Figure 2.3: Each group's contribution should pay for its own costs***

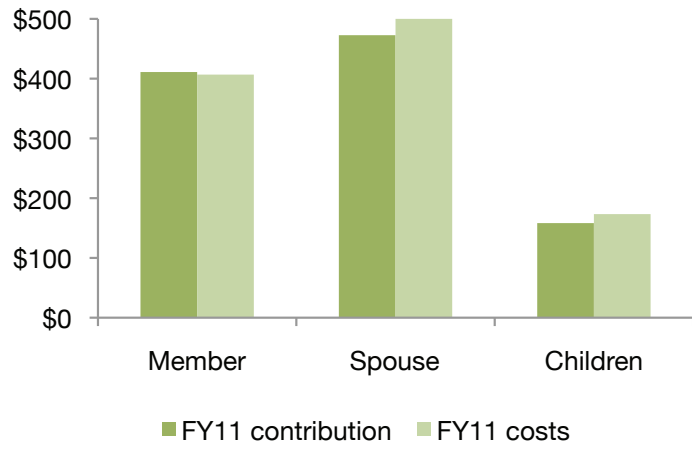
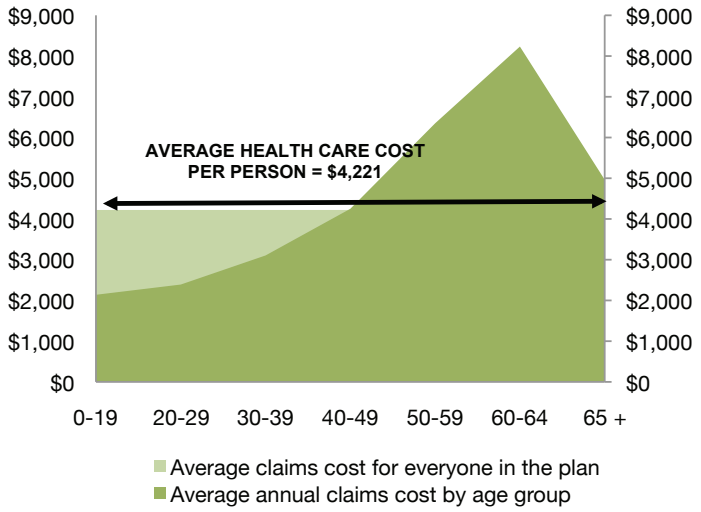


***Figure 2.4: ERS averages costs so the plan stays affordable for the group***

*(HealthSelect annual claims data, FY11)*




If employees or their family members have an unforeseen health event, they will reap the benefit of their monthly investment in the plan. Costs are spread among everyone in the plan so that health insurance never becomes too expensive for people when they need it the most.

**"The only way to reduce contributions is to reduce costs."**

The main thing to remember about changing the contribution strategy, is that it only changes the revenue stream; it doesn't control claim costs. If costs go up, revenue (contributions) must also go up, or benefits must be cut. The only way to reduce contributions is to reduce costs. Options to reduce claim costs will be covered in later sections of this report.

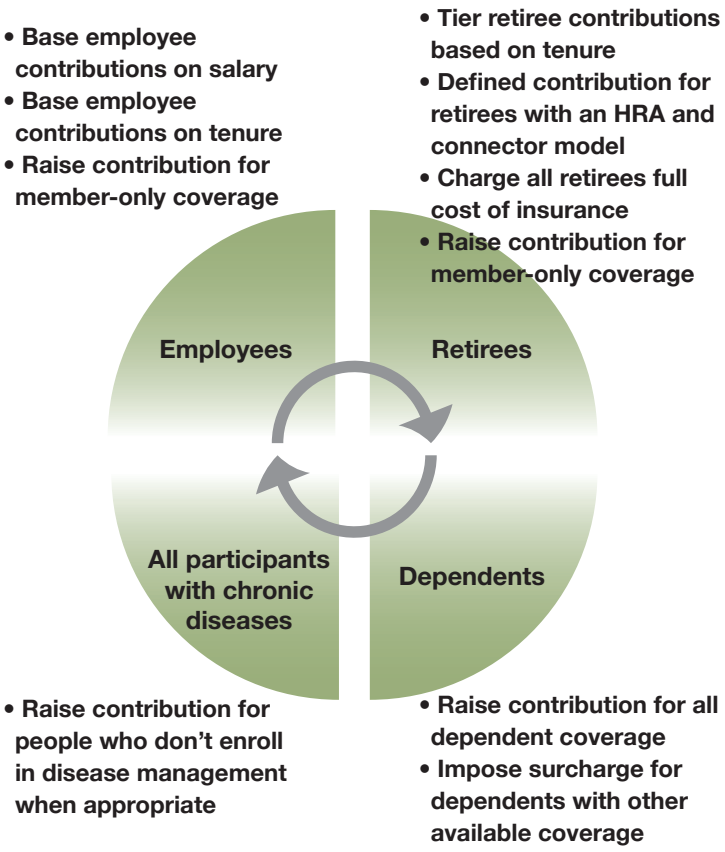
## WHO WOULD BE AFFECTED BY CONTRIBUTION STRATEGY CHANGES?

ERS examined nine different options for changing the contribution strategy. Every group who receives health insurance benefits through the GBP would be affected by at least one of the options.

The "fairness" of one strategy over another is debatable. Some people feel that costs should be spread evenly among the members of the group, so that coverage is more affordable for everyone who needs it. An example of this would be the option to raise monthly contributions for all members.

Others believe that those who cost the plan more should pay more. An option that targets expensive groups would be raising the contribution for people who don't enroll in disease management when appropriate.

***Figure 2.5: Groups who would be affected by contribution strategy changes***



## IMPACT OF THE CONTRIBUTION STRATEGY ON SUSTAINABILITY.

A contribution strategy change is essentially a cost-shifting measure, but it can be done in a way to offer more meaningful choices. For example, in North Carolina, the State pays 100% for a basic plan and employees can buy up to a more generous plan by paying an additional 3-5% of the monthly premium. Under the North Carolina basic plan, employees pay a 30% coinsurance for medical services and under the higher-level plan, employees pay a 20% coinsurance.

Because the cost for employee health insurance comes out of the employer's budget, when the State saves money on contributions, this means that state and higher education employers save money. Retiree health insurance is also funded by state, higher education, or local funds, depending upon the employer.

Due to the complex combination of funding sources, the IBS analysis generally refers to "savings to the State" as "savings to the employer." When considering contribution strategy changes, it is important to know that dramatic savings for the employer means dramatic dollar-for-dollar cost increases for the affected members of the plan.

A decision to grandfather any group of people will greatly reduce the employer's savings from the contribution strategy change. The ERS consulting actuary costed all of the options with the assumption that no one would be grandfathered. The best way to make a significant impact on costs is not to grandfather. Even without grandfathering, some of the options still provide only minimal savings.

***Figure 2.6: Employers pay about 61 cents of every health plan dollar***
*(FY11, source of funds for GBP health insurance benefits, does not include member out-of-pocket costs)*

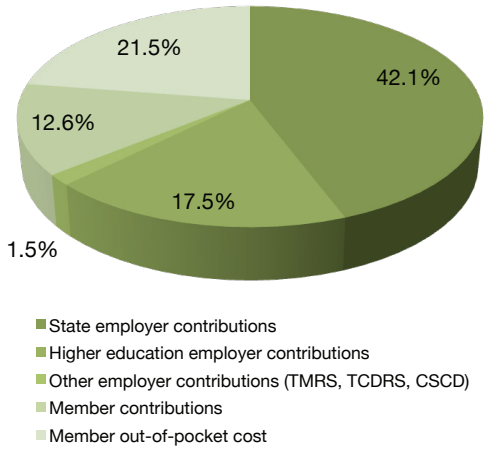



***Figure 2.7: Impact of change in contribution strategy on sustainability***

| **Change the contribution strategy**<br><br>**Employees**<br>• Base contributions based on salary or tenure<br><br>**Retirees**<br>• Tier contributions based on tenure<br>• Provide a defined contribution with connector model<br>• Charge retirees full cost of insurance<br><br>**Dependents**<br>• Raise contribution for all dependent coverage<br>• Impose a surcharge for dependents who have access to other insurance<br><br>**All participants**<br>• Raise contribution for member-only coverage<br>• Raise contribution for people who don't enroll in disease management when appropriate | **Does it manage health care costs?** | No |
|---|---|---|
| | **Does it reduce cost to the employer?** | Yes, over a wide range. Any amount of grandfathering will reduce or eliminate immediate savings to the plan. |
| | **Does it share risk with providers and responsibility with members?** | Changing the contribution strategy is a cost-shifting measure, designed to save the State money by requiring members to pay more.<br>It has no impact on providers. |
| | **Does it ensure a basic level of comparable benefits?** | The State could increase member-only contributions to 10%-20% and retiree contributions up to 50% and still be in line with other employers. The current State dependent contribution is less generous than other employers. |
| | **Does it encourage behavior change and improve health outcomes** | No, except for contributions that incentivize healthier behaviors, or those that require spouses with access to other coverage to pay a surcharge. |
| | **Do the Legislature and/or ERS have the authority to make the change?** | As the employer, the Legislature has the power to change the contribution strategy. The ERS Board of Trustees does not. |
| | **Does federal health care reform have an impact?** | The ACA would not impact the employee coverage options unless it raises member-only contributions to more than 9.5% of income. |
| | **Does it affect the projected Other Post-employment Benefits (OPEB) cost?** | Any option to eliminate or reduce retiree coverage would reduce the projected OPEB cost. |
| | **Who is affected and to what extent by this option?** | All options to change the contribution strategy will shift costs to some or all members of the plan–employees, retirees, and/or dependents. |

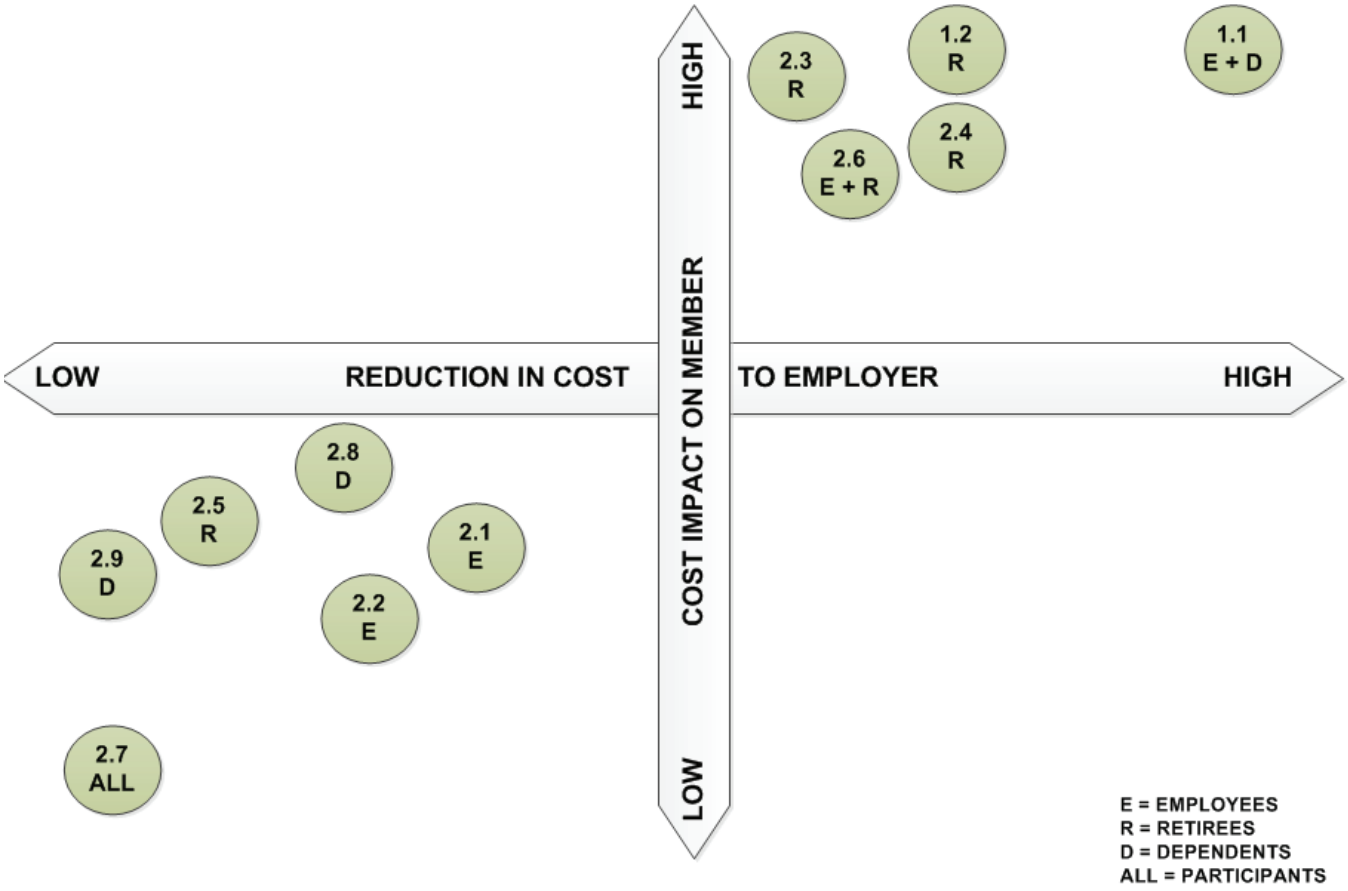
## ACTUARIAL ANALYSIS OF CONTRIBUTION STRATEGY OPTIONS.

All analyses project employer savings for each of the strategies for the FY14-15 biennium based on projected employer contributions of $4.1 billion. This includes all contributions from all employers: the State, higher education institutions, and others. GBP employer contributions are composed of about 54% General Revenue/General Revenue Dedicated (GR/GRD) and 46% federal, local, and all other funds.

- ERS did not project increases in employer contribution rates or changes in enrollment for FY14-15. This approach was intended to simplify the analysis and to avoid the potential confusion that could arise from comparing current contributions with future savings inflated by the health care benefit cost trend.
- Current contributions were assumed to be adequate to cover the cost of coverage; i.e., no adjustments were made in recognition of the contingency fund being used to supplement revenues.
- Current contributions for the various membership categories (member only, member + spouse, member + children, member + family) were assumed adequate in the aggregate to cover the cost for each of the categories; i.e., for this purpose, no attempt was made to address cross-category subsidies.
- The distribution between active and retired members was assumed to stay the same for FY14-15.

***Figure 2.8:** Relative impact of various contribution strategy and eligibility opions for FY14-15*

*(Assuming no grandfathering)*




**Eligibility options**

1.1 Eliminate coverage and send all employees to the federal exchange

1.2 Eliminate all retiree coverage

**Contribution strategy options**

2.1 Base employee contributions on salary

2.2 Base employee contributions on tenure

2.3 Defined contribution with connector model for Medicare retirees

2.4 Charge all retirees the full actuarial cost of their insurance

2.5 Tier retiree contributions based on years of service

2.6 Raise member-only contributions

2.7 Disease management incentive

2.8 Raise dependent contribution

2.9 Surcharge for spouses with access to other coverage

## PROJECTED EMPLOYER SAVINGS OF CONTRIBUTION STRATEGY OPTIONS.

Figure 2.8 shows the total projected employer savings for FY14-15 of implementing any of the options reviewed in this section of the report. The value of 1% in plan savings is $41 million for the biennium. We estimated the maximum potential savings by assuming there would be no grandfathering.

For example, Option 2.1—requiring members to pay some percent of their monthly contribution based on their salary—would save employers 8.2% in total plan costs, or $336.2 million. Option 2.5—tiering the retiree contribution based on length of service – would save employers 3.2% or $131.2 million.

All options, except 2.7 and possibly 2.9, save money for the employers by shifting cost to members. For the member to retain the current level of coverage, they would have to pick up the cost currently paid by the employer on a dollar-for-dollar basis. For example, requiring members to pay 10% of the monthly contribution would save employers $332 million over the biennium by shifting that cost to the members. Percentage savings are not equivalent. For example, an 8% savings for the employer would result in a 40% cost shift to the member.

***Figure 2.9: Contribution strategy options: projected employer savings FY14-15***
*(expressed as a percentage of $4.1 billion in projected employer contributions, based on FY13 enrollment and contribution rates)*
**(ALL FUNDS - ALL EMPLOYERS)**

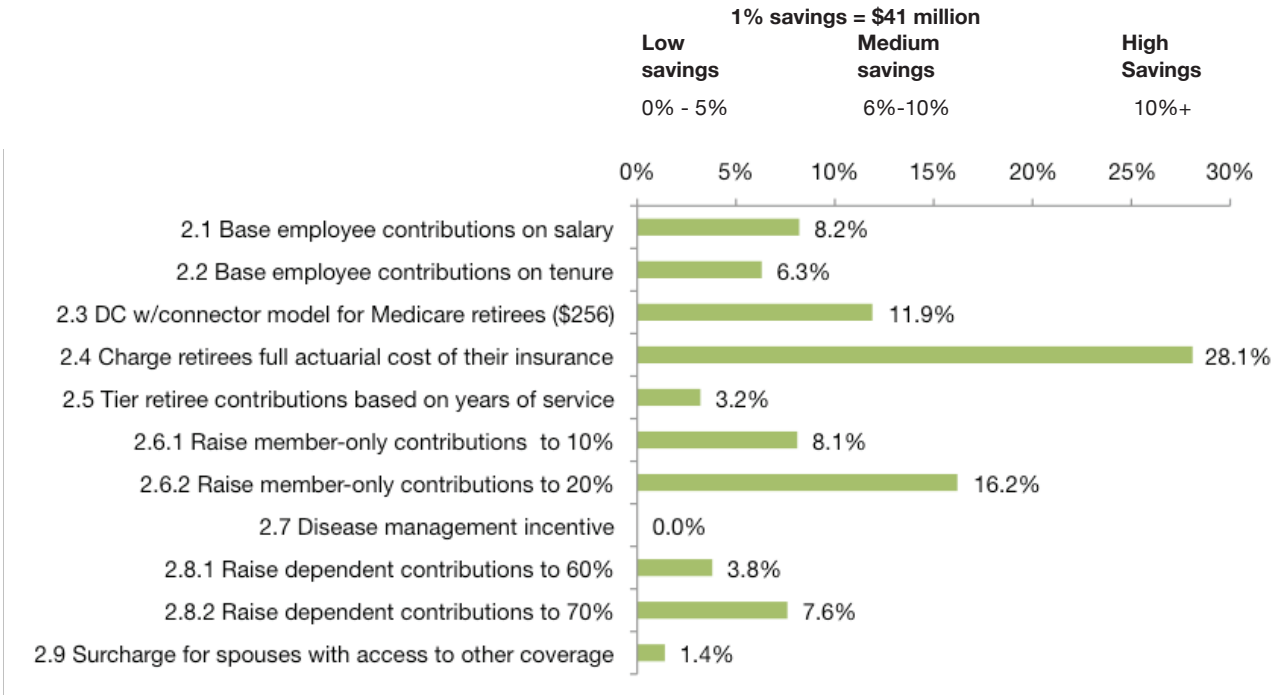


***Figure 2.10: Actuarial assumptions and projected financial impact of contribution strategy options, assuming no grandfathering (ALL FUNDS - ALL EMPLOYERS)***

| Estimated savings to the State* | Estimated reduction to the projected OPEB cost | Option |
|---|---|---|
| **MEDIUM**<br>**8.2%** | 0% | **2.1 Base employee contributions on salary**<br>**Assumptions:** Employees would contribute 2% of their salary, up to 20% of the monthly contribution rate. No grandfathering assumed.<br>**Action required:** Changing the contribution strategy requires legislative action. The contribution strategy is set in a budget rider to the General Appropriations Act. |
| **MEDIUM**<br>**6.3%** | 0% | **2.2 Base employee contributions on tenure**<br>**Assumptions:** The employee's contribution would start at 20% of the monthly contribution rate upon hiring date, and would be reduced 2% a year until s/he reached 10 years of service, after which the employer would pay 100% of the cost of employee coverage.<br>If an employee comes into the system with proportionate service from another entity (such as the Teachers Retirement System), s/he would also start at 20% until s/he builds up state creditable service, i.e., was eligible for health insurance coverage under the GBP. No grandfathering.<br>**Action required:** Changing the contribution strategy requires legislative action. The contribution strategy is set in a budget rider to the General Appropriations Act. |
| **HIGH**<br>11.9% | TBD | **2.3 Defined contribution for Medicare-primary retirees deposited into a health reimbursement arrangement (HRA) with a "connector model"**<br>**Assumptions:** ERS estimated the employer's defined contribution at $256 per month, which is the member-only rate of the lowest-level Medicare Advantage plan providing 100% coverage for retirees. Dependent contribution was estimated at 50%. If the contribution never rose, the projected OPEB cost would decrease significantly, because OPEB considers future increases in the cost of coverage. No grandfathering.<br>**Action required:** Changing the contribution strategy requires legislative action. The contribution strategy is set in a budget rider to the General Appropriations Act. This option would also require statute change and rule changes, as well as an authorization for ERS to deposit money into the HRA. |
| **HIGH**<br>28.1% | 100% | **2.4 Charge retirees full actuarial costs of their insurance**<br>**Assumptions:** This proposal would mean that the retirees would be eligible to buy insurance under the GBP, but they would be required to pay the full actuarial contributions for themselves and their dependents. Retiree contribution was assumed to be the projected cost of coverage (or the uniform contribution rate). No grandfathering.<br>**Action required:** Changing the contribution strategy requires legislative action. The contribution strategy is set in a budget rider to the General Appropriations Act. Would also require amendment of Ch.1551 and a change in administrative rules. |
| **LOW**<br>3.2% | 10% | **2.5 Tier retiree contributions based on tenure**<br>**Assumptions:** Savings were calculated as follows:<br>• Retirees with less than 10 years of service pay the entire premium.<br>• Retirees with10-15 years of service pay 50% contribution.<br>• Retirees with 15-20 years of service pay 25% contribution.<br>• Retirees with 20 or more years of service pay nothing.<br>No grandfathering.<br>**Action required:** Changing the contribution strategy requires legislative action. The contribution strategy is set in a budget rider to the General Appropriations Act. This option would also require amendment of Ch.1551.102 and a change in administrative rules. |

**Expressed as a percentage of $4.1 billion in projected FY14-15 employer contributions, based on FY13 enrollment and contribution rates*

| Estimated savings to the State* | Estimated reduction to the projected OPEB cost | Option |
|---|---|---|
| **MEDIUM**<br>8.1% | 7% | **2.6 Raise member contributions for member-only coverage**<br><br>**Assumptions:** This option would increase the member contribution to either 10% or 20%, reducing the employer's contribution to 90% or 80%. Each one point increase in the member's contribution, would shift $16.6 million in annual cost to the member. No grandfathering assumed.<br><br>**Action required:** Changing the contribution strategy requires legislative action. The contribution strategy is set in a budget rider to the General Appropriations Act. |
| **HIGH**<br>16.2% | 14% | **2.6.2 Raise member contributions for member-only coverage to 20%**<br><br>**Assumptions**: This option would increase the member contribution to 20%, reducing the employer's contribution to 80%. Each one-point increase in the member's contribution would shift $16.6 million in annual costs to members. No grandfathering.<br><br>**Action required:** Changing the contribution strategy requires legislative action. The contribution strategy is set in a budget rider to the General Appropriations Act. |
| **NEGLIGIBLE** | 0% | **2.7 Raise contribution for participants who do not participate in disease management when appropriate**<br><br>**Assumptions:** This proposal would require a higher monthly contribution amount for participants who choose not to participate in the disease management program. The assumption is that the payment differential would be $30 per person per month. Participants would be identified by the third-party administrator (TPA) through health risk assessments, and claims analysis. Savings are for the FY14-15 biennium only; unable to estimate long-term savings. No grandfathering.<br><br>**Action required:** Changing the contribution strategy requires legislative action. The contribution strategy is set in a budget rider to the General Appropriations Act. |
| **LOW**<br>3.8% | 3% | **2.8.1 Raise member contributions for dependent coverage to 60%**<br><br>**Assumptions:** This option would increase the member contribution for dependent coverage to 60%, reducing the employer's contribution to 40%. For each one-point increase in the member contribution for dependent coverage, the employer shifts $7.8 million in annual cost to the member. No grandfathering.<br><br>**Action required:** Changing the contribution strategy requires legislative action. The contribution strategy is set in a budget rider to the General Appropriations Act. |
| **MEDIUM**<br>7.6% | TBD | **2.8.2 Raise member contributions for dependent coverage to 70%**<br><br>**Assumptions:** This option would increase the member contribution for dependent coverage to 70%, reducing the employer's contribution to 30%. For each one-point increase in the member contribution for dependent coverage, the employer shifts $7.8 million in annual cost to the member. No grandfathering.<br><br>**Action required:** Changing the contribution strategy requires legislative action. The contribution strategy is set in a budget rider to the General Appropriations Act. |
| **LOW**<br>1.4% | 0% | **2.9 Surcharge for employees' spouses who have access to other coverage**<br><br>**Assumptions:** In FY10, 26% of HealthSelect participants reported that their dependents have access to other employer-based health care coverage, but use GBP coverage as their primary form of insurance. Financial impact was estimated assuming that 26% of spouses would pay an additional 20% of the spousal rate (about $100 per month). No grandfathering.<br><br>**Action required:** Changing the contribution strategy requires legislative action. The contribution strategy is set in a budget rider to the General Appropriations Act. Would require legislation with a corresponding rider. Also would require a new administrative rule. |

**Expressed as a percentage of $4.1 billion in projected FY14-15 employer contributions, based on FY13 enrollment and contribution rates*

## OPTIONS THAT WOULD AFFECT EMPLOYEES

### OPTIONS 2.1 Base employee contributions on salary

For this option, ERS assumed that employees would contribute 2% of their salary, up to 20% of the contribution rate for member-only coverage. The State of New Jersey bases its employee contributions on salary. According to Mercer, about one in 10 large employers also has salary-based health premiums, including GE and Pitney Bowes.[14]

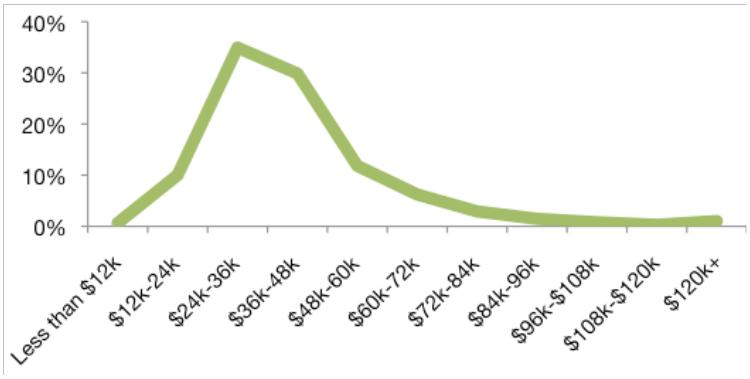
The chart below shows the impact on employees using the FY13 member-only rate for health insurance coverage of $468.16. Under this scenario, the monthly contribution would be increased for every $10,000 in pay, until the employee reached a salary of about $60,000 a year, at which point it would cap out at $93.63 per month. Savings for the employers result in a dollar-for-dollar increase in cost to employees.

***Figure 2.11: Example of salary-based contribution strategy for employee-only coverage***

| Annual salary | 2% of monthly salary | 20% of $468.16 | Total rate due |
|---|---|---|---|
| $20,000 | $33.33 | $93.63 | $33.33 |
| $30,000 | $50.00 | $93.63 | $50.00 |
| $40,000 | $66.67 | $93.63 | $66.67 |
| $50,000 | $83.33 | $93.63 | $83.33 |
| $60,000 | $100.00 | $93.63 | $93.63 |

***Figure 2.12: Only 13% of state employees enrolled in the GBP make more than $60,000/year***

(GBP data, full-time state employee insurance salary, does not include higher education, June 2012)




Aon Hewitt suggested another approach used by some employers: instituting a flat contribution for all employees within a given salary range. "While less complex administratively, this approach does create scenarios in which pay increases that push employees into a higher salary range could be more than offset by the increase in contributions required for medical coverage."[15] In other words, a pay raise could turn into a pay cut.

| PROS | CONS |
|---|---|
| • The higher your salary, the more you could afford to pay for your benefits.<br>• This option would save employers money by charging members more.<br>• This option could be seen as fairer a way to increase member contributions than a flat percentage. | • Contribution strategy changes do not reduce health care costs for the plan, they just reduce costs for the employer by cost-shifting to members.<br>• Lower-paid members would be required to contribute a larger percentage of total earnings than higher-paid members.<br>• Could create more barriers to recruitment for low-paid, high-turnover positions.<br>• Significantly increases administrative complexity. |

## OPTION 2.2 Base employee contributions on tenure

For this option, ERS assumed that the employee's contribution for member-only coverage would start at 20% and go down 2% a year until the employee reaches 10 years of service, after which the employer would pay 100% of the cost of his/her coverage. If an employee comes into the system with proportionate service (such as time with the Teachers Retirement System), s/he still starts at 20% until state creditable service is built up (i.e., when s/he reaches eligibility for GBP health insurance coverage). The 50% cost-sharing approach for dependent coverage would not change.

Figure 2.14 shows an example of how this option would work using the FY13 member-only rate for health insurance coverage of $468.16. Savings for the employers result in a dollar-for-dollar increase in cost to employees.

***Figure 2.13: 42% of all full-time employees enrolled in the GBP have 10+ years of service***
*(includes higher education, elected class, and others)*
*(as of June 2012)*

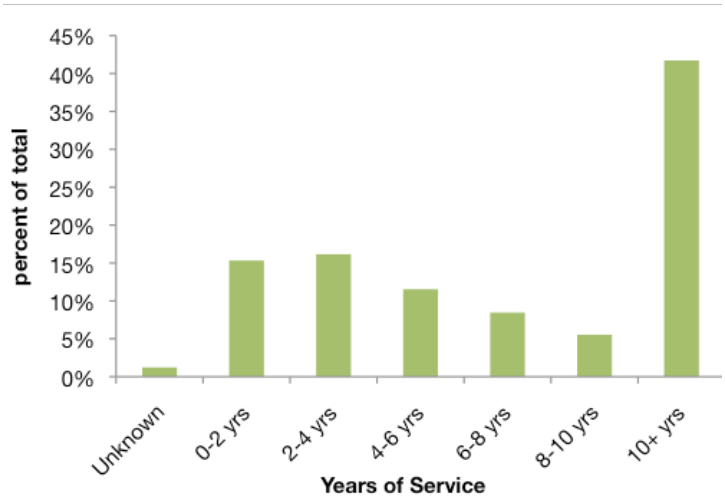



***Figure 2:14: Example of tenure-based contribution strategy for member-only coverage***

| Years of Service | 20% of $468.16 | 2% annual rate reduction | Total rate due |
|---|---|---|---|
| 0-1 | $93.63 | ($0) | $93.63 |
| 1-2 | $93.63 | ($9.36) | $84.27 |
| 2-3 | $93.63 | ($18.72) | $74.91 |
| 3-4 | $93.63 | ($28.08) | $65.55 |
| 4-5 | $93.63 | ($37.44) | $56.19 |
| 5-6 | $93.63 | ($46.80) | $46.83 |
| 6-7 | $93.63 | ($56.16) | $37.47 |
| 7-8 | $93.63 | ($65.52) | $28.11 |
| 8-9 | $93.63 | ($74.88) | $18.75 |
| 9-10 | $93.63 | ($84.24) | $9.39 |
| 10+ | $93.63 | ($93.63) | $0 |

| PROS | CONS |
|---|---|
| • Rewards longevity.<br>• Could be an effective retention strategy.<br>• Could have positive impact on the retirement fund if people worked longer or didn't retire at first eligibility.<br>• Would save money for employers because members are paying more.<br>• Could be perceived as a fairer way to increase member contributions than a flat percentage. | • Recruitment issue for people starting out with a low salary, because $93.63 a month is more of a burden on a low-income employee.<br>• Contribution strategy changes do not manage health care claims cost, they just reduce costs for the employer by cost-shifting to members.<br>• Significantly increases administrative complexity for ERS. |

## OPTIONS THAT WOULD AFFECT RETIREES

### OPTION 2.3 Defined contribution deposited to an HRA account for Medicare retirees with a connector model

Under this option, the employer's contribution for Medicare retirees would become a fixed monthly deposit to an HRA account. ERS would contract with a vendor to provide the connector model and ERS would administer the HRA. A connector model is similar to an exchange where multiple insurance plans are sold in a centralized location, except that the vendor provides benefit advisors to help people negotiate the marketplace. Plans in the connector model would be underwritten on an individual basis. Due to the added administrative cost and geographic cost variations, Medicare retirees may pay much more for coverage equal to what they now have.

ERS estimated the employer's defined contribution at $256 per month, which is the member-only rate of the lowest-level Medicare Advantage plan providing 100% coverage for Medicare retirees. Medicare retirees would use the $256 a month subsidy to buy an insurance product that suits their individual needs through a "Medicare Exchange" or connector model vendor. If a Medicare retiree did not spend his/her entire subsidy toward a premium, s/he could accumulate a balance in the HRA and use the money for other medical expenses. Dependents would get a 50% subsidy under this option.

A vendor (ExtendHealth) presented the connector model option to ERS at a Solution Session on February 7, 2012. Its model would provide benefit advisors to help Medicare-primary retirees use their subsidies to find medical and pharmacy plans to supplement their Medicare benefits. The vendor would receive commission payments from insurance carriers.

The State of Nevada and some city and county plans have ended their group plan for Medicare-primary retirees and moved to a defined contribution with a connector model. Large corporations like GM, Boeing Corporation, and many others are also using this model. In Nevada the vendor gave 80 to 100 educational and communication presentations to retirees (not including enrollment fairs), to help them with the transition.

During an annual open enrollment period, the vendor would match each retiree to nearby health and pharmacy plans in the area, according to ZIP code, that meet the retiree's needs. The vendor continues to be a resource for the retirees' insurance needs throughout the year.

Aon Hewitt suggested another approach: a retiree subsidy cap without a connector model. "Under this approach, a maximum flat-dollar contribution amount is set, and as costs increase over time, all costs above the cap are passed on to the members."[15] The financial impact to the state would be similar to Option 2.3.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Increases in retiree contributions would be at the discretion of the Legislature, rather than driven by increases in the GBP health care cost trend.<br>• The Legislature could set the amount of the employer's defined contribution at any amount it wants. In FY13, each Medicare-primary retiree is expected to cost about $310 per month under HealthSelect and $256 per month under Medicare Advantage.<br>• If the contribution never rose, the projected OPEB cost would be decreased significantly, because OPEB factors in the future increases in the cost of coverage.<br>**Member Impact**<br>• Retirees would have more plan options to choose from.<br>• Retirees could use any money in their HRAs that they don't spend on premiums and apply it toward other medical expenses.<br>**Policy Issues**<br>• Private sector plans have moved in this direction, so it would address the public perception that state retiree benefits are more generous than those in the private sector.<br>• This option has been implemented in another state (Nevada).<br>• This concept is already being debated at the national level, as an idea for a defined contribution has been proposed for the Medicare program. | **Budget Issues**<br>• Because ERS has already gone to Medicare Advantage, the savings would not be substantial.<br>• The cost for contracting with a vendor is unknown.<br>• TRS' attempt to implement an HRA several sessions ago ended because the HRA administrative fee used up so much of the $500 annual contribution that it resulted in a benefit of limited use to retirees.<br>• With grandfathering, immediate impact on employer savings is limited. Presumably would have greater immediate impact on projected OPEB costs.<br>• May have to change the rating model to redistribute the contribution cost to other members who would no longer be subsidized by Medicare-primary retirees.<br>**Member Impact**<br>• It could change costs (up or down) for retirees who are on a fixed income.<br>• Retirees would be opposed. Many believe that their insurance benefits are a promise from the State, which potentially could lead to litigation. Insurance benefits are not guaranteed in statute.<br>• Insurance available in the exchange may not be comparable to the GBP benefit.<br>• Increased number of choices could be confusing to retirees who have always had a limited number of options to choose from.<br>• Removing ERS from the administration of the insurance benefit could also create retiree confusion about where to go when they have problems with enrollment, claims, or other administrative issues.<br>• Taking Medicare retirees out of the risk pool could increase costs for other participants.<br>**Policy Issues**<br>• Not grandfathering could create a "rush to retirement," which would negatively affect the pension fund and could have an impact on the operational effectiveness of some employers.<br>**Legal Issues**<br>• Under the Age Discrimination in Employment Act (ADEA) administered by the Equal Employment Opportunity Commission (EEOC) and the Department of Labor (DOL), employers must be careful when making benefit changes that benefit younger members at the expense of older members. (Age 40 is the cut-off). All options relating to retiree coverage must be thoroughly vetted for issues with the ADEA.<br>**Operational Issues**<br>• ERS would have to bid services for the connector model and for the HRA and monitor the contract for quality.<br>• Grandfathering would add to administrative complexity of the plan, thus increasing operational costs. |

### OPTION 2.4 Charge retirees the full actuarial cost of their insurance

This option would mean that the retirees would be eligible to buy insurance under the GBP, but they would have to pay the full actuarial cost of coverage for themselves and their dependents. They also would have the option to go on the open market and buy insurance on their own. Any savings for the employer would result in a dollar-for-dollar cost increase to retirees.

The actuarial cost is based on actual health claims for a specific group, rather than the current "blended rate," which averages costs across the plan so that all members pay the same amount.

Of course, currently all retirees pay nothing for member-only coverage, so paying any amount would be an increase over what they currently pay. The FY13 monthly employer cost for HealthSelect member-only coverage is $470.

Because pre-65 retirees have higher claims than other groups, their rate under this option would be much higher than the current blended rate. Based on their claims experience, the full actuarial cost for a pre-65 retiree would be $750 per month.

Because Medicare retiree costs are subsidized to a certain extent by Medicare, their full actuarial cost would be $306 a month for HealthSelect coverage or $256 a month for Medicare Advantage coverage.

Most private sector employers that still offer retiree health insurance charge their retirees about 50% of the premium. About one-third of private sector employers charge their retirees the full cost of their insurance. The State of Florida also charges retirees the entire cost of coverage for a choice of six different plans in 2012, with costs around $475-$550 per month for pre-65 retirees and $250-$375 per month for Medicare retirees.[17]

Alternatively, the employer could provide fixed contributions to retirees, which they could apply toward their HealthSelect or Medicare Advantage coverage under the GBP. Increases in the contribution are at the discretion of the Legislature. Initial savings for the fixed contribution would be similar to the savings for Option 2.3.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Eliminates state liability for retiree health insurance.<br>• Eliminates projected OPEB costs.<br>**Member Impact**<br>• Retirees could have access to GBP plans, which would give them the benefit of buying into a group program, rather than purchasing insurance on the open market.<br>**Policy Issues**<br>• Would significantly reduce the number of people who retire before age 65, which would have a positive impact on the retirement fund. | **Budget Issues**<br>• Grandfathering would significantly delay any savings to the state.<br>• Not grandfathering could create a "rush to retirement," which would negatively affect the pension fund.<br>• Contribution strategy changes do not reduce health care costs for the plan, they just reduce costs for the state by cost-shifting to members.<br>**Member Impact**<br>• Significantly increases costs for retirees who are on a fixed income.<br>**Policy Issues**<br>• Significant adverse selection risk if only the sickest retirees chose to continue coverage with HealthSelect.<br>**Legal Issues**<br>• Under the ADEA administered by the EEOC and the DOL, employers must be careful when making benefit changes that benefit younger members at the expense of older members. (Age 40 is the cutoff). All options relating to retiree coverage must be thoroughly vetted for issues with the ADEA.<br>**Operational Issues**<br>• Would add to administrative complexity of the plan, increasing operational costs. |

### OPTION 2.5 Tier retiree health contributions based on tenure

This option would tier contributions for retiree-only coverage in the GBP based on their length of service at retirement. This option has been recommended by the Legislative Budget Board, and the savings have been estimated several times in past sessions by ERS. Ten other state-employer plans also use this approach.

An option costed by ERS in the past, and proposed by the Texas Public Employees Association (TPEA) at a 2012 Solution Session would have the following tiers:

- Retirees with less than 10 years of service pay the entire contribution.
- Retirees with 10-15 years of service pay 50% contribution.
- Retirees with 15-20 years of service pay 25% contribution.
- Retirees with 20 or more years of service or more pay 0% contribution.

Any savings for the employer result in a dollar-for-dollar cost increase to retirees. Our cost estimate assumed this option does not apply to dependents.

Even though grandfathering reduces short-term employer savings, over time the savings would grow as more employees retire under the tiered contribution strategy. In addition to reducing OPEB costs over the long-term, this strategy would also be likely to slow the rate of retirement, which would have a positive impact on the pension plan.

Note: 62% of retirees in the GBP (over the past 10 years) have retired with 20 years or more of service.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Without grandfathering, this option would reduce the cost to the employer by $131.4 million in the next biennium.<br>• With grandfathering of current retirees, this option would reduce the cost to the employer by $8.4 million in the next biennium.<br>• Would reduce projected OPEB costs.<br>**Member Impact**<br>• The TPEA proposed the second option above, so a large state employee association supports it.<br>• Employee groups are familiar with the concept and seem to generally support it.<br>• Almost two-thirds of the retirees in the GBP program have at least 20 years of service, so most would not be affected by the change.<br>**Policy Issues**<br>• Could have a positive effect on retention if employees started working longer to earn a more generous contribution from the State.<br>• Ten other states tier retiree contributions: AL, DE, LA, ME, OR, NE, NV, OH, RI and TN.<br>• Would have a positive effect on the pension plan over the long term if people worked longer.<br>• Improves public perception of fairness.<br>• May increase number of post-65 retirees enrolled in lower-cost alternative, such as the Medicare Advantage HMO or PPO. | **Budget Issues**<br>• Grandfathering would significantly delay any savings to the State.<br>• Not grandfathering could create a “rush to retirement,” which would negatively affect the pension plan and the workforce.<br>• Contribution strategy changes do not reduce health care costs for the plan, they just reduce costs for the state by cost-shifting to members.<br>• The average state employee retires at age 57 with 23 years of service. Since most retirees have 20 years or more of service, the savings would be limited to some extent.<br>**Member Impact**<br>• If it increased costs too much for retirees, it could cause some Medicare-primary retirees to opt out of the plan.<br>• Would have biggest impact on non-contributing members with 10+ years of service, even with grandfathering.<br>• Increased premium costs would disproportionately affect retirees on a fixed income.<br>**Policy Issues**<br>• Would discourage retirements, resulting in fewer opportunities for younger employees to move up.<br>**Legal Issues**<br>• Under the ADEA administered by the EEOC and the DOL, employers must be careful when making benefit changes that benefit younger members at the expense of older members. (Age 40 is the cutoff). All options relating to retiree coverage must be thoroughly vetted for issues with the ADEA.<br>• Would need to clarify how it applied to proportionate retirees.<br>**Operational Issues**<br>• Would add to administrative complexity of the plan, thus increasing operational costs. |

## OPTIONS THAT WOULD AFFECT ALL MEMBERS

### OPTION 2.6 Raise contributions for member-only coverage

The employer currently pays 100% of the monthly cost for member-only health insurance coverage, and the member (employee or retiree) pays nothing.

This option would increase the member contribution to either 10% or 20%, reducing the employer's contribution to 90% or 80%. Each one-point increase in the member's contribution shifts $16.6 million in annual cost to the members.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Employers could save an estimated $16.6 million annually for each additional point of the total cost paid by members.<br>**Policy Issues**<br>• The employer's contribution for member-only coverage is more generous than other private and public sector plans.<br>o Only four other state plans pay 100% of the contribution for member-only coverage.<br>o The average public sector employer contribution for member-only coverage is 87%.<br>o The average private sector employer contribution for member-only coverage is 77%.<br>• Allows for flexibility in offering multiple plan designs. | **Budget Issues**<br>• Contribution strategy changes do not reduce health care claims costs, they just reduce costs for the employer by cost-shifting to members.<br>**Member Impact**<br>• Would have a disproportionate effect on employees with low income.<br>• This would be seen as a cut in benefits, which could affect recruitment and retention efforts.<br>**Policy Issues**<br>• Changing the current contribution strategy would reverse a long-standing state benefits policy that employees should be provided member-only coverage at 100%.<br>**Operational Issues**<br>• Would add to administrative complexity of the plan, thus increasing operational costs. |

## OPTIONS THAT WOULD AFFECT PARTICIPANTS WITH CHRONIC ILLNESS

### OPTION 2.7 Raise contribution for GBP participants who do not participate in disease management when appropriate

This proposal would create a higher contribution for GBP participants who choose not to participate in a disease management program when appropriate. For purposes of the analysis, we have assumed that the payment differential would be $30 per participant per month. GBP participants would be identified by the TPA through health risk assessments and/or claims analysis. The savings for the FY14-15 biennium would be negligible. ERS was unable to predict the long-term impact of this measure, although wellness incentives should save money and improve health outcomes over the long term.

This option could trigger Protected Health Information (PHI) and/or Health Insurance Portability and Accountability Act (HIPAA) issues when identifying participants for any kind of differential contribution. Also, differential contributions for some employees would appear in the payroll process, which could alert an employer of an employee's health status. Current payroll processes generally do not contain PHI- or HIPAA-protected information.

To avoid the issues of PHI and HIPAA, ERS could alter the plan design and reduce benefits for participants who elect not to enroll in a disease management program when appropriate. ERS did not calculate the cost impact of this approach to this option.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• This would be one of the few contribution strategy changes that might also reduce health care costs over the long run, and not just reduce contribution costs for the employer.<br>**Policy Issues**<br>• GBP participants would enroll in the disease management program which is designed to better manage care and reduce long-term health care costs.<br>**Operational Issues**<br>• Using the TPA to identify participants for outreach would not cost any more than it does currently. | **Budget Issues**<br>• Using health risk assessments, biometric screenings, or claims analysis to identify applicable participants would increase costs for the plan in the short term.<br>• Outsourcing identification of participants to a third party could cost the plan money.<br>**Legal Issues**<br>• A careful legal analysis of PHI and/or HIPAA issues should be a part of any proposal for a "charge" or "penalty" for refusing or failing to enroll in disease management.<br>• This option could trigger PHI and/or HIPAA issues when identifying participants for a program that will be billed through their payroll process.<br>**Operational Issues**<br>• Introducing any form of PHI- or HIPAA-protected information into the payroll process could require substantial legal review and payroll changes.<br>• Some smaller agencies or institutions of higher education may not have the budgets or computer expertise to make their payroll process HIPAA compliant, and the changes could more than offset the savings. |

## OPTIONS THAT WOULD AFFECT DEPENDENTS

### OPTION 2.8 Raise member contributions for dependent coverage

This option would increase the member contribution for dependent coverage from 50% to 60%, reducing the employer's contribution to 40%. Each one-point increase in the member's contribution for dependent coverage shifts $7.8 million in annual cost to the members.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Employers could save an estimated $7.8 million annually for each additional point of the total cost paid by members. | **Budget Issues**<br>• Contribution strategy changes do not reduce health care costs for the plan, they just reduce costs for the state by cost-shifting to members.<br>**Member Impact**<br>• People with dependent coverage will see it as unfair.<br>• This option was opposed by a majority of respondents to a recent survey of ERS members.<br>• Many state employees in low-wage, high-stress, high-turnover jobs do not sign up for dependent coverage because they can't afford it.<br>• This would be seen as a cut in benefits, which could affect recruitment and retention efforts.<br>**Policy Issues**<br>• At 67%, the State's contribution for dependent coverage is slightly less generous (competitive) than most private and public sector plans.<br>o The average private sector employer contribution for dependent coverage is 70%. |

### OPTION 2.9 Impose surcharge on spouses who have access to other coverage

As a group, the most expensive HealthSelect participants are dependent spouses. Eight of the top 10 highest HealthSelect claims are paid on behalf of dependents. Part of the reason spouses are more expensive than employees is due to age and gender differences between the two populations; e.g., a lower rate of younger members elect spouse coverage.

In FY10, 26% of HealthSelect participants reported that their dependents have access to other employer-based health care coverage, but use GBP as their primary source of insurance coverage. The financial impact was estimated assuming that 26% of spouses would pay 20% of the spousal rate (about $100). ERS assumed that this change would not apply to retiree dependents.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Adding an alternative coverage surcharge could have a positive impact on plan costs if dependents (a) opted out of HealthSelect, and/or (b) made HealthSelect the secondary payer, because it would reduce the number of traditionally expensive enrollees in the program.<br>• The additional revenue from the surcharge would be used to offset health plan costs.<br>**Policy Issues**<br>• Precedent exists for this option in the public sector: the State of Delaware and the State of Georgia charge more for dependents who have other coverage but choose the state plan. | **Budget Issues**<br>• There would be no impact on the state budget, as the surcharge would be above and beyond the state contribution.<br>• Contribution strategy changes do not reduce health care claims costs, they just reduce costs for the employer by cost-shifting to members.<br>**Member Impact**<br>• This would be seen as a cut in benefits, which could affect recruitment and retention efforts.<br>**Policy Issues**<br>• Hard to predict enrollment impact.<br>• Without a comparability test to ensure that the otherwise available employer-based insurance is equivalent to GBP coverage, this could be seen as an unfair penalty.<br>**Operational Issues**<br>• The collection of revenue would be based on a voluntary reporting of information, which could lower the potential value.<br>• Minimal benefit to the plan for a significant administrative expense.<br>• There would be a significant administrative burden of verifying accuracy or availability of eligible dependents' insurance status. |

[1]Employers participating in the GBP include state agencies, institutions of higher education in Texas (except for the University of Texas and Texas A&M University), community colleges, community supervision and corrections departments, state and district and appeals courts, all legislative offices, the Texas Municipal Retirement System, and the Texas County and District Retirement System.
[2]The employer's 67% cost for member + family health coverage accounts for the employer's 100% contribution for member-only coverage, plus the 50% contribution for family coverage.
[3]National Conference of State Legislatures," 2011 State Employee Health Benefits: Monthly premium costs (family and individual coverage)," September 2011.
[4]Mercer, National Survey of Employer-Sponsored Health Plans, p. 20.
[5]National Conference of State Legislatures, "2011 State Employee Health Benefits: Monthly premium costs (family and individual coverage)," September 2011.
[6]Texas Insurance Code, §1551.002 (1).
[7]Employee Benefit Research Institute, Fundamentals of Employee Benefit Programs (2009), p. 424.
[8]Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011.
[9]Towers Watson and the National Business Group on Health, "The Road Ahead: Shaping Health Care Strategy in a Post-Reform Environment," 2011.
[10]Ibid.
[11]Clark, Robert L., "Will Public Sector Retiree Health Benefit Plans Survive? Economic and Policy Implications of Unfunded Liabilities," paper presented to annual meeting of the American Economic Association, January 2009.
[12]Governor's Task Force on State Employee Health Insurance, Quality and Cost Containment, Recommendation #1, page 3, (September 27, 1984).
[13]Texas Insurance Code, §1551.211.
[14]Mercer Survey.
[15]Aon Hewitt Commentary on Sustainability of the State of Texas Group Benefits Program, Report to the 82nd Legislature, July 31, 2012, p.10.
[16]Aon Hewitt Commentary, p. 13.
[17]http://www.myflorida.com/mybenefits/pdf/2011_RetireeHealthInsurancePremiumRateChart_03-15-12.pdf.

## SECTION 3: APPROPRIATIONS

***What is the proper funding level? Does the funding process provide flexibility?***

The Texas Legislature meets every other year and allocates health care funding for the coming biennium. Health and other insurance benefits for employees and retirees are subject to change based on available State funding. The Texas Legislature determines the level of funding for such benefits and has no continuing obligation to provide those benefits each fiscal year.

If funding is not adequate to cover biennial health care costs, the State can make an emergency appropriation. History shows that a more likely scenario is changing the benefits package and shifting costs to employees to cover any projected funding shortfall, after spending down the plan's contingency fund. This can occur in the middle of a biennium if funding is projected to run out before the Legislature meets again. Future funding decisions made by the Legislature or changes to state law could affect the plan design or even the availability of the state employees' benefits package.

This section will report on the current state of the Group Benefits Program (GBP) and how the GBP appropriations process works. It also reviews the concepts of risk management and the health care benefit cost trend, explains the financing formula, makes suggestions for defining an acceptable rate increase for the plan, and discusses other funding considerations. This report focuses on the health plan only, as health insurance has the largest financial impact and it was the focus of the legislative charge.

## STATE OF THE GBP

ERS administers health insurance benefits for the following entities: state agencies, higher education institutions other than the University of Texas and Texas A&M university systems, community colleges, certain quasi-state agencies and Community Supervision and Correction Departments. ERS offers two statewide managed health plans and three regional Health Maintenance Organization (HMO) options. ERS also offers a number of optional insurance coverages, such as dental, life, and disability at the employee's expense.

***Figure 3.1: Enrollment in GBP Health Insurance Plans***
*(as of June 2012)*

| Plan Type | Funding Method | Members | Participants |
|---|---|---|---|
| HealthSelect (POS) | Self-funded | 251,086 | 443,118 |
| Scott & White (HMO) | Fully-insured | 11,959 | 20,150 |
| Community First (HMO) | Fully-insured | 3,221 | 5,975 |
| KelseyCare (MA-HMO) | Fully-insured | 478 | 581 |
| Humana (MA-PPO) | Fully-insured | 36,214 | 44,382 |
| **Total GBP enrollment** | | **302,958** | **508,231** |

Most GBP participants (87%) are enrolled in HealthSelect℠ of Texas, which is a self-insured Point-of-Service (POS) plan. The rest enroll in a fully-insured HMO, or a Medicare Advantage plan. On the first day of the month following a 90-day waiting period, eligible employees are automatically enrolled in HealthSelect unless they choose an HMO or waive coverage.

Starting January 1, 2012, Medicare eligible retirees in the GBP were automatically enrolled in a Medicare Advantage Preferred Provider Organization (MA-PPO) plan administered by Humana. While retirees are still required to pay Medicare Part B premiums, the MA-PPO replaces both Medicare and HealthSelect as the retirees' primary and secondary medical coverage. Retirees in the MA-PPO plan continue to receive prescription drug benefits under HealthSelect. Retirees can return to the HealthSelect medical plan at any time. As of June 2012, 63% of retirees chose to stay in the HealthSelect Medicare Advantage (MA-PPO) plan.

**Self-funded v. fully-insured coverage.** According to the National Conference of State Legislatures, 92% of state governments offer a self-funded health insurance plan to workers.[1] This is similar to large private sector employers where 96% of private sector employees working in the largest firms (20,000 or more employees) are covered by a self-funded health insurance plan.[2] Self-funding means the plan—not an insurance company—assumes responsibility and bears the risk for providing health care benefits to employees. Employers and employees pay monthly contributions that are pooled into an insurance fund to pay claims and administrative costs.

In the case of the GBP health plan, ERS holds and invests the money in the group insurance fund until it is needed to pay claims. This allows for prudent fund management while reducing or eliminating insurance company commissions and profit margins. Self-funding also gives employers more cost control, more flexibility in benefits design, and the ability to reduce claims through wellness initiatives and cost management practices.

**Who administers the benefits?** ERS contracts with third-party administrators (TPAs) to administer the GBP self-funded health plans. As of September 1, 2012, UnitedHealth care administers the HealthSelect medical benefits and Caremark administers the prescription drug benefits. TPA contracts are bid and renegotiated on a regular basis. Their services include:

- managing a provider network,
- processing claims,
- providing disease management and wellness programs,
- communications and customer service,
- data analysis and reporting, utilization review, actuarial services, and
- pharmacy benefits management.

In contrast, Health Maintenance Organizations (HMOs) are fully-insured health insurance plans. Under the GBP, ERS contracts with an HMO to assume financial responsibility for claims and administrative costs. An HMO usually provides comprehensive medical services in a regional area; e.g., Scott & White provides health services in the central Texas region. Contractual arrangements vary among and within HMOs. Financial risks may be shared with the HMO network providers.

**Administrative costs are low**. Out of every dollar collected in revenue, 97 cents goes toward paying health and pharmacy claims, and the other three cents pays the cost of administering the program. The policy debate surrounding federal health reform has drawn extra attention to the administrative overhead of many insurance companies. In fact, the ACA has set a standard that 85 cents of every dollar collected by large plans be spent on health care claims. At 97 cents, the GBP far exceeds this standard.

***Figure 3.2: Group Benefits Program***
***Self-Funded v. Fully-Insured Programs***

| | Self-Funded | Fully-insured |
|---|---|---|
| GBP Programs | HealthSelect of Texas (including medical and prescription drug benefits); Dental PPO; Income protection/disability plans. | HMOs; Dental HMO; Life, Medicare Advantage HMO and PPO |
| Risk | Borne by the plan. | Borne by insurance carrier; may be shared with network providers. |
| Networks | Lower out-of-pocket cost for staying in network; higher out-of-pocket cost for going out of network. | Must use in-network provider to receive services. |
| Contract | ERS contracts with third-party administrators to set up a networks and process claims. | ERS contracts with HMOs and insurers |
| Plan Design | Controlled by ERS Board of Trustees. | Controlled by ERS Board of Trustees;HMOs and Medicare Advantage plans must provide coverage comparable to HealthSelect. |
| Payments | Claims payments are made on a fee-for-service basis, and then they are reimbursed by the plan's insurance fund. | Employer and/or members pay premiums. The HMO or insurance company pays for all claims. |

## A SUSTAINABLE PLAN WOULD ALLOW ERS TO CONTROL RATE INCREASES

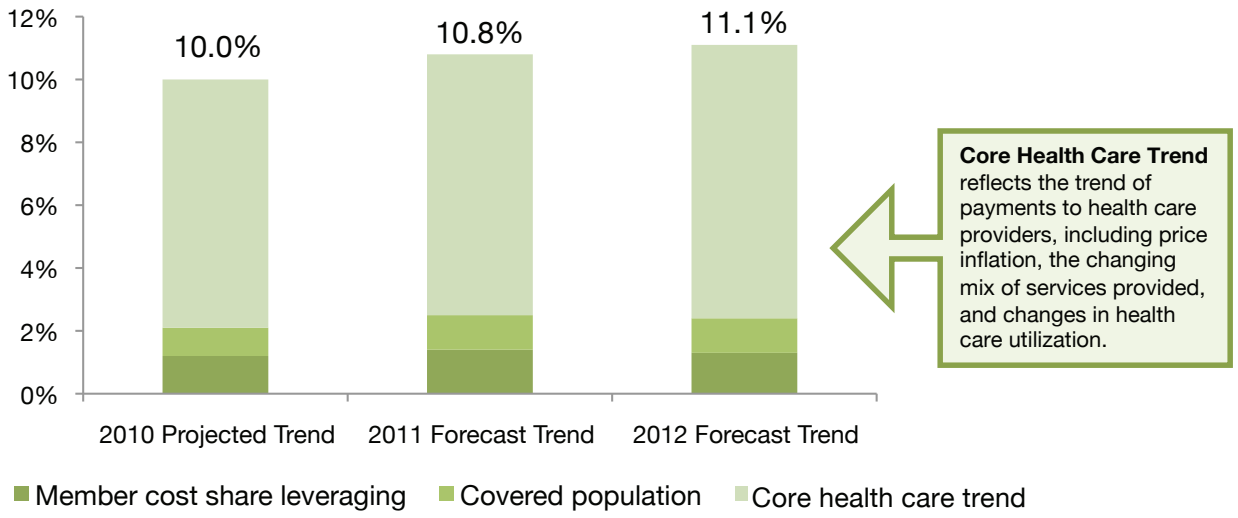
ERS identified the structural elements needed to create and sustain a viable health plan for the long term. These include:

- Rate increases would occur at a predictable, controlled level, providing the State a reliable way to budget for the plan.
- Adequate revenue would allow the GBP to avoid routine reliance on the contingency fund as a substitute for contribution revenue.
- Plan design changes would occur on a predictable basis, allowing GBP members the ability to plan and budget for cost shifts and out-of-pocket increases.

**Federal impact on health care cost trend.** Cost shifting to insurance plans from federal discount payers such as Medicare and Medicaid, and mandates from federal health care reform legislation also increase costs for insurance plans.[4] For example, federally required provisions of the Affordable Care Act (ACA), which was recently upheld by the Supreme Court, are projected to cost the plan $82.8 million in the FY12-13 biennium.

Additional costs due to the ACA were offset somewhat by $70.9 million in federal government subsidies in FY11-12 from the Early Retiree Reinsurance Program (ERRP), which was 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 ended during the FY12 plan year, two years earlier than originally established because federal funding for this program was exhausted. See Appendix D for more detail about the impact of the ACA on the plan.

***Figure 3.3: Components of national health care cost trend***
*(Aon Hewitt survey of 60 leading health care vendors, average for all health plans, 2011)*



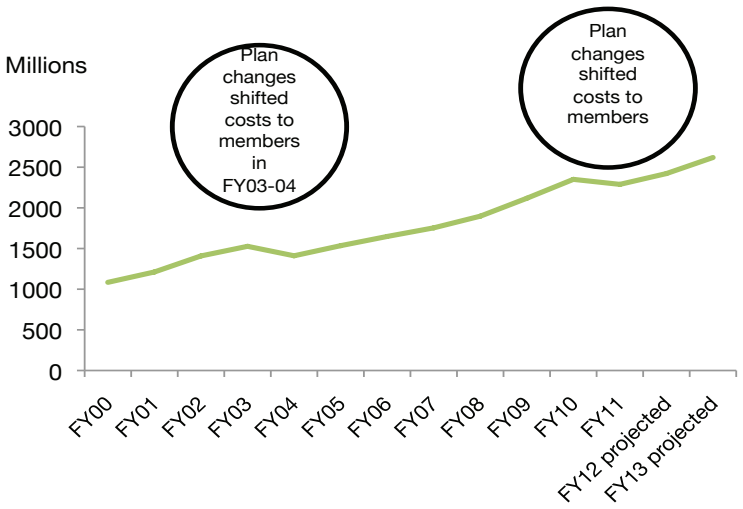

**The GBP has performed well against the national health care cost trend**. One way of judging how well a plan is controlling costs is the health care cost trend. A plan's core health care cost trend is a complex measure of the annual rate of change in payments to health care providers, including price inflation, the mix of services provided, and changes in health care utilization.[3] Stacked on top of this is the impact of changing demographics, plan design changes, state and federal mandates, member cost share leveraging, technological advances, and unhealthy choices. See Appendix X for a more detailed description of the components of the GBP health care benefit cost trend.

In 2011, the health care cost trend fell across the nation due to a slowdown in utilization, reduced capital spending in response to the sluggish economy, and an increased use of generic drugs.[5] According to Segal Consulting, "projected managed-care cost trends for 2012 range from 9.6% to 10.4%. At 8%, the GBP underlying health benefit cost trend for FY12 is well below the national average.[6] Even so, GBP costs are increasing at a rate more than double that of general inflation.

GBP health plan benefit cost expenditures fell in FY11 in large part because of significant cost shifting to members through plan design changes that year. The same temporary drop in spending occurred after benefit cuts were made in 2003 and 2004. If no changes are made to the plan, contributions will likely need to increase each year in order to maintain the same level of coverage.

**At 8%, the GBP underlying health benefit cost trend for FY12 is well below the national average**

*Figure 3.4: Expenditures drop briefly after costs are shifted to members*




**Funding the cost of future retiree health insurance benefits.** A shared concern among employer-sponsored health plans that still provide retiree health insurance coverage is funding the cost of future retiree benefits. ERS reports the projected cost of Other Post-Employment Benefits (OPEBs) for current and future retirees in the Comprehensive Annual Financial Report. States do not have to fund OPEB projections, only report them. See Appendix F for more information about OPEB costs and the GBP.

Wise management of retiree health insurance costs is essential. ERS uses plan design, coordination of benefits, and leveraging of federal subsidies and manufacturer rebates to make retiree health insurance coverage more affordable for retirees and for the State. For example, the implementation of the Medicare Advantage PPO in January 2012 is expected to reduce plan cost by $30 million in FY13 and will lower the estimated future cost of covering retirees (the OPEB amount) by 6.7%.

## THE APPROPRIATIONS PROCESS

ERS requests appropriations for the Group Benefits Program on a biennial basis through the Legislative Appropriations Request (LAR) process. ERS submits its LAR for the GBP to the Legislative Budget Board (LBB) prior to the beginning of each legislative session. The long-term nature of the process requires ERS to project funding requirements for the GBP nearly three years into the future, using actual claims experience and the health benefit cost trend.

The LAR provides for a base level of funding, and allows agencies to request "exceptional" funding for items that go above the base. In addition, ERS requests funding, as required by statute, for a claims reserve ("contingency") fund.

**Setting the base level budget.** Currently, LBB sets the base-level budget for the GBP. The base is an average of the previous two years of spending in the program. It is calculated simply by adding together the two years of expenditures and dividing by two. ERS then calculates the projected program costs for the next two years and compares them to this base. The differences are considered an extraordinary item. However this method does not recognize the actual funding for the current fiscal year on a per-capita basis. This requires ERS to request "exceptional" item funding just to maintain the existing program. If the Legislature appropriated only the base level of funding, the first year of the new biennium would actually decrease the amount of money available for the program.

**Options to consider when budget forecasting.** One way to achieve a more accurate estimate of increased revenue needed to fund the upcoming biennium is for LBB to calculate the base budget on the current year's per capita rates rather than a diminished average. The rate could then be applied to LBB's estimated enrollment numbers. With this method, exceptional items would reflect year-over-year increases in health care cost rather than the average cost of the prior biennium. Aon Hewitt remarked that their "state clients generally use the latest available claims and census data to formulate their projected budget needs."[7]

**Assigning costs by coverage category.** Currently, contributions are established at the same "blended" rate for everyone. Legislators may wish to consider changing the funding appropriation to be based on coverage categories or classes such as active employees, pre-65 retirees, and post-65 retirees. Each of these classes of employees has a different health care cost. Although calculating the contribution based on these classes will not necessarily change the total cost of health care, it can help identify cost so that the impact of funding decisions can be more easily addressed.

The Legislature agrees upon the final budget, which is signed into law by the Governor following the end of the legislative session. Projected funding requirements for higher education are included in Article III of the appropriations bill.

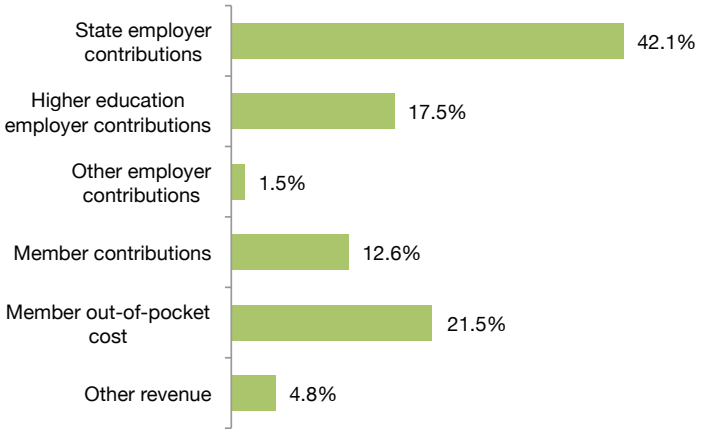
***Figure 3.5: Legislative appropriations process (FY14-15)***

| August 2012 | January 2013 | February 2013 | May 2013 |
|---|---|---|---|
| ERS submits its Legislative Appropriation Request (LAR) to the Legislative Budget Board (LBB) | The LBB recommends to the Legislature a base budget amount for the biennium | ERS submits updated trend estimates to the LBB and the Legislature | The Legislature appropriates funding and the Governor signs the budget for the biennium beginning Sept. 1. |

## WHO PAYS FOR GBP BENEFITS?

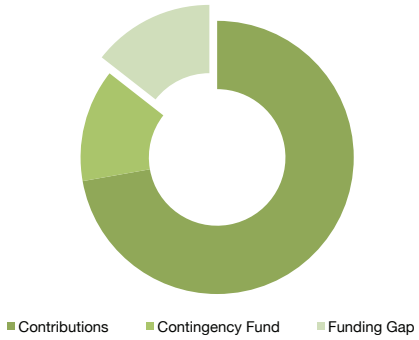
Health care provided through the GBP is paid for through a combination of state, local, and member contributions to the health plan; miscellaneous revenues flowing into the health plan through investment income; refunds, rebates and subsidies from the federal government; and member cost sharing paid directly to providers. The share of the cost covered by each of these sources in FY12 is as follows:

***Figure 3.6: Employers pay about 61 cents of every health plan dollar***



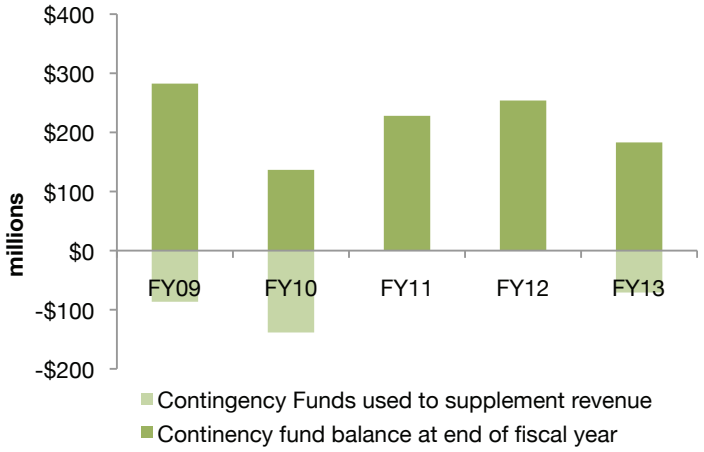

**What happens when revenue falls short?** Figure 3.7 shows what happens when the GBP receives less revenue than it needs to pay claims. A structural deficit in program funding occurs when the plan must spend down the contingency fund to cover short-term revenue shortfalls. The statute requires ERS to include in the Legislative Appropriation Request the amount needed to provide a contingency fund equal to 60 days of self-funded expenditures.[8] In FY09 and FY10, the GBP used $248 million in contingency funds to cover revenue shortages.

***Figure 3.7 Recurrent revenue shortfalls led to a structural funding deficit in FY11***




When funding falls short, the plan must either use the contingency fund or shift costs by cutting benefits. In the past, with legislative guidance, the plan has spent down the contingency fund before cost shifting measures were implemented. Despite this historical reliance on the contingency fund, it was not intended to be a regular source of revenue. Best practice for the contingency fund would be using it to cover unanticipated expenses arising from adverse fluctuations in claim costs. ERS estimates the balance necessary to cover 60 days of claims cost to be $489 million as of August 31, 2013.

***Figure 3.8: Ongoing reliance on the contingency fund to balance the budget***




Other options when revenue falls short are to reduce benefits and/or increase costs to members. Member cost shifting can be done through plan design (raising copays, deductibles, and coinsurance) or by increasing member contributions.The ERS Board of Trustees can change the plan design, but only the Legislature can change the contribution strategy.

Without regular funding at a level that accounts for projected costs, a funding gap is inevitable. In FY11, the funding gap was closed by shifting costs to members through plan design changes and by lower-than-expected costs. This left the program $92 million in the black with a $228 million balance in the contingency fund. See Appendix N for a projection of GBP fund balance as of July 2012.

**"If no changes are made to the plan, ERS anticipates that contributions will continue to increase each year to sustain the program at the status quo."**

**What is a sustainable cost increase?** With the exception of a few years, the GBP health benefit cost trend has remained in the single digits over the last 20 years. Over the last 10 years, the HealthSelect benefit cost trend has averaged about 5.5%.

If no changes are made to the plan, ERS anticipates that contributions will continue to increase each year to sustain the program at the status quo.

Rather than allowing future contribution increases to be subject to fluctuations in the health care marketplace, the Legislature could set a maximum annual rate increase, and the GBP could draw that money as needed. Some suggestions for defining an acceptable cost increase in the future might include:

- Rates equal to or less than general inflation (1.7%) or medical services inflation (4.3%)[9],
- Rates equal to or less than health care cost trend for other large public/private employers (11.7% forecasted for 2012)[10] , or
- Rates equal to or less than a fixed percentage of the total state budget (for the FY12-13 budget, health insurance benefits cost 3.3% of General Revenue, or 1.6% of All Funds).

Although these options may seem simple, a rigid application could create unintended consequences, requiring the GBP to adjust future plan benefits in order to balance revenue with anticipated healthcare expenses.

### A FLEXIBLE APPROACH THAT OFFERS CHOICE AND FINANCIAL INCENTIVES WILL FACILITATE BEHAVIOR CHANGE.

The budget process would ideally give ERS additional flexibility to manage the program within the constraints of the biennial budget process. Flexibility might provide for the ability to allocate some portion of contributions toward programs to reward member choices, such as deposits to health savings accounts or wellness incentives.

Aon Hewitt remarks that "the ability to use funding strategy to incentivize behavior change is an important tool to be used as part of an overall health care strategy. Reducing the demand for health care through improving member behaviors and overall health can have a substantial long-term impact on cost trends."[11]

**Using the funding strategy to encourage choice**. ERS recognizes that many private and public sector employers now offer their employees more choices among health insurance plans. The GBP currently offers five plan choices: HealthSelect, a statewide point-of-service (POS) plan, two regional Health Maintenance Organizations (HMOs), and two Medicare Advantage plans.

The policy decision to pay 100% of member-only coverage is a significant barrier to offering more choice among plans. In general, when multiple plan options are available, members tend to select the program that best fits their needs. When the State pays 100% for any choice they make, there is no incentive to choose among plans. Most members will choose the most generous (and most costly) benefit option.

To incentivize people to choose between multiple plans, the State would need to change the contribution strategy. The question is not whether employers should offer more choice, but how to offer choice in a way that maintains the stability and affordability of the insurance plan. It has been a long-standing policy of the Texas Legislature to offer the 100% contribution strategy in recognition of the lower salaries of public servants and as an incentive for recruiting and retaining qualified employees.

This could still be done by offering a 100% contribution for a somewhat lower benefit, with the option for employees to buy up to the current HealthSelect benefit. Keeping everyone in the risk pool would be essential, and it would be advisable to create restrictions on the ability of people to move back and forth between plans when a significant benefit design difference exists. A number of contribution strategy options are explored in Section 2 of this report.

**Using the funding strategy to incentivize change.** The ERS Board of Trustees does not have the authority to change the contribution strategy in a way that incentivizes members to take more responsibility for their health. While ERS has researched making targeted plan design changes to encourage wellness and increase participation in chronic disease management programs, these ideas often have upfront costs. Unfortunately, the nature of the Texas Legislature's two-year funding cycle can be a barrier to long-term health outcomes planning, especially in the area of wellness where return-on-investment may not be immediate or easy to measure.

[1]National Conference of State Legislatures, “States that Self Insure and Self-fund their State Employee Health Plan,” January 2011
[2]Mercer survey, p. 22.
[3]Aon Hewitt 2011 Health Insurance Trend Driver Survey, p.6.
[4]Ibid, pgs 4-5.
[5]Aon Hewitt 2011 Health Care Trend Survey, p.4
[6]2012 Segal Health Plan Cost Trend Survey, p.1
[7]Aon Hewitt Commentary on the Sustainability of the State of Texas Group Benefits Program Report to the 82nd Legislature, July 31, 2012, p. 18.
[8]US Department of Labor, Bureau of Labor Statistics (as of June 2012)
[9]Aon 2011 Health Insurance Trend Driver Survey , p. 23.
[10]General Appropriations Act for the 2012-2013 Biennium, 82nd Texas Legislature, Regular Session, 2011, Text of Conference Committee Report on House Bill No. 1
[11]Aon Hewitt Commentary, 2012, p. 19.

***How do cost management initiatives save the plan money?***

The Employees Retirement System (ERS) sets and enforces high performance standards for the health plan to slow the benefit cost trend and to ensure that fraud and abuse do not occur. ERS lowered plan charges by $7.3 billion in FY11 through tough cost-management practices, aggressive contract negotiations, avoiding unnecessary costs, and low administrative overhead. See Appendix F for a detailed account of the history of cost containment activities for the HealthSelect program.

**"The best way to avoid the necessity of shifting costs to employees is to reduce unnecessary plan expenses…ERS has done an admirable job of professional cost management."**

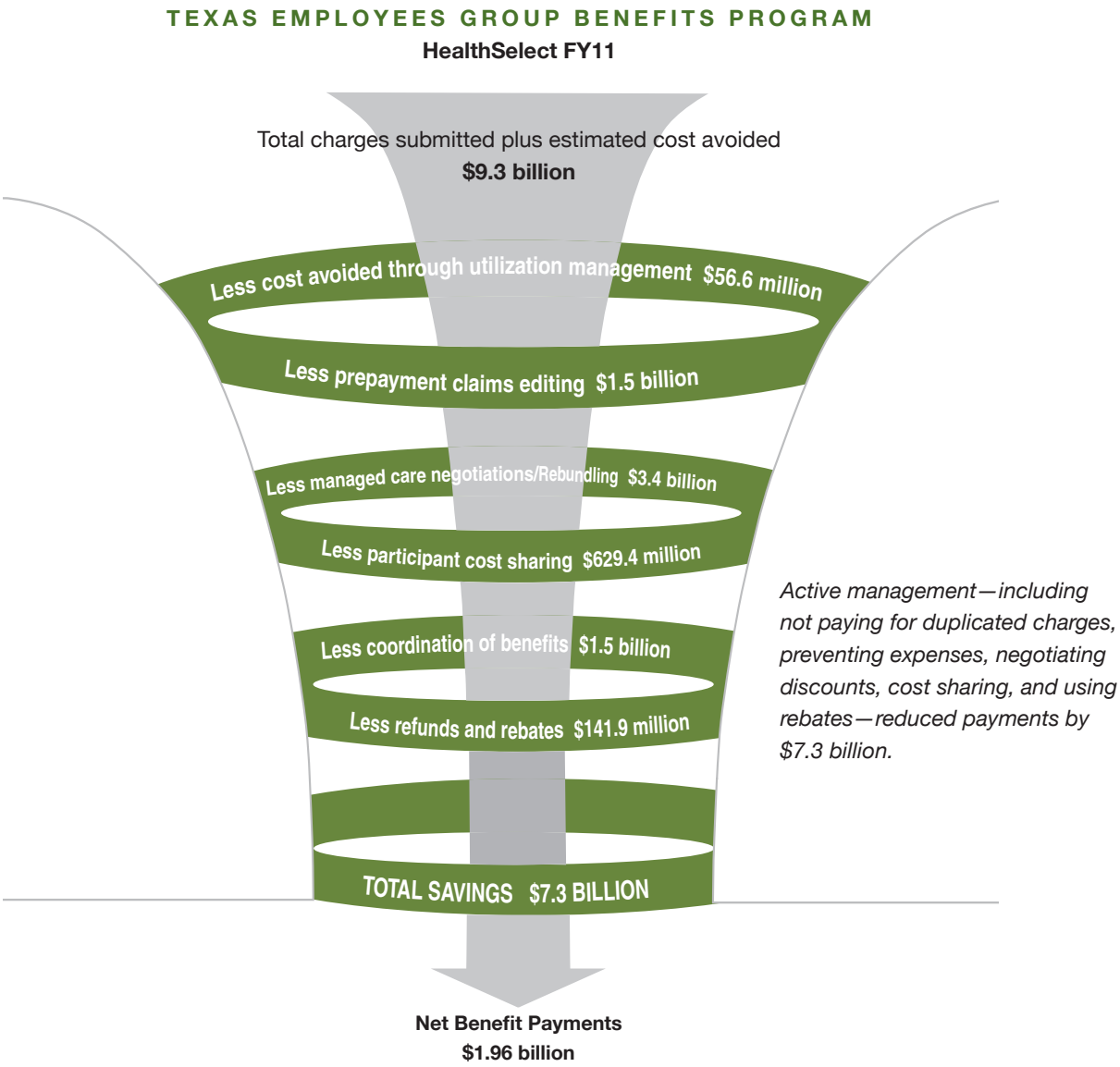
*Aon Hewitt Commentary on Sustainability of the State of Texas GBP: Report to the 82nd Texas Legislature*

This section of the report discusses important ways that ERS works behind the scenes to control costs for the plan—professional cost containment practices, contracting, alternative payment programs, and administrative solutions. This section also provides a special focus on efforts to manage costs for the growing GBP retiree population.

## COST MANAGEMENT: lowering plan charges by $7.3 billion in FY11

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 FY11 equaled $7.3 billion. Nearly half this amount came from negotiated discount rates with providers who agreed to participate in the managed care network.

***Figure 4.1: Texas Employees Group Benefits Program cost management***




*Active management—including not paying for duplicated charges, preventing expenses, negotiating discounts, cost sharing, and using rebates—reduced payments by $7.3 billion.*

Without cost management programs, the FY11 member only contribution would have been $1,938 a month, rather than $411. See Appendix O for a financial summary of HealthSelect cost management reporting for FY11.

**Avoiding charges through utilization management**. It is well known nationally that about 20% of the population is responsible for 80% of health care costs. 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 the plan decide whether 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 costs in FY11.

**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. COB saved the plan $1.5 billion in FY11.

**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 $197 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. The program, called the Early Retirement Reinsurance Program (ERRP), provides subsidies to employers that continue health coverage for pre-65 retirees. HealthSelect collected $70 million in ERRP reimbursements since FY11. We do not expect to receive more money from the program since federal funding appears to be exhausted.

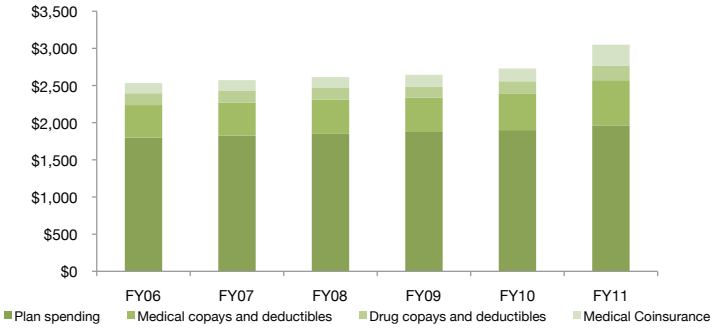
Another way the plan saves money is through the 100% pass-through of all drug manufacturer rebates collected by the HealthSelect pharmacy benefit manager. During FY11, ERS received about $63 million in rebates. We recently conducted an audit to confirm that the plan was properly paid 100% of all rebates.

**Claims audits.** The Pharmacy Audit Program recouped over $500,000 in FY11 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.

E**ligibility audits.** ERS also recently conducted a 100% 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 saved the plan $14.8 million for FY12.

***Figure 4.2: HealthSelect participants paid 23% of their medical costs in FY11, up from 20.6% five years ago***

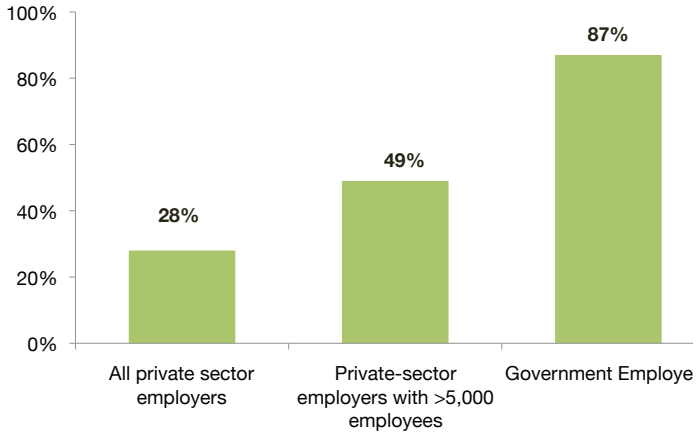
*FY07-FY11 (in millions)*




**Cost sharing**. Sharing costs with participants is also a large part of controlling costs for the plan. In FY11, employees, retirees and their dependents paid $629 million—or 23% of the total cost of their medical expenses—through coinsurance, deductibles, and medical and prescription drug copays. Cost sharing has increased 11.7% in five years.

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. A more detailed discussion of how ERS can design the plan to align cost incentives with health risks can be found in the Plan Design section of this report.

*Figure 4.3 87% of government employers offer health insurance to retirees*




## RETIREE BENEFITS: wise management is essential

Most state and local governments offer health insurance benefits to their Medicare retirees. Many private employers do not. 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.

Early retiree coverage with the GBP is no different than active employee coverage. The State pays 100% of the cost of coverage for the pre-65 retiree, and 50% of the cost of coverage for their dependents. Early retirees are defined as those younger than age 65, who are not eligible for primary coverage under Medicare. They have the choice of enrolling in HealthSelect, or one of two regional HMOs. The large majority (more than 90%) of pre-65 retirees choose HealthSelect.

When GBP retirees reach age 65 and become eligible for primary coverage under Medicare, they are automatically enrolled in the employer-sponsored Medicare Advantage Preferred Provider Organization (MA-PPO) plan.

Medicare retirees can opt out of the MA-PPO and choose from four other options: HealthSelect, two regional HMOs, or a Houston area Medicare Advantage HMO. About 63% of Medicare-primary retirees and their Medicare-primary spouses remain in a Medicare Advantage (MA) plan, while the rest choose HealthSelect or one of the HMOs.

To get the most from their GBP benefits, Medicare retirees in all GBP health plans must have Medicare Part A (hospital) and Part B (other medical) coverage. Part A is free for retirees and Part B premiums start at $115 a month, 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 either the MA-PPO or 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 subsidizes most plan member medical expenses since it is the primary payer. MA plan enrollees continue to receive prescription drug coverage through HealthSelect for no additional charge. The benefits offered to GBP retirees under the MA plan must be comparable to HealthSelect.

**Early Retiree Reinsurance Program.** Starting in FY11, ERS collected $70 million in funds from the Early Retiree Reinsurance Program (ERRP) covering claims incurred in FY10 and FY11. The ERRP is a federal incentive program enacted with the passage of the ACA, and is designed to encourage employers to continue covering pre-65 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, we do not expect to receive any additional ERRP funding.

During any year a plan receives ERRP funding, federal regulations require that the money only be spent to reduce premium or health benefit costs for the plan or the pre-65 retiree. Plans must continue to provide at least the same contribution level to support their plan as they did prior to receipt of ERRP funding, as described in guidance from the Center for Medicare and Medicaid Services (CMS).

It does not appear that there are federal regulations restricting plan design changes to subsequent years beyond a specific contract

*Figure 4.4: The ABCs of Medicare Coverage*

**Part A — Hospital Insurance** is free for Americans when they turn 65, if they have earned enough Medicare credits while working.

**Part B — Other Medical Insurance** premiums start at $115 a month for eligible recipients who earn less than $85,000 a year.

**Part C — Medicare Advantage** is an insurance policy that replaces traditional Medicare and employer coverage. It is provided by a private insurance company.

**Part D — Prescription Drug Coverage** is a separate insurance policy just for prescription drugs. GBP retirees don't need Part D coverage because they have drug coverage through the GBP.

**Part F — Medigap coverage** is a supplemental plan that covers a portion of the difference between the expenses reimbursed by Medicare and the total eligible charges.

term, however, this fact should be confirmed prior to significant plan design modifications to ensure that there no restrictions based on a plan's possession of residual funds beyond a contract term.

**In six years, ERS has collected $197 million in drug subsidies for Medicare retirees.**

**Medicare Part D program.** Medicare-eligible retirees in the GBP do not get prescription drug coverage through Medicare, but instead receive their drug benefits through their state health plan. Since 2006, the Medicare Part D program has offered prescription drug coverage for Medicare retirees. In general, retirees shop for a plan on the open market, for which they pay a small monthly premium. After the $310 deductible is met, the retiree pays 25% of the benefit until they hit the "donut hole." In the donut hole, they pay 100% of all drug costs until their out-of-pocket costs are high enough to qualify for catastrophic coverage. At that point, Medicare pays 95% of the cost.

In 2011, Medicare Part D began gradually expanding reimbursement for generic and brand-name coverage with the goal of phasing out the donut hole by 2020. To further this goal, drug manufacturers are required to pay a 50% discount on brand name drug costs incurred in the "donut hole "at point-of-sale. In a regular Medicare Part D plan, the 50% discount saves money for the retiree and the Part D carrier.

**Medicare Part D Retiree Drug Subsidy (RDS)**. Beginning January 1, 2006, Medicare-eligible individuals could enroll in the Medicare Part D prescription drug program, paid in part by the federal government. ERS chose to continue prescription drug coverage for Medicare retirees through the GBP and offset a portion of drug costs with the federal Retiree Drug Subsidy (RDS). In the six years since the inception of the RDS, HealthSelect has collected $197 million in drug subsidies.

Each year that the GBP receives RDS funding, ERS must perform an actuarial review of the plan and confirm that the total value of benefits provided to its Medicare retirees is at least as generous as standard Medicare Part D coverage.

In 2013, RDS payments will become taxable, which will reduce the value of the RDS and make it much less attractive to private sector employer-sponsored plans. Although the GBP is not subject to federal taxes, ERS is also exploring other options for subsidizing Medicare retiree prescription drug costs.

**Plan design considerations.** As noted above, receipt of funds from the RDS and ERRP programs may impose potential limitations on a plan's ability to enact significant plan design modifications, however, these appear to be of limited scope and duration. Applicable guidance and regulations should be thoroughly reviewed, however, prior to any significant changes.

### OPTION 4.1 Retiree Drug Subsidy past claims reprocessing

During the Solution Sessions held at ERS in January of 2012, a vendor presented an option for reopening ERS' past RDS requests in an effort to identify and reclaim any missed reimbursements. The Center for Medicare & 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 reopen requests and file for reimbursements that were missed the first time around, potentially as far back as 2006.

The vendor's service was not an audit; rather it was a collection and reprocessing of six years of claims data, to be stored in a data warehouse in the correct format in case of a future CMS audit. If ERS were subject to a CMS audit in the future, the vendor would work with the company managing the audit. The vendor would provide a 100% claims audit guarantee.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• The vendor claims that the average RDS subsidy increase for previously reconciled years is 5% to 15%, and if they find a net liability, they do not get paid.<br>• Fees may be on a contingent basis – a percent of the amount above and beyond past collections, which provides motivation for the vendor to find all misfiled claims data.<br>**Operational Issues**<br>• The vendor provide a 100% claims audit guarantee.<br>• This process would help close out the Retiree Drug Subsidy with a total claims audit should ERS elect to go with an EGWP + Wrap program in the future. | **Budget Issues**<br>• Vendors who charge on a percentage of collections could collect a significant windfall at the plan's expense.<br>• It takes 12 to 18 months before payments would be made.<br>**Legal Issues**<br>• Could take up to five months to set up legal agreements with existing and past third-party administrators for the plan.<br>**Operational Issues**<br>• Implementation would require complicated eligibility and claims data collection, with stringent personal health information protections and legal agreements. |

As with any process that reopens the books, there is also the potential to find overpayments. If the vendor found that the GBP had underpaid, they would not be paid. The fee is on a contingency basis—a percent of the amount above and beyond past collections. It takes 12 to 18 months before payment would be made.

They do both automated and manual processing, with close attention paid to data continuity during transitions between pharmacy benefit managers; Medicare Part D formulary and plan design changes over the relevant time period; member enrollment data; verification of copays and deductibles; and identification of Medicare Part B claims that should have been filed as Medicare D.

This service is subject to competitive bidding, so on April 2, 2012, ERS published a Request for Information, with a potential effective date of November 1, 2012.

### OPTION 4.2 Employer Group Waiver Program + Wrap-around Supplemental Plan (EGWP + Wrap)

Employers who are now getting the RDS may save money above and beyond their RDS by switching to an EGWP + Wrap. The EGWP is a basic Medicare Part D program combined with a wraparound provision that brings 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.

The savings with the EGWP approach comes from a new provision in federal law that requires drug manufacturers to pay a 50% discount on all brand name drug costs incurred in the "donut hole." When retirees are in the "donut hole," they pay 100% of all drug costs until their out-of-pocket costs are high enough to qualify for catastrophic coverage.

Much of the savings in an EGWP + Wrap occur in the "donut hole" of drug expenses not currently covered by Medicare —basically, the plan gets the benefit of the extra 50% brand name drug discount.

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.

EGWP plans were originally administered by employers as a direct contracting arrangement with CMS. Few employers took advantage of this approach, and state systems that did so reported mixed results. Direct contracting is still available, but now there are third-party vendors (generally, large Pharmacy Benefit Managers (PBM)} that will manage the EGWP + Wrap process for a fee. Both the EGWP and the Wrap are self-insured plans.

In the benchmarking survey performed for this study, ERS asked large public sector plan sponsors how they pay for retiree prescription drug costs. Nine of 13 surveyed currently use the Retiree Drug Subsidy (RDS) approach. Only three use the Employer Group Waiver Program (EGWP) approach to obtain federal subsidies for retiree prescription drug coverage.

The ERS Board of Trustees approved an EGWP + Wrap program for the GBP effective January 1, 2013.

### CONTRACTING: Managed care saved the plan $3.4 billion in FY11

ERS contracts with third-party administrators (TPAs) to process claims and build 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 taxpayers.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• It appears that EGWP + Wrap could save the State money and reduce GBP prescription drug plan costs.<br>• ERS would receive CMS payments more quickly than the RDS.<br>• HealthSelect will continue to receive 100% pass through on all rebates<br>• EGWP will reduce the OPEB liability.<br>**Member Impact**<br>• Members could benefit from lower out-of-pocket costs once they hit the CMS-defined catastrophic level.<br>**Operational Issues**<br>• Changing the drug deductible to a calendar year start will align it with the schedule for current coinsurance provisions. | **Member Impact**<br>• Potential confusion among retirees who dislike change.<br>• The member experience may not be seamless.<br>• Vendors may not be able to exactly duplicate plan design.<br>**Policy Issues**<br>• The EGWP + Wrap provides a customizable plan, but it may not mirror current coverage in all respects.<br>• Unknown outcomes due to newness of the program<br>**Legal Issues**<br>• CMS rules and regulations govern most aspects of the program.<br>**Operational Issues**<br>• Increased administrative duties and expense. |

**Keeping administrative costs low.** ERS is not an insurance company. Instead, we contract for certain aspects of program management with TPAs to contain costs for the program. Starting September 1, 2012, the TPA for the medical program is UnitedHealth care. The pharmacy benefit manager (PBM) is Caremark.

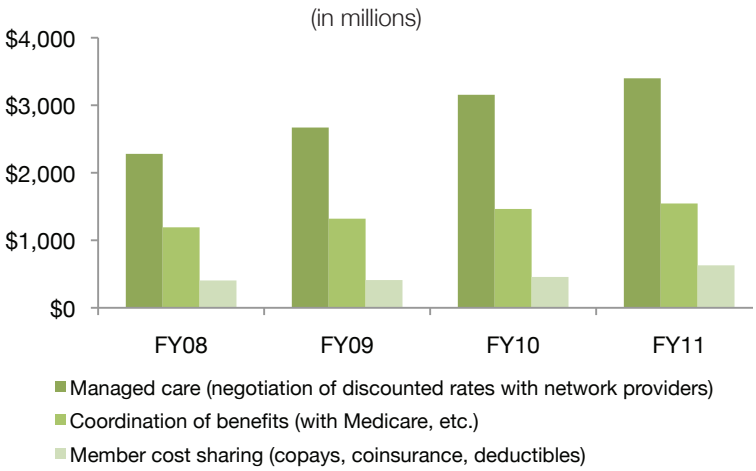
In general, about 97 cents of every HealthSelect dollar is spent directly on health care claims. Between 2004 and 2011, the HealthSelect administrative fee decreased 26%. Some of the administrative services provided by HealthSelect TPAs include:

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

"About 97 cents of every HealthSelect dollar is spent directly on health care claims."

Nearly $3.4 billion in cost reductions in FY11 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 facilities 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.

***Figure 4.5: Negotiated provider discounts produce the greatest cost savings to the plan***




**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** gatekeeper means a participant must see a network primary care physician (PCP) for specialist referrals or for extra services such as lab work, x-ray, or an MRI.
- **Non-network** coverage refers to services with non-contracted providers or outside the direction of a PCP. Members can go out of network but they pay more.
- **Out-of-area** coverage refers to coverage for members who reside outside the state 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 member more.

Network limitations save the plan money by offering financial incentives for members to use contracted providers. In a survey conducted by ERS in 2010, members said they were willing to pay more to have access to the provider of their choice. With this in mind, future changes to the health plan must balance cost with choice and access with quality.

### OPTION 4.3 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 doctor they want, but if they choose a doctor that is not ranked as a high performer, they will have to absorb the extra cost.

This model generally focuses on specialists rather than primary care or hospitals. When utilizing a specialist, 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.
- 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 expense 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. Also, people do not generally choose a hospital, but they do choose their physician who in turn directs them to a hospital.

Primary care physicians are also 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.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Potential savings to the plan due to steering members to more efficient providers.<br>**Member Impact**<br>• A survey of 45,000 plan members showed a general willingness to consider a tiered network of specialists, labs, and pharmacies.<br>**Policy Issues**<br>• The high performance network would only apply to specialists, not PCPs or hospitals, making it more palatable to members as access would be less restricted.<br>• High-performance networks can motivate providers to become more efficient.<br>• The network is based on adherence to evidence-based care and not solely on provider reimbursements.<br>**Legal Issues**<br>• The ERS board of trustees may authorize the HealthSelect TPA to set up a tiered network within the existing statutes, although legislative support would be optimal.<br>**Operational Issues**<br>• The HealthSelect TPA handles all provider network contracts.<br>• The current TPA already has quality ratings for some providers, currently used for informational purposes only. | **Budget Issues**<br>• Currently, any savings estimates for tiering the network are based only on price, not on quality or access to care. For example, restricting the network based on cost alone would eliminate 80% of current contracting hospitals from the preferred network.<br>**Member Impact**<br>• Many GBP participants in smaller cities or rural areas believe that any limitation of the provider network, especially the hospital network, would negatively affect them.<br>• Some GBP participants are fearful that if the insurance plan limited the network too much, that they would only have less experienced and lower quality doctors to choose from.<br>• Some GBP members could experience higher costs if their current network specialist did not fall into Tier 1.<br>**Policy Issues**<br>• Members will need access to transparent information to clearly identify high performance providers.<br>• There would have to be provider buy-in for the manner in which the rankings are determined<br>**Operational Issues**<br>• Some increase in administrative complexity and expense. |

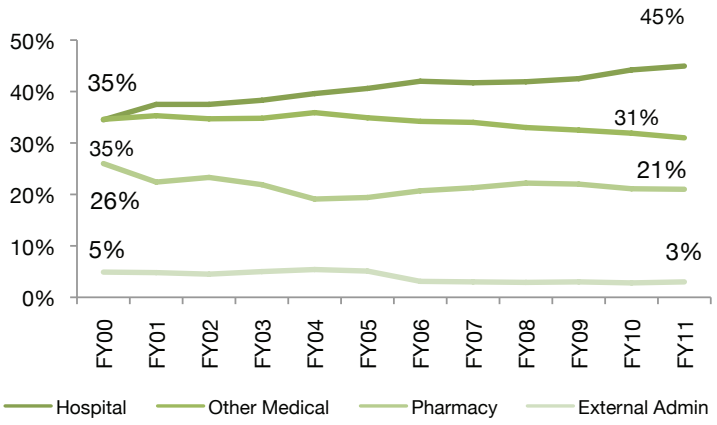
The use of high-performance networks has been slow to catch on due to the lack of information about quality standards. Providers and patients have also resisted the idea of restricted networks.

ERS conducted a survey of its membership in 2010 regarding their health insurance benefits with 45,000 responses. 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 situation. Some respondents were fearful that if the insurance plan limited the network too much, that they would only have less experienced and lower quality doctors to choose from.

***Figure 4.6: Hospital costs have grown from 35% to 45% of total plan expenditures since FY00***




**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 45% of total expenditures. According to Segal consulting, price inflation for inpatient hospital services is the largest component of overall plan cost trend nationwide.[4]

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 member 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.

**Physician-owned hospitals in Texas.** The nature of the Texas hospital market also increases costs. Texas is home to fully one quarter of the United States' physician-owned hospitals (POHs). While supporters of the institutions cite better outcomes and higher rates of patient satisfaction, opponents say that economic incentives for physicians to profit from ordering unnecessary tests or procedures create a conflict of interest. Further, most POHs tend to focus on money-making specialties like cardiology and orthopedic surgery, allowing them to draw patients for these services away from community hospitals that need those more profitable procedures to help subsidize the high cost of emergency room, obstetrics, and mental health services used by their uninsured and Medicaid patients.[5]

**Reduced competition due to large hospital consolidations.** Another concern is the trend toward large hospital systems buying up small hospitals in rural areas. Experience in Texas and other regions has shown that when a large hospital system dominates the market, it increases prices and may engage in anticompetitive behavior. Supporters of consolidation say that it leads to greater efficiency and cost-effectiveness. However, a 2011 Department of Justice investigation found that a Wichita Falls-based hospital system—with a 90% market share of general acute-care inpatient services and 65% share of outpatient surgical services–engaged in anticompetitive practices leading to average inpatient rates that were 70% higher than its closest competitors. Texas' many rural hospitals are prime targets for buyouts by big hospital systems, which make the State—and the GBP, which must provide access to services for members statewide—especially susceptible to cost increases due to this issue.

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. This study explored several options for limiting hospital cost increases through the contracting process.

- The TPA can negotiate directly with providers at the time of contracting; for example, making it a condition of the contract that hospitals meet certain quality standards—such as low rates of hospital-acquired infections.
- Another approach is for the TPA to steer participants toward Centers of Excellence in the State of Texas with proven outcomes for certain procedures.
- And as one step further, some companies pay for members to travel to other states or even countries to get the most cost efficient, highest quality care.

### OPTION 4.4 Results-based hospital contracts 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.

Quality metrics typically include reductions in hospital-acquired infections, never events, 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 an incentive based compensation metric in lieu of an across the board increase in contractual reimbursement rates.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Reduced readmission and infection rates save the plan and the member money.<br>**Member Impact**<br>• Customers receive better quality of care and have better outcomes.<br>**Policy Issues**<br>• Improves inpatient hospital quality of care and outcomes.<br>• Removes some of the fee-for-service incentives and ties compensation to performance.<br>• Medicare/Medicaid payment reforms support results-based contracts.<br>• This is an opportunity to use the payment system to recognize hospitals for quality outcomes.<br>**Legal Issues**<br>• To be successful, quality targets must be clearly delineated in any contractual agreement. | **Budget Issues**<br>• The hospitals with the best outcomes are not always the least expensive, so financially rewarding high-performing hospitals may not reduce plan costs in the short term.<br>• Once a hospital reaches 100% of its target, it is hard to negotiate for more savings, thus it is possible to reach a point of diminishing returns.<br>**Member Impact**<br>• Success is dependent upon member adherence to the guidance of the discharge planner and physician.<br>**Policy Issues**<br>• At this point, these contracts do not share risk with providers for outcomes; i.e. the plan cannot penalize a hospital for poor outcomes<br>• Hospitals do not believe that the payment system will fairly compensate quality providers<br>**Legal Issues**<br>• Vendors and hospitals must warrant compliance with all applicable law and clearly articulate performance standards and quality targets. |

### OPTION 4.5 Surgical Centers of Excellence and/or medical tourism

Many insurance plans now have contracts with surgical "Centers of Excellence" that are recognized for achieving consistently good outcomes for high-volume, high-risk, and high-cost areas of specialty care. Objective criteria for the designation are generally established in collaboration with a professional surgical society or a specialty's medical association.

Some large corporations with self-funded employer insurance plans make patients travel to an accredited Center of Excellence for certain procedures, even if it means traveling out of state. For example, Lowe's sends all of its cardiac surgery cases to the Cleveland Clinic. The cost of the surgery includes transportation and lodging during the care.

**Medical tourism.** Medical tourism refers to the act of traveling to another country to seek specialized or economical medical care with the help of a support system. According to a study by Deloitte Touche, "medical care in countries such as India, Thailand, and Singapore can cost as little as 10% of the cost of comparable care in the United States. The price is remarkably lower for a variety of services, and often includes airfare and a stay in a resort hotel."

The Joint Commission International (JCI) has been inspecting and accrediting health care facilities and hospitals outside of the US since 1999. It is an independent, private sector not-for-profit organization that develops nationally and internationally recognized procedures and standards that improve patient care and safety. A small number of recognized American medical schools and clinics —such as the Cleveland Clinic and Duke Medical School—have formed partnerships with international providers.

***Figure 4.7: Preferred centers for knee and hip surgeries in the State of California***

"Blue Shield developed a knee and hip surgery preferred centers network to provide CalPERS Blue Shield members with high quality, cost-effective providers statewide. The preferred centers network utilizes facilities called "Blue Distinction Centers" that are distinguished by the BlueCross BlueShield Association for clinical care and processes."

**http://www.calpers.ca.gov/eip-docs/about/forms-pubs/er-pubs/er-news/spring12.pdf**

HealthSelect currently has designated Centers of Excellence for bariatric surgery, cardiac care, rare and complex cancers, transplants, knee and hip replacements, and spinal surgery. Other than bariatric surgery, members are not incentivized through plan design to use them. ERS will continue to explore the expansion of Centers of Excellence programs.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Domestic Centers of Excellence are proven to have better outcomes, which lead to lower overall health care costs.<br>• The cost of medical care outside the US is significantly lower.<br>**Policy Issues**<br>• A Center of Excellence is a good way to assess and learn about the use of bundled payments surrounding a single episode of care.<br>• By using only JCI-accredited centers, members would have some assurance of the safety and level of quality care at an international facility.<br>**Operational Issues**<br>• ERS could direct members to Centers of Excellence through benefit design.<br>• HealthSelect already requires the use of a Center of Excellence for bariatric surgery.<br>• TPA would not negotiate contracts, but instead would create and credential a network of international providers | **Member Impact**<br>• If we required members to use certain Centers of Excellence, they still may not be accessible to a majority of our members and/or their caregivers.<br>**Policy Issues**<br>• After international care, there may be a lack of clinical support to ensure continuity of care when a patient returns to the U.S.<br>• Outside the U.S., we might not have control over the quality of the facility.<br>**Legal Issues**<br>• Vendors and participants would need to indemnify the plan in the event of a poor outcome.<br>• Domestic centers of excellence would require a contract.<br>**Operational Issues**<br>• Increased administrative expense for legal and communications activities. |

## ALTERNATIVE PAYMENT MODELS: Sharing risk with providers

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 and every 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.[10] These concerns are compounded by the growing number of doctors who have ownership in for-profit facilities, such as labs or free-standing radiology centers.

Moving away from fee-for-service 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 primary care provider – 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.[11]

**Capitation shifts risk and reduces costs.** Some HMO models pay providers a capitated fee per patient, instead of a fee for service. In exchange for lower out-of-pocket costs, the member agrees to stay within the HMO's closed network of providers. A closed network reduces choice but it also reduces complexity for the patient when navigating the health care system. Critics of the HMO model say that closing the network reduces choice for participants, and that capitation gives the insurance company too much motivation to lower costs by denying care.[12]

The HMO is the original integrated practice model, with a focus on communication among providers, increased efficiency, and reduced duplication of service. Some HMOs are now developing their own value-based plan designs, aligning incentives and rewards, and making coverage contingent upon patient compliance.

**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.[13] 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.[14]

Effective January 1, 2011, ERS launched three successful Patient Centered Medical Homes in response to initiatives by the Texas Legislature.[15] The 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.

## OPTION 4.6 Accountable Care Organizations (ACOs)

An ACO is a fully-integrated health care delivery model. It was originally developed for Medicare as part of federal health care reform, and is now being explored by insured and self-funded employer-sponsored health plans as well. The ACO must include a full range of providers—from primary and specialty physicians to physician extenders (such as nurse practitioners) to hospitals. A self-funded employer can directly contract with a provider system that is forming an ACO, or they can get access to an ACO through a health insurer.

The ACO agrees to be accountable for the quality, cost, and overall care of an assigned set of participants in a traditional fee-for-service program. Providers accept more financial risk but have the opportunity to earn financial rewards for delivering better care at lower costs. Bundled payments and global capitation can be used to set rates for a single episode of care in advance, rather than allowing providers to submit a new charge every time another service is provided.

Key features of an ACO include:

- a team health care approach,
- population health management,
- bundled payments to align doctor and hospital incentives,
- financial rewards based on meeting quality standards and cost targets,
- comprehensive coordinated care throughout the system,
- use of health information technology, and
- an intense focus on wellness and prevention.

ERS has collaborated with Austin Regional Clinic and Seton Hospital to explore how HealthSelect may benefit from their proposed pilot ACO in Austin.

A fully-insured HMO has approached ERS with a proposal to expand its integrated practice model, which already contains hospitals and salaried physicians. It is unclear whether state law would allow the GBP to directly contract with an HMO using an alternative payment system. When ERS piloted its Patient-Centered Medical Home program, no HMOs responded to the request for proposal.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Moving away from fee-for-service can potentially reduce health care costs.<br>**Member Impact**<br>• Increased integration of care and a focus on wellness results in improved quality outcomes for the patient.<br>• The goal of the ACO is to provide higher quality, integrated health care to members without disrupting access to providers.<br>**Policy Issues**<br>• Bundled or capitated payments can incentivize "value-based" or "outcome-based" systems rather than "volume based" systems.<br>• ACOs are designed to improve patient outcomes while helping the plan better manage the increasing cost of care.<br>• The model transfers much of the plan risk to the providers, giving them a motivation to cut costs.<br>**Operational Issues**<br>• ERS has already set up three "Patient Centered Medical Home" projects. | **Budget Issues**<br>• It is too early to estimate the overall impact on health care spending.<br>**Policy Issues**<br>• Acceptance by the provider community is contingent on shared savings being distributed fairly among all providers in the group. Doctors believe that hospitals will get all/more of the savings.<br>• Provider community believes it will not be rewarded for better outcomes.<br>**Legal Issues**<br>• Barriers to change include the Corporate Practice of Medicine statute and anti-trust issues.<br>• Capitation/risk transfer to providers is not allowed outside the HMO setting.<br>**Operational Issues**<br>• Increased administrative expense for legal, reporting and analytics, and communications activities. |

## OPTION 4.7 Patient-Centered Medical Homes (PCMHs)

The Patient Centered Medical Home (PCMH) model is similar to the ACO, but the provider team is made up of an integrated multi-specialty practice. The focus is mainly on primary care and thus, it does not include a hospital as part of the team.

Key features of the PCMH model include:

- an ongoing relationship with a personal primary care physician,
- an integrated system of care using advanced information technology,
- quality and safety are ensured through the use of evidence-based medicine and clinical decision-support tools,
- enhanced access, such as open scheduling, expanded hours, and new options for communication between provider and participant (email), and
- Shared savings payments are awarded 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 coordinator. The purpose of the flat payment is to incentivize enhanced care coordination not found in the standard fee-for-service practice.

In January of 2011, ERS launched its PCMH model program within the GBP, 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 fee-for-service payments. The goal is to reduce trend, while meeting quality standards of care.

All three plans reduced trend below the target in the first year, and two performed so well they earned a shared savings payment. Against the target, the Austin Regional Clinic saved $8.4 million, Kelsey Seybold saved $2.5 million, and Trinity saved $370,000, for a total of $11.4 million in savings. Drug therapy costs for all three medical home projects rose, but there were significant decreases in other services, such as inpatient stays.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Three existing PCMH practices all saved money during the first year as compared to their targets, and two received shared savings payments.<br>• The PCMH project saved money for the plan and for providers with a demonstrated reduction in health care cost trend.<br>• Upfront care coordination payments are considered along with other health plan costs in determining whether shared savings payments are made.<br>**Member Impact**<br>• The goal of the PCMH is to provide higher quality, integrated health care to members without disrupting access to providers.<br>• Because our members are already required to select and use a primary care physician, the model does not require action on the part of the member.<br>**Policy Issues**<br>• Federal initiatives and demonstrations are financially supporting this model.<br>**Legal Issues**<br>• This model only requires a broad multi-specialty practice and not a hospital, so the Corporate Practice of Medicine statute is not a limitation.<br>**Operational Issues**<br>• Current experience with three successful Patient Centered Medical Home contracts would facilitate expansion of this model. | **Budget Issues**<br>• In the short term, plan costs will rise for the care coordination payment and for certain other services, such as drug therapy, so an upfront investment is required.<br>• An additional care coordination fee must be paid to the practice to cover its increased administration needs.<br>• Setting an aggressive but achievable target that keeps the physician interested in participating in the program can be challenging.<br>**Policy Issues**<br>• The model only works for larger multi-specialty practices.<br>**Legal Issues**<br>• A legal hurdle prohibits the plan from requiring networks of hospitals and physicians to assume insurance risk outside the HMO setting.<br>**Operational Issues**<br>• Could be difficult to recruit providers because of the newness and limited track record of PCMHs.<br>• There are additional data sharing requirements between the practice and the TPA. |

### ADMINISTRATIVE TOOLS: Better data produces 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; for example an unusual cost increase for a specific diagnosis or facility. Claims analysis is also used to identify people with very high claims cost 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 HIPAA and PHI rules when these tools are used. See Appendix L for an overview of the legal issues affecting the GBP.

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 quickly and accurately 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 winter Solution Sessions 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 through the IBS process.

### OPTION 4.8 Management tools

Some vendors promote management tools that offer a data driven approach to benefit design. Vendors offer tools that can benchmark the total value of the GBP benefits package against other plans. They also can conduct cost/benefit and risk analyses on benefit transition alternatives. They offer strategic planning and development assistance, diagnostic tools, identification of critical success factors, project work plans, and member engagement campaigns.

| PROS | CONS |
|---|---|
| **Member Impact**<br>• Vendors claim to be successful in improving employee's healthy behavior patterns with a corresponding positive effect on health care trends.<br>• Vendors' ability to assess the impact of changes on customers could help ERS identify plan design issues.<br>• Additional communication resources could also help customers.<br>**Policy Issues**<br>• Outside vendors could offer new ideas for lowering costs and encouraging healthy behaviors. | **Budget Issues**<br>• Hiring consultants to do work that is already being done internally, by the TPA, or consulting actuary could be duplicative.<br>• Return on investment for many of these tools cannot be quantified.<br>**Legal and Operational Issues**<br>• An Request for Proposal (RFP) would have to be developed and analyzed, and the contract(s) would have to be bid, reviewed, and monitored. |

### OPTION 4.9 Data mining tools

There are other vendors in the marketplace that can provide sophisticated health plan data-mining tools for different purposes:

- **Group profiling of plan membership** by integrating medical and pharmacy data with attitudes/behaviors surveys, health risk assessments (HRA), and/or biometric screenings. These diagnostic tools can help the plan understand costly conditions, treatment plans, patient adherence, and clinical outcomes. Presumably this information would then inform plan design decisions.
- **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 (demographics, utilization, cost, and use), recommend and model benefit design changes, flag areas of concern, and provide predictive forecasting. These products can also provide internal audit trails of user queries.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Some vendors can work on a contingent fee basis and receive payment based on finding savings in the system.<br>• Could assist in data gathering to demonstrate the financial impact of benefit changes.<br>**Member Impact**<br>• Can be used for the early identification of individuals who might benefit from a disease management program.<br>**Policy Issues**<br>• Can be used to establish a risk profile/score to help benchmark GBP health cost versus that of other groups.<br>**Operational issues**<br>• Gives outside perspectives to health plan data analysis and some tools may add value to TPA reporting capabilities.<br>• Readily available reports provide access to standard templates in a customizable dashboard format.<br>• High-level data expertise is not required to use the dashboards.<br>• Standardized templates could provide fast and accurate data retrieval for internal reporting and analytics purposes.<br>• Personal health information could be restricted to individual users with security clearance.<br>• This is a service that could be implemented internally without any statutory or administrative rule changes. | **Budget Issues**<br>• No guarantee of financial savings.<br>• Unclear who would pay for the HRA and biometric screenings needed to collect group profiling data.<br>• There would be an upfront cost to run diagnostics on the plan membership.<br>• The Legislature does not currently allocate money to incentivize people to complete HRA or biometric screenings.<br>**Member Impact**<br>• Participants may view a required HRA or biometric screening as intrusive.<br>• Voluntary participation in HRA is already extremely low.<br>• Creating a tool that would give our customers the ability to analyze their own health care costs would pose additional IT security issues.<br>**Policy Issues**<br>• HRA information would be required to make group profiling tools fully functional.<br>**Legal Issues**<br>• For provider data, ERS would need to competitively bid a new contract and negotiate a new data reporting standard with the current TPA.<br>• Would require a rigorous review of current laws about PHI and genetic data to be sure ERS was in compliance<br>**Operational Issues**<br>• May duplicate existing TPA capabilities.<br>• Could be more cost effective to build additional functionality into the existing TPA data reporting package. |

### OPTION 4.10 Cultural assessment of targeted segments of the GBP population

At one of the Solution Sessions, Cerner, a health care data consulting organization, recommended that ERS conduct a "Cultural Assessment" of the GBP population. This process would include an organizational assessment such as; workplace interviews and surveys; an analysis of health plan demographics and overall health status; and a review of agency wellness policies, practices, communications, competencies, and readiness for change.

After the 8-10 week assessment, the vendor would develop a data-driven profile of our membership. This data could then be used to drive decision making when developing value-based insurance benefit design (VBID). See Section 5 for an analysis of VBID options for the plan. Final deliverables include three to five year road maps for implementation of incentive and communication plans. The assessment would help determine the most effective engagement strategies for our population and would recommend and assist in developing specialized messaging segmented by population groups

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Having a 3-5 year plan specific to our population to present to the Legislature would provide a clear roadmap for a budget request dedicated to improving population health.<br>• Increasing healthy behavior among health plan participants could ultimately lower plan costs.<br>**Member Impact**<br>• Could raise awareness and provide motivation among participants regarding their employer's wellness policies.<br>• Provides specific and actionable data based on the GBP population.<br>• Provide targeted communication about programs that benefit participants.<br>• Gives participants an opportunity to be engaged in benefit design.<br>**Operational Issues**<br>• ERS will explore this option as a biddable service. | **Budget Issues**<br>• Initial assessment creates an additional short term cost to the plan. Taking money out of the fund for the assessment could mean cutting benefits elsewhere.<br>• Return on investment is difficult to determine.<br>• Funding the assessment could require a separate appropriation.<br>• Funding limitations could prevent the GBP from acting upon the recommendations in the 3-5 year plan.<br>**Legal Issues**<br>• Must determine whether there would be legal privacy concerns with collecting personal health information during the assessment process.<br>• Employers may have to give permission for contractor to be on site or otherwise contact employees<br>**Operational Issues**<br>• With the size and scope of the GBP, the initial sample size would have to be limited to one large agency as a pilot project.<br>• Added administrative cost for communications, contracting, and data collection activities. |

### OPTION 4.11 Required health risk assessment (HRAs) and/or biometric screenings with personal coaching and ongoing data collection

Require biometric screenings and Health Risk Assessments (HRAs) of all participants. After the data is collected, conduct personal (face-to-face) coaching to share the results of biometric screening and HRA with the person. Implement ongoing data collection to continue targeting services. NOTE: Texas Public Employees Association (TPEA) support making HRAs mandatory for all participants.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Cost of additional contracted services would be in addition to plan costs.<br>– 48% of the largest employers offer their employees incentives to take an HRA. The average cash value of private sector incentive is $125.<br>– 30% of large employers offer incentives to take biometric screenings.<br>**Member Impact**<br>• Members would gain information about their health status and risks, and with health plan programs in place, could receive targeted interventions to help them manage their illnesses.<br>**Policy Issues**<br>• This would significantly boost participation in the HRA and give us more data about the overall health status of our population. This would enhance our ability to target services. | **Budget Issues**<br>• Additional contracted services would generate cost on top of regular health plan cost.<br>– Additional contracted services would generate cost on top of regular health plan cost.<br>– Achieving 100% participation without a financial penalty could be difficult to achieve.<br>**Member Impact**<br>• General employee population may have concerns that employer might have access to personal health information.<br>**Policy Issues**<br>• Difficult to get buy-in of all employers for consistent implementation.<br>• There would need to be clearly defined and enforced parameters for the use of the information collected.<br>**Legal Issues**<br>• Legal issues regarding protection of personal health information—high level of risk for claims of discrimination.<br>• Biometric screening information of individual participants may fall under the Genetic Information Nondiscrimination Act (GINA), a subset of HIPAA passed by Congress in 2008. Further research into the implications of requiring biometric screenings and use of resulting data would be required before recommendation of this strategy item.<br>• HRA's would be subject to HIPAA wellness guidelines—would have to determine if surcharge/reward concept and process apply to this area in the same manner as to the tobacco surcharge program.<br>**Other Issues**<br>• Some suggestions would require significant buy-in and expense for employers (i.e. installing onsite kiosks to collect fitness data).<br>• A comprehensive effort would need to include dependents, which is very difficult. |

### OPTION 4.12 Incentives to encourage healthy behaviors and participation in lifestyle management programs at work

This option would establish a more aggressive stance by the State in supporting worksite incentives to encourage exercise, weight loss, smoking cessation, and other health initiatives. Incentives presumably reduce future cost of providing health insurance because participants should adopt healthier behaviors.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• If no monetary rewards are offered by the State, this option is relatively inexpensive to implement since each agency should already have a wellness committee.<br>**Member Impact**<br>• Participation in wellness programs can result in improved health of members.<br>• Healthier members can result in lower health plan costs.<br>**Policy Issues**<br>• Structure already in place to support initiative at the state level with HB 1297 – all agencies have a wellness coordinator. | **Budget Issues**<br>• Monetary incentives would require additional funding and would increase administration to track and determine award of incentives.<br>• Understanding the target population would require some sort of assessment or survey.<br>**Member Impact**<br>• People must be willing to participate for this to work, and, based on response to current incentives, it might require substantive efforts to encourage behavior change.<br>**Policy Issues**<br>• Worksite wellness activities need to adhere to current agency policies for time off and worker's compensation waivers.<br>**Operational Issues**<br>• Management must be supportive of a healthy culture at work.<br>• Not all agencies have a full-time designated wellness coordinator; usually it is an added job responsibility for a human resources benefits coordinator. |

### OPTION 4.13 Require tobacco user opt-out rather than opt-in

Currently, tobacco users pay an additional $30 per person per month, up to a maximum of $90 per family with three or more smokers. Reporting tobacco use is voluntary. Estimated incidence of tobacco use in the GBP is 18%. The current voluntary reporting level is about 5.8% of the GBP adult population (age 18 and older).

Alere Wellbeing provides targeted smoking cessation services. They recommend to all their clients that there be an opt-out policy, in order to reach the highest possible number of eligible participants with a tobacco cessation support program.

This proposal would assume that every GBP participant is a tobacco user and would make it the participant's responsibility to "opt out" of the higher premium by reporting to ERS that they do not smoke. Alere Wellbeing also recommends the implementation of a multi-faceted cessation program, which is analyzed in the Plan Design section of this report.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Improves fiscal strength of the GBP with increased contributions from the tobacco premium differential.<br>• Vendor asserts that long-term health plan costs attributable to tobacco usage would decline.<br>**Member Impact**<br>• Quitting tobacco is proven to improve health and reduce health care costs.<br>• Each tobacco user would pay higher contributions.<br>• Surveyed members overwhelmingly support the tobacco-user premium differential.<br>**Policy Issues**<br>• Charging more to people who engage in unhealthy behavior supports perceived "fairness" of the program.<br>• Most large public sector plans surveyed during this study have tobacco incentives in place, usually positive ones. | **Budget Issues**<br>• ERS would incur a one-time cost to support the initial opt out period.<br>• Longer term, member contributions to the GBP would begin to decline from the tobacco premium differential as people successfully quit using tobacco.<br>**Member Impact**<br>• Immediate out-of-pocket employee contributions to the GBP would increase as more tobacco users paid the tobacco premium differential.<br>• One-time opt out period will require action on the part of GBP participants who do not use tobacco products to exercise their choice to opt out. Some non-tobacco users who failed to act in time might end up paying higher rates.<br>• Puts additional burden on employers to communicate and certify.<br>**Policy Issues**<br>• The tobacco cessation program may be redundant to programs already offered through our health plans.<br>• This would change the passive enrollment policy to an active enrollment policy, which would place more of a burden on the non-using participants to opt out.<br>**Legal Issues**<br>• There would have to be a process for appeals/exceptions/collections.<br>**Operational Issues**<br>• Increased administrative expense due to added communications and customer benefits activities. |

[1] Kaiser and the Health Research & Educational Trust, Employer Health Benefits 2010 Annual Survey, Exhibits 11.3 and 11.4

[2] Hewitt Associates, Employers' Initial Reaction to Health Care Reform: Retiree Strategy Survey, 2010

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

[4] Segal 2011 Health Plan Cost Trend Survey

[5] Texas Tribune, "Texas' physician-owned hospitals may be in danger.",November 20, 2009

[6] Roy, Avik., "Hospital Monopolies: The Biggest Driver of Health Costs That Nobody Talks About," Forbes.com, August 22, 2011.

[7] Healthcare Financial Management Association, "DOJ Settlement Dismantles Texas Hospital's Monopoly," March 2, 2011.

[8] Deloitte Touche Center for Health Solutions, "Medical Tourism: Consumers in Search of Value," 2008.

[9] Catalyst for Payment Reform, "Action Brief: Improving Fee-for-Service Payment," 2012

[10] Catalyst for Payment Reform, "Payment Reform Framework."

[11] Millenson, Michael L., "Analysis: ACOs could have the Medicare muscle to transform health system," Kaiser Health News, May 2, 2012.

[12] Schneider, Eric C., et al., "Payment Reform: Analysis of Models and Performance Measure Implications, RAND Health Technical Report, 2011.

[13] Texas Insurance Code, Art. 4, Ch. 848, as enacted by SB7 (Nelson), 82nd Texas Legislature, 2011.

[14] HB 4586, Supplemental Appropriation Bill, 81st Texas Legislature, 2009

## SECTION 5: PLAN DESIGN

***"How can the plan design offer choice and align incentives with health risks?"***

When it comes to changing the GBP, ERS and the Legislature have designated responsibilities that control the decision-making framework. The Legislature controls the amount of funding for the plan (appropriations), who receives benefits (eligibility), and how the cost is shared between the employer and the member (contribution strategy). The Legislature also requires a basic level of coverage, plus specific health benefit coverages (e.g., bariatric surgery).

**"ERS and the Legislature have done an admirable job of delivering lower-than-average cost trends while listening to member feedback and implementing plan changes that have the smallest impact possible on members."**

*Aon Hewitt Commentary on Sustainability of the State of Texas GBP: Report to the 82nd Texas Legislature "*

The ERS Board of Trustees controls what the benefits will look like within Legislative parameters (plan design), how they will be provided (financial arrangements, negotiation of contracts and selection of vendors), and how costs will be managed (cost containment).

This section of the report explores options for changing the health plan design. The plan design describes what kinds of plans are available and how much members will pay in out-of-pocket costs for medical and prescription drug services.

Employees care a great deal about their benefits. ERS consistently heard from state agency human resources professionals that because starting salaries are low and employees rarely get raises, the health insurance benefit is one of the best recruitment and retention tools they have.

**"Employers expressed concern that lower income employees are unable to afford family coverage."**

Employers expressed concern that lower-income employees are unable to afford family coverage, and they were open to having more choices to attract talent to the state workforce. They frequently remarked that changes to the benefit package without a concurrent increase in salary would be viewed by employees as a pay cut. See Common Appendix II for a summary of employer responses to an ERS survey on benefits and the state workforce.

Current state law requires the GBP to provide uniformity in health benefit coverage to all members.[1] This means that everyone who is eligible for the GBP has access to a uniform, or equivalent, benefit.

So even though the GBP offers several choices—HealthSelect, HMOs, and Medicare Advantage plans—all the plans must offer a comparable set of health services for roughly comparable out-of-pocket costs.

### OFFERING PARTICIPANTS MORE PLAN CHOICES

Other private and public sector employers tend to offer more plan choices with different levels of benefits. The question arises whether "one size fits all" benefits are still practical for the state workforce.

ERS can design a multiple level benefit with a variety of plans to choose from, but because the State provides member-only coverage at no cost, employees and retirees have little incentive to choose anything but the most generous plan. ERS must operate within the constraints of the funding level and the contribution strategy when considering plan designs and benefit options.

**Although some risks exist, the flexibility to create and price multiple plan design options could be one of the most significant ways to improve the long-term sustainability of the health plan.**

Although some risks exist, the flexibility to create and price multiple plan design options could be one of the most significant ways to improve the long-term sustainability of the health plan.

**Adverse selection raises cost when offering multiple plans.** One of the most important things to remember when offering multiple plan designs is that choice costs money. Offering choice among plans can raise cost due to the risk of adverse selection.

An adjustment for adverse selection recognizes that people will generally choose in their own best interest. In other words, the youngest, healthiest, and lowest-income individuals will choose the lower-level benefits, and the oldest, sickest, highest-income individuals will choose the higher-level benefits.

Offering members the choice of a lower-level plan won't stop costs from rising. It will just reset the baseline and costs will continue to rise from there. Many believe that offering a lower-level benefit—such as a high-deductible health plan (HDHP)—will lower the health benefit cost trend, but a recent Segal consulting survey reports a projected 2012 benefit cost trend of 9.8% for HDHPs, compared to 8% for HealthSelect.[2]

**The importance of the risk pool.** The rating strategy essentially prices the plan based on risk. The riskier the group of people enrolled in the plan, the higher the cost will be. The advantage of having one large plan like HealthSelect is that everyone stays in the same risk pool—everybody belongs to the same group and shares risks across the board for the most expensive claims. Sharing risk keeps costs down for everyone.

In the 1980s, the State offered a choice among several insurance plans—a high, medium, and low benefit. And even though all participants were kept in the same risk pool, allowing members to switch annually among plans increased costs, as employees and retirees learned that they could enroll in the more generous plan in years that they expected to have higher health care costs, then switch back to the lower plan in other years.

**Learning from the past.** In response to a 1984 Governor's Task Force on State Employee Health Insurance, ERS adopted a single plan because adverse selection among multiple state insurance plans had increased costs to an unsustainable rate.[3] The logic was that requiring all participants to enroll in one plan would increase administrative efficiencies, attract more competitive bids, prevent adverse selection, and ultimately allow ERS to keep cost increases to a manageable level.

The GBP could rate multiple plans together in one risk pool or create a separate risk pool for each plan. Some plans split the risk pool intentionally as they implement higher- and lower-level benefits, in order to accelerate the process of moving everyone to the lowest-level benefit. When the higher-level plan becomes unaffordable, it goes into a "death spiral" and becomes unattractive to anyone but the most desperately ill people.

**Policy questions to consider**. In short, the question is not whether employers should offer more choice, but how to offer it in a way that maintains the stability and affordability of the insurance plan. Changing the contribution strategy across the board could create a financial burden to lower-income employees. A flat 20% contribution of $90 a month may be fine for some, but it could create a financial burden for lower-income employees, or cause some people to opt out of coverage altogether.

**"The question is not whether employers should offer more choice, but how to offer choice in a way that maintains the stability and affordability of the insurance plan."**

It has been a long-standing policy of the Texas Legislature to offer the 100% contribution strategy in recognition of the lower salaries of public servants, and as an incentive for recruiting and retaining qualified employees. This could still be done, by offering a 100% contribution for a somewhat lower benefit, with the option for employees to "buy up" to the current HealthSelect benefit. Keeping everyone in the risk pool would be essential, and it would be advisable to create restrictions on the ability of people to move back and forth between plans when a significant benefit design difference exists.

Two questions to ask when considering this option:

- Will the higher-level benefit ultimately become so expensive that it is unaffordable for anyone in the group? This policy may put a disproportionate burden on people with expensive health problems such as cancer, who have no choice but to buy the highest-level benefit.
- Is the lowest-level benefit so "bare bones" that having meaningful coverage requires people to buy up? This policy may put a disproportionate burden on the lowest-income employees, who can only afford the lowest-level coverage.

**Aligning incentives with health risks.** A key goal when designing a benefit plan is to keep medical costs reasonable and manageable for the state and the member. One way to get there is aligning incentives with health risks and encouraging members to make healthy and cost-effective decisions.

According to Aon Hewitt, "Private sector employers have for several years been successfully offering incentives such as payroll credits, additional employer contributions in a reimbursement or health savings account, gift cards, and even avoidance of a surcharge in order to motivate plan members to make better decisions with regard to managing their health."[4]

Unlike private sector employer-based health plans, the GBP does not have the budget authority to implement financial-based incentives through the health plan. Any kind of financial reward or penalty requires legislative support through the appropriations process.

Many of the options discussed throughout the report have a financial impact on members. While increased cost sharing can encourage members to make more responsible decisions, excessive cost sharing can discourage members from getting necessary care.

Five basic categories of plan design options were presented in the educational forums and during the solution sessions.

***Figure 5.1: Plan design options reviewed in Section 5***

| PLAN CHOICES | CARVE OUTS | INCENTIVE-BASED PRICING | GENERIC DRUG INCENTIVES | EMPLOYER SOLUTIONS |
|---|---|---|---|---|
| 5.1 Offering a basic benefit with the option to buy up | 5.5 Care-coordination for early (under 65) retirees | 5.8 Value based insurance design (VBID) | 5.10 Step therapy | 5.13 Nurse practitioner clinics |
| 5.2 Consumer driven health plan | 5.6 Partial carve-out for behavioral health | 5.9 Minimally invasive procedures | 5.11 Therapeutic substitution | |
| 5.3 Managed care plan with a deductible | 5.7 Carve out program for tobacco cessation | | 5.12 Reference based pricing | |
| 5.4 Indemnity plan with deductible | | | | |

**Voluntary benefits provide choice but do not contribute to sustainability.** Several vendors presented voluntary benefit options to ERS during the Solution Sessions. Voluntary insurance benefits such as dental discount programs and income replacement insurance are not funded by the State. Members can shop for these benefits on their own or choose from a variety of ERS-screened vendors during Annual Enrollment. If voluntary benefits are purchased through the GBP, members can pay for them through payroll deduction.

ERS analyzed the viability of several voluntary benefit coverages. Although they provide additional options for members, because they are not State-funded they will not contribute to the sustainability of the health plan. ERS will continue to evaluate these offerings in the future.

### OPTION 5.1 Offering multiple plans

Most employers provide multiple plan choices to their employees. ERS analyzed other potential plan design options during the research phase of the Interim Benefits Study. Some options include:

- adding a deductible to HealthSelect,
- offering a traditional indemnity plan, and/or
- offering a consumer-driven health plan (CDHSection 4 of the report (Professional Management) discusses ways to provide more choice through the contracting process. These types of choices involve specialized contracting for "plans within a plan."

For example:

- high-performance networks,
- Accountable Care Organizations, or
- HMO integrated-care practice models.

Section 4 also provides a special focus on actions ERS is already taking to reduce the costs associated with retiree coverage.

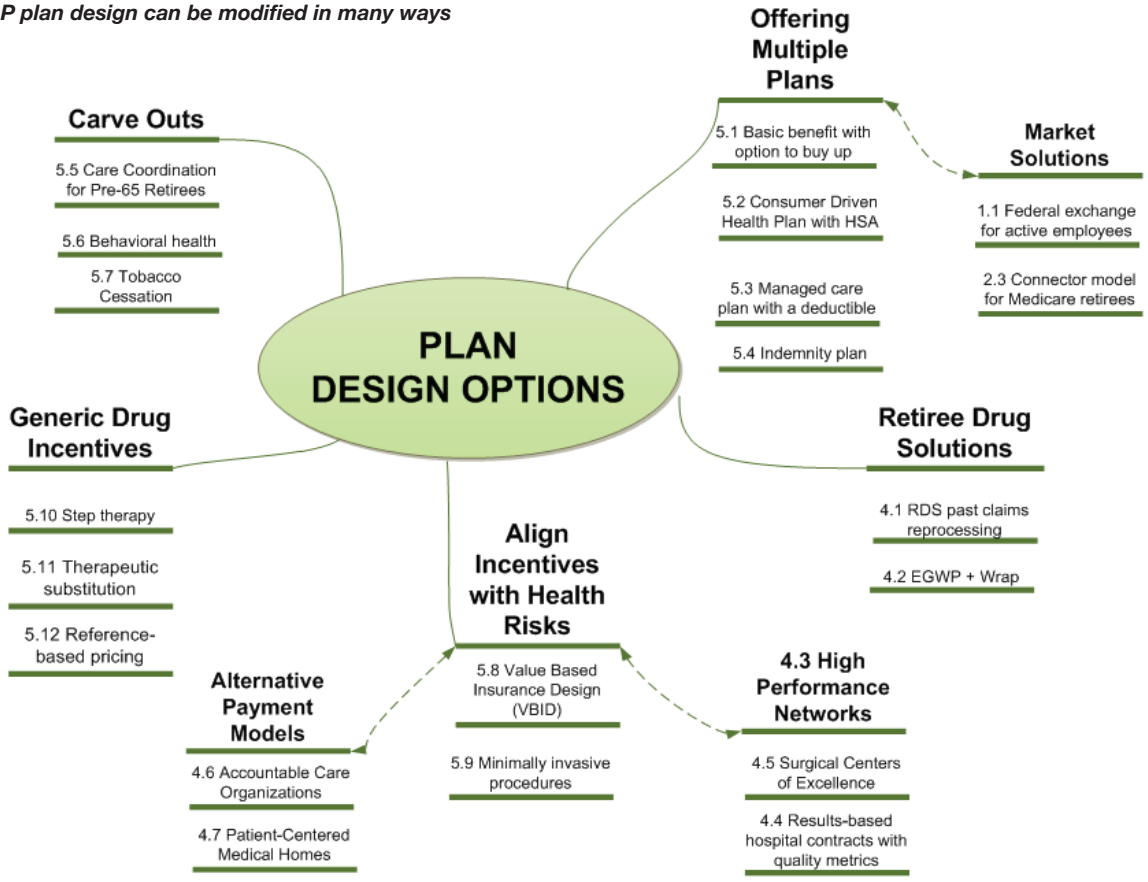
Section 1 of the report (Eligibility) analyzes two market solutions for offering choice:

- sending participants to the federal health exchange in 2014, or
- sending retirees to a "connector model." With this approach, the State would give each member a fixed contribution, then send members out on the market to purchase insurance plans that best meet their individual needs.

**Basic benefit with the option to buy up.** The Legislature could continue to offer the 100% contribution strategy for a somewhat lower benefit, with the option for employees to buy up to more generous plans.

This would be a significant legislative policy change: the State would now ensure access to a minimum level of benefits, rather than provide uniform benefits for all. Keeping everyone in the risk pool would be essential, and it would be advisable to create restrictions on the ability of people to move back and forth between plans when a significant benefit design difference exists.

***Figure 5.2: The GBP plan design can be modified in many ways***

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**OPTION 5.1 Offering multiple plans**

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• The additional cost of providing more choice could be mitigated by keeping all participants in the same rating pool and preventing movement between plans.<br>**Member Impact**<br>• GBP members have expressed a desire for more plan choices in recent health plan surveys.<br>• Choices offer each member the ability to find a plan that will best suit his/her individual needs.<br>• More choices have recently become available to retirees (i.e., Medicare Advantage plans), so they are learning that choices can save them money without greatly reducing their benefits.<br>**Policy Issues**<br>• Adding even a small deductible now could facilitate the implementation of a CDHP in future years.<br>• Having more choice would bring the GBP more in line with the private sector.<br>• Changing the contribution strategy would provide the ERS Board of Trustees with much more flexibility to offer more plan choices to participants. | **Budget Issues**<br>• Offering choice among plans can raise costs due to the risk of adverse selection<br>**Member Impact**<br>• Customers would have more choices, but they could also be confused by the increased complexity of the plan.<br>• Setting the base level of benefits too low could create a situation where only the healthiest and lowest-income members would choose the base plan.<br>**Policy Issues**<br>• Plans would have to be carefully rated to avoid the impact of adverse risk selection.<br>• If the contribution strategy stayed at 100%, the base-level benefit would have to be much lower (about 20% less generous) than the current HealthSelect plan.<br>**Legal Issues**<br>• Would require change to the Insurance Code to address "uniformity of benefits."<br>• Would require statutory and appropriations changes to facilitate State contributions to employee savings accounts.<br>**Operational Issues**<br>• Increased complexity of offering multiple plans increases demand for member communications and customer service. |

Should the State reduce the benefit enough to generate substantial savings, it could share some of the savings with the member through a tax-favored vehicle such as a health savings account (HSA) or health reimbursement arrangement (HRA). The current legislative appropriation does not allow ERS to deposit money to a savings account. This would require legislative action. See Appendix P for a comparison of various types of tax-deferred medical savings accounts that could be made available to employees.

### OPTION 5.2 Consumer-driven health plan (CDHP)

A CDHP is a high-deductible health plan (HDHP) with a tax-favored HSA used to pay qualified medical expenses. To work in tandem with an HSA, the high-deductible health plan must meet certain criteria.

According to Aon Hewitt, "One of the most effective ways to encourage good health care decision-making by plan members is to introduce consumerism concepts into the plan design ... Increasing a member's exposure to the 'true' cost of health care through increased out-of-pocket costs and elimination or reduction of copays has proven to be an effective consumerism tactic, as long as care is taken to not increase costs to the point that members will avoid or delay care."[5]

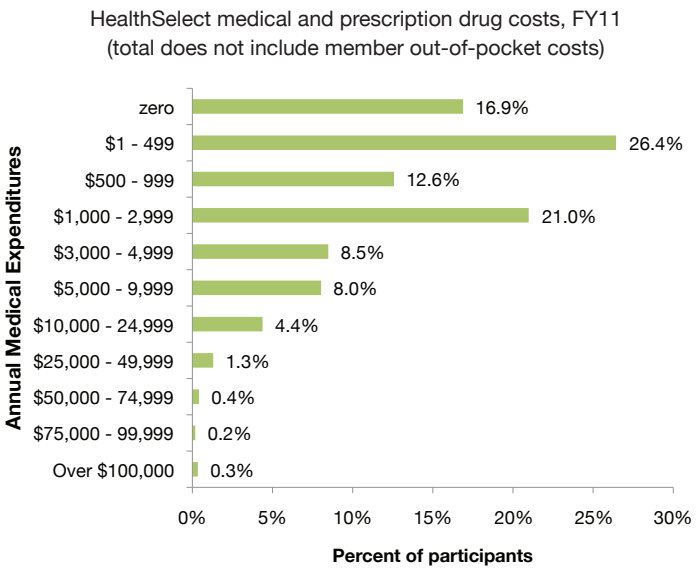
***Figure 5.3: 2013 IRS Criteria for HDHP/HSA Combination***

| | SINGLE | FAMILY |
|---|---|---|
| HDHP Minimum Annual Deductible | $1,250 | $2,500 |
| HDHP Maximum Out-of-Pocket Limit | $6,250 | $12,500 |
| HSA Annual Contribution Limit (plan plus member contribution) | $3,250 | $6,450 |
| Catch-up" contribution for 55+ | | $1,000 |

Twenty-four states offer HDHPs with HSAs for their employees, mostly small- to mid-sized states.[6] According to Mercer, almost half (48%) of large employers with more than 20,000 employees offer a CDHP, and enrollment in CDHPs reached 13% of all covered employees in 2011.[7]

**High deductibles would have the greatest effect on low-income families.** In order to offer a tax-favored HSA, the annual deductible of the employer health plan must be at least $1,250 for single coverage and $2,500 for family coverage.[8] The member would pay 100% of the out-of-pocket cost for care up to the deductible, then the State would pay 80% until they reached the maximum out-of-pocket amount, currently $6,250 for individuals and $12,500 for families.

***Figure 5.4: 43% of HealthSelect participants incur less than $500 a year in health expenses***




A CDHP works well for healthy members, because they have the potential to save money in their HSA and roll it over every year. More than 43% of HealthSelect participants incur less than $500 a year in health expenses. These are the people who would most benefit from this option.

A CDHP can also work well for those with catastrophic health care costs. About 15% of HealthSelect participants incurred more than $5,000 in health care expense in FY11. Once an individual reaches his/her out-of-pocket limit, the plan picks up the rest of their expenses.

For those with moderate health care costs – usually people with chronic illness—the CDHP may not be a good choice. They will always exceed their deductibles, but they may never meet their out-of-pocket maximums. A recent study by the Robert Wood Johnson Foundation suggests that HDHPs place an extra burden on low-income families, especially when a family member has a chronic health condition. Low-income is defined as four-times the federal poverty level, or $92,200 for a family of four.[9] Just 2% of state employees enrolled in the GBP make more than $92,000 a year.

If only the healthiest people sign up for the CDHP option, there would be an increase in plan cost due to adverse selection. HealthSelect would then become the plan of choice for older and sicker participants.

**Employers can encourage enrollment with HSA contributions.** Employers aren't legally required to contribute to the HSA, but most do. Sharing the savings of a lower cost plan with the employee through an HSA contribution is one way that employers can encourage enrollment.

***Figure 5.5: Annual deposits by other public sector employers to employee tax-free savings accounts***

| | ANNUAL DEPOSIT (single coverage) | ANNUAL DEPOSIT (family coverage) |
|---|---|---|
| **State of Florida** | Up to $500 in HSA | Up to $1,000 in HSA |
| **State of Pennsylvania** | $1,000 HRA credit | $2,000 HRA credit |
| **City of Houston** | $500 into HRA | $1,000 in HRA |

The average annual private-sector employer contribution to an employee's HSA is $1,058.[10] The average deductible for a CDHP plan in the large-group market is $2,400 for single coverage and $3,900 for family coverage.[11] More than half of HSA accounts have an average account balance of less than $500.[12]

**HSAs have tax benefits.** Employee HSA contributions are tax-deductible and they can be pre-tax if made by payroll deduction. Interest earned on the account is tax free and may be used for qualified medical expenses. Unused funds and interest are carried over, without limit, from year to year. The HSA is portable, even when the employee changes plans or retires.

The HSA is administered by a trustee (a bank, an insurance company, or other entity already IRS-approved as an IRA trustee). Employees may still have limited-purpose flexible spending accounts (i.e., for vision and dental).

Participants can use their HSAs for many qualified expenses, including:

- out-of-pocket medical and dental expenses, and
- insurance premiums for long-term care, COBRA, coverage while on unemployment, and Medicare.

HSAs cannot be used to pay premiums for Medicare supplemental policies (Medigap) and, as of 2010, non-prescription medicines (other than insulin) are not covered.

**Indiana offers CDHP to its state employees.** In 2011, ERS studied the State of Indiana CDHP option for state employees. Indiana covers up to half the premium for two HDHPs and a traditional PPO. HSAs are provided for employees who enroll in an HDHP. In the first year the CDHP was offered, the State deposited a $2,750 incentive into each employee's HSA. In 2011, the State's HSA initial contribution was reduced to $626 for CDHP1 and $376 for CDHP2.

If the GBP were to offer a plan exactly like the State of Indiana, the cost to the State (the monthly contribution) would increase by 32% plan cost; i.e., the state contribution would increase by 32%. See Appendix Q for more information on the impact that an Indiana-style CDHP would have on the GBP.

**Legislative history of CDHPs for Texas state employees.** For five legislative sessions in a row, bills has been filed that would create a CDHP option for state employees. A CDHP option is still not in place, but in 2005 HB 2772 by Farabee required ERS to study the impact of offering an HRA and HSA/HDHP. Milliman's actuarial evaluation in response to HB 2772 can be found on the ERS website.[13]

- 2003: HB 3359 by Delisi would have established a defined-contribution health care benefits program (HRA) for state employees, retired state employees, active school employees, and retired school employees, allowing participants to choose between primary care and catastrophic plans. The bill was left pending in the State Health Care Expenditures Select Committee.
- 2005: HB 2772 by Farabee required ERS to study the long-term impact of establishing an HRA and HSA/HDHP for the GBP.
- 2007: HB 1269 by Crownover would have created a voluntary CDHP option, keeping the same contribution strategy as for regular coverage with any remainder deposited to an HSA. The bill was recommitted (sent back to the House Insurance Committee) after a point of order.
- 2009: HB 1176 by Crownover was identical to the 2007 bill. It was reported from the House Committee on Pensions Investments and Financial Services.
- 2011: HB 1766 by Crownover would have created a voluntary CDHP option, keeping the same contribution strategy as for regular coverage with any remainder to be used at the ERS Board's discretion. Floor amendments were added to ensure that group rating would remain and a sunset study would be conducted after five years. The plan option would end in 2017. The bill was left pending in Senate State Affairs.

See Appendix P for more detailed information comparing the features of an HSA with an HRA with other tax-favored health savings accounts.

**Option 5.2 Consumer-driven health plan (CDHP)**

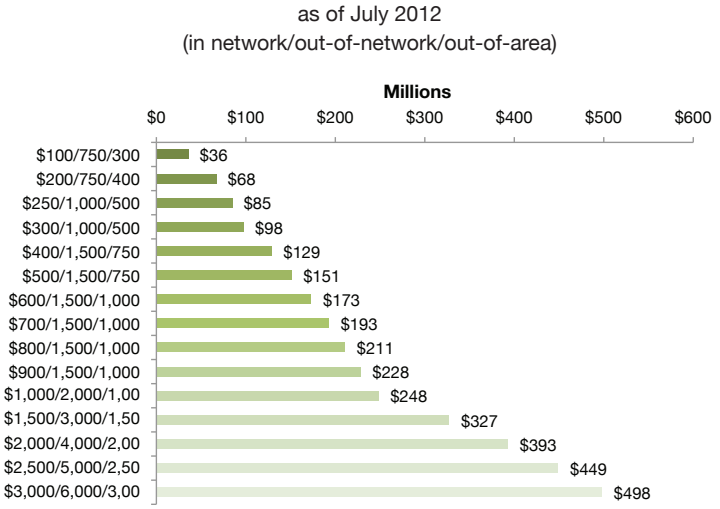
| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Changing the State's contribution to a fixed dollar amount (rather than a percentage) could save the employer money.<br>• There are tax advantages to the employee and the employer.<br>**Member Impact**<br>• An HSA is portable, so employees can take it with them when they change jobs.<br>• Unused contributions roll over from year to year, which can help employees save for future expenses.<br>• If a member has a major catastrophic event early in the plan year, their out-of-pocket costs could reach the cap with the first event, after which the GBP would pick up 100% of their costs.<br>**Policy Issues**<br>• A CDHP increases personal responsibility and encourages people to make more cost-conscious decisions.<br>• Knowledge of the true cost of health care makes people more aware of their health status and incentivizes them to make healthier decisions.<br>• A recent study shows that people enrolled in CDHPs are "more likely than those with traditional coverage to exhibit "cost-conscious behaviors."[14]<br>• Federal employees and state employees in 24 other states already have the ability to choose an HSA.<br>• Preventive care is covered at 100% under the ACA, which mitigates any financial disincentive to get basic care under a high-deductible plan. | **Budget Issues**<br>• If the Legislature contributed any amount of money to the HSA, it would be spending more on the 17% of HealthSelect participants who currently cost the plan nothing.<br>• Offering a choice among plans could increase total plan costs because individual members tend to make decisions based on their personal needs. Keeping the rating pool intact will not prevent adverse selection.<br>**Member Impact**<br>• High deductibles may discourage participants with chronic conditions from getting needed care.<br>• A CDHP works well for the healthy or the very sick, but may cost more for the chronically ill.<br>• A high-deductible plan is disproportionately hard on low-income employees and retirees, especially those with families.<br>• When surveyed, ERS members are overwhelmingly opposed to a high deductible.<br>**Policy Issues**<br>• Poor regulations and oversight have resulted in consumer fraud by unscrupulous health savings account trustees.<br>• Consumer information may not be available/ accessible to help participants make wise choices (i.e., actual cost of a drug, hospitalization, doctor visit).<br>• Employees who leave state employment would take any state money contributed to their HSA with them. This would increase cost to the State.<br>• There could be a risk that employees would withdraw the money from their accounts for non-health care expenses, generating a penalty and a tax expense, and diverting state funds from their intended purpose. |

### OPTION 5.3 Deductible with a managed care plan

This option would simply add a deductible to the existing HealthSelect managed care plan. HealthSelect does not have a deductible for in-network medical services, although it does have a $50 prescription drug deductible and a $500 deductible for out-of-network services. The main choice would be how high to set the deductible.

ERS estimated the financial impact to employees and retirees of adding a deductible to the HealthSelect plan. Depending on its size, a deductible could shift a significant amount of cost to participants. A $100 deductible would have a $36 million impact, while a $3,000 deductible would have a $498 million impact.

***Figure 5.6: The financial impact of adding a deductible to HealthSelect, in millions***




**GBP members prefer predictable cost-sharing.** In April 2011, in response to a potentially large budget shortfall for the health plan, ERS asked members to submit their choices online for balancing the GBP budget. To save the plan $400 million using only a deductible and no other changes to the plan would require a deductible of $1,900.

Some data highlights:

- About 20% of survey participants chose a large deductible ($1,000 or more) with no change to their premiums.
- 54% chose a $250-$500 deductible with a 95/5 or 90/10 premium split.
- Medicare-eligible retirees were more willing to pay a deductible of $250-$500 than were active employees or pre-65 retirees.

**Deductibles are common in other employer-sponsored plans.** Deductibles are common in the public and private sector. According to a Segal 2011 study of state employee health plans, only 22% of state managed care plans do not have a deductible.[15] Note that the total is 99% in original report due to rounding:

- 22% of state PPO/POS plans do not require a deductible,
- 40% of state PPO/POS plans require a $1-$499 deductible,
- 32% of state PPO/POS plans require a $500-$999 deductible, and
- 5% require a deductible that is more than $1,000.

According to a recent Mercer employer survey, the median deductible in a private sector managed care plan was $500 for individual coverage and $1,000 for family coverage.[16]

***Figure 5.7: Examples of deductibles for public sector POS/PPO (or similar) plans***

| | SINGLE DEDUCTIBLE | FAMILY DEDUCTIBLE |
|---|---|---|
| Texas (ERS) | $0 in-network<br>$500 out-of-network<br>$50 drug deductible | $0 in-network<br>$1,500 out-of-network<br>$50 drug deductible per person |
| California | $500 | $1,000 |
| Florida | $250 | $500 |
| Michigan (for employees hired after 4/1/10) | $400 | $800 |
| Ohio | $200 | $400 |
| Travis County, TX | $300 | $900 |
| City of Austin, TX | $500<br>+$50 drug deductible | $1,500<br>+$50 drug deductible per person |
| City of Houston, TX | $400 | $800 |
| Texas A&M University | $700<br>+$50 drug deductible | $2,100<br>+$50 drug deductible per person |
| The University of Texas | $0 in-network<br>$300 out-of-network<br>+$100 drug deductible | $0 in-network<br>$1,050 out-of-network<br>+$100 drug deductible per person |

**Option 5.3 Deductible with a managed care plan**

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• By sharing more of the cost with the participants, a deductible reduces expenses for the plan.<br>**Member Impact**<br>• Members could plan for the expense by setting aside money tax free in their flexible spending accounts (TexFlex).<br>**Policy Issues**<br>• Gives participants "skin in the game" and encourages them to make responsible choices.<br>• Preventive services are already covered without cost share to member<br>• Some members believe it is fairer for those who use the most care to pay the most cost. Deductibles ensure that health care costs are borne by those using the health plan.<br>• A slowly increasing deductible could get participants used to the idea of moving toward a CDHP.<br>**Operational Issues**<br>• Fairly easy to implement. | **Budget Issues**<br>• Deductibles are essentially cost-shifting measures to participants.<br>• A very high deductible is required to save a substantial amount of money for the plan.<br>**Member Impact**<br>• Employees and retirees cannot plan for this expense as easily as they can for a small monthly contribution.<br>• None of the employee or retiree associations currently support this option.<br>• Many participants do not understand how a deductible works.<br>**Policy Issues**<br>• Sharing costs with participants could be done in a more intentional way to align incentives with health risks or encourage healthy behavior change. A deductible is pure cost shifting.<br>• Low-income employees or participants with chronic health conditions could defer care to avoid paying the deductible.<br>• If the State is saving money by cutting benefits, there should be equivalent ways for participants who are making healthy choices to share in the savings.<br>• An optional plan with a deductible could be more palatable to members, but a full replacement plan would save the employer more money.<br>**Legal Issues**<br>• If offered as an option, would require a change in the contribution strategy to incentivize members to sign up for the plan. |

### OPTION 5.4 Indemnity plan with a deductible and coinsurance

A conventional indemnity plan allows members to choose any provider, pay for their medical coverage up front, and then get reimbursed by the health plan later on. In other models, payment can be arranged so that the member pays 20% at the time of service, and the provider collects the balance from the plan.

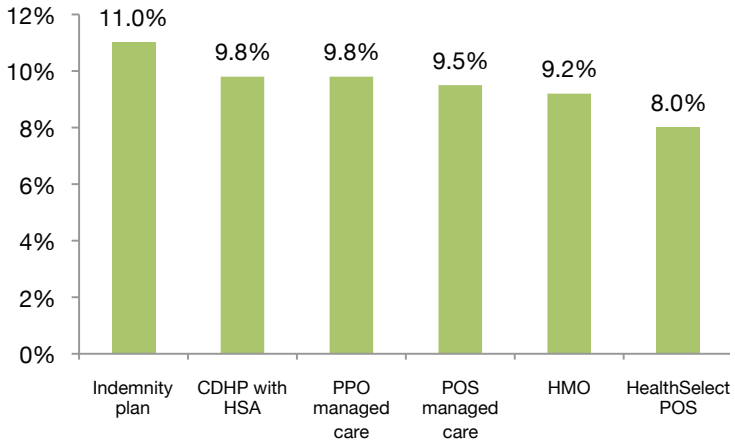
In an indemnity plan there is usually an upfront deductible, and the participant pays 20% coinsurance after the deductible is met.

An indemnity plan does not require members to stay in a network, nor does it require specialist referrals.

According to a recent Segal cost trend survey, the 2012 projected cost trend for an indemnity plan with drug coverage is 10.9%, compared to 8% for HealthSelect Point of Service.[17]

Due to the cost, indemnity plans are being phased out in the private and public sector marketplace. Only six states still offer their employees the choice of an indemnity plan, mostly small to medium sized states. None of the eight largest state employee plans offer an indemnity option.[18]

*Figure 5.8: Traditional indemnity plans have the highest annual projected cost trend for 2012*




| PROS | CONS |
|---|---|
| **Budget Issues**<br>• GBP would limit its exposure, or even keep costs the same, by establishing an allowable amount – a ceiling of what the plan would pay.<br>**Member Impact**<br>• The biggest benefit of an indemnity plan is that you can choose your own doctors without the limitations of a network.<br>• Some participants would pay a higher monthly premium in exchange for the flexibility of choosing their own doctors.<br>• Participants have unlimited choice of providers.<br>**Policy Issues**<br>• Reduces the complexity associated with the health insurance plan.<br>• If the deductible was high enough, it could be tied to an HSA.<br>**Operational Issues**<br>• Relatively simple benefit to administer. | **Budget Issues**<br>• Most plan design changes are cost-shifting measures that share more cost with participants.<br>**Member Impact**<br>• Because the plan is no longer negotiating discounted provider rates, the members would no longer be protected from balanced billing.<br>• Members would pay substantially more out of pocket for their health care.<br>**Policy Issues**<br>• The fact that there are no negotiated network discounts makes indemnity plans the most expensive types of insurance plans on the market, for both the member and the plan sponsor.<br>• Offering an indemnity plan would be moving against the marketplace. Few employers still offer them.<br>• No coordinated wellness or disease management programs would be available to the participant. |

## CARVING OUT SERVICES TO SPECIALIZED PROVIDERS

A "carve-out" simply means that a specialized (usually expensive) area of the plan is separated ("carved out") from the rest of the benefit package and handled by a vendor with expertise in that area. Most carve-outs are biddable services offered by multiple vendors and would be subject to an RFP process. This requires an upfront investment (i.e., extra expense) by the plan for a service from which long-term savings are expected.

The carve-out options in this report were brought to ERS by vendors, and all of them address services or populations with traditionally high costs—disease management for pre-65 retirees, behavioral health and substance abuse benefits, and tobacco cessation efforts

### OPTION 5.5 Carve out care coordination for pre-65 retirees

This option was presented by Humana at a Solution Session on January 24, 2012. This health care management carve-out program links medical and behavioral care with social services to improve health status, reduce cost of care, and ease transition to Medicare coverage for the pre-65 retiree. The services offered include:

- complex care management – for participants with multiple conditions or facing end-of-life concerns,
- chronic condition management – for conditions such as diabetes, chronic obstructive pulmonary disease, or congestive heart failure,
- specialty conditions program – for 13 conditions with high-cost drug management, such as hemophilia, multiple sclerosis, Parkinson's disease, and rheumatoid arthritis,
- HomeCare Solutions – post-discharge planning, social services, and family support – which can also be purchased as an "a la carte" service, and
- Customized Special Needs plans.

The vendor has community health educators and social service managers who provide telephonic and field care support. Telephonic support can include "robocalls" to remind participants to take their medication or test their blood sugar.

Participants can refer themselves to the program, or their provider can refer them. Evidence of insurability (EOI) is not required. The health plan pays the cost on a per-participant per-month (PPPM) basis, only for the participants enrolled, for as long as they are enrolled. In most other plans that offer this service, it is provided at no cost to the participant, although it is possible to make it a chargeable service. Participants can disenroll whenever they want to. After one year, they retake their health risk assessments and stay in the program, transition to a new level of care, or graduate.

ERS could choose to buy levels of care or a la carte services, such as discount pharmacy cards, medication dispensers, biometric screenings, or 24/7 monitored alarm systems with emergency help lines or home monitoring. The vendor will also provide private labeling of the plan-design websites, assess population response

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Participation levels in disease management are not currently optimal, so increasing enrollment could save money in the long run.<br>• It would mitigate risk for the plan if early retirees with chronic or complex conditions moved to the MA-PPO when they aged into Medicare, and it would have a positive impact on costs.<br>**Member Impact**<br>• Carving out chronic and complex condition management to a vendor program that is exclusively focused on this service could result in better experiences for members.<br>• Some of the services offered – like home assessments – could be offered a la carte to members who are interested in purchasing them on their own.<br>**Policy Issues**<br>• Targets the most expensive demographic in the program, the pre-65 retiree.<br>**Operational Issues**<br>• All of the services (except the a la carte services) are already integrated with the Humana MA-PPO, so this program could create an easier transition into the MA-PPO for pre-65 retirees. | **Budget Issues**<br>• There would be an added upfront cost and it would be difficult to measure the return on investment.<br>• If care coordination services were no longer provided by the TPA, their administrative fee may have to be revisited.<br>• The program claims that it reduces the cost of care, but it's unclear where the savings would come from, as the disease management services being added are for the most part already provided by the current TPA.<br>**Member Impact**<br>• Carving out services could be confusing for retirees who are used to getting all medical services from one TPA.<br>**Legal Issues**<br>• Data exchange and coordination between entities could lead to legal complexity, in terms of any necessary agreements and privacy protections (e.g., data exchange agreements).<br>**Operational Issues**<br>• Adds administrative complexity, which could increase operational costs.. |

rates, and determine marketing and outreach responsibilities. Although the service is designed for pre-65 retirees, it could also be offered to active employees.

The HealthSelect TPA provides disease management services at no additional cost to pre-65 retirees. All of the carve-out services in this option are already integrated into the GBP Medicare Advantage PPO.

### OPTION 5.6 Partial carve-out for behavioral health services

This option was presented to ERS by Alliance Work Partners (Alliance) at a Solution Session on February 14, 2012. About 80% of State of Texas agencies pay Alliance to offer an Employees Assistance Program (EAP) to their employees. Employers currently pay Alliance on a per-member per-month basis from their operating budgets.

One of the more popular services offered by Alliance EAP is six therapist visits at no charge to the employee. Alliance manages its own mental health and substance abuse network in Texas and nationwide. Substance abuse-related issues comprise about 25% of their client contacts.

Of the EAP clients seen for mental health and substance abuse issues, 93% are handled by Alliance, and 7% are referred to the health insurance plan. Alliance claims that this results in a 24% reduction in health plan costs for mental health- and substance abuse-related claims, and a 20% reduction in participant costs. The GBP spent $53.6 million on mental health- and substance abuse-related claims and drugs for the period of February 2011 through January 2012. ERS was not able to substantiate the vendor's claims for plan savings.

The primary service proposed by Alliance in the Solution Session is a gateway ("triage") service—intended to prevent behavioral health crises by intervening earlier in the process. This would be a partial carve-out requiring employees to use Alliance as their first stop prior to accessing plan benefits. This would require an upfront investment (i.e., extra expense) by the plan for a service from which long-term savings are expected.

No other state plans are using the fully integrated mental health and substance abuse programs, although a few municipalities and some private sector companies are. Included in this contract would be:

- online intake and referral assessment,
- dozens of self-evaluation tools with prompts based on outcomes,
- telephone counselors – triage, assessment, referral (crisis stabilization),
- case managers assigned to serious cases,
- a limited number of behavioral health visits at no cost to the participant,
- 24/7 contact line, and
- follow-up with participants who have been referred to 12-step, family, or elder care.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Vendor claims that 93% of people who use the EAP program resolve the issue before they ever access GBP health plan benefits, thus potentially reducing plan cost.<br>**Member Impact**<br>• Member could potentially receive six mental health sessions at no out-of-pocket cost.<br>• Members would have better support and referral services for finding behavioral health professionals who suit their individual needs.<br>• Could improve quality of care for people who otherwise would have gone to their primary care physician for mental health issues.<br>• Participants would have lower cost access to mental health services. | **Budget Issues**<br>• Plan would have to pay for a service that many agencies are already paying for.<br>• It would be difficult to determine the return on investment of this service.<br>**Member Impact**<br>• Members might perceive the requirement to go outside the health plan as a barrier to care.<br>• If the provider network is not identical to the TPA network, members could pay more when they transition to GBP health plan services.<br>**Legal Issues**<br>• Could be a coordination of care and data exchange issue between Alliance and current TPA.<br>**Other Issues**<br>• Alliance network doctors may not be in the HealthSelect network, which could create continuity of care issues. |

### OPTION 5.7 Outsource a comprehensive tobacco cessation program

This option was presented to ERS by Alere Wellbeing at a Solution Session in February 2012. They provide targeted tobacco cessation support services to help tobacco users quit using nicotine and become healthier. The service includes counseling and free nicotine replacement therapy (NRT). The potential total cost for an individual quit attempt is $285. This is a biddable service and would be subject to an RFP process.

This would require an upfront investment (i.e., extra expense) by the plan for a service from which long-term savings are expected.

| PROS | CONS |
|---|---|
| **Member Impact**<br>• This level of assistance should enable some participants to successfully quit smoking who otherwise would not be able to quit.<br>• A program like this could be piggy-backed with the current plan coverage of tobacco cessation drugs such as Chantix. For example, the GBP could require that members participate in the contracted program before they are given access to prescription drugs for tobacco cessation.<br>**Policy Issues**<br>• Because there is very low participation in the current TPA's tobacco cessation program, any efforts to successfully engage members to change unhealthy behaviors would be positive.<br>**Legal Issues**<br>• As long as participants are self-reporting their tobacco use, there would be no member data exchange agreements to negotiate.<br>**Operational Issues**<br>• Alere has high name identification because of the backing of the American Cancer Society.<br>• If outsourced, vendor will provide the services for outreach and follow-up. | **Budget Issues**<br>• There would be an upfront cost to contract for a service that is already being provided to some extent by the TPA.<br>• If tobacco cessation counseling and outreach were no longer provided by the TPA, their administrative fee may have to be revisited.<br>• It is difficult to determine the return on investment of this service.<br>**Member Impact**<br>• Some people will quit without this added level of intervention.<br>**Other Issues**<br>• Other support is available for tobacco cessation – for example the state Quitline for certain counties. There is also a federal Quitline, and many other online resources |

## ALIGNING INCENTIVES WITH HEALTH RISKS THROUGH VALUE-BASED INSURANCE DESIGN (VBID)

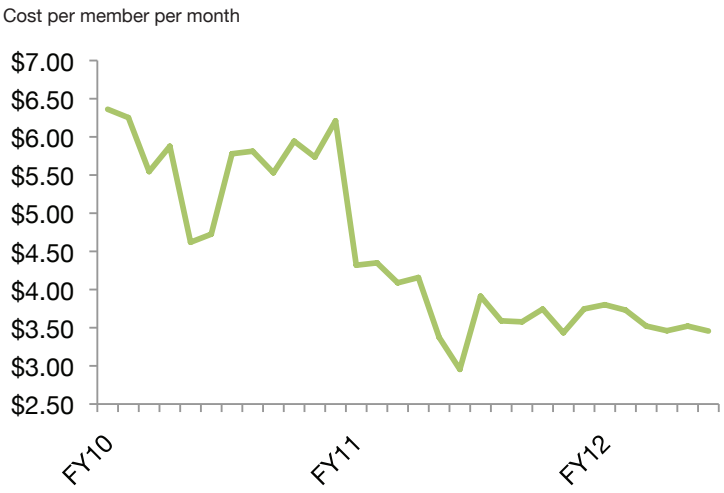
Value-based insurance design (VBID) incentivizes clinical value as a way to lower plan costs and improve health outcomes. Incentives such as reduced or waived copayments make the most effective treatments more accessible for potentially costly medical visits or conditions.

The goal of VBID is to remove barriers to high-quality, clinically beneficial care so that populations are healthier and cost less to treat. Another goal is to make members more accountable for their choices. Effective September 1, 2010, ERS implemented a $50 urgent care copay at the same time that the ER copay increased to $150. So now, members who choose to visit the ER with an upper respiratory infection rather than going to an after-hours or urgent care clinic will pay more.

ERS enacted another VBID incentive in FY11 with the addition of a $100 copay for high-tech radiology scans, in addition to 20% coinsurance. ERS also encourages participants to "shop around" for high cost procedures such as MRIs, because not all facilities charge the same amount. Both usage and plan costs declined and have generally stayed at a lower level for the first 18 months after implementation, with no observable decrease in quality of care.

***Figure 5.10: HealthSelect plan costs for high-tech radiology decreased after a $100 copay was added in FY11***

(MRI, CT, PET, MRA, and nuclear medicine scans, per member per month)




VBID strategies are also considered as a consequence of federal health reform. Section 2713c of the Affordable Care Act (ACA) gives the Secretary of Health and Human Services authority "… to develop guidelines for group health plans and health insurance issuers offering group or individual health insurance coverage to utilize value-based insurance designs as part of their offering of preventive health services."[19]

***Figure 5.9: Example of VBID incentive: higher ER copay with lower urgent care copay***

| | URGENT CARE COPAY | ER COPAY |
|---|---|---|
| **Texas (ERS)** | $50 | $150 + 20% coinsurance |
| **California** | $20 | $50 deductible + 10% coinsurance |
| **Florida** | $25 | $100 |
| **Michigan** (for employees hired after 4/1/10) | $20 | $200 |
| **Ohio** | $25 | $75 |
| **Travis County, TX** | $25 | $125 |
| **City of Austin, TX** | $35 | $125 |
| **City of Houston, TX** | $60 | $200 |
| **Texas A&M University** | $30 | Deductible + 30% coinsurance |
| **The University of Texas** | $35 | $150 |

**Value-based insurance design basics.** VBID can be implemented through positive incentives such as reduced cost sharing for prescription drugs and other treatments, reduced cost sharing for individuals who select high-value providers, and incentives for participation in disease or care management programs.[20] Incentives can also be negative, such as imposing higher out-of-pocket costs for medical treatments that have low clinical value. The use of negative incentives in VBID is less common.[21]

***Figure 5.11: City of San Antonio diabetes VBID***

The City of San Antonio has a value-based copay arrangement for diabetes drugs. Tier 1 generic diabetes prescription drugs are dispensed at no cost to the participant, and copays for Tier 2 and Tier 3 diabetes drugs are reduced. **http://www.sanantonio.gov/hr/employee_information/benefits/pdf/2012_Civilian_Benefit_Matters.pdf**

According to Aon Hewitt, 25% of surveyed employers incorporate VBID into their plan designs now, and more than half plan to do so in the next three to five years, However, "the majority (91%) do not impose any requirements (e.g., completion of a health risk assessment, required program participation, behavior compliance, physician qualification form) to receive enhanced benefits at this time."[22]

### OPTION 5.8 Using VBID in the GBP

VBID can be applied to these four target areas:[23]

- Service – Incentives (such as reduced or waived copayments) are given for specific medications or services regardless of patient characteristics.
- Condition – Patients with certain conditions are eligible for incentives applied to a set of interventions.
- Severity of condition – Patients who are identified as "high risk" are eligible for incentives.
- Disease management participation – Incentives are offered to high-risk patients who are actively participating in an established disease management program.

**Benefit-based copay can increase medication adherence rates.** The most frequently used VBID is the "benefit-based copay," originally developed as a way to improve medication adherence by charging lower copays to patients who choose higher-clinical-value drugs. This and other strategies have been employed by public and private sector plans, most successfully in the area of diabetes management. See Appendix R for examples of four public sector programs that have used VBID incentives to encourage members with diabetes to participate in disease management and increase medication adherence.

At least one member cost-sharing provision under federal health care reform uses the VBID concept. The ACA requirement that insurance plans provide preventive care services (annual exams, immunizations, etc.) at no cost to the member was designed to remove barriers to basic primary care. This particular provision is expected to cost the GBP $51.9 million in the FY12-13 biennium. The Legislature can also create incentives through the contribution strategy, such as increasing monthly premiums for participants who do not enroll in disease management when appropriate. This option is covered in Section 2 of the report.

**Upfront cost is the greatest potential barrier.** The main obstacle for implementing VBID strategies is that they require targeted upfront investments with the hope for lowered overall costs in the future. Since the GBP is a pay-as-you-go plan, reducing out-of-pocket costs for some services would have to be offset by increasing member costs for other services. Another way to offset reduced cost sharing would be to increase state or member contributions.

If ERS were to implement a more aggressive VBID to increase medication adherence, plan costs would increase in the short run, and predicting long-term cost savings as the result of such a change would be difficult. For example, we monitor utilization trends and track whether participants are using their maintenance medications. But when utilization goes up (or down), it's hard to establish cause-and-effect relationships between a particular VBID and individual behavior change. For example, utilization may decrease because the cost of a particular drug went up, because lifestyle or environmental changes improved their condition, or other unknown reasons. How members react within a traditional plan design cannot be used to predict how they will react to a value-based plan design.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• VBID could lower overall plan costs in the long term based on better consumer choices (e.g., increased adherence to medication regimens).<br>**Member Impact**<br>• Lower out-of-pocket costs could make services and medications more accessible and more affordable for some plan members.<br>**Policy Issues**<br>• Should improve health outcomes.<br>• Encourages the use of services with quality outcomes without exposure to unnecessary risks (i.e., an x-ray is safer than a CT scan).<br>• VBID is growing in popularity among other employer-based plans and are also consistent with the direction of the ACA. | **Budget Issues**<br>• VBID would require a substantial upfront investment of plan resources.<br>**Member Impact**<br>• Reduced member costs for some services would have to be offset by increasing costs for other services.<br>•Costs could go up in the short term if identified participants receive more care and fill more prescriptions as the result of their disease management treatment plan.<br>•Identification of participants qualified for VBID through claims analysis may be perceived as intrusive.<br>•Inclusion of certain illnesses or conditions for VBID provisions could be seen as unfair to some members (i.e., why is diabetes chosen over high blood pressure?)<br>**Policy Issues**<br>• Difficult to assess whether behavior change happened because of plan design change or for some other reason.<br>• How members react within a traditional plan design cannot be used to predict how they will react to a VBID.<br>**Operational Issues**<br>• Adds complexity to plan design, which could increase operational costs. |

***Figure 5.12: Using VBID to increase medication adherence in North Carolina***

*Medication adherence pilot program for retirees who take diabetes and cardiovascular medications*

Retirees who take medications to manage their cholesterol, blood pressure, or blood sugar can order a 90-day supply of their medications from selected pharmacies for 2½ times the copay. Select diabetes supplies are also eligible for the reduced copay amount.

*Medication adherence pilot program for members who take cholesterol lowering medications*

The copay for all generic cholesterol-lowering medications is $4 for a one-month supply and $10 for a three-month supply. The North Carolina State Health Plan website reports: "Members have saved over $2.5 million in copays in the year since the program was launched, and there has been a 2% increase in member adherence to cholesterol medications. This evidence suggests that lowering the cost of generic cholesterol medications has encouraged members to take their medications on a more regular basis; thus, the Plan will continue this program indefinitely."

More information about these programs can be found here: **http://www.shpnc.org/myPharmacyBenefits/rxPrograms/default.aspx**

### OPTION 5.9 Minimally invasive procedures (MIPs)

This option was presented by Ethicon (Johnson & Johnson) at a Solution Session on February 10, 2012. The proposal was to incentivize participants with a lower copay to have minimally invasive surgery for certain procedures in an outpatient setting, rather than open surgery inside the hospital. Johnson & Johnson is the manufacturer of the equipment required to perform MIPs.

MIPs build upon the success of laparoscopic surgery, allowing some procedures to now be performed via natural orifice (e.g., appendectomies, hysterectomies). Reducing the size and occurrence of open wounds results in a shorter lengths of hospital stays, less recovery time, quicker return to work, less scarring and pain, and 50% fewer staph infections for certain procedures.

Ethicon estimated the savings for using MIPs for seven common surgeries for GBP participants would be $6.5 million in the first year, with $34.5 million cumulative savings by year five. The cost savings are split 60/40 between direct medical costs and reduced absenteeism.

Increasing the number of MIP surgeries could be incentivized with a lower copay/coinsurance and/or through a default steerage mechanism to a select list of surgeons that perform MIPs. Surgeon and site-specific credentials would be required under the provider contract.

The vendor provides communications free of charge to members and providers, educating them on the benefits of the procedures.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• The vendor projects this option would save money for the plan and the member.<br>• Cost could go down if participants choose to utilize MIPs. Members could still choose to have other procedures at a higher cost.<br>**Member Impact**<br>• Using MIPs could result in shorter lengths of hospital stays, less recovery time, quicker return to work, less scarring and pain, and 50% fewer staph infections for certain procedures.<br>**Policy Issues**<br>• MIPs fit well with episode-based bundled payments because they lower cost and improve quality.<br>**Operational Issues**<br>• No contract and no cost would be required for vendor educational efforts with doctors and members. | **Budget Issues**<br>• Most plan design changes are intended to shift more cost to participants.<br>• Projected savings from reduced absenteeism would not accrue to the plan.<br>**Legal Issues**<br>• The issue of the GBP possibly directing participants to certain providers should be explored in greater detail prior to any implementation if adoption of this strategy is considered.<br>**Other Issues**<br>• The TPA would have to verify that facilities that handle the procedures are charging less.<br>• It would be a low administrative burden to manage the benefit.<br>• Vendor communications effort would have to be supported by ERS. |

## INCENTIVIZING PARTICIPANTS TO USE GENERIC DRUGS

Using higher priced for brand-name drugs instead of therapeutically equivalent generic drugs increases plan costs. In FY11, the plan spent about $100 million on the Top 10 most utilized drugs, or 22% of the total plan cost for prescription drug coverage. Because members pay flat copays for their drugs, the more expensive the drug, the more the plan pays. For example, the plan pays about two-thirds of the cost for a drug like Lipitor, but for a specialty drug like Enbrel, the plan pays 98% of the cost. Ten percent of HealthSelect participants incur prescription drug claims of $10,000 or more a year.

Drug trend was down in 2011 for the first time in many years, mainly because FY11 plan design changes increased the member cost share to 30%, compared to an industry average of 18%. Higher costs encourage more participants to find cheaper generic alternatives.

Five of the top 10 HealthSelect drugs will have generic alternatives by 2013. For example, Lipitor – the most utilized drug and long-time cost leader for the plan – went generic in November 2011, with a projected savings to the plan of $4.4 million in the first year. After a brand-name drug goes generic, it takes some time before the plan realizes savings, because marketing of the generic alternative is limited to a single manufacturer until six months after the brand-name drug's patent expires.

***Figure 5.13: Five of the Top 10 most utilized drugs go generic by 2013***

(HealthSelect reporting period = February 2011 – January 2012)

| RANK | DRUG NAME | PRIMARILY USED FOR | GENERIC LAUNCH | PLAN SPENDING |
|---|---|---|---|---|
| 1 | Lipitor | High Cholesterol | Q4-2011 | $13.3 million |
| 2 | Plavix | Blood Agent | Q2-2012 | $12.3 million |
| 3 | Enbrel | Anti-Inflammatory | Specialty drug[24] | $12.2 million |
| 4 | Humira | Anti-Inflammatory | Specialty drug | $11.9 million |
| 5 | Crestor | High Cholesterol | N/A | $10.0 million |
| 6 | Nexium | Ulcers | N/A | $ 9.5 million |
| 7 | Cymbalta | Anti-depressant | Q4-2013 | $ 8.7 million |
| 8 | Actos | Diabetes | Q3-2012 | $ 8.2 million |
| 9 | Copaxone | Multiple Sclerosis | Specialty drug | $ 7.5 million |
| 10 | Singulair | Asthma | Q3-2012 | $ 7.1 million |

**Generic substitution saves the plan and the member money.** Substituting generic drugs for brand-name drugs where appropriate can save the plan and the member money. Increasing the generic dispensing rate (GDR) by 1% reduces total prescription drug costs by more than 2.5%, saving about $11 million dollars for the plan in FY11. In the first quarter of FY12, the HealthSelect GDR was 74.1%, up from 66.6% two years ago. ERS has made great strides in increasing the GDR, but "best-in-class" plans are still in front, achieving GDRs of up to 82%.[25]

The GDR may be slightly reduced by participants filling generic prescriptions outside the plan. For example, many retail pharmacies offer $4 generic programs that provide a better deal to participants than their $15 copay through HealthSelect. This same practice could be making medication adherence rates look lower than they really are. Without claims data, there is no way of knowing how often people fill their prescriptions outside the plan. This same thing happens with all employer-sponsored plans, but potentially more so with plans like the GBP that have high generic copays.

***Figure 5:14: Member pays the difference***

The GBP plan design requires that if a member chooses to fill a brand-name drug when a generic is available, then the member pays the generic copay plus the difference between the brand-name and the generic drug costs.

**Florida, Illinois, Travis County, the City of Houston, Texas A&M University, and the University of Texas also have this "member pays the difference" policy in place.**

The American College of Physicians recently issued guidelines calling for doctors to steer patients away from high-dollar brand drugs when a proven generic exists. They specifically recommend the generic drug Metformin as a first line of defense for diabetes, rather than Actos, Januvia, or Avandia. Metformin costs $14 a month compared to $230 to $370 a month for the popular brand-name drugs.[26]

### OPTION 5.10 Reference-based pricing

Reference-based pricing is a form of price regulation used by private and public sector drug plans to limit expenditures on drugs that vary widely in cost within a therapeutic class. Under this policy, the plan sets a fixed price that it will pay for drugs in a certain therapeutic class, passing the remainder of the cost onto the patient. This approach is most common in Canadian and European systems, in which government plans have some influence over the marketplace. Reference-based pricing only applies to drugs within the same class that are considered therapeutically equivalent, but may be different chemically and structurally. It usually only applies to a limited number of classes within the formulary.

The price can be set in a number of ways:

- the least expensive drug in the class,
- a weighted average or a mean of all prices for all drugs in the group,
- an average of various low prices, or
- the price of the product considered to be the most cost effective in the class.

If a patient decides to fill the prescription for a more expensive drug, the patient pays the difference.

Most often, reference based pricing is applied to the following classes of drugs:

- proton-pump inhibitors (PPIs) used to reduce gastric acid production and relieve heartburn (Nexium is an example of this type of drug),
- non-steroidal anti-inflammatory drugs (NSAIDs) for the treatment of arthritis (Celebrex is an example),
- anti-hyperlipidemic drugs used for lowering cholesterol (Lipitor is an example),
- anti-depressants for mood disorders (Cymbalta is an example), and
- hypnotics, such as Ambien or Lunesta.

Most systems that use this method have an exception policy. For example, in British Columbia, a physician can choose not to switch medications for a patient if there are harmful side effects or other adverse consequences.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Would allow ERS to limit expenditures on high-cost, high-volume drug classes where many proven generics or lower cost brands exist.<br>• Reducing costs for retiree prescription drugs could reduce the projected OPEB cost over the long term.<br>**Member Impact**<br>• It makes the true cost of medications more transparent to the member.<br>• It will encourage members to speak with their doctors about generics or other less costly alternatives.<br>**Policy Issues**<br>• A price could be set that would still include a choice of medications, ensuring choice and access.<br>• In Canadian and European systems where this policy is used, the price of pharmaceuticals tends to adjust to the reference-based price. Even though it is a large plan, HealthSelect would likely not be able to "move the market" like an entire country could.<br>**Operational Issues**<br>• An exception system could be created to safeguard against poor outcomes for patients who have already adjusted to a successful therapeutic plan. | **Budget Issues**<br>• This option would shift more cost to participants.<br>**Member Impact**<br>• May restrict patient access to medications prescribed by their physicians.<br>• Significant customer impact for those who would have to change medications.<br>**Policy Issues**<br>• Even if a participant is well managed on his current medication, he could be forced to use another medication that the doctor did not prescribe.<br>• This option could interfere with the doctor-patient relationship.<br>• Studies have shown reduced medication adherence under this structure.<br>• Highly controversial process because of the impact on the drug industry and on physician's prescribing methods.<br>**Legal Issues**<br>• No explicit legal proscription against enacting this policy, but it is highly controversial. Legislative approval would be desirable.<br>**Operational Issues**<br>• Adds administrative complexity to the prescription drug plan. |

## OPTIONS 5.11 Step therapy

Step therapy – also called "Step Protocol"—requires a patient to try less expensive drugs first, before an expensive brand name drug is covered. For example, a doctor prescribes an expensive non-preferred brand like Zocor to lower a patient's cholesterol. The plan would first cover the least expensive alternative, the generic of Zocor, Simvastatin. If the generic didn't work, a less expensive brand (Lipitor or Crestor) could be prescribed. And if that didn't work, the Zocor could be prescribed.

***Figure 5.15: Step therapy programs in other large states***

**Pennsylvania:** Step therapy in prescription drug plan is used for these drug classes: angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) for hypertension, and COX-2 inhibitors and NSAIDs for pain/arthritis.

**Ohio:** Step therapy/approval required for 11 drug classes. Current users are grandfathered in.

**North Carolina:** Required step therapy for certain classes of drugs.

**Illinois:** Members whose prescription benefits are administered through the Quality Care Health Plan or one of the self-insured managed care plans and who use Medco as their prescription benefit manager are subject to step therapy protocol for specific drugs.

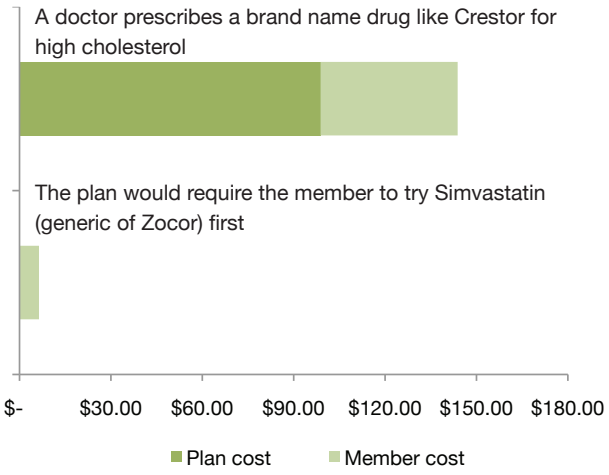
## OPTION 5.12 Therapeutic substitution

Therapeutic substitution allows a pharmacist to substitute a chemically different drug—generic or brand-name—within the same therapeutic category. The plan and the member both save money by opting for the less expensive drug.

For example, if a doctor prescribed a brand-name drug like Crestor for high cholesterol, the pharmacist could substitute Simvastatin, an inexpensive generic in the same therapeutic class. Some therapeutic substitution policies require doctor permission, others don't. There is no universally accepted definition of therapeutic substitution, which makes it more controversial.

***Figure 5.16: Therapeutic substitution saves the plan and the member money***

*(cost of a 30-day supply at retail, April 2012)*




| PROS | CONS |
|---|---|
| **Budget Issues**<br>• Allows the State to limit expenditures on high-cost, high-volume drug classes where many proven generics or lower-cost brands exist.<br>• The use of chemically or therapeutically equivalent generics or lower-cost brand-names will lower drug acquisition costs, plan costs, and member costs.<br>• Could have a minimally positive effect on projected OPEB costs.<br>**Member Impact**<br>• Step therapy allows a patient to try to use a low-cost medication first, rather than immediately using the highest-cost therapy.<br>**Policy Issues**<br>• Changing to a therapeutically equivalent drug with a more convenient dosing schedule could increase compliance, which would lead to better health outcomes and lower plan costs. | **Budget Issues**<br>• This is a cost-shifting measure that requires participants to pay more for certain drugs.<br>**Member Impact**<br>• Significant customer impact on those who would have to change medications.<br>**Policy Issues**<br>• Therapeutic substitution interferes with the patient-doctor relationship by allowing pharmacists to make decisions for doctors.<br>• Generics can compromise the quality of care and lead to adverse outcomes, especially for participants with complex conditions.<br>• ERS is already achieving high generic compliance with its "member pay the difference" policy.<br>**Legal Issues**<br>• No explicit legal proscription against therapeutic substitution, but it is highly controversial.<br>**Operational Issues**<br>• Adds administrative complexity to the prescription drug plan. |

## EMPLOYER-BASED SOLUTIONS

Employers participating in the GBP also play a part in the sustainability of the plan. Employers should take responsibility for creating an environment of wellness in the workplace, encourage the use of the GBP's many wellness resources, and inform their workforce about the benefits and the value of those benefits as part of their overall compensation. Some of the State's largest employers have expressed an interest in taking it a step further by making onsite nurse practitioner or wellness clinics available to their employees.

### OPTION 5.13 Onsite nurse practitioner or wellness clinic

Onsite nurse practitioner clinics were proposed at Solution Sessions by the Texas Public Employees Association and by Cerner.

The GBP established an onsite clinic through the nurse practitioner pilot project in 2006 with the Texas Commission on Environmental Quality (TCEQ). TCEQ employees were satisfied with the clinic, and the agency continued the Austin Regional Clinic contract for a nurse practitioner and supervising physician, paid for with the TCEQ's operating budget. The member savings from not paying primary care copays did not offset the GBP costs during the eight-month pilot program. TCEQ paid to build out the clinic, and the GBP paid the nurse practitioner's and the supervising physician's salaries. The GBP also paid for clinic supplies and the additional TPA administrative cost for overseeing operation of the clinic during the initial pilot.

***Figure 5.17: San Antonio's City Employee Health + Wellness Center***

The wellness center is dedicated for use by City of San Antonio employees only. There is a wellness library, an onsite pharmacy, X-rays, and blood draws. The center offers "any medical service that can be accessed at a primary care provider," and employees who are covered by the City's health plan pay half of their regular copay when they access care at the center.

**http://www.sanantonio.gov/hr/employee_information/wellness/em_center.asp**

Cerner also provides onsite clinics for employers. At Toyota, where Cerner provides an onsite health center, 78% of eligible patients used the center over a one-year period. There was a 31% reduction in Occupational Safety & Health Administration (OSHA) claims and 21% reduction in first aid cases. Centene Corporation also uses Cerner onsite clinics, and they estimate that they reduced time away from work by 1.5 hours per visit.

| PROS | CONS |
|---|---|
| **Budget Issues**<br>• An onsite clinic could prevent long-term higher costs by identifying chronic illnesses earlier in the disease process.<br>**Member Impact**<br>• Employees who come to work with contagious illnesses may seek onsite care, reducing the risk of spreading illness among their coworkers.<br>• TCEQ nurse practitioner prevented a more serious cardiac event by identifying an employee's symptoms early and getting him to the hospital.<br>**Policy Issues**<br>• An onsite clinic could reduce absenteeism as employees would not have to take time off to see a health provider.<br>• The clinic becomes a hub for wellness activities and can be used to provide onsite management of chronic illness.<br>**Operational Issues**<br>• TCEQ, the State Capitol, and Travis County already have experience with different levels of onsite clinics and can serve as models for implementation.<br>• Large campus employers, such as DSHS, HHSC, DADS, and DFPS have expressed strong interest in this idea and a willingness to share the cost of a clinic at the HHSC complex in north Austin.<br>• Other concentrated areas of state workers could also benefit from the economies of scale. | **Budget Issues**<br>• Health plan costs could go up, as members who would not normally go to the doctor seek care at the clinic and may be referred to their doctor and incur a health plan charge.<br>• Majority of immediate savings come to employer as reduced employee absenteeism and increased employee morale.<br>• Any savings to health plan would be long term and the return on investment would be difficult to calculate.<br>**Policy Issues**<br>• Onsite clinics are not under the purview of ERS as no funding is allocated through the GBP to support the concept.<br>**Operational Issues**<br>• Additional cost to the employer to build out the clinic and maintain the contract.<br>• Administration of TCEQ onsite clinic contract difficult for ERS due to separation of agencies.<br>• ERS has little or no effective remedies if employer does not meet payment schedule.<br>• Contract administration is complicated if done by health plan. For the TCEQ clinic, ERS is a pass-through for the onsite clinic but did not receive any administrative fee for being the pass-through. |

[1]Texas Insurance Code, §1551.002.
[2]2012 Segal Health Plan Cost Trend Survey, p. 1.
[3]Governor's Task Force on State Employee Health Insurance, Quality and Cost Containment, Recommendation #1, p. 3, (September 27, 1984).
[4]Aon Hewitt, "Commentary on Sustainability of the State of Texas Group Benefits Program Report to the 82nd Texas Legislature," July 31, 2012, p. 5.
[5]Ibid.
[6]2011 Segal Survey of State Employee Health Insurance Plans.
[7]Mercer, "2011 National survey of employer-sponsored health plans," p. 6.
[8]IRS Rev. Proc. 2012-26; IRS Publication 969.
[9]Robert Wood Johnson Foundation, "Changes in Health Care Financing & Organizations, Findings Brief: Families with Chronic Conditions in High-Deductible Health Plans Facing Substantial Financial Burden," Vol. XIV, No. 1, March 2011.
[10]AHIP Center for Policy and Research, "An Analysis of Health Savings Account Balances, Contributions, and Withdrawals in 2009," December 2010.
[11]Ibid.
[12]Ibid.
[13]Lee, Tim, et al., Milliman, "Actuarial Evaluation of Long-Term Impact of Health Savings Accounts or Health Reimbursement Accounts and High Deductible Health Plans Within the Texas Employees Group Benefits Program," November 9, 2006.
[14]Employee Benefit Research Institute, "Fast Facts: Patients in Consumer-Driven Health Plans Show More Cost Conscious Behavior," #220, January 31 2012.
[15]2011 Segal Survey of State Employee Health Plans; note: total equals 99% due to rounding.
[16]Mercer, "2011 National survey of employer-sponsored health plans," p. 20.
[17]2012 Segal Health Plan Cost Trend Survey, p.1.
[18]2011 Segal Survey of State Employee Health Insurance Plans.
[19]"Rules and Regulations." Federal Register. Vol. 75, No. 137. N.p.: n.p., 2010. Print.
[20]Choudhry, Niteesh, Rosenthal, Meredith, and Millstein, Arnold, "Assessing The Evidence For Value-Based Insurance Design." Health Affairs 29.11 (2010): 1988-1994. Print.
[21]Ginsburg, Marjorie. "Value-Based Insurance Design: Consumers' Views on Paying More For High-Cost, Low-Value Care." Health Affairs 29.11 (2010): 2022-2026. Print.
[22]Aon Hewitt, "Health care survey, New paths. New approaches", (2011), p. 36.
[23]Ibid.
[24]Note: Specialty drugs do not have generic equivalents.
[25]Insights 2012 Connected: Advancing the Science of Pharmacy Care, Caremark, p.19.
[26] ACP recommends Metformin to treat Type 2 Diabetes based on Comparative Effectiveness Analysis of oral medications, Feb. 7. 2012

## SECTION 6: BENCHMARKING STUDY

### FRAMEWORK FOR THE ANALYSIS

The Interim Benefits Study is structured around five basic policy areas affecting GBP health insurance benefits—eligibility, contribution strategy, appropriations, management, and plan design. Our benchmarking analysis provides supplemental data about public and private sector health insurance coverage, and when possible, makes broad comparisons to the GBP.

By necessity, our benchmarking analysis focuses on areas where the most recent and comprehensive data for other plans was available. We tried to get a big picture sense of what "typical" private and public sector employer-sponsored health plans look like, who they cover, and how they share costs. We also explored best practices for incentivizing members to take more responsibility for their health.

**It's important to remember that ERS is not the employer.** The State of Texas (through legislative action) appropriates funds for the program and makes critical decisions about who is covered and how contributions are shared between the employer and the employee. The Legislature also ensures that a basic uniform health benefit is available, and ERS assists employers by designing the benefit, contracting for a benefits administrator, and managing the enrollment process.

Hundreds of individual employers across Texas—state agencies and institutions of higher education—have the most direct interaction with employees, and each has its own unique needs. For example, recruiting prison guards for the Texas Department of Criminal Justice is a different process than recruiting professors at Texas Tech University. In recognition of this, ERS also surveyed and met with state and higher education employers in Texas to get their opinions on the impact of potential benefit changes on their recruitment and retention efforts. See Common Appendix II for a summary of their comments.

### METHODOLOGY

Information about private sector health plans was obtained from three large annual surveys:

- 2011 Health Care Survey conducted by Aon Hewitt ("Aon Hewitt survey"),
- National Survey of Employee-Sponsored Health Plans conducted by Mercer ("Mercer survey"), and
- Employer Health Benefits: 2011 Annual Survey conducted by Kaiser Family Foundation and Health Research and Educational Trust ("Kaiser/HRET survey").

See Appendix S for a detailed description of each survey's methodology, design, and implementation.

ERS also attempted to gather data from several large private sector employers in Texas. While we received some private sector information from UnitedHealthcare, we were unable to supplement and verify most of the data with Internet research or direct communications with benefit professionals. Because of this, the data was not included in the report. See Appendix T for the list of questions we posed of public sector entities in our benchmarking survey.

ERS also conducted a survey of large public sector employer insurance plans. We attempted to collect data for 18 entities —nine large states, the federal employees health plan, and eight non-state public sector plans. The data was first collected from UnitedHealthcare and Internet research during May and June 2012. The collected data was then submitted to benefit professionals within the individual public entity benefit systems. We only included data that could be verified with a health benefits program contact for the public entity. Our final sample consisted of 13 public sector entities: California, Florida, Georgia, Illinois, Michigan, North Carolina, Ohio, Pennsylvania, Travis County, City of Austin, City of Houston, Texas A&M University, and the University of Texas.

When possible, public sector data was supplemented by the Segal 2011 Study of State Employee Health Benefits and the National Conference of State Legislatures' (NCSLs') 2011 State Employee Health survey.

### SUMMARY OF FINDINGS

With public sector decision making, context matters. It is important to note that a big picture analysis can mute the ways in which important factors—such as employer size, enrollment numbers, member population characteristics, and member attitudes about change—can influence plan decision-making. Stepping back to assess general health plan characteristics also does not take into account the political climate and legislative environment within which public sector plan decisions must be made.

**Who is eligible for coverage?** According to the Kaiser Family Foundation, employer-sponsored insurance is the primary source of health coverage for 150 million non-elderly Americans. Fully 99% of employers with 200 or more workers offer some form of health insurance coverage to their full-time workers.[1] Likewise, all 50 states offer health insurance as part of their employee compensation packages.[2] As discussed in previous sections of the report, health benefits are an important recruitment and retention tool for state employers, and employees care a great deal about their health benefits.

Retiree health insurance is a different story. Many private sector plan sponsors do not extend coverage to their pre-65 or Medicare-eligible retirees. Only one in four large private sector firms (>200

employees) still offers retiree health insurance benefits. But nearly half (49%) of the largest employers—those with more than 5,000 employees—still offer retiree health insurance coverage.

Retiree health benefits carry different weight in the public sector compensation package. All 13 of the public sector entities surveyed for this report indicated that they offer some form of coverage to retirees. Eligibility requirements for retiree coverage are frequently based on the individual's age and/or number of years of service. GBP-participating employers provide retiree health insurance benefits at age 65 with 10 years of service, or when they meet the Rule of 80. The Texas Legislature decides who is eligible for GBP health benefit coverage.

**How do employers share the cost of coverage?** After employers decide who is eligible for coverage, they must decide how to pay for it. Plan sponsors make cost-sharing decisions for three major enrollee groups: active employees, retirees, and dependents.

Private sector employees typically contribute around 20% of the premium for employee-only coverage. The average state employee contribution for standard employee-only coverage is 13%. In 2011, only five states (including Texas) made 100% employer contributions for this type of coverage.[3] Policymakers should exercise caution when comparing employer contributions. There is significant variation around the average annual premium as a result of factors such as benefits, cost sharing, and geographic cost differences."[4]

## BOTTOM LINE: HOW DOES THE GBP COMPARE?

**Private-sector findings**

*The value of the HealthSelect plan design (i.e., how much members pay out of pocket for health services) is comparable to the typical private sector plan.*

- Most private sector plans have a deductible. HealthSelect does not, but GBP participants generally pay more for their prescription drug coverage.

The 100% state contribution for employee-only and retiree-only coverage is outside of the norm. The principal difference between HealthSelect and "typical private sector plans" is the contribution strategy. The state contribution is more generous for employee-only coverage and somewhat less generous for employee and family coverage.

When contributions and plan design are counted toward the total value of insurance coverage, we found the following:

- member coverage with the GBP has a 22-28% higher value than the typical private-sector plan, and
- member and family coverage with the GBP has a 2-7% lower value than the typical private-sector plan.

Half of employers with 5,000+ employees still offer retiree coverage, and 45% of jumbo employers (20,000+ employees) vary retiree contributions based on age or years of service.

**Public-sector findings**

*Given the unique context within which each public sector entity must make health benefit decisions and the limited sample size for this study, it is difficult to draw specific conclusions about how GBP benefits compare. That being said, we believe that the following observations are noteworthy.*

- Most public sector benefit plans (87%) extend coverage to retirees, and like the GBP, five of our 13 survey participants have options for which 100% employer contributions for retiree coverage are available.
- With a 100% employee-only contribution, the GBP is outside of the norm for most public sector plans. Only one of the large states included in this survey (North Carolina) currently makes 100% employer contributions to employee-only monthly premiums. This finding is consistent with other available public sector data.
- Four of the 13 public sector entities surveyed offer a CDHP plan – Florida, Georgia, Pennsylvania, and the City of Houston. The State of Illinois reported that this type of plan will be implemented soon.
- Ten of 12 survey participants (83%) with managed care plan options reported charging a per person deductible. The 2011 Segal Study reports that 77% of state-offered PPO/POS plans have deductibles. The GBP has a $50 per person prescription drug deductible.
- Like the GBP, 11 of the 13 public sector entities surveyed reported that they use incentives and/or penalties to discourage tobacco use among members. Nine entities report implementing positive tobacco use incentives (as opposed to penalties).
- The most common type of VBID reported by the surveyed public sector entities is lower copays for urgent care compared to emergency room care. Like the GBP, 11 of the 13 public sector entities incentivize members to choose an urgent care facility over the emergency room.

When private sector plan sponsors cover retirees, they expect them to pay for some or all of their monthly premiums. Jumbo employers (20,000+ employees) are the most likely to vary retiree contributions based on age or years of service.

Among the public sector entities surveyed for this report, employer contribution rates for retiree coverage varied from 0% to 100%. For example, Florida offers access to coverage but expects the retiree to pay the entire monthly premium. In contrast, California, Pennsylvania, Michigan, North Carolina, and the University of Texas have options in which 100% employer contributions for retiree coverage are available. GBP employers pay 100% of the monthly cost for retiree-only coverage.

In the survey, we asked public sector plan sponsors how they pay for retiree prescription drug costs. ERS provides prescription drug coverage to Medicare-eligible retirees through the GBP and offsets a portion of drug costs with the federal Retiree Drug Subsidy (RDS). Employers who are now getting the RDS may save money by switching to an Employer Group Waiver Program (EGWP) + Wrap, which is a basic Medicare Part D program combined with a wraparound provision that brings the plan design up to par with current employer coverage. Eight of the 13 survey participants currently use the RDS, two use the EGWP + Wrap approach, and two use a combination of both to obtain federal subsidies for retiree prescription drug coverage. One state did not report using either approach. Effective January 1, 2013, the GBP will switch from RDS to an EGWP + Wrap plan for retiree drug coverage.

Most private sector employers require an employee contribution for dependent coverage. Private sector employees generally pay about 30% of the monthly premium for family coverage. Among state-offered health plans, employees contribute an average of 20% for standard family coverage, and only two states (North Dakota and Oregon) paid 100% of the premium for standard family coverage in 2011.[5] Among the public entities surveyed for this report, employer contributions for family coverage varied widely, and one indicated that members pay 100% of the cost for dependent coverage. GBP employers pay 100% of the cost of member-only coverage and 50% of the cost of dependent coverage. This works out to a blended employer contribution of 67% for employee plus family coverage.

The Texas Legislature sets the contribution strategy and determines the allocation of the monthly premium between the employer and the member.

**How do employers use plan design to provide choice and incentivize healthy behavior?** To compare the GBP plan design to other public and private sector plans, we also review the number of plans offered, plan choices, and plan cost-sharing features such as deductible, copay, coinsurance, and out-of-pocket maximums.

Many employer-sponsored plans are turning away from short-term cost-shifting measures to explore long-term ways to encourage member responsibility, change behaviors, and improve health outcomes. Incentives can be built into the plan to help members make healthy choices (or deter them from making unhealthy choices). These include incentives to boost participation in health risk assessments, biometric screenings, and tobacco cessation programs. Plan design can also be used to encourage the use of generic drugs, or deter the use of expensive services like the emergency room.

For the GBP, plan design decisions involve the Texas Legislature, ERS, and members. Contribution and eligibility decisions made by the Texas Legislature can constrain (or give flexibility to) ERS in making plan design changes. ERS must make balanced decisions about plan design that are sensitive to member concerns while preserving the plan's long-term sustainability.

## DETAILED FINDINGS OF THE SURVEY

The rest of this section provides more detailed reporting of our benchmarking analysis findings. We compare private and public sector data for each survey question, and we highlight notable examples of best practices when appropriate.

### What does retiree coverage look like in other plans?

Discussions about retiree benefits in the private versus public sector are inherently different. Retiree benefits carry different weight in the public sector compensation package. The average employee who retires from the State of Texas has 23 years of state service. This type of career longevity with a single employer is no longer as common in the private sector.

**Private sector findings.** Many private sector health plans do not offer retiree coverage. According to the Kaiser study, approximately one-quarter (26%) of large private sector employers with 200 employees or more offered benefits to their retirees in 2011.[6] But according to the Kaiser Family Foundation, nearly half of the largest employers – those with more than 5,000 employees – still offer coverage for their retirees.[7]

Both Kaiser and Mercer found that when retiree benefits are available, they are more commonly provided for pre-65 retirees. Among employers who still cover retirees, 71% offer coverage to Medicare-eligible retirees and 91% offer coverage to pre-65 retirees.[8]

The Mercer survey also looked at how many jumbo employers still offer retiree health benefits to new hires. Among those, 45% offer pre-65 retiree health coverage and 35% offer Medicare–eligible retiree health coverage to new hires.[9]

**Public sector findings.** All 13 of the public sector entities surveyed for this report indicated that they offer retiree health coverage. The City of Houston noted that Medicare-eligible retirees must enroll in Medicare Advantage plans, and Florida noted that pre-65 retirees can choose the same plans as employees but they must pay the full premium amount. In Ohio, Medicare-eligible retirees are offered a Humana Medicare Advantage preferred provider organization (PPO) plan, and pre-65 retirees can choose between three levels of a PPO plan (Basic, Intermediate, or Enhanced).

**The GBP automatically enrolls Medicare-eligible retirees into a Medicare Advantage PPO, but they can switch back to HealthSelect if they wish. Pre-65 retirees have the same choices as employees.**

### If coverage is offered, how is the cost shared between the retiree and the employer?

**Private sector findings.** In the private sector, retirees usually must pay for some or all of their monthly premiums. When Medicare-eligible retiree coverage is offered, 18% of employers pay the full cost, half share a portion of the cost with retirees, and 32% require retirees to pay the full cost.[10] When pre-Medicare-eligible retiree coverage is offered, 16% of employers pay the full cost, half share a portion of the cost with retirees, and 34% require retirees to pay the full cost.[11]

Most private sector plan sponsors keep retirees in the same risk pool with the same coverage options as active employees. According to the Mercer survey, only 15% of all employers and only 26% of jumbo employers offer separate plans for retirees.[12] The majority of retiree plan sponsors have the same contribution rates for all retirees. Jumbo employers are the most likely to vary retiree contributions based on age or years of service. 45% of jumbo retiree plan sponsors vary contributions for pre-65 retirees and 46% vary contributions for Medicare-eligible retirees based on age or years of service.[13]

**Public sector findings**. The portion of retiree coverage cost paid by the employer varies considerably among the public sector entities surveyed – from 0% (Florida), to 75% (Georgia and City of Houston), to 100%. Five out of 13 survey participants have options in which 100% employer contributions for retiree coverage are available (California, Pennsylvania, Michigan, North Carolina, and the University of Texas).

More than half (eight of 13) of the public sector entities included in the survey offer separate plans for retirees—California, Florida, Georgia, Ohio, Pennsylvania, Travis County, City of Houston, and Texas A&M University. Only four of 13 rate retirees separately.

In Ohio, retiree benefits are offered through the Ohio Public Employees Retirement System (OPERS), whereas active state employee health benefits are administered through Ohio's Department of Administrative Services. OPERS uses a complicated tiered contribution strategy for retiree health care benefits, profiled in Figure 6.1

***Figure 6.1: Retiree health benefits through the Ohio Public Employees Retirement System (OPERS)***

***Fast Facts***

- OPERS is a stand-alone organization (not a state agency) that administers health benefits to college and university non-teaching retirees, and to state, county, municipal, and miscellaneous retirees in the State of Ohio.
- 184,948 retirees and beneficiaries receive a monthly pension and/or health benefits through OPERS. As of July 2012, 58,313 state retirees (39,919 retirees from the Department of Administrative Services alone) accessed health care benefits through OPERS..

***Tiered Contribution Strategy***

- OPERS currently has three groups of retirees based on when they retired or were eligible to retire.
- Depending on the retiree group (1, 2, or 3) and whether the retiree is categorized as Law Enforcement, retirees and/or spouses are responsible for a certain percentage of their monthly health care premiums.
- Retirees can pay anywhere from 0% to 75% of their monthly health care premium, and spouses can pay between 10% and 87.5% of the monthly health care premium. Spouses have a $40 minimum premium.

**Retiree drug coverage.** The Retiree Drug Subsidy (RDS) approach is the predominant option used to obtain federal subsidies for retiree prescription drug coverage among the public sector entities surveyed. Eight participants—California, Florida, Michigan, Pennsylvania, Travis County, City of Austin, University of Texas, and Texas A&M—use the RDS approach. Georgia and North Carolina currently use the Employer Group Waiver Program (EGWP) + Wrap approach, and California plans to transition to EGWP in 2013. Ohio (OPERS) and the City of Houston currently use a combination of RDS and EGWP. Illinois did not report using either approach. This

information was not available in the private sector surveys reviewed for this report.

**Under the GBP, employers pay 100% of the monthly cost for retiree-only coverage. The GBP automatically enrolls Medicare retirees into a Medicare Advantage PPO option, does not rate retirees separately, and will transition from the RDS approach to an EGWP + Wrap program January 1, 2013.**

**Retiree eligibility for coverage.** Most of the public entities surveyed use age and/or years of service to determine retiree coverage eligibility. For example, like the State of Texas, the University of Texas and Texas A&M University use the Rule of 80 or 65 years old and 10 years of service to determine eligibility for retiree health coverage. Travis County and the City of Houston use the Rule of 75.

California has a tiered contribution strategy based on the number of years the retiree served—the State pays 0% if the retiree worked fewer than 10 years, whereas retirees who have given 20 or more years of service receive a 100% state contribution.

Michigan also provides a state subsidy for retiree insurance coverage, and the percentage depends on when the person retired (the rules changed in 1997) and/or number of years of service. In Michigan, the maximum state subsidy is 90% with 30 or more years of service.

In Georgia, eligible retirees must be age 60 and have completed 10 years of service or meet other eligibility requirements of the retirement system.

Illinois reported that employees must work at least eight years to be eligible for insurance when they retire, and effective July 1, 2012, all retirees will have to make a contribution (not determined yet) toward their health care. Currently 90% of retirees in Illinois do not pay a contribution for their health care coverage.

In North Carolina, five years of service qualifies an employee for retiree health coverage. Pennsylvania reported that retiree coverage eligibility rules are based on age and years of service that are determined by the State Employees' Retirement System. Retired state employees in Ohio are eligible for an OPERS health care plan when they have a minimum of 10 years of qualifying service credit and retire from the Traditional Pension Plan or the Combined Plan.

## ARE SELF-FUNDED PLANS COMMON?

For both private and public-sector plans, the answer is yes.

**Private sector findings**. According to the Mercer survey, 72% of all large employers and 93% of jumbo employers have self-funded PPO plans.[14] According to the Kaiser study, 60% of all employees and 96% of employees in firms with 5,000+ employees are covered by partially or completely self-funded plans.[15] Additionally, 70% of employees in PPOs are covered by partially or completely self-funded plans.[16]

**Public sector findings**. According to the NCSL, 92% of state governments offer self-funded health insurance plans to workers.[17] All of the public sector entities surveyed indicated that at least some of their plan options are self-funded.

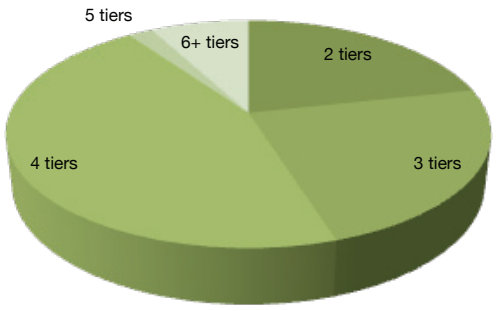
**The GBP has self-funded plan options. HealthSelect is a self-funded plan.**

### How many coverage tiers are typically available?

**Private sector findings.** Coverage tier data was not available for private-sector employers.

**Public sector findings.** More than half of the public sector entities surveyed (seven of 13) have four coverage tiers. The range for all of the survey participants was two to six coverage tiers. The 2011 Segal survey reports that the "vast majority of states offer four or fewer family coverage tiers."[18]

***Figure 6.2: 90% of state-offered employee health plans have four coverage tiers or less.***




Source: Segal 2011 Study of State Health Benefits, Spring 2012

**The GBP has four coverage tiers: member-only, member and spouse, member and children, and member and family.**

### Do most plans have a single risk pool for active employees and retirees?

In a single risk pool, all members are combined in one pool for rating purposes—"riskier" members who tend to cost the plan more are pooled together with less risky, healthier members who cost the plan significantly less. Risk is shared among a diverse group of members and this keeps costs down for everyone. As a general rule, self-funded health insurance plans reduce risk (and cost) by rating members together in a single risk pool.

**Private sector findings**. Specific risk pool data for private sector employer-sponsored plans was not available.

**Public sector findings.** Ten of the 13 public sector entities surveyed indicated that they have a single risk pool. Two participants did not respond to this question, and North Carolina reported that it does not have a single risk pool. In Ohio, employee and retiree benefits are administered by two different entities, so they are not pooled together.

**The GBP keeps the large majority of participants, including retirees, in a single risk pool.**

### For employee-only coverage, how is the cost shared between the employer and the employee?

**Private sector findings.** Most private sector employers expect the employee to contribute to employee-only coverage. According to the Mercer survey, 92% of employers require an employee contribution for employee-only PPO coverage.[19]

Based on surveys reviewed for this study, private sector employees are typically expected to contribute around one-fifth, or 20%, of the premium for employee-only coverage. The Mercer survey reported an average employee contribution rate of 23% for PPO employee-only coverage.[20] The Aon Hewitt survey reported the employee contribution for employee-only coverage at 22% for 2010 and 23% for 2011.[21] The Kaiser survey reported that employees contribute 18% of the premium for employee-only coverage.[22]

**Public sector findings.** Only one of the large states (North Carolina) included in this public sector survey currently makes 100% employer contributions to employee-only monthly premiums. In this case, the State of North Carolina pays 100% for the basic plan and then the retiree/employee can "buy up" to a higher-level plan by paying an additional 3-5% of the monthly premium. In the basic benefit plan, the employee pays 30% coinsurance for medical services, and in the higher-level plan, the employee pays 20% coinsurance.

According to the 2011 NCSL report, North Carolina is one of only five states (along with Iowa, Kentucky, Minnesota, and Texas) that pay 100% of the premium for standard employee-only insurance plans. The average state employee contribution is 13% for the other 45 state plans.[23]

Among the other public sector entities surveyed, Travis County, City of Austin, and the University of Texas make 100% employer contributions to employee-only coverage. The lowest employer contributions reported by survey participants for employee-only coverage are the State of Georgia at 75% and Texas A&M at 78% (for the A&M Care plan for active employees).

**GBP employers pay 100% of the monthly contribution for member-only coverage.**

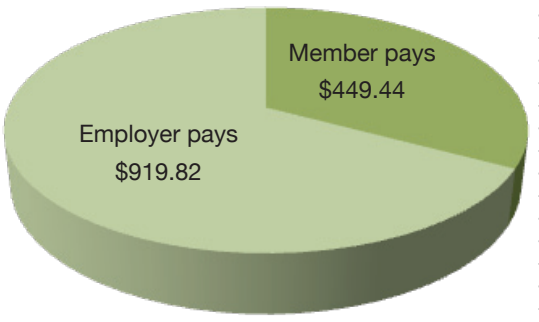
### For family coverage, how is the cost shared between the employer and the employee?

**Private sector findings.** Most private sector employers require an employee contribution for family coverage. According to the Mercer study, 96% of large employers require an employee contribution for family PPO coverage, and the average employee contribution for family coverage in a PPO plan is 31%.[24] The Aon Hewitt survey reported the 2013 employee contribution for family coverage at 30%, up from 29% in 2010.[25] The Kaiser survey reported a 28% contribution rate for family coverage.[26]

**Public sector findings**. According to the 2011 NCSL report, state employees contribute an average of 20% to standard family policy option monthly premiums. Only two states (North Dakota and Oregon) paid 100% of the premium for the State's standard family insurance policy options.[27]

***Figure 6.3: GBP employers pay 67% of member + family contribution***

(based on FY13 contribution of #1,369.26)



Among the public entities surveyed for this report, the employer contribution to family coverage varies widely—from 0% to roughly 80% of the monthly premium. The respondent from North Carolina reported that the member pays 100% for dependent coverage. The Texas A&M respondent reported a 50% employer contribution for monthly coverage for the A&M Care Plan and indicated that the contribution is calculated in a way similar to the GBP.

Public sector respondents with more generous family contributions include: California (80%), Illinois (up to 84% in Open Access Plan), Michigan (80% for PPO for employees hired on or after April 1, 2010), Travis County (up to 80%), and City of Houston (83%)

## HOW MANY PLAN CHOICES ARE TYPICALLY OFFERED?

**Private sector findings.** The average number of plan choices was not available in the private-sector surveys reviewed for this report.

**Public sector findings.** Among the public-sector entities surveyed, the number of plans offered ranges from one (Ohio and University of Texas) to 11 (Pennsylvania) different plans.

The GBP employer pays 100% of the cost of member coverage and 50% of dependent coverage. This works out to be a 67% employer contribution for member and family coverage.

The GBP offers two statewide managed health plans (one of which is a Medicare Advantage plan) and three regional HMOs (one of which is a Medicare Advantage plan.)

## WHAT TYPES OF PLANS ARE OFFERED?

### PPO/POS (point-of-service) plans

**Private sector findings**. PPO plans are the most frequently offered plan type by private sector employees and have the highest employee enrollment rate compared to other plan types. According to the Mercer survey, 92% of large employers offer PPO plans.[28] In terms of the number of enrollees, the Mercer study reports that 65% of all covered employees were enrolled in PPO plans.[29] The Aon Hewitt survey reports an average PPO enrollment rate of 79% and the Kaiser survey reports that 55% of employees were enrolled in PPO plans in 2011.[30]

**Public-sector findings**. According to the 2011 Segal report, 48 states offer PPO or point-of-service (POS) plans and this is "the predominant type of medical coverage offered in each region."[31] Nine out of 13 (69%) of the public entities surveyed offer at least one PPO plan option. Two of the 13 public sector survey participants reported that they have POS plan options (City of Austin and City of Houston). The City of Houston noted that their POS option is a Medicare Advantage POS plan. Illinois offers an Open Access plan that is comparable to a PPO. The City of Houston also has an Open Access plan option for active employees. The State of Georgia is the only survey respondent that does not offer a PPO/POS (or similar) plan.

The GBP offers HealthSelect, a point-of-service plan.

### Health maintenance organization (HMO) plans

**Private sector findings.** While still a part of some private-sector health plan designs, HMOs are not the most common plan type nor do they garner the highest employee enrollment rates. The Mercer survey reports that 36% of all employers and 67% of employers with 20,000 or more employees offer HMO plans.[32] In terms of enrollment rates, the Aon Hewitt survey reports an average of 41% of private-sector employees enrolled in HMO plans, Kaiser survey reports an enrollment rate of 17% for HMO plans, and the Mercer survey reports a 21% HMO enrollment rate in 2011.[33]

**Public sector findings.** HMO plans are a common plan offering among the public sector entities surveyed. According to the 2011 Segal report, 30 states offer HMO/exclusive provider organization (EPO) plans.[34] Eight out of 13 (62%) of the public entities surveyed offer at least one HMO/EPO plan option.

The GBP offers three regional HMO plan options, one of which is a Medicare Advantage HMO.

### Consumer-driven health plans (CDHPs) and high-deductible health plans (HDHPs)

**Private sector findings.** According to the Aon Hewitt survey in 2010, nearly half (46%) of employers offered a CDHP, and 10% offered the CDHP as a full-replacement plan.[36] The Mercer survey reports that CDHPs are offered by 32% employers with 500 or more employees and 48% of jumbo employers.[37] The Kaiser report looked at HDHP with savings options (HDHP/SOs). These survey results indicated that 23% of all employers and 41% of employers with 1,000 or more employees offer HDHP/SOs.[37]

A common theme among the private sector employer surveys reviewed for this report is that CDHP and HDHP plans are on the rise.

- "2011 saw the biggest increase ever in the adoption of consumer-directed health plans by large organizations. Now, 32% of all employers with 500 or more employees offer a CDHP, up sharply from 23% in 2010."[38]

- "23% of firms offering health benefits offer an HDHP/SO, up from 15% in 2010.[39]
- "…CDHPs appear to be gaining traction with an 11 percentage point increase over the last year alone." (In terms of percentage of employers who offer this type of plan.)[40]

**Public-sector findings**. According to the 2011 Segal study, 24 states currently off an HDHP/CDHP plan option.[41] 31% (4 of 13) of the public sector entities surveyed offer a CDHP plan—Florida, Georgia, Pennsylvania and the City of Houston. Illinois reported that this type of plan will be implemented soon.

The GBP does not offer an HDHP or CDHP plan option.

### Medicare Advantage Plans

**Private sector findings.** Information about Medicare Advantage plans in the private sector was not readily available.

**Public sector findings.** Medicare Advantage plans were less common than other plan types among the public entities surveyed —four currently offer at least one Medicare Advantage PPO option (Georgia, Ohio, Pennsylvania, and the City of Houston) and three currently offer at least one Medicare Advantage HMO option (Florida, Pennsylvania, and the City of Houston).

The GBP offers one Medicare Advantage PPO and one Medicare Advantage HMO.

## WHAT DOES A "TYPICAL" PPO/POS PLAN LOOK LIKE?

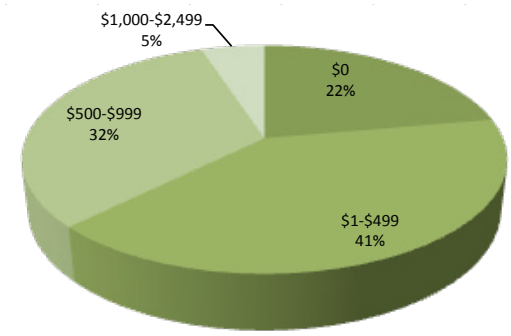
### Annual deductibles

**Private sector findings**. Based on the surveys used for this report, it appears that a typical private sector deductible for employee-only coverage is in the $500 to $700 range. According to the Mercer survey, the average employee-only in-network deductible for large employer PPO plans was $587 in 2011, and almost 20% of employers have deductibles that exceed $1,000.[42] The same study reports that among all large employers, the median annual deductible for employee-only coverage in PPO plans is $500 in network and $750 for out-of-network charges.[43] The Kaiser survey reports an average employee-only deductible amount of $675 for PPO plans.[44]

The Mercer survey reports median annual deductibles for PPO plan family coverage of $1,000 in-network and $1,800 for out-of-network charges.[45]

***Figure 6.4: 77% of state-offered PPO/POS plans have deductibles***

(% of states charging deductible amount)




Source: Segal 2011 Study of State Health Benefits, Spring 2012
Total does not equal 100% due to rounding in original report

**Public-sector findings**. Eighty-three percent of the survey participants (10 of 12 with PPO/POS or similar plan options) reported a per-person deductible amount. Employee-only and family deductible information reported by the public sector survey participants varies widely. For example, Pennsylvania does not require a deductible for in-network employee-only or family coverage. On the other end of the spectrum, North Carolina has a $700 in-network single deductible and $2,100 in-network family deductible in the 80/20 Standard Plan.

Illinois, City of Austin, and Texas A&M University reported a $50 per person annual prescription drug deductible, and the University of Texas reported a $100 prescription drug deductible per person.

GBP HealthSelect has a $50 per person deductible for prescription drugs.

***Figure 6.5: PCP office visit copays in state-offered PPO/POS plans (in-network)***

| | PERCENT OF PLANS OFFERING COPAY AMOUNT |
|---|---|
| $0 | 1% |
| $10- $14 | 9% |
| $15- $19 | 23% |
| $20- $24 | 40% |
| $25- $29 | 17% |
| $30+ | 9% |

Source: Segal 2011 Study of State Health Benefits, Spring 2012. Total does not equal 100% due to rounding in original report.

### Primary care physician copays

**Private-sector findings.** The Mercer survey reports that 81% of private sector employers require copays for in-network primary care physician (PCP) office visits and that the average copay amount is $22 per visit.[46] The Kaiser survey also reports an average copay of $22 for in-network PCP office visits.[47]

***Figure 6.6: Primary care physician copays for PPO/POS (or similar) plan options***

| | |
|---|---|
| GBP | $25 |
| CA | $20 |
| FL | $15 |
| IL | $15 |
| MI | $20 |
| NC | $30 |
| OH | $20 |
| PA | $15 |
| Travis Co. | $25 |
| City of Austin | $25 |
| City of Houston | $35 |
| A&M | $30 |
| UT | $30 |

*Note: CA info is for PERS Care Plan; IL amount is for Open Access Plan Tier 1; MI amount is for employees hired after April 1, 2010 in-network; NC amount is for in-network 80/20 Standard Plan; OH amount is in-network; Travis Co amount is in-network; City of Houston amount is for Open Access Plan; and A&M amount is for A&M Care Plan in-network.*

GBP HealthSelect participants pay $25 for a primary care visit.

### Specialty care visit copays

**Private-sector findings.** According to the Kaiser survey, employees pay an average of $32 for in-network specialty care visits.[48] The Mercer survey reports that nearly half (48%) of large PPO plan sponsors require specialist care copays that are higher than PCP visit copays and the median copay amount for specialty care is $35 (when the specialist copays are higher than PCP copays).[49]

**Public-sector findings.** The specialty care copay amounts reported by our public-sector survey participants are illustrated in Figure 6.8.

***Figure 6.7: Specialist office visit copays in state-offered PPO/POS plans (in-network)***

| | % OF PLANS OFFERING COPAY AMOUNT |
|---|---|
| $0 | 0% |
| $10- $14 | 6% |
| $15- $19 | 7% |
| $20- $24 | 18% |
| $25- $29 | 21% |
| $30+ | 49% |

*Total does not equal 100% due to rounding in original report.*

*Source: Segal 2011 Study of State Health Benefits, Spring 2012*

GBP HealthSelect participants pay a $150 per-day copay for inpatient care (up to $750 per hospital stay) and a $100 copay for outpatient care. Both services have an added 20% coinsurance.

***Figure 6.8: Specialty care copays for PPO/POS (or similar) plan options***

| | |
|---|---|
| GBP | $40 |
| CA | - |
| FL | $25 |
| IL | $15 |
| MI | - |
| NC | $70 |
| OH | $20 |
| PA | $25 |
| Travis Co. | $40 |
| City of Austin | $35 |
| City of Houston | $60 |
| A&M | $45 |
| UT | $35 |

*** CA info is for PERS Care Plan; FL amount is for in-network services; IL amount is for Tier 1 Open Access Plan; NC amount is for in-network 80/20 Standard Plan; OH amount is for in-network services; Travis Co amount is in-network; City of Houston amount is for in-network services in Open Access Plan; and A&M amount is for A&M Care Plan in-network*

GBP HealthSelect participants pay $40 to visit a specialist.

### Emergency room copays

**Private sector findings.** Information about emergency room (ER) copays was sparse in the private sector surveys reviewed for this report. The Mercer survey reported that 80% of all employer plans require copays for ER visits, and the median amount is $100.

**Public sector findings.** The ER copay amounts reported by our public sector survey participants are illustrated in the table below.

***Figure 6.9: Emergency room copays for PPO/POS (or similar) plan options***

| GBP | $150+C |
|---|---|
| CA | D+C |
| FL | $100 |
| IL | $200 |
| MI | $200 |
| NC | $233+C after D |
| OH | $75+C |
| PA | $50 |
| Travis Co. | $125 |
| City of Austin | $125 |
| City of Houston | $200 |
| A&M | C after D |
| UT | $150 |

** C = coinsurance; D = deductible Note: CA info is for PERS Care Plan; IL amount is for Tier 1 Open Access Plan; MI amount is for employees hired after April 1, 2010; NC amount is for 80/20 Standard Plan; City of Houston amount is for Open Access Plan; and A&M amount is for A&M Care Plan.*

HealthSelect participants pay $150 to visit the emergency room, plus 20% coinsurance.

### Copay/coinsurance for inpatient and outpatient services

In both the private and public sectors, it is common to have a coinsurance rate applied in addition to or in lieu of a copayment for inpatient and outpatient services.

**Private sector findings.** According to the Mercer study, 72% of large PPO sponsors require coinsurance for in-network hospital services, and the median rate is 20% of eligible charges.[51] 19% of plan sponsors require a specific amount per hospital stay – the median amount is $250.[52] 93% of employers require coinsurance for out-of-network hospital services, and the median coinsurance rate is 40% of eligible charges.[53]

The Kaiser survey reports that after the general annual deductible, the average coinsurance rate for hospital admissions is 17%, the average copay and per diem rates are $246 per admission, and the average separate hospital deductible is $627.[54] A significant majority of large group health plans incorporate out-of-pocket limits under their plans. This limit generally applies to the coinsurance costs and may not include the deductible and various plan copays.

***Figure 6.10: Inpatient services (PPO, POS, or similar plans)—public sector survey responses,***

| | |
|---|---|
| California (PERS Care Plan) | $250 hospital admission deductible, then 10% coinsurance |
| Florida | 20% coinsurance on allowed amount after calendar-year deductible |
| Illinois (Open Access Plan) | Tier 1: 100% covered after $275 copay per admission |
| Michigan (hired on or after April 1, 2010) | 10% coinsurance after deductible |
| North Carolina (80/20 Standard Plan) | $233 copay plus 20% coinsurance after deductible |
| Ohio | 20% coinsurance in network |
| Pennsylvania | $0 copay in network |
| Travis County | $200 copay then 10% coinsurance on eligible in-network expenses |
| City of Austin | 20% coinsurance after deductible |
| City of Houston | 20% coinsurance after deductible |
| Texas A&M University (A&M Care Plan) | 30% coinsurance after deductible |
| University of Texas | $100 copay per day ($500 maximum per admission), then 20% coinsurance |

***Figure 6.11: Outpatient services (PPO, POS, or similar plans)—public-sector survey responses***

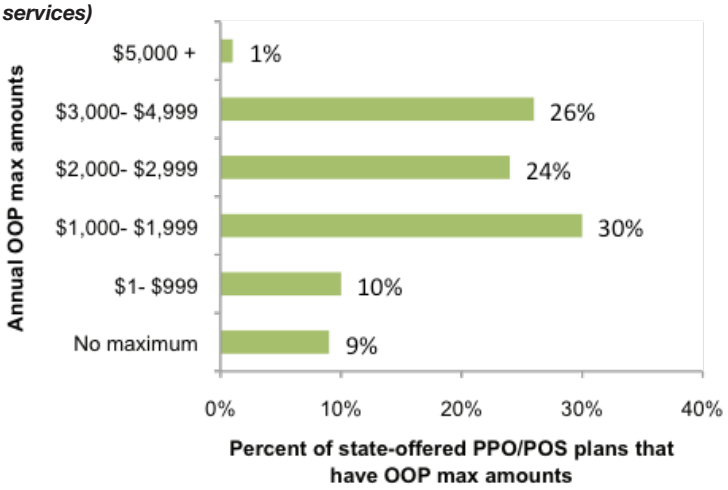
| | |
|---|---|
| California (PERS Care Plan) | 10% coinsurance for preferred provider |
| Florida | 20% coinsurance on allowed amount after calendar-year deductible |
| Illinois (Open Access Plan, surgery) | Tier 1: 100% covered after $15 copay/$20 copay for specialist |
| Michigan (hired on or after April 1, 2010) | 10% coinsurance after deductible |
| North Carolina (80/20 Standard Plan) | 20% coinsurance after deductible |
| Ohio | 20% coinsurance in network |
| Pennsylvania | $0 copay in network |
| Travis County | 10% coinsurance in network |
| City of Austin | $75, then 20% coinsurance after deductible |
| City of Houston | 20% coinsurance after deductible |
| Texas A&M University (A&M Care Plan) | 30% coinsurance after deductible |
| University of Texas | 20% coinsurance after $100 copay |

**Public sector findings.** Most (nine of 13) of the public sector survey participants reported out-of-pocket maximums per person or for employee-only coverage in the $1,500 to $3,200 range. Pennsylvania did not report any out-of-pocket maximums, and Texas A&M reported the highest individual out-of-pocket maximum ($5,000) and family out-of-pocket maximum ($10,000).

### Out-of-pocket maximums

**Private sector findings.** The Mercer survey reports that 86% of all employer-sponsored plans have an out-of-pocket maximum. The median amounts are $2,000 for in-network employee-only coverage and $4,000 for out-of-network.[55] According to the Kaiser study, 83% of employees with insurance have an out-of-pocket maximum for employee-only coverage, 38% of employees have out-of-pocket maximums of $3,000 or more, and 14% are in plans with out-of-pocket maximums less than $1,500.

***Figure 6.12: Annual out-of-pocket maximums (OOP max) for employee-only coverage required by state-offered PPO/POS plans (in-network services)***




*Source: Segal 2011 Study of State Health Benefits, Spring 2012*

***Figure 6.13: Coinsurance out-of-pocket maximums – large states***

| GBP | California | Florida | Illinois | Michigan | North Carolina | Ohio | Pennsylvania |
|---|---|---|---|---|---|---|---|
| **Individual**: $2,000 per person, per calendar year | Individual: $2,000<br><br>Family: $4,000 | Individual: $2,500 per person<br><br>Family: $5,000 | **Tier 1**<br>Not applicable<br><br>**Tier 2**<br>Individual: $600<br>Family: $1,200<br><br>**Tier 3**<br>Individual: $1,500<br>Family: $3,500 | **Hired before** 04/01/10<br><br>Individual: $1,000 in network, $2,000 out of network<br><br>Family: $2,000 in network, $4,000 out of network<br><br>**Hired on** or after 04/01/10<br><br>Individual: $1,500 in network, $3,000 out of network<br><br>Family: $3,000 in network, $6,000 out of network | Individual: $3,210 in network, $6,420 out of network<br><br>Family: $9,630 in network $19,260 out of network | Individual: $1,500 in network, $3,000 out of network<br><br>Family: $3,000 in network, $6,000 out of network | N/A |

*Note: CA info is for PERS Care Plan, IL amount is for Open Access Plan, and NC amount is for 80/20 Standard Plan.*

*Figure 6.14: Coinsurance out-of-pocket maximums – other public sector entities*

| Travis Co. | City of Austin | City of Houston | Texas A&M | Univ. of Texas |
|---|---|---|---|---|
| **Individual**: $2,000 in network, $2,500 out of network<br><br>**Family**: $4,000 in network, $7,500 out of network | $3,000 (including deductible) for POS | **Individual:** $3,000<br><br>**Family:** $6,000 | **Individual:** $5,000<br><br>**Family:** $10,000 | **Individual**: $2,500<br><br>**Family:** $7,500 |

*Note: City of Houston amount is for Open Access Plan, and A&M amount is for A&M Care Plan.*

GBP HealthSelect has a $2,000 per person out-of-pocket maximum per calendar year.

### Copays for generic drugs

**Private sector findings.** The Kaiser survey reports that 85% of PPO plans have a copay-only option for generic drugs, and the average generic copay amount was $10 in 2011.[57] The Mercer survey also reports an average retail copay amount of $10 for generic drugs.[58]

**Public sector findings**. According to Segal, about half of state-offered plans have a generic copay of $1-$9, and the other half have a generic copay of $10-$19.

The generic drug copay amounts reported by our public sector survey participants are illustrated in Figure 6.16.

*Figure 6.15: Generic retail prescription drug copays for in state-offered plans*

| | PERCENT OF PLANS OFFERING COPAY AMOUNT |
|---|---|
| $0 | 0% |
| $1-$9 | 51% |
| $10-$19 | 48% |
| $20-$29 | 1% |

*2012*

*Figure 6.16: Generic drug copays for public sector entities*

| | |
|---|---|
| GBP | $15 |
| CA | $5 |
| FL | $7 |
| IL | $10 |
| MI | $10 |
| NC | $12 |
| OH | $10 |
| PA | $10 |
| Travis Co. | $10 |
| City of Austin | $10 |
| City of Houston | $10 |
| A&M | $10 |
| UT | $10 |

*Note: Amounts differ for maintenance, mail-order, and 90-day prescriptions. Note: CA value is short-term use amount for PERS Care Plan; FL amount is for in-network charges; IL amount is for Open Access Plan; NC amount is for 80/20 Standard Plan; no Rx deductible applied to City of Austin amount; City of Houston amount is for Open Access Plan; and A&M amount is for A&M Care Plan.*

HealthSelect participants pay a $15 generic drug copay.

### Copays for preferred brand name-drugs

**Private sector findings.** According to the Kaiser survey, 73% of PPO plans have copay-only options for preferred-brand drugs and the average preferred-brand copay amount was $29 in 2011.[59] The information about preferred-brand drug copays is similar in the Mercer study—an average retail copay amount of $30 for preferred-brand drug copays is reported.[60]

**Public sector findings**. According to Segal, two-thirds of state-offered plans have a preferred-brand copay of $29 or less. The preferred-brand drug copay amounts reported by our public sector survey participants are illustrated in the table below.

*Figure 6.17: Preferred-brand retail prescription drug copays in state-offered plans*

| | PERCENT OF PLANS OFFERING COPAY AMOUNT |
|---|---|
| $0 | 0% |
| $1-$9 | 0% |
| $10-$19 | 42% |
| $20-$29 | 34% |
| $30-$39 | 18% |
| $40-$49 | 5% |
| $50-$59 | 1% |

*Source: Segal 2011 Study of State Health Benefits, Spring 2012*

***Figure 6.18: Preferred-brand drug copays for public sector entities***

| | |
|---|---|
| GBP | $35 |
| CA | $20 |
| FL | $30 |
| IL | $24 |
| MI | $30 |
| NC | $40 |
| OH | $25 |
| PA | $18 |
| Travis Co. | $30 |
| City of Austin | $30 |
| City of Houston | Coinsurance |
| A&M | $35 |
| UT | $35 |

*Note: Amounts differ for maintenance, mail-order, and 90-day prescriptions. Note: CA value is short-term use amount for PERS Care plan; FL amount is for in-network charges; IL amount is for Open Access Plan; MI amount is for employees hired after April 1, 2010; NC amount is for 80/20 Standard Plan; PA is amount "plus cost difference between the brand and the generic if one exists;" Houston info is referring to Open Access Plan ($45 minimum/ $100 maximum); and A&M amount is for A&M Care Plan.*

GBP HealthSelect participants pay a $35 preferred-brand drug copay.

### Copays for non-preferred-brand drugs

**Private sector findings.** The Kaiser survey reported that 69% of PPO plans have a copay-only option for non-preferred brand drugs, and the average non-preferred brand drug copay amount was $49 in 2011. The Mercer survey also reported an average copay amount of $49 for retail non-preferred brand drugs.

**Public sector findings.** According to Segal, 67% of state-offered plans have a preferred-brand copay of $49 or less. The non-preferred-brand drug copay amounts reported by our public sector survey participants are illustrated in Figure 6.19.

***Figure 6.19: Non-preferred-brand retail prescription drug copays in state-offered plans***

| | PERCENT OF PLANS OFFERING COPAY AMOUNT |
|---|---|
| $0 | 0% |
| $1-$9 | 0% |
| $10-$19 | 6% |
| $20-$29 | 2% |
| $30-$39 | 24% |
| $40-$49 | 35% |
| $50-$59 | 19% |
| $60-$69 | 11% |
| $70-$79 | 1% |
| $80+ | 3% |

*Total does not equal 100% due to rounding in original report.*
*Source: Segal 2011 Study of State Health Benefits, Spring 2012*

***Figure 6.20: Non-preferred-brand drug copays for public sector entities***

| | |
|---|---|
| GBP | $35 |
| CA | $60 |
| FL | $50 |
| IL | $48 |
| MI | $60 |
| NC | $64 |
| OH | $50 |
| PA | $38 |
| Travis Co. | $50 |
| City of Austin | $50 |
| City of Houston | Coinsurance |
| A&M | $60 |
| UT | $50 |

Note: Amounts differ for maintenance, mail-order, and 90-day prescriptions. Note: CA value is short-term use amount for PERS Care plan; FL is for in-network charges; IL is for Open Access Plan; MI amount is for employees hired after April 1, 2010; NC amount is for 80/20 Standard plan; PA is amount "plus cost difference between the brand and the generic if one exists;" Houston info is for Open Access Plan ($55 minimum/ $150 maximum); and A&M amount is for A&M Care Plan.

GBP HealthSelect participants pay a $60 non-preferred-brand drug copay.

## WHAT DOES A "TYPICAL" CDHP PLAN LOOK LIKE?

Information about private and public employer-sponsored CDHP plans is limited in the surveys used for this report. The Mercer survey reports that the median individual out-of-pocket maximum for health savings account (HSA)-eligible and health reimbursement account (HRA)-based CDHP plans is $3,000, and the median family amount is $6,000.[63]

**Private sector findings**. According to the Kaiser report, 60% of employers who offer employee-only coverage through HSA-qualified HDHPs contribute to the employee's HSAs.[64] For employee-only coverage, the average annual HSA employer contribution is $886, and the average annual HRA employer contribution is $861.[65] The Mercer survey reports that 75% of HSA plan sponsors made contributions to employee HSA accounts in 2011, and the median contribution is $500.[66] The median employer contribution to HRAs is also reported to be $500.[67]

For family coverage, the Kaiser survey reports that 57% of employers make contributions to eligible HSAs.[68] The average annual HSA employer contribution for family coverage is $1,559, and the average annual HRA employer contribution for family coverage is $1,539.[69] According to the Mercer study, the median employer HSA contribution for family coverage is $1,200, and the median HRA employer contribution for family coverage is $1,000.[70]

**Public sector findings**. Four of the 13 public entities that participated in our survey currently offer a CDHP plan. The details of these plans are illustrated in the table below.

The GBP does not offer an HDHP or CDHP plan option.

***Figure 6.21: Features of a "typical" CDHP plan***

| | Florida | Georgia | Pennsylvania | City of Houston |
|---|---|---|---|---|
| **Individual deductible per year** | $1,250 | $1,300 | $1,500 | $1,500 in network, $3,000 out of network |
| **Individual out-of-pocket max per year** | $3,000 | $3,000 | $500 after HRA in network, $3,500 after HRA out of network | $5,000 in network, $10,000 out of network |
| **Employer deposit to HSA for individual coverage per year** | Up to $500 ($41.66 per month for full-time employees with individual coverage) | N/A | $1,000 HRA credit (Members receive credits annually and can roll over any remaining funds from year to year.) | $500 HRA credit |
| **Family deductible per year** | $2,500 | $3,250 | $2,000 | $3,000 in network, $6,000 out of network |
| **Family out-of-pocket max per year** | $6,000 | $7,000 | $1,000 after HRA in network $7,000 after HRA out of network | $10,000 in network, $20,000 out of network |
| **Employer deposit to HSA for family coverage per year** | Up to $1,000 ($83.33 per month for family coverage) | N/A | $2,000 HRA credit (Members receive credits annually and can roll over any remaining funds from year to year.) | $1,000 HRA credit |

*Note: Georgia refers to HRA Wellness option. Illinois plans to implement this type of plan later in the plan year.*

## WHAT INCENTIVES ARE USED TO ENCOURAGE HEALTHY BEHAVIORS?

### Health risk assessments

**Private sector findings.** Based on the surveys reviewed for this report, private sector employers appear to use incentives most frequently to encourage participation in health risk assessments.

- According to the Aon Hewitt survey, 49% of employers offered incentives for health risk assessments—more than half (66%) used monetary incentives and 20% used nonmonetary incentives.
- The Mercer survey reported that 37% of employers with 500 or more employees and 57% of jumbo employers use incentives to encourage health assessment completion.
- When these incentives are offered, 43% of employers offer a lower employee premium contribution; 40% offer cash; 10% contribute to an HRA, HSA, or FSA; and 7% offer lower deductibles, copays, or other forms of cost sharing. Among the 43% of employers that lower the employee's premium contribution when the employee completes a health risk assessment, the median annual reduction is $240.
- The Kaiser survey reports that 42% of large employers with 200 or more employees offer financial incentives for health risk assessment completion.
- This survey also reports that among the employers who offer health risk assessment incentives, 41% offer gift cards, travel, merchandise, or cash; 23% offer smaller employee share of the monthly premium; 12% offer smaller deductibles; and 1% offer lower coinsurance rates.

The GBP does not require participants to take a health risk assessment, but they can earn wellness program points if they do.

**Public sector findings.** Five of the 13 public sector entities surveyed reported that they offer an incentive or penalty to encourage members to complete a health risk assessment. The table below describes the type of incentive or penalty used.

***Figure 6.22: Use of incentives/penalties for health risk assessments***

| GBP | Georgia | Ohio | City of Austin | City of Houston | Texas A&M |
|---|---|---|---|---|---|
| None, voluntary | $25 HRA credit for employee and covered spouse | Financial incentive of $50 for "Well-Being Assessment" | Four hours paid time off | Employees must complete or pay $25 monthly surcharge. | $50 annual deductible reduction for each family member over 18 who takes a health risk assessment each year |

*Note: Only survey participants that have incentives or penalties are included in table.*

***Figure 6.23: State of Pennsylvania's use of health risk assessments in the Get Healthy program***

State of Pennsylvania plan members can qualify for a "Get Healthy waiver" on monthly premium contributions.

According to a 2012 postcard sent to employees about participating in the program, "Completing a Health Assessment is easy and it's 15 minutes that could save you $750. Average savings based on reducing the contribution from 3% to 1.5% of annual gross base salary." **(https://www.pebtf.org/Uploads/Publications/1332146765.pdf)**

**Step 1:** Members must complete the health assessment every year to get the savings. Employee and spouse/domestic partner (if covered on employee's plan) must take the health assessment to qualify for the savings.

**Step 2:** Members are sorted into one of three groups: Healthy Profile, At-Risk Profile, or Chronic Profile.

**Step 3**: Depending on what category the member is in, he or she has to complete certain requirements to be eligible for the waiver on monthly premiums. For example, members in the Chronic Profile must participate in a disease management program to be eligible for the waiver.

**Get Healthy program participation rules can be viewed here:**
**https://www.pebtf.org/PDF/Get%20Healthy%20Program%20Participation%20Rules.pdf#search="get healthy"**

### Biometric screenings

**Private sector findings.** The Mercer survey reports that 22% of employers with 500 or more employees and 27% of employers with 20,000 or more employees use incentives to encourage member completion of biometric screenings.[77] According to the Aon Hewitt survey, 33% of employers offer incentives for biometric screenings—more than half (65%) used monetary incentives and 22% used non-monetary incentives.[78]

**Public sector findings**. Four of the 13 public entities included in our survey reported some sort of incentive offered to plan members to encourage participation in biometric screenings. The incentives are described in the table below.

***Figure 6.24: Biometric screening incentives***

| GBP | Georgia | Ohio | City of Houston | Texas A&M |
|---|---|---|---|---|
| N/A | Part of "Wellness Promise" – must complete to have the opportunity to enroll in Wellness Plan the following year | Financial incentive of $75 | Offered free to members | $50 annual deductible reduction for each family member who completes an annual physical |

*Note: Only survey participants that have incentives are included in table.*

The GBP does not require biometric screenings.

***Figure 6.25: State of Ohio's use of incentives through the Take Charge! Live Well! program***

Eligible employees and spouses can each earn up to $350 in reward cards by completing the "Pathway to Health" process.

**Step 1:** Assessment
- Biometric screening – earn $75
- Well-being assessment – earn $50
- Complete both by November 30, 2012 – earn an extra $25

**Step 2:** Action

*Online Pathway*
- Complete Well-being Plan – earn $100
- Complete four web items – earn $100

Coaching Pathway
- Participate in four coaching calls – earn $200

**http://www.tclw.das.ohio.gov/Default.aspx?tabid=308**

***Figure 6.26: Wellness plan options in the State of Georgia***

**Eligibility**

State Health Benefit Plan (SHBP) members and their covered spouses are eligible to enroll in a Wellness Plan option. Members can choose to enroll in Wellness HMO, HRA, or HDHP plan. If members cover their children and enroll in a Wellness Plan option, the children do not have to satisfy the requirements of the Wellness Promise. If a member currently has health issues (such as high blood pressure), s/he can still participate in a Wellness Plan option as long as s/he fulfills the "Wellness Promise" requirements.

**Wellness Promise**

To enroll in a Wellness Plan option, a member and his/her covered spouse are asked to keep the "Wellness Promise." The promise requires members to:

1. Complete an online health assessment through third-party administrator (Cigna or UnitedHealthcare) between January 1 and June 30, 2012.
2. Get a biometric screening at a SHBP screening event or doctor's office between July 1, 2011 and June 30, 2012. Screenings examine four metrics: blood pressure, body mass index, cholesterol, and glucose.

Members not wishing to take Wellness Promise steps may elect to enroll in the Standard HRA, Standard HMO, or Standard HDHP. Covered services under the Standard options are the same as benefits under the Wellness options, but members pay higher premiums and out-of-pocket expenses.

If a member or spouse who enrolls in a Wellness Plan option does not take the actions required under the Wellness Promise, s/he will be limited to enrollment in one of the Standard Plan options for 2013 and will likely pay a higher monthly premium and have more out-of-pocket expenses.

Incentives to participate include:
- lower premiums (premium savings are 6% for Plan Year 2012),
- lower copays, deductibles, and maximum out-of-pocket limits,
- additional HRA credits, and
- waiver of certain drug costs for HRA members who actively engage in the Disease State Management (DSM) programs for cardiovascular disease, diabetes, or asthma.

### Tobacco cessation incentives

**Private sector findings.** The Mercer survey reports that 17% of all large employers and 35% of jumbo employers offer rewards to employees who do not use tobacco.[79] According to the Aon Hewitt survey, 27% of employers offer incentives to employees who participate in tobacco cessation programs.[80]

**Public sector findings**. Eleven of the 13 public sector entities surveyed reported that they offer incentives and/or penalties to discourage tobacco use among members. Figure 6.27 describes these incentives and penalties.

***Figure 6.27: Tobacco use incentives***

| California | Illinois | Michigan | North Carolina | Ohio |
|---|---|---|---|---|
| PERS Select, PERS Choice: Plan pays 100% of smoking cessation program fees, up to $100 per calendar year. | Smoking cessation program gives each member a $200 rebate for successful completion. | Plan offers:<br>• free smokers Quit-Kit online,<br>• one-time reimbursement for nicotine replacement patch, if enrolled in cessation counseling,<br>• one-time reimbursement up to $50 for Smoking Cessation Abatement Assistance (receipt and completion certificate required), and<br>• individual benefits offered by PPO and HMO plans. | Quitline NC (available 24/7) offers support by phone and free nicotine replacements patches when member talks to a coach and enrolls in the multi-call program. All prescription meds and physician behavioral health counseling are covered by state plan. | State employees and spouses are eligible to participate in the phone coaching program for a $200 incentive if they have completed both a Well-Being Assessment and the biometric screening; tobacco cessation is an option. (See Figure 6.25.) |
| **Travis County** | **City of Austin** | **Texas A&M** | **Univ. of Texas** | |
| Pharmacy benefit waives six months of copays if members choose Zyban or Chantix (prescription smoking cessation drugs) via Travis County wellness clinic. | Program waives six months of copays/ deductibles for prescription smoking cessation drugs and over-the-counter (OTC) nicotine replacement therapy, if member attends smoking cessation course. | Tobacco cessation programs are available through BCBS and smoking cessation products are covered through the drug plan. | Program offers free nicotine replacement therapy, tobacco cessation medications, and counseling. | |

*Note: Only survey participants that have incentives are included in table.*

***Figure 6.28: Tobacco use penalties***

| GBP | Georgia | City of Houston | Texas A&M | Univ. of Texas |
|---|---|---|---|---|
| $30 added contribution per tobacco user per month, up to $90 per family | $80 monthly contribution per family who has a tobacco user | $25 monthly surcharge to tobacco users | Starting September 1, 2012: $30 tobacco premium per tobacco user per month, up to $90 per family | $30 tobacco premium per tobacco user per month, up to $90 per family |

*Note: Only survey participants that have penalties are included in table.*

## VALUE-BASED INCENTIVE DESIGN (VBID)

As discussed in the Plan Design section of this report, value-based incentive design (VBID) bases the cost that a member pays on the clinical value of the service or drug. The purpose of VBID is to steer individuals toward clinically valuable care by reducing the amount that members have to pay. The idea is that a lower cost will incentivize use of clinically effective drugs and services and, in the long run, lower overall health care costs for a health plan. For example, a member with diabetes may be more likely to purchase and adhere to medications if the copay cost is lowered for the diabetes-related drug classes that are most clinically effective. The member's increased use of and adherence to diabetes drugs could then prevent the expensive diabetes-related conditions down the line that place a heavy cost burden on the plan as a whole. Another VBID approach could increase the cost of an expensive or over-utilized service—such as the emergency room or high-tech radiology—to steer members away from it.

**Private sector findings**. In the private sector surveys reviewed for this report, information about the use VBID varies. According to the Aon Hewitt survey, 23% of employers reported that they will include VBID in their health plans in 2011 and another 55% are considering VBID inclusion in their plan design strategies over the next three to five years.[81] Among employers who currently use a VBID approach, 91% do not have specific requirements for members (i.e., the completion of a health risk assessment to be eligible for lower copays) and 16% of employers use VBID features to target specific health conditions—diabetes, asthma, hypertension, and cardiovascular diseases are the most popular targeted conditions.[82] The Mercer study reports that 17% of all large employers and 31% of jumbo employers used VBID provisions in their plans in 2011.[83]

**Public sector findings.** The most common type of VBID reported by the public sector entities surveyed for this report is offering lower copays for urgent care compared to emergency room care. Again, the idea is that lower copays for urgent care will encourage members to choose this less expensive option. Eleven of the 13 public sector entities surveyed have plan incentives that encourage members to choose urgent care over emergency room care. The details of these incentives are illustrated in the table below.

GBP HealthSelect participants pay a $150 copay for ER services compared to a $50 copay for urgent care. Both services require a 20% coinsurance after the copay.

***Figure 6.29: Emergency room deterrence incentives***

| GBP | California | Florida | Illinois | Michigan | North Carolina |
|---|---|---|---|---|---|
| $150 copay for ER vs. $50 copay for urgent care. Both services also have a 20% coinsurance. ER copay waived if admitted to the hospital. | ER $50 deductible (waived if admitted) + 20% coinsurance vs. urgent care $20 copay in network, 40% coinsurance out of network. | $100 copay for ER vs. $25 copay for urgent care. | $200 copay for ER vs. $15 copay for urgent care. | Hired before 04/01/10 $50 copay for ER, if not admitted, vs. $15 copay for in-network urgent care.<br><br>Hired on or after 04/01/10 $200 copay for ER, if not admitted, vs. $20 copay for in-network urgent care.<br><br>$233 copay plus 20% coinsurance after deductible for ER (both in and out of network) vs. $87 copay for urgent care (both in and out of network). | 80/20 Standard Plan<br><br>$233 copay plus 20% coinsurance after deductible for ER (both in and out of network) vs. $87 copay for urgent care (both in and out of network). |
| **Ohio** | **Travis County** | **City of Austin** | **City of Houston** | **Texas A&M** | **Univ. of Texas** |
| $75 copay for ER vs. $25 in-network copay or $30 out-of-network copay for urgent care, with same coinsurance. | $125 copay for ER under all plans vs. $25 copay for in-network urgent care or 30% co-insurance for out-of-network urgent care. | $125 copay for ER vs. $35 copay for urgent care POS. | $200 copay for ER vs. $60 copay for urgent care. | Deductible and 30% coinsurance for ER vs. $30 copay for urgent care. | $150 copay for ER vs. $35 copay for urgent care. |

*Note: Only survey participants that have incentives are included in table.*

***Figure 6.30: Other value-based incentive designs***

| GBP | Ohio | North Carolina |
|---|---|---|
| $100 copay for high-tech radiology + 20% coinsurance. | Free diabetic supplies and free diabetic medications, including insulin, when enrolled. | Retirees who take medications to manage their cholesterol, blood pressure, or blood sugar can order a 90-day supply of their medications from selected pharmacies for 2 ½ times the copay. Select diabetes supplies are also eligible for the reduced copay amount. |
| **City of Austin** | **City of Houston** | **Texas A&M** |
| $100 copay for high-tech radiology. | $100 copay for outpatient high-tech radiology. (No copay for inpatient high-tech radiology.) | $50 annual deductible reduction for each family member over 18 who takes a health risk assessment each year |

*Note: Only participants that have incentives are included in this table.*

### Generic drug incentives

**Private sector findings.** According to Mercer, the most common generic drug incentive used by large companies is a "mandatory generic" provision. Nearly half (45%) of large employers (1,000+ employees) have a mandatory generics program in place. About a quarter (26%) have a "member pays the difference" provision, which requires the member to pay the generic copay, plus the extra amount above the generic copay if they choose to fill a brand-name drug when an identical generic is available.[84]

**Public sector findings.** Eleven of the 13 public sector entities surveyed reported that they have a generic drug incentive in place. These incentives are summarized in the tables below.

Prescription drug coverage under the GBP includes a retail maintenance fee (RMF). The RMF is an additional copay applied to a maintenance drug filled at a retail pharmacy. It acts as a convenience fee and essentially requires the member to absorb the extra cost of purchasing a maintenance drug at a retail pharmacy instead of using the less expensive mail-order service. Some pharmacies in the HealthSelect network will fill an extended-days supply at the mail-order rate. A list of participating pharmacies is available on the HealthSelect pharmacy benefit manager's website.

GBP HealthSelect participants are subject to a "member pays the difference" penalty when they choose to fill a brand-name drug and an identical generic is available.

***Figure 6.31: Generic drug incentives – large states***

| GBP | Florida | Georgia | Illinois |
|---|---|---|---|
| If a member chooses to fill a brand-name drug when a generic is available, the member pays the generic copay plus the difference between the brand-name and the generic drug | If a member chooses to fill a brand-name drug when a generic is available, the member pays the brand copay plus the difference between the brand-name and the generic drug. | **HRA Wellness Traditional Preferred Drug List:**<br><br>Tier 1<br>Member pays 15%<br>($20 min/ $50 max).<br><br>Tier 2<br>Member pays 25%<br>($50 min/ $80 max).<br><br>Tier 3<br>Member pays 25%<br>($80 min/$125 max). | If a member chooses to fill a brand-name drug when a generic is available, the member pays the generic copay plus the difference between the brand-name and the generic drug. |
| **Michigan** | **North Carolina** | **Ohio** | **Pennsylvania** |
| If the employee chooses to fill a brand-name drug when a generic is available, the member pays a higher co pay for the drug. | Pilot program to reduce the cost of cholesterol-lowering generic drugs | Non-preferred brand generic unavailable $50 for 30-day supply, $125 for mail-order 90-day supply, $150 for 90-day retail supply.<br><br>Non-preferred brand generic available Same copays and member pays price difference between brand-name and generic. | Lower copays for generic drugs. |

*Note: Only participants that have incentives are included in this table.*

***Figure 6.32: Generic drug incentives – other public sector entities***

| Travis County | City of Houston | Texas A&M | Univ. of Texas |
|---|---|---|---|
| If a member chooses to fill a brand-name drug when a generic is available, the member pays the generic copay plus the difference between the brand-name and the generic drug. | If a member chooses to fill a brand-name drug when a generic is available, the member pays the generic copay plus the difference between the brand-name and the generic drug. | If a member chooses to fill a brand-name drug when a generic is available, the member pays the generic copay plus the difference between the brand-name and the generic drug. | If a member chooses to fill a brand-name drug when a generic is available, the member pays the generic copay plus the difference between the brand-name and the generic drug. |

*Note: Only participants that have incentives are included in this table.*

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## GLOSSARY OF TERMS

**Accountable Care Organization (ACO):** A fully integrated health care service delivery model that includes primary care physicians, specialists, physician extenders (nurse practitioners, pharmacists, physical therapists, etc.), and hospitals. An ACO agrees to be accountable for the quality, cost, and overall care of an assigned set of participants.

**Affordable Care Act (ACA):** federal law signed by President Barack Obama on March 23, 2010. This law enacted 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.

**Certificate of Need (CON):** A legal document that is required by some federal and state entities before major health care facilities can be acquired, expanded, or built. CONs verify that facility plans appropriately meet community needs. CON programs were created to limit the health care price inflation that occurs when the supply of health care services outweighs the demand in the local community.

**Medicare Connector model:** An exchange model provided by a vendor that helps a Medicare retiree access insurance coverage. Retirees use employer subsidies (often deposited in a Health Reimbursement Arrangement) to purchase commercial insurance products through the vendor

**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 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; outlines what portion of total health plan costs will be paid by the employer and what portion will be paid by the members (expressed as a percentage).

**Corporate Practice of Medicine:** A legal doctrine that prohibits corporations, entities, or individuals (i.e. non-physicians) from practicing medicine. Physicians are prohibited from entering into partnerships, employee relationships, fee splitting, or other situations with non-physicians where the physician's practice of medicine is in any way influenced by a non-physician.

**Death spiral:** An insurance concept occurring when healthy, low cost members drop out of a health insurance plan because they find cheaper coverage elsewhere, and sicker members—who can't afford to leave—stay in the plan. When this happens, the average cost per member increases rapidly, leading to a further concentration of unhealthy (expensive) members. Eventually the plan will be discontinued due to unaffordability.

**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. This approach is one method for a plan sponsor to obtain federal subsidies that offset prescription drug costs incurred by plan members.

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

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

**Grandfathering:** When an 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 payments to health care providers, including price inflation, the mix of services provided, and changes in health care utilization.

**HMO plan:** A pre-paid health program where health care services are arranged for the members through specific, closed network of providers.

**Health reimbursement arrangement (HRA):** A tax-advantaged account that allows employers to set aside a specific amount of money (usually annually) that employees can then use to pay for health care-related expenses.

**Health savings account (HSA):** A tax-advantaged account that individuals use to pay for 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.

**Indemnity plan:** A type of insurance plan that allows members to see any provider that they want—there is no in-network or out-of-network distinction. Members usually pay a deductible and then a portion of the cost of each medical service used.

**Insurance exchange:** A centralized and regulated place for individuals to access health insurance; further developed as a provision under the Accountable Care Act.

**Medicare Advantage plan:** A type of insurance plan that is provided by private insurance companies. It replaces 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 C:** This part of Medicare pertains to Medicare Advantage plans.

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

**Medicare Part F:** This part of Medicare pertains to Medigap coverage.

**Medigap coverage:** A supplemental plan that covers part of the difference between the expenses reimbursed by Medicare and total eligible charges.

**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.

**Other post-employment benefits (OPEB):** The benefits that an employee receives during retirement. Can include health benefits; pension benefits are not included.

**PAYGO (Pay-As-You-Go):** A financing method where you pay for expenditures with available funds rather than borrowed funds investment returns from a trust.

**Point-of-Service (POS) plan:** A type of managed care insurance plan where the member chooses an in-network primary care physician who provides and directs all medical care for the member. The primary care physician makes referrals as necessary and members pay more if they choose providers that are not in the network.

**Preferred Provider Organization (PPO) plan:** A type of managed care insurance plan where members receive the highest level of benefits when they choose a health care provider that is contracted with the administrator (in-network). Unlike POS plans, PPO plan members do not have to go through a primary care physician to see a specialist.

**Reference based pricing:** A cost containment policy in which the plan sets a fixed price that it will pay for drugs within a certain therapeutic class.

**Retiree drug subsidy (RDS):** A program offered by the federal government under Medicare Part D. The federal government pays a plan sponsor a subsidy for a portion of the drug costs of eligible retirees who do not enroll in Medicare Part D but instead continue to receive drug coverage through their former employer's plan.

**Risk pool:** The total number of participants eligible for coverage under the plan regardless of whether or not they are enrolled in the plan.

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

**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."

**Therapeutic substitution:** A cost containment policy that allows a pharmacist to substitute a chemically different drug — for example, changing a brand-name prescription to a generic within the same therapeutic category.

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

**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. Increased access to, and use of, clinically valuable drugs and services can improve member health outcomes and save the plan money.

**Acronym List**

**ACA**: Affordable Care Act

**ACO**: Accountable Care Organization

**ADEA**: Age Discrimination in Employment Act

**CBO**: Congressional Budget Office

**CDHP**: Consumer Driven Health Plan

**CON**: Certificate of Need

**EGWP**: Employer Group Waiver Plan

**EOI**: Evidence of Insurability

**ERRP**: Early Retirement Reinsurance Program

**ERS**: Employees Retirement System

**FFS**: Fee for Service

**FY**: Fiscal Year

**GBP**: Group Benefits Program

**GDR**: Generic Dispensing Rate

**GINA**: Genetic Information Nondiscrimination Act

**HDHP**: High Deductible Health Plan

**HIPAA**: Health Insurance Portability and Accountability Act

**HMO**: Health Maintenance Organization

**HSA**: Health Savings Account

**HRA**: Health Reimbursement Arrangement; Health Risk Assessment

**MA**: Medicare Advantage

**OPEB**: Other Post-Employment Benefits

**PAYGO**: Pay-As-You-Go

**PCMH**: Patient Centered Medical Home

**PCP**: Primary Care Physician

**PHI**: Personal Health Information

**POH**: Physician-Owned Hospital

**POS**: Point of Service

**PPO**: Preferred Provider Organization

**RDS**: Retiree Drug Subsidy

**TPA**: Third Party Administrator

**VBID**: Value Based Incentive Design

## APPENDIX A: POLICY FRAMEWORK AND REPORT METHODOLOGY

The Interim Benefits Study (IBS) report on the sustainability of the Texas Employees Group Benefits Program (GBP) is the result of a year-long research process designed to be transparent and inclusive of all stakeholders with an interest in the future of the plan. ERS' research goals were to present a balanced analysis of a range of options for the Legislature's consideration, and to provide data on the comparability of GBP benefits to other large public and private sector employer benefit plans.

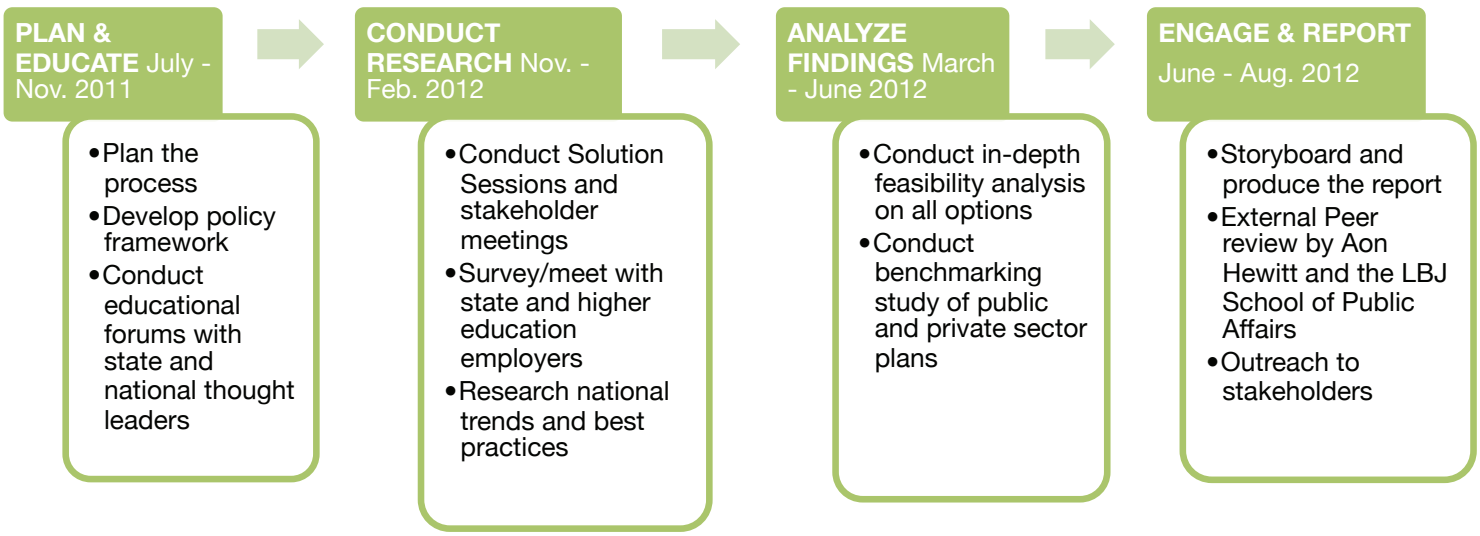
The IBS was designed to be a four-part process, illustrated in Figure A1. Along the way, we provided multiple opportunities for interested parties to comment on, contribute to, and monitor the progress of the report. See Common Appendix I for a complete list of participants in the IBS.

**Stage 1: Plan and educate**. ERS began in the summer of 2011 with a strategic planning process that defined the policy framework for the analysis. We convened an internal Executive Steering Committee comprising a cross-divisional team of agency leadership. As a foundation for analyzing options for sustainability, the committee identified a basic set of assumptions for the report:

- The cost of the current health care plan is unsustainable and will continue to rise.
- The State will continue to experience budget pressures.
- Competition for limited resources will always exist.
- Plan membership will continue to grow, especially the retiree population.
- Projected costs for future retiree health insurance benefits will continue to grow until addressed.
- Members believe that health insurance is an essential part of the benefits package.
- High quality standards for provider care and professional management should be met.
- Benefits should be comparable to the private sector.
- Health care costs should be reasonable and manageable for the plan and for participants.
- Responsibility for health decisions and costs should be shared with members and providers.
- A changing workforce may need different types of benefits choices.

In consideration of the breadth of the report assumptions, the high visibility of the study, and potential impact of study outcomes on a wide range of stakeholders, ERS added an educational component to the study process. In November 2011, we hosted an onsite educational forum to report on the State of the ERS, and to gather input on national health trends and best practices from leading authorities in the benefits field, academic and policy experts, and legislative representatives. The educational forum was live streamed on the internet, and all presentations and materials are posted on ERS' website in a special area dedicated to the IBS.

***Figure A1: Interim Benefits Study research process***



**Stage 2: Conduct research.** From October 2011 through February 2012, ERS conducted an extensive literature review and solicited feedback from employee and retiree associations, policy and advocacy groups, and representatives from physician, hospital, and pharmacist associations. We also hosted 15 live-streamed Solution Sessions so that vendors could present specific savings ideas for the plan.

During this time period, ERS developed a policy framework for organizing and analyzing the options that arose during the research phase of the report. This framework became the working outline for the report. The intention was to address major policy questions in five areas under the governance of the Legislature and/or the ERS Board of Trustees—eligibility, contribution strategy, appropriations, professional management, and plan design.

A sixth section was added to report on ERS' benchmarking study of how GBP benefits compare in the marketplace. We collected private sector data from a selection of authoritative national surveys, and our consulting actuary used this data to model the GBP benefit against a "typical" private sector plan. We also gathered public sector data through internet research and by sending surveys to 19 large state, city, county, and higher education employer-based health insurance programs. Only data that could be confirmed with a benefits professional employed by the public sector entity was included in the benchmarking study. Our final sample size included 13 public entities.

Concurrent with its study of the health plan, ERS also conducted a study of the pension plan. Supplemental to both reports, ERS gathered research on the state workforce through a literature review, an employer survey and numerous meetings with Texas state agencies and institutions of higher education. This research focused on characteristics of the state workforce, how benefits contribute to the recruitment and retention of qualified employees and the perceived impact of potential benefit changes on employers' ability to meet their operational goals. The health and pension reports share several "common appendices" that describe the outcomes of our workforce research and the shared stakeholder participation in both reports.

**Stage 3: Analyze findings.** In March 2012, the process of consolidating and analyzing the dozens of options identified during the research process began.

ERS developed a working definition of the word "sustainability" and a set of general sustainability "screening questions" to guide our analysis of the many options gathered during the research phase.

1. Does it manage health care costs?
2. Does it reduce cost to the employer?
3. Does it share risk with providers and responsibility with members?
4. Does it ensure a basic level of comparable benefits?
5. Does it encourage behavior change and improve health outcomes?
6. Do the Legislature and/or ERS have the authority to make the change?
7. Does federal health care reform have an impact?
8. Does it affect the projected cost of Other Post-employment Benefits (OPEB)?
9. Who is affected and to what extent by this option?

***Figure A2: Policy analysis framework***

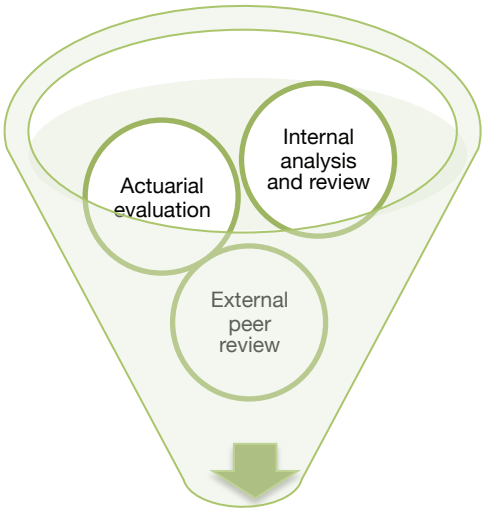
| REPORT SECTION: SUBJECT AREA | GOVERNANCE OF THIS AREA | POLICY QUESTIONS | TYPES OF OPTIONS ANALYZED |
|---|---|---|---|
| Section 1: Eligibility | Legislature | Who should be eligible for coverage under the plan? | Two options for changing eligibility for certain groups currently covered by the GBP |
| Section 2: Contribution Strategy | Legislature | How should the employer and the member share the cost of coverage? | Nine options for changing the contribution strategy for employees, retirees, and/or dependents |
| Section 3: Appropriations | Legislature | What is the proper funding level? Does the funding process provide flexibility? | The legislative appropriations process, how the funding process could facilitate sustainability, and how to use appropriated funds to incentivize behavior change |
| Section 4: Professional Management | ERS Board of Trustees | How do cost management initiatives save the plan money? | Thirteen options and best practices for managing costs, maximizing the coordination of Medicare benefits contracting, alternative payment systems, and administrative tools |
| Section 5: Plan Design | Legislature and ERS Board of Trustees | How can the plan design ensure quality, provide choice, and align incentives with health risks? | Thirteen options for offering plan choice, carving out specialized services, value-based insurance design (VBID), generic drug incentives, and employer solutions |
| Section 6: Benchmarking Study | Independent analysis conducted by ERS | How do GBP benefits compare? | Comparison of a "typical" private sector plan against the GBP and reporting on the major features of 13 other large public employer benefit programs (state, county, city, and higher education). |

During the screening process, some options were combined with others, and some were dropped from the report because they were not found to substantially contribute to the sustainability of the program. The final report includes 37 option analyses.

> Sustainability means… managing health care costs to the State, while continuing to offer participants and employers health insurance benefits that are comparable to other large private/public sector employers.

ERS then performed a second, more comprehensive feasibility analysis on each of the remaining 37 options. We established an internal working group composed of subject-matter experts in the areas of finance, contracts, legal, government relations, customer benefits, information systems, and communications. The working group was then further divided into five teams correlated with the major policy areas identified in Figure A2.

***Figure A3: Option analysis and review process***




Each feasibility analysis produced a complete background review of the option, outlined the major pros and cons of the option, and also reviewed the fiscal impact, the customer impact, the legal, policy and operational impact. Each option is presented in the final report with a condensed version of its feasibility analysis.

This dual evaluation framework was applied to each option publicly presented to ERS during one of the "Solution Sessions," as well as to other best practices that we encountered in the educational forum and in our literature review. The ERS consulting actuary calculated the financial implications of options presented in the eligibility and contribution strategy sections of the report. All option analyses were then subject to a senior-level review by the Executive Steering Committee.

**Stage 4: Engage and report.** In the summer of 2012, ERS stepped back to conduct a comprehensive, big-picture review of all the data and options collected to date. During this process a section was added to the Executive Summary addressing underlying cost drivers and other potential barriers to change in the health care system. This became an essential part of the analysis, as our research shows that the best employer-sponsored plans are not just shifting costs to employees, but instead are making serious efforts to understand why the system is unsustainable, then using that information to design strategic, targeted solutions.

The report was visually structured using a comprehensive "storyboarding" technique that mapped out how each of the 37 options relates to identified cost drivers and responds to the policy questions posed, and that also showed where the options fall in the governance structure (that is, who has the authority to make changes necessary to implement any particular option). As the report was written, multiple stakeholder groups were invited to visit ERS for a personal tour of the "storyboard room." Many of their comments were used to flesh out the "pros and cons" in the option analyses.

Finally, ERS felt strongly about presenting the Legislature with a balanced analysis, so before publication, we submitted an advanced draft of the report for independent peer review by Aon Hewitt and the LBJ School of Public Affairs at The University of Texas at Austin to validate our research process and findings. The report received a favorable review from both peer reviewers and a number of their suggestions were addressed in the final version of the report.

Upon completion, the report was submitted to the governor and legislative leadership on September 4, 2012. This date marked the beginning of an ongoing process of educating our stakeholders on the outcomes of the report.

In addition, because FY12 data on the GBP was not available at publication date, the entire report will be updated again as that data becomes available. The report will be published online, and only a limited number of reports will be printed until final data becomes available. The updated report is scheduled for publication in January 2013, around the start of the 83rd legislative session.

## APPENDIX B: 2012 INTERIM BENEFITS STUDY – Sustainability Review of GBP OPTIONS

| Does it manage health care costs? | Does it reduce cost to the employer? | Does it share risk with providers and responsibility with members? | Does it ensure a basic level of comparable benefits? | Does it encourage behavior change and improve health outcomes? | Do the Legislature and/or ERS have the authority to make the change? | Does federal health care reform have an impact? | Does it affect the projected cost of OPEB? |
|---|---|---|---|---|---|---|---|
| **1.1 Eliminate coverage for all members and send them to the exchange in 2014** | | | | | | | |
| No. | Yes. | Shifts costs to retirees, employees, and their dependents. | No. | No. | The Legislature, yes.<br><br>ERS, no. | Yes. | Without grandfathering, 100% reduction in projected OPEB cost. |
| **1.2 Eliminate coverage for retirees** | | | | | | | |
| No. | Yes. | Shifts costs to retirees and their dependents. | Yes. | No. | The Legislature, yes.<br><br>ERS, no. | No. | Without grandfathering, 100% reduction in projected OPEB cost. |
| **2.1 Tier employee contributions based on salary** | | | | | | | |
| No. | Yes. | Shifts more cost to employees with higher income. | Yes. | No. | The Legislature, yes.<br><br>ERS, no. | Yes, to the extent that it doesn't increase the member-only contribution to more than 9.5% of an individual's income. | No impact on projected OPEB cost. |
| **2.2 Tier employee contributions based on tenure** | | | | | | | |
| No. | Yes. | Shifts more cost to employees with shorter length of service. | Yes. | No. | The Legislature, yes.<br><br>ERS, no. | Yes, to the extent that it doesn't increase the member-only contribution to more than 9.5% of an individual's income. | No impact on projected OPEB cost. |
| **2.3 Defined contribution for Medicare-primary retirees deposited into a Health Reimbursement Arrangement (HRA), with a "connector model"** | | | | | | | |
| No. | Yes. | Could change costs up or down for retirees. | Yes for private sector. Not necessarily for public sector. | No. | The Legislature, yes.<br><br>ERS, no. | No. | Unclear. |
| **2.4 Charge retirees full actuarial cost of their insurance** | | | | | | | |
| No. | Yes. | Shifts costs to retirees. | Yes. | No. | The Legislature, yes.<br><br>ERS, no. | No. | Without grandfathering, 100% reduction in projected OPEB cost. |
| **2.5 Tier retiree contributions based on years of tenure** | | | | | | | |
| No. | Yes. | Shifts costs to retirees with less than 20 years of service. | Yes. | No. | The Legislature, yes.<br><br>ERS, no. | No. | Without grandfathering, 10% reduction in projected OPEB cost. |
| **2.6 Raise member contributions for member-only coverage** | | | | | | | |
| No. | Yes. | Shifts costs to members. | Yes. | No. | The Legislature, yes.<br><br>ERS, no. | Yes, to the extent that it doesn't increase the member-only contribution to more than 9.5% of an individual's income. | At a 90/50 contribution strategy for all actives and retirees, there would be a 7% reduction in projected OPEB cost.<br><br>At an 80/50 contribution strategy for all actives and retirees, there would be a 14% reduction in projected OPEB cost. |

| Does it manage health care costs? | Does it reduce cost to the employer? | Does it share risk with providers and responsibility with members? | Does it ensure a basic level of comparable benefits? | Does it encourage behavior change and improve health outcomes? | Do the Legislature and/or ERS have the authority to make the change? | Does federal health care reform have an impact? | Does it affect the projected cost of OPEB? |
|---|---|---|---|---|---|---|---|
| **2.7 Raise contribution for participants who do not participate in disease management** | | | | | | | |
| Potentially manages costs if chronically ill members are better managing their care. | Yes. | Shifts costs to eligible people who do not enroll in disease management. | Yes. | Yes. | The Legislature, yes.<br><br>ERS, no.<br><br>Plan design would have to address potential HIPAA implications. | Yes, to the extent that it doesn't increase the member-only contribution to more than 9.5% of an individual's income. | No impact on projected OPEB cost. |
| **2.8 Raise member contributions for dependent coverage** | | | | | | | |
| No. | Yes. | Shifts costs to members with dependents. | No. | No. | The Legislature, yes.<br><br>ERS, no. | No. | Without grandfathering, 3% reduction in projected OPEB cost. |
| **2.9 Surcharge for employee's spouses who have access to other coverage** | | | | | | | |
| No. | Yes. | Shifts costs to some members with dependents. | Yes. | Yes. | The Legislature, yes.<br><br>ERS, no. | No. | No impact on projected OPEB cost. |
| **4.1 Retiree Drug Subsidy (RDS) past claims reprocessing** | | | | | | | |
| No. | Maybe. Additional RDS federal subsidies for Medicare Part D members, for past four years, potentially back to 2006. | No. | No. | No. | Yes.<br>ERS can make this change without legislative change. | RDS became taxable 01/12 (no effect on GBP)<br><br>This change has encouraged some private sector employers to switch to EGWP. | No. |
| **4.2 Employer Group Waiver Program + Wraparound Supplemental Plan (EGWP + Wrap)** | | | | | | | |
| No. | Yes, potential for additional federal subsidies for Medicare Part D members. | No. | Yes. Basic Medicare Part D plan required. | No. | Yes.<br>ERS can make this change without legislative change. | 50% subsidy of brand-name drugs in the "donut hole" by drug manufacturers. | Yes. |
| **4.3 High-performance networks** | | | | | | | |
| Yes. | Could save money by providing more cost effective treatment with the same or better outcomes.<br><br>Does not add to administrative costs. | Yes, provider networks would be tiered based on cost and quality outcomes.<br><br>Many current in-network providers would be moved to networks that would cost the member more.<br><br>Shares cost with members. | This is being used in other plans, but not to a wide extent. | Value-based benefit should improve health outcomes by steering members to more effective providers. | ERS could implement this. | No. | Small impact over the long term. |
| **4.4 Results-based hospital contracts using quality metrics** | | | | | | | |
| Yes, by reducing the number of expensive events (e.g., readmissions "never events") that increase costs to the plan. | Yes, it allows the TPA to negotiate lower rates. | Yes, shares risk with providers.<br><br>Relatively easy form of provider incentive with low administrative costs. | This is in line with Medicare policy not to pay for "never events."<br><br>Helps keep hospitals in the network. | Doesn't encourage behavior change but does improve health outcomes. | Yes,<br>ERS can work with the TPA to make this change. | No impact. | Minimal impact. |

| Does it manage health care costs? | Does it reduce cost to the employer? | Does it share risk with providers and responsibility with members? | Does it ensure a basic level of comparable benefits? | Does it encourage behavior change and improve health outcomes? | Do the Legislature and/or ERS have the authority to make the change? | Does federal health care reform have an impact? | Does it affect the projected cost of OPEB? |
|---|---|---|---|---|---|---|---|
| **4.5 Surgical Centers of Excellence and/or medical tourism** | | | | | | | |
| Yes. | Yes, through improved outcomes. | Relatively easy form of member incentive with low administrative costs. | Yes, many private employers direct care to Centers of Excellence. | Incentivizes behavior change by directing members to more efficient providers.<br><br>Potential to improve health outcomes. | Yes, ERS can work with the TPA to make this change. | No impact. | Minimal impact. |
| **4.6 Accountable Care Organizations (ACOs)** | | | | | | | |
| Yes, it has the potential to manage costs, even in the short term. | Yes, it has the potential to reduce costs with no increase in administrative costs. | Yes. It moves some risk to provider and rewards them for managing it.<br><br>Shared savings with providers depend upon reduced cost trend and quality outcomes. | Yes, alternative payment programs are consistent with national trends.<br><br>ERS is ahead of the curve with its Patient-Centered Medical Home projects. | No direct incentive exists for the member, although the ACO model should improve health outcomes through an intense focus on wellness and better coordination of care. | An ACO requires that a hospital be integrated into the spectrum of contracting medical providers.<br><br>In Texas, this could require legislative changes to the Corporate Practice of Medicine Act, and to the Insurance Code to allow shifting of risk to the provider outside the HMO setting. | Yes, the ACO model is now being used in the Medicare program. | It may have a small impact over the long term. |
| **4.7 Patient-Centered Medical Home (PCMH)** | | | | | | | |
| Yes. This is proven to reduce costs. | Yes, with no increase in administrative costs. | Yes. Shared savings with providers are dependent upon reduced trend and quality outcomes. | Yes, alternative payment programs are consistent with national trends. ERS is ahead of the curve with its' pilot projects. | No direct incentive for member, although it should improve health outcomes through better coordination of care. | Yes, ERS has already implemented three Patient-Centered Medical Homes. | Yes, alternative systems have been used in the Medicare program. | Small impact over the long term. |
| **4.8 Management tools** | | | | | | | |
| Potentially, in the long term. | Vendors claim it will reduce cost. | No. | Yes, other plans use management tools. | No. | Yes,<br>ERS can do this. | No. | No. |
| **4.9 Claims data mining tools** | | | | | | | |
| Potentially, in the long term. | Vendors claim it will reduce cost. | No. | Yes, other plans use data mining tools. | No. | Yes,<br>ERS can do this. | No. | No. |
| **4.10 Cultural assessment of targeted segments of the GBP population** | | | | | | | |
| Potentially, in the long term.<br><br>Could help target messaging and communication strategies. | Could increase cost. | Increases awareness of the member. | This option is not widely used. The vendor had used the assessment with its own employee population. | Potentially. Depends on what is done with the data collected. | Yes,<br>ERS can do this. | No. | No. |
| **4.11 Required health risk assessments (HRAs) and/or biometric screenings with personal coaching and ongoing data collection** | | | | | | | |
| Potentially, in the long term. | Biometric screenings are expensive and therefore cost prohibitive for many plans.<br><br>Difficult to document soft savings from avoided costs. | Would increase incentives for members to get blood pressure, cholesterol, and BMI screenings, which could lead to greater awareness of health risks. | Many private sector employers provide financial incentives to employees for completing an HRA. | To the extent that it identifies and encourages more eligible members to enroll in disease management. | Would require statutory change to require HRAs and biometric screenings.<br><br>ERS can provide optional risk assessment tools without legislative change. | No. | No. |

| Does it manage health care costs? | Does it reduce cost to the employer? | Does it share risk with providers and responsibility with members? | Does it ensure a basic level of comparable benefits? | Does it encourage behavior change and improve health outcomes? | Do the Legislature and/or ERS have the authority to make the change? | Does federal health care reform have an impact? | Does it affect the projected cost of OPEB? |
|---|---|---|---|---|---|---|---|
| **4.12 Incentives to encourage healthy behaviors and participation in lifestyle management programs at work** | | | | | | | |
| Potentially, in the long term. | Providing financial incentives to participate would cost money up front.<br><br>Difficult to document soft savings from avoided costs. | Shares responsibility with members to improve their health. | Yes, incentives for participating in disease management are common among employer-based plans. | Effective incentives should change behaviors and improve health outcomes. | ERS can implement a plan without incentives.<br><br>Any kind of employer-based incentive/reward would need special funding from the Legislature. | No. | Small effect in the long term. |
| **4.13 Require tobacco user opt-out rather than opt-in** | | | | | | | |
| If it successfully incentivizes members to quit using tobacco, it could reduce health care costs over the long term. | Yes. It collects premiums from tobacco users who may have been missed in the voluntary reporting model. | Yes, it shifts costs to tobacco users, and it requires non-tobacco users to affirmatively opt out of the higher premium. | Yes, other plans have done this. | Yes, it should create incentives for tobacco cessation. | Yes,<br>ERS can do this. | No. | No. |
| **5.1 Offering multiple plans** | | | | | | | |
| Offering choice may cost more due to the risk of adverse selection.<br><br>The aggregate cost of providing multiple plans could be higher than the cost of providing one plan. | Yes, if a lower-level benefit option were offered in addition to HealthSelect. | No risk is shared with providers.<br><br>Members will choose the plan that suits their individual needs. | Yes, most employers provide multiple plan choices. | Any time member costs increase, utilization will likely decrease, at least in the short term. | If you cut the basic plan to a low enough level and cover it at 100%, you could provide several buy-up options without a legislative change.<br><br>Ideally, you would want the flexibility to change the contribution strategy.<br><br>Would also need legislative change to fund health savings account (HSAs) with employer money. | Yes,<br>essential benefits package must be covered (60% of the total cost).<br><br>Must not charge individual member more than 9.5% of his/her salary in the basic plan. | Yes. |
| **5.2 Consumer-driven health plan (CDHP) with health savings account (HSA)** | | | | | | | |
| Yes, if it reduces utilization. | Depends on the plan design.<br><br>Yes, it shifts responsibility for a certain amount of the initial cost of care to the member, excluding preventive care services which are paid at 100%. | Doesn't share risk with provider.<br><br>Does share responsibility with member. | Yes, but the HSA can only be used by employees and pre-65 retirees, not by Medicare retirees. | Any time member costs increase, utilization will likely decrease. | If it's an option, need legislative change to the contribution strategy<br><br>Need legislative change to redirect employer contribution to the HSA.<br><br>Potential legislative change to authorize new payroll deduction. | No, not discussed in the law. | Minimal to none (indirectly). |

| Does it manage health care costs? | Does it reduce cost to the employer? | Does it share risk with providers and responsibility with members? | Does it ensure a basic level of comparable benefits? | Does it encourage behavior change and improve health outcomes? | Do the Legislature and/or ERS have the authority to make the change? | Does federal health care reform have an impact? | Does it affect the projected cost of OPEB? |
|---|---|---|---|---|---|---|---|
| **5.3 Deductible with a traditional managed care plan** | | | | | | | |
| Yes, if it reduces utilization. | Yes, it shifts responsibility for a certain amount of the initial cost of care to the member, excluding preventive care services which are paid at 100%. | Yes, it shares responsibility for additional costs with members. | Yes. | Encourages members to make more responsible choices. | Yes.<br>ERS can add this to the plan design. | Preventive services would be covered at 100%. | To the extent that it affects retiree benefits. |
| **5.4 Indemnity plan with a deductible and coinsurance** | | | | | | | |
| No. | No. | Yes, it shares responsibility for additional costs with members. | Very few employers offer it as a choice. | No, but it could make the cost of health care more transparent. | Yes.<br>ERS can add this to the plan design. | Preventive services would be covered at 100%. | No. |
| **5.5 Carve out care coordination for pre-65 retirees** | | | | | | | |
| Designed to control cost by managing care of high-risk individuals.<br><br>Pre-65 retirees in the GBP have the highest claims cost. | Very small net savings.<br><br>Could direct bill to the retiree. Increases administrative cost but reduces claims cost. | With providers, no. With members, potentially (depends on whether people are required to enroll or not). | Potentially steers high risk members toward Medicare Advantage.<br><br>Higher level of benefits than what is currently being offered by TPA. | Yes, participation in disease management encourages behavior change. | Yes.<br>ERS can add this to the plan design without legislative change.<br><br>If retirees were billed directly for the service, it could require legislative change. | No. | Minimal to none (indirectly). |
| **5.6 Partial carve-out for behavioral health services** | | | | | | | |
| Potentially. | Potentially, but it could require an upfront investment. | Vendor takes the risk on the funding, because it's a capitated arrangement.<br><br>Doesn't technically share the plan's cost risk. | Potentially broadens coverage, outside the health plan.<br><br>Depending on how it is designed, it could count toward ACA essential benefit. | Potential to improve health outcomes. | Yes.<br>ERS can add this to the plan design. | Depending on how it is designed, it could count toward ACA essential benefit. | Minimal to none (indirectly). |
| **5.7 Outsource a comprehensive tobacco cessation program** | | | | | | | |
| Vendor claims that the outreach will reduce costs.<br><br>If more members stop using tobacco, it might reduce costs in the long term. | Would cost more for the program in the short term.<br><br>Could be paid for by premium differential, but the $30 assessment is not currently earmarked for tobacco cessation in the appropriations bill. | Shares risk (cost) with member if it is combined with a premium differential. | Yes. | Effective interventions should change behaviors and improve health outcomes. | Plan has implemented this type of program by raising contributions for tobacco users, as directed by the Legislature. | No. | Minimal to none. |
| **5.8 Using VBID (value-based incentive design) in the GBP** | | | | | | | |
| Yes. | Yes. | No risk shared with providers.<br><br>Does provide financial encouragement to member to use lower-cost services. | Yes. | Yes, encourages member to use lower-cost, high-value services. | Yes.<br>ERS can add this to the plan design. | The ACA requirement for the plan to cover preventive care at no cost to the participant is one example of a VBID policy. | Minimal to none (indirectly). |

| Does it manage health care costs? | Does it reduce cost to the employer? | Does it share risk with providers and responsibility with members? | Does it ensure a basic level of comparable benefits? | Does it encourage behavior change and improve health outcomes? | Do the Legislature and/or ERS have the authority to make the change? | Does federal health care reform have an impact? | Does it affect the projected cost of OPEB? |
|---|---|---|---|---|---|---|---|
| **5.9 Minimally invasive procedures (MIPs)** | | | | | | | |
| Yes, these are less expensive procedures. | Yes. | Directs care to specific providers.<br><br>Members would pay less to have this procedure. | Yes, all procedures would still be available.<br><br>Member cost share could differ according to their choice of surgeon or procedure. | Yes. | Yes.<br>ERS can add this to the plan design and make it either voluntary or steer participants through cost sharing in the plan design. | No. | Minimal to none (indirectly). |
| **5.10 Reference-based pricing** | | | | | | | |
| Yes. Encourages members to use lower-cost medications when multiple choices are available. | Yes, if utilization goes down. | Yes, with members, who should be discussing costs of various drugs with their providers.<br><br>Major educational effort with members and providers. | Provides a baseline benefit.<br><br>Only applies to certain drug classes.<br><br>Could be applied to other benefits as well. | Potentially keeps health outcomes the same at a lower cost. | Yes.<br>ERS can make this change without legislative change; however it is a controversial policy. | No. | Minimal to none (indirectly). |
| **5.11 Step therapy** | | | | | | | |
| Yes. Encourages members to use lower-cost medications when multiple choices are available. | Yes, by encouraging people to use the lower-cost alternative. | Yes,<br>with members. | Yes.<br>All drugs are still covered. | Yes.<br>Focuses on low-cost alternatives. | Yes.<br>ERS can make this change, without legislative change. | No. | Minimal to none (indirectly). |
| **5.12 Therapeutic substitution** | | | | | | | |
| Yes. | Yes, not enough to outweigh the disruption.<br><br>Not as much as it would have in the past, since our generic dispensing rate is already high. | Yes | Yes.<br>All drugs are still covered. | Yes.<br>Focuses on l ow-cost alternatives. | Yes. ERS can make this change, but it is a controversial policy and would require legislative support. | No. | Minimal to none (indirectly). |
| **5.13 Onsite nurse practitioner or wellness clinic** | | | | | | | |
| Could cost more in the short term if people are getting care they otherwise would have avoided.<br><br>Could save in the long term if people are managing their health better. | Does not reduce cost to the GBP, but to the employer where the onsite clinic is located, it could reduce absenteeism. | No. | Some large private sector employers are doing this. | Potentially, yes. | The GBP could contract for the provider or outsource with vendor, but the agency would have to pay for all costs of the clinic out of its operating budget. | It could lead to an increased number of claims for preventive care services, which are covered at 100% by the plan. | No. |

## APPENDIX C: COMPONENTS OF THE GBP HEALTH BENEFIT COST TREND

HealthSelect's 8% underlying benefit cost trend, used in setting contributions, compares favorably to the nationwide 11.1% trend observed by Aon Hewitt.[1] We achieved this positive comparison to the benchmark due to forward-looking contract negotiation, aggressive cost management, targeted member communications, and low administrative overhead.

**Three components of the health benefit cost trend.** The major components of the benefit cost trend are increases in:

- utilization, driven by how often members go to the doctor, get services, or fill prescriptions,
- the cost per unit of care, driven by inflation and more complex care, also known as service intensity, and
- member cost share leveraging, driven by the health plan paying a larger share of total costs while member copays stay the same.

These three components fluctuate each year. For 2013, higher unit prices and increased utilization are expected to impact the benefit cost trend the most. Other factors that influence the trend are the aging population, the impact of plan design changes, and other actions taken by ERS and the third-party administrator. These factors are included in the general categories shown in the chart.

**Costs vary by type of service.** The projected benefit cost trend is expected to increase for hospitals, pharmacies, and professional services—but for different reasons.

For example, unit price inflation is the primary cost driver for the hospital sector, while pharmacy costs increased due to a fairly even split of all three factors: inflation, utilization, and member cost share leveraging.

Per capita plan expenditures for hospital services are expected to increase at an annual rate of about 9% per year over the next five years, while per capita expenditures for pharmacy benefits rank a close second, with an expected annual rate of increase of about 8%. Increases in per capita hospital expenditures have a greater impact on the plan because they represent 45% of total expenditures. Per capita plan expenditures for professional services are expected to increase less quickly, in part because reimbursement rates for professional services have increased more slowly than inflation for the past five years.

[1]Aon Hewitt 2011 Health Insurance Trend Driver Survey, p. 6.

**PROJECTED HEALTH BENEFIT COST TREND FY13**

| | Utilization | Cost/Unit | Member Cost Share Leverage | Plan Cost Trend |
|---|---|---|---|---|
| **Hospital** | 2.6% | 5.9% | 1.0% | 9.5% |
| **Professional** | 1.9% | 2.6% | 0.5% | 5.0% |
| **Pharmacy** | 2.5% | 2.9% | 3.6% | 9.0% |
| **Total** | 2.4% | 4.2% | 1.4% | 8.0% |

## APPENDIX D: IMPACT OF THE AFFORDABLE CARE ACT ON THE GBP

The Affordable Care Act (ACA) is a United States federal statute signed into law by President Barack Obama on March 23, 2010. This law enacted significant regulatory reforms of the U.S. health-care system. The constitutionality of the law was upheld by the U.S. Supreme Court on June 28, 2012.

Most Affordable Care Act (ACA) reform efforts have been focused on restructuring methods of finance, rather than on reducing health care costs. However, the ACA has heightened public awareness of a number of policy issues:

- Focusing on provider risk sharing through alternative payment models,
- Establishing a minimal level of acceptable health benefits,
- Increasing scrutiny of insurance company administrative costs,
- Removing financial barriers to preventive care,
- Ensuring access for people with pre-existing conditions,
- Encouraging employers to cover "early retirees" (retirees younger than age 65),
- Spreading risk by setting requirements that people participate in the system, and
- Attempting to limit the cost of coverage for lower income Americans.

The Texas Legislature amended the GBP on September 1, 2011, to comply with the requirements of federal health reform. The ACA requires GBP to implement the following plan changes during the FY12-13 biennium.

- Effective September 1, 2011, the ACA required ERS to amend the plan to cover children up to age 26, cover preventive care at no cost to the participant, and eliminate the lifetime maximum for out-of-network benefits.
- Effective September 1, 2012, the plan must provide coverage for contraceptives at no cost to the member as required by the ACA.
- Also, the GBP will be required to pay fees to the Patient Centered Outcomes Research Trust (PCORT) Fund during FY13.

These ACA-required revisions are projected to cost the plan about $82.8 million during the FY12-13 Biennium.

Additional costs due to the ACA were offset somewhat by $70.9 million in federal government subsidies in FY11-12 from the Early Retiree Reinsurance Program (ERRP), which was 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 ended during the FY12 plan year, two years earlier than originally established because federal funding for this program was exhausted.

The state's acceptance of the federal ERRP subsidies for FY11 and FY12 required a commitment to maintain certain levels of insurance and state expenditures in the program for a period of time. Any significant changes proposed to the health insurance program should be reconciled with the State's commitment to the federal government under ERRP.

### PROJECTED ADDITIONAL PLAN COST FOR FY12-13 BIENNIUM RELATED TO THE AFFORDABLE CARE ACT*

| | PROJECTED PLAN COST ($ MILLIONS) | | |
|---|---|---|---|
| | FY12 | FY13 | Total |
| **Expand coverage to dependents to Age 26** | $7.8 | $12.6 | $20.4 |
| **Cover preventive care at 100%** | $25.0 | $26.9 | $51.9 |
| **Eliminate lifetime maximum for out-of-network services** | $0.3 | $0.3 | $0.6 |
| **Patient Centered Outcomes Research Trust (PCORT)** | $0.0 | $0.5 | $0.5 |
| **Cover contraceptives at 100%** | $0.0 | $9.4 | $9.4 |
| **Total Excluding EOI** | $33.1 | $49.7 | $82.8 |

*Projected additional plan cost for all GBP participants. Estimates updated Aug, 2012.
Revised August 1, 2012

## APPENDIX E: LINKING SOLUTIONS WITH UNDERLYING COST DRIVERS

| COST DRIVERS | LEGISLATIVE AUTHORITY | BOARD OF TRUSTEES AUTHORITY |
|---|---|---|
| **AGING WORKFORCE INCREASES COSTS FOR EMPLOYER-SPONSORED PLANS** | | |
| • Generous eligibility standards for retirees<br>• Retirees who are not yet eligible for Medicare have relatively high health benefit costs<br>• Higher incidence of chronic illness<br>• Increased pharmacy utilization | **Eligibility**<br>• Eliminate coverage<br>• Require retirees to pay full or partial cost<br><br>**Contribution strategy**<br>• Tiered contributions based on years of service<br>• Defined contribution with connector model | **Over 65 Medicare retirees**<br>• Medicare Advantage<br>• Medicare coordination of benefits<br><br>**Early (Over 65 retirees)**<br>• Carve out care coordination for <65 retirees |
| **FEE FOR REIMBURSEMENT SYSTEM IS INEFFICIENT AND COSTLY** | | |
| • Fee-for-service incentivizes overuse<br>• Insurance disconnects consumers from actual price of services<br>• Wide variation in cost/price by locale and setting<br>• Demand for price transparency<br>• Increased provider accountability/risk sharing<br>• Potential for fraud | **Statutory changes**<br>• Health Care Collaboratives (SB7)<br>• Facilitate price transparency<br>• Expanded scope of licensing<br>• Allow transfer of risk outside the HMO setting | **Alternative payment systems**<br>• Accountable Care Organizations<br>• Patient Centered Medical Homes<br>• Integrated care practice model<br><br>**Claims management**<br>• Pre-payment claims editing<br>• Utilization management<br>• Audits |
| **HOSPITAL COST INCREASES ARE UNSUSTAINABLE** | | |
| • Inflated reimbursement rates<br>• Mergers and acquisitions<br>• Proliferation of hospitals<br>• Cost shifting because of uninsured population<br>• Inability to hire physicians (barriers to ACOs)<br>• High technology<br>• Limited competition | **Statutory changes**<br>• Accountability reporting, i.e., infection rates<br>• Price and outcome transparency<br><br>**Federal law**<br>• Antitrust issues (federal law)<br>• Block grant waiver flexibility<br>• Hospital quality initiatives (ACA) | **Contracting**<br>• Results-based hospital contracts<br>• High performance networks<br>• Surgical Centers of Excellence<br>• Aggressive negotiation of provider discounts<br><br>**Value based incentive designs (VBID)**<br>• Higher copays for ER visits and lower copays for urgent care<br>• Copay for high tech radiology |
| **MEMBERS NEED TO TAKE MORE RESPONSIBILITY FOR THEIR HEALTH** | | |
| • Unhealthy lifestyles<br>• Insurance disconnects consumers from actual price of services<br>• Movement toward consumer responsibility<br>• Suboptimal management of chronic health conditions<br>• Focus on wellness | **Contribution strategies**<br>• Incent disease management<br>• Financial rewards<br>• Tobacco premium differential<br>• HSA deposits for CDHP<br>• Raise member and/or dependent contribution<br>• Raise contribution for dependents with other coverage<br><br>**Fund employer solutions**<br>• Onsite nurse practitioner clinics | **Identify:** Administrative tools such as data mining, cultural assessment, health risk assessments, biometric screenings<br><br>**Plan Design:** Value based benefits, carve-outs, consumer driven health plan (CDHP)<br><br>**Communicate:** Electronic health records, other technological advances (mobile apps) |
| **HIGHER PRICES FOR BRAND NAME DRUGS INCREASE PLAN COSTS** | | |
| • Increased use of specialty drugs<br>• Blockbuster brand name drugs<br>• Retirees not yet eligible for Medicare have higher utilization<br>• Insurance disconnects consumers from actual price of drugs | **Support for generic drug incentives**<br>• Therapeutic substitution<br>• Reference-based pricing<br>• Potential changes to scope of practice licensing | **Generic drug incentives**<br>• Step therapy<br><br>**Medicare Part D**<br>• Retiree drug subsidy (claims reprocessing)<br>• EGWP plus wrap |

## APPENDIX F: OTHER POST-EMPLOYMENT BENEFITS (OPEB)

ERS administers the OPEB provided under the GBP (health and basic life insurance) for state agencies, community colleges, certain quasi-state agencies and Community Supervision and Correction Departments, and higher education institutions other than the University of Texas and Texas A&M.

### PAY-AS-YOU-GO FUNDING

GBP OPEB costs are funded on a pay-as-you-go basis (PAYGO); i.e., employer funding for OPEB is limited to the amount necessary to provide for current benefits.The total employer contributions for GBP OPEB for FY 2011 were $513 million, which covered about 27% of the Annual Required Contribution (ARC). As long as OPEB is funded on a PAYGO basis, the projected OPEB cost will continue to grow.

Under standards prescribed by the Governmental Accounting Standards Board (GASB), the State would have to contribute $1.9 billion a year (the ARC) to a trust fund in order to prevent further growth in the current projected OPEB cost of $21.5 billion. In reality though, states are not required to contribute the ARC each year. They are only required to disclose the amount by which the state's actual contribution falls short of the ARC in its annual financial statement.[1]

Alternatively, the State could advance fund retiree health benefits in much the same way that it funds retirement benefits: by making annual contributions to a trust fund in amounts that are sufficient to cover both current benefits and a portion of the projected cost of future benefits.

### WHAT AFFECTS OPEB PROJECTIONS?

Future OPEB projections can change due to a number of factors, including:

- Changes in the health care cost trend,
- Demographic changes among the plan's membership,
- Changes in the benefits package, and

Changes in eligibility for benefits. In FY 2011, the GBP experienced a decrease (6.7% or $1.54 billion) in projected OPEB cost as a result of the implementation of a statewide Medicare Advantage option.

Federal health reform increased projected OPEB costs in FY 2011, by requiring that the plan cover certain preventive services at 100%, cover dependents up to age 26, and other provisions.

Even factoring in some savings for FY11, the GBP's projected OPEB cost will continue to grow as long as OPEB is funded on a PAYGO basis.

### WHAT HAPPENS IF GBP HEALTH BENEFITS ARE CHANGED?

Any option that reduces current or future retiree health benefits will have a significant impact on the projected OPEB cost. Options to change health benefits for active employees will not have a significant impact on the projected OPEB cost.

Health insurance benefits are not guaranteed beyond the time period that they are funded.

[1]In Texas, the projected OPEB cost is reported in the notes and supplementary section of the State of Texas Comprehensive Annual Financial Report.

## APPENDIX G: BENCHMARKING HEALTHSELECT AGAINST THE TYPICAL PRIVATE SECTOR PLAN

(conducted by Rudd & Wisdom, ERS Consulting Actuary)

Using the data developed from the private sector surveys reviewed for this report, we constructed a "Typical Private Sector Plan" (TPSP) and compared it to the HealthSelect in-network benefit design and contribution strategy. A comparison of HealthSelect (in-network) with the TPSP is presented below.

| | HEALTHSELECT | TYPICAL PRIVATE SECTOR PLAN (TPSP)[1] |
|---|---|---|
| **Medical Benefits** | | |
| Calendar Year Deductible (Individual/Family) | none | $500/$1,000 |
| PCP copay (per visit) | $25.00 | $20.00 |
| Specialist copay (per visit) | $40.00 | $35.00 |
| Inpatient copay | $150 per day | $250 per admission |
| Outpatient copay (per admission) | $150.00 | $150.00 |
| Emergency Room copay (per visit) | $150.00 | $100.00 |
| Coinsurance | 20% | 20% |
| Coinsurance Maximum | $2,000 | $2,000 |
| **Prescription Drug Benefits** | | |
| Calendar Year Deductible | $50 Applicable to Prescription Drugs Only | none |
| Generic Copay | $15.00 | $10.00 |
| Preferred Brand copay | $35.00 | $30.00 |
| Non-Preferred Brand copay | $60.00 | $50.00 |
| Retail Maintenance Fee[2] | yes | no |
| **Employer Contribution** | | |
| Employee | 100% | 80% |
| Employee and Family[3] | 67% | 70% |

[1] The TPSP design is based on surveys published by Aon Hewitt, Mercer, and the Kaiser Family Foundation. Each benefit is an average of the results from the survey, when the relevant data was available. When possible, the median was used rather than the mean. The amounts/percentages selected are rounded to the near $5 or 5%.

[2] The Retail Maintenance Fee is an additional fee of $5 generic/$10 preferred brand/$15 non-preferred brand for a maintenance script dispensed at a retail pharmacy that has not accepted reduced mail service pricing for an extended day supply.

[3] Employee and Family coverage includes coverage for the employee, spouse and children.

The above comparison indicates the following key differences between HealthSelect in-network and the TPSP.

- The TPSP has a significant medical deductible while HealthSelect has only a small deductible applicable exclusively to prescription drugs. Due to the absence of the deductible, the HealthSelect has more generous medical benefits than those included in the TPSP

- The TPSP has more generous prescription drug benefits than those included in HealthSelect.

- Under the TPSP, the employer pays about 80% of the cost of Employee Only coverage, while the employer pays 100% of the cost of Employee Only coverage under HealthSelect.

- Under the TPSP, the employer pays about 70% of the cost of Employee and Family coverage, while the employer pays 67% of the cost of Employee and Family coverage under HealthSelect.

An actuarial analysis of the two plans indicates the following.

- The actuarial value of the HealthSelect (in-network) benefits is about 2.6% greater than the TPSP benefits.

- When the more valuable HealthSelect benefits are coupled with the more generous H ealthSelect employer contribution strategy for Employee Only coverage, we concluded that HealthSelect has an overall value to the employee that is about **28% greater than that of the TPSP.**

- **In the case of the Employee and Family coverage, the slightly more valuable HealthSelect benefits are more than offset by the less generous HealthSelect employer contribution strategy so that the overall value to the employee is about 2% less than that of the TPSP.**

The development of the TPSP is, by nature an inexact process. For example, what is an appropriate population of plans for comparison "large" plans, all plans, nationally, statewide—or what is "typical" mean, median, weighted average?

Therefore, we decided that it was necessary to seek another independent source for confirmation of the conclusions developed above. For this purpose, we selected the 2012 Milliman Medical Index (MMI), a research report published by Milliman, an international provider of actuarial and related products and services. (**http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2012.pdf**)

## APPENDIX H

## TEXAS EMPLOYEES GROUP BENEFITS PROGRAM
## FY11 HEALTH PLAN COST-SHARING CHANGES

**Effective September 1, 2010**

| PLAN CHANGE | | % SAVINGS |
|---|---|---|
| Primary Care Office Visit Copay Retain PCP Referral | Increase primary care visit copays to $25 | 0.28 % |
| Specialist Office Visit Copay | Increase specialist visit copay to $40 | 0.46% |
| Prescription Drug Deductible | No change to $50 prescription drug plan deductible | n/a |
| Prescription Drug Copay | Increase copays to $15 generic/$35 preferred brand/$60 non-preferred brand | 2.63 % |
| HealthSelect Coinsurance Stop Loss | Increase to $2000/$7000/$3000 | 1.28 % |
| Inpatient Copay | Increase to $150 per day/5 day max; no change to 20% coinsurance | 0.13 % |
| Outpatient Facility Copay | No increase | n/a |
| Emergency Room Copay | Increase to $150; no change to 20% coinsurance | 0.21 % |
| Urgent Care | Add new $50 copay; down from $100; plus 20% coinsurance | 0.04 % |
| Chiropractic Care | 30 visits per year max, $75 max charge per visit | 0.18 % |
| High Tech Radiology (CT Scans, MRI and Nuclear Medicine) | $100 copay, no change to 20% coinsurance | 0.14 % |
| | **TOTAL % SAVINGS** | **5.35%** |

## APPENDIX I

### HISTORY OF COST MANAGEMENT PROGRAMS

**FY 2002 - FY 2013**

| | |
|---|---|
| **FY2002** | • Legislative intent rider to grant no rate increases for provider participants<br>• Required prior authorization on certain prescription drugs<br>• Expanded use of quantity limits on prescription drugs<br>• ERS January 2002 restructured contract with Medco and improved contract rates |
| **FY2003** | • Reduced HealthSelect Plus availability to only major metropolitan areas<br>• Froze enrollment in HealthSelect Plus<br>• Medco takes over as PBM for HealthSelect Plus-Better discounts and contract rates; more consistent administration |
| **May 2003 changes** | • Eliminated HealthSelect Plus<br>• 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<br>• Mail order copays for 90-day supply increased to three 30-day supply copays<br>• Retail maintenance fee created for maintenance drugs<br>• 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<br>• Standardized retail pharmacy network-Removed tiered discounts<br>• Increased emergency room copay from $50 to $100<br>• Increased participants coinsurance percentages for network from 10% to 20%, non-network from 30% to 40%, out-of-area from 20% to 30%<br>• Implemented $100 a day copay for inpatient charges and outpatient surgery |
| **FY2004** | • Implemented 90-day waiting period for new employees<br>• 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<br>• Reduced state contribution to part-time rate for employees working less than 40 hours per week<br>• Discontinued board member state contribution<br>• Tightened eligibility for retiree insurance for those not meeting the Rule of 80 or 10 years and age 65-(GAP Coverage)<br>• Implemented $50 prescription drug plan year deductible<br>• Reduced payment for specialty pharmacy medications through medical component<br>• Increased out-of-pocket coinsurance maximum to $1,000 for network, $3,000 for non-network, and $1,000 for out-of-area services |
| **FY2005** | • Enhanced management of radiological services<br>• Non-sedating antihistamines moved from Tier 2 to Tier 3 for HealthSelect<br>• Developed additional Prior Authorization programs<br>• 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<br>• FCR-Formulary Coverage Review-encourages the use of the least expensive drug in the same category<br>• Audit to eliminate non-eligible dependents with ongoing monitoring of dependent eligibility |
| **FY2006** | • New third-party administration contact for HealthSelect saves $79 million over the next three years<br>• New pharmacy benefit manager contract for HealthSelect saves $48 million over the next three years<br>• Added the BlueCare Connection programs to HealthSelect<br>  • 24/7 Nurse Hotline<br>  • Special Beginnings program<br>  • Disease Management<br>  • Wellness Programs<br>  • Care and Case Management<br>  • 100% Claims Audit-Ongoing<br>  • Participate in the Medicare Part D subsidy |

## HISTORY OF COST MANAGEMENT PROGRAMS

**FY 2002 - FY 2013**

| | |
|---|---|
| **FY2007** | • Personal Health Manager<br>• Opt-Out Credit<br>• Continue to participate in Medicare Part D subsidy |
| **FY2008** | • 100% PBM claims audit<br>• Wellness committee established<br>• Continue to participate in Medicare part D subsidy |
| **FY2009** | • New pharmacy benefit manager transparency contract for HealthSelect saves $288 million in prescription drug costs over the next four years<br>• Continue to participate in Medicare part D subsidy |
| **FY2010** | • Coordination of benefits with Medicare Part B prescription drugs<br>• Pharmacy re-contracting regarding average wholesale price modification<br>• Unclaimed funds process established<br>• Continue to participate in Medicare part D subsidy<br>• AWP lawsuit saves $49 million over 3 years |
| **FY2011** | • Dependent eligibility audit to save $15 million<br>• Increase HealthSelect PCP office visit copay from $20 to $25 and specialist office visit copay from $30 to $40; HMO PCP copay decrease from $30 to $25 and specialist copay level at $40<br>• Ability to fill extended day prescriptions at retail participating pharmacies<br>• Increase prescription drug copay from $10 to $15 for generics, $25 to $35 for preferred brand-name drugs, and $40 to $60 for non-preferred brand name drugs<br>• Increase 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<br>• Increase emergency room copay from $100 to $150; new urgent care copay of $50<br>• Implement $100 a day copay for high tech radiology (MRI, Nuclear Medicine, CT scan)<br>• Limit annual visits and lower allowable charges for chiropractic care |
| **FY2012** | • Implement tobacco use contribution differential effective January 1, 2011<br>• Continue and potentially expand medical home/accountable care practice model pilot programs<br>• Implement Medicare Advantage (MA) Programs for Retirees and Medicare-Enrolled dependents with same benefits as HealthSelect. The MA HMO was effective 9/111 and the MA-PPO will be effective January 1, 2012<br>• Cost Savings of $20 million annually from Most Favored Nations (MFN) clause for the PBM contract<br>• Received $30 million from Early Retiree Reinsurance Program (ERRP)<br>• Evaluate the use of an Employer Group Waiver Plan (EGWP) plus Wrap to replace the Retiree Drug Subsidy Program (RDS) |
| **FY2013** | • Contracted with Part D Advisors to audit the Retiree Drug Subsidy programs<br>• Negotiated a two year extension of the PBM contract saving an estimated $40 million on the 2-year period<br>• Contracted with a new Third Party Administrator saving the plan $25 million in administrative expense.<br>• Implemented an EGWP + Wrap 1/1/2012, which will save the plan $29 million in calendar year 2013. |

## APPENDIX J: THE GBP HAS A POSITIVE $2 BILLION IMPACT ON TEXAS ECONOMY

**County-level reporting**

| State | County | HealthSelect Participants (Employees, Retirees and Dependents) | HealthSelect Members (Employees and Retirees) | Medical Claims | Rx Claims | Total Claims |
|---|---|---|---|---|---|---|
| TX | Anderson, TX | 5,406 | 3,047 | $18,022,013 | $4,768,804 | $22,790,817 |
| TX | Andrews, TX | 128 | 65 | $329,038 | $66,814 | $395,852 |
| TX | Angelina, TX | 4,331 | 2,385 | $13,827,882 | $3,359,282 | $17,187,164 |
| TX | Aransas, TX | 406 | 252 | $796,330 | $553,586 | $1,349,916 |
| TX | Archer, TX | 291 | 157 | $1,066,854 | $246,890 | $1,313,744 |
| TX | Armstrong, TX | 130 | 62 | $193,548 | $119,768 | $313,316 |
| TX | Atascosa, TX | 553 | 315 | $1,710,284 | $547,572 | $2,257,856 |
| TX | Austin, TX | 821 | 464 | $2,045,824 | $824,002 | $2,869,826 |
| TX | Bailey, TX | 78 | 43 | $391,212 | $84,524 | $475,736 |
| TX | Bandera, TX | 317 | 185 | $1,313,060 | $364,099 | $1,677,159 |
| TX | Bastrop, TX | 4,839 | 2,789 | $20,628,274 | $5,162,593 | $25,790,867 |
| TX | Baylor, TX | 192 | 101 | $350,154 | $198,988 | $549,141 |
| TX | Bee, TX | 3,342 | 1,805 | $11,653,363 | $1,857,897 | $13,511,260 |
| TX | Bell, TX | 1,227 | 784 | $2,859,741 | $664,894 | $3,524,635 |
| TX | Bexar, TX | 13,589 | 9,008 | $35,600,596 | $12,979,465 | $48,580,061 |
| TX | Blanco, TX | 334 | 180 | $965,199 | $384,644 | $1,349,843 |
| TX | Borden, TX | 26 | 13 | $118,056 | $11,240 | $129,296 |
| TX | Bosque, TX | 231 | 136 | $452,985 | $164,728 | $617,713 |
| TX | Bowie, TX | 2,231 | 1,182 | $5,439,016 | $1,402,245 | $6,841,261 |
| TX | Brazoria, TX | 7,080 | 3,804 | $24,136,711 | $6,034,975 | $30,171,686 |
| TX | Brazos, TX | 1,516 | 876 | $3,219,223 | $1,007,014 | $4,226,237 |
| TX | Brewster, TX | 1,047 | 574 | $2,433,283 | $704,008 | $3,137,291 |
| TX | Briscoe, TX | 154 | 73 | $861,408 | $66,821 | $928,229 |
| TX | Brooks, TX | 143 | 73 | $420,082 | $93,553 | $513,635 |
| TX | Brown, TX | 1,837 | 1,010 | $6,627,484 | $1,712,776 | $8,340,260 |
| TX | Burleson, TX | 251 | 154 | $876,033 | $262,057 | $1,138,090 |
| TX | Burnet, TX | 770 | 464 | $3,192,230 | $1,062,491 | $4,254,721 |
| TX | Caldwell, TX | 1,993 | 1,094 | $7,126,926 | $1,547,052 | $8,673,978 |
| TX | Calhoun, TX | 205 | 111 | $331,409 | $196,243 | $527,652 |
| TX | Callahan, TX | 753 | 440 | $2,330,980 | $578,359 | $2,909,339 |
| TX | Cameron, TX | 5,718 | 3,091 | $12,438,605 | $3,140,451 | $15,579,056 |
| TX | Camp, TX | 210 | 119 | $589,280 | $175,107 | $764,387 |
| TX | Carson, TX | 261 | 140 | $1,087,122 | $207,310 | $1,294,432 |
| TX | Cass, TX | 1,040 | 533 | $2,386,879 | $771,892 | $3,158,771 |
| TX | Castro, TX | 139 | 73 | $565,963 | $94,902 | $660,865 |
| TX | Chambers, TX | 267 | 147 | $721,255 | $215,906 | $937,161 |
| TX | Cherokee, TX | 4,190 | 2,469 | $14,371,239 | $4,287,412 | $18,658,651 |
| TX | Childress, TX | 844 | 438 | $2,555,269 | $605,132 | $3,160,401 |
| TX | Clay, TX | 389 | 220 | $1,001,068 | $394,472 | $1,395,540 |
| TX | Cochran, TX | 76 | 39 | $418,791 | $51,721 | $470,512 |
| TX | Coke, TX | 110 | 62 | $374,817 | $76,710 | $451,527 |
| TX | Coleman, TX | 258 | 139 | $1,587,400 | $284,545 | $1,871,945 |
| TX | Collin, TX | 4,720 | 2,615 | $16,819,172 | $4,899,339 | $21,718,511 |

| State | County | HealthSelect Participants (Employees, Retirees and Dependents) | HealthSelect Members (Employees and Retirees) | Medical Claims | Rx Claims | Total Claims |
|---|---|---|---|---|---|---|
| TX | Collingsworth, TX | 165 | 89 | $922,968 | $135,342 | $1,058,310 |
| TX | Colorado, TX | 454 | 229 | $1,685,314 | $379,182 | $2,064,496 |
| TX | Comal, TX | 2,076 | 1,167 | $5,320,578 | $2,035,750 | $7,356,328 |
| TX | Comanche, TX | 237 | 139 | $801,673 | $178,863 | $980,536 |
| TX | Concho, TX | 97 | 49 | $624,703 | $83,680 | $708,383 |
| TX | Cooke, TX | 1,323 | 778 | $4,840,167 | $1,109,147 | $5,949,314 |
| TX | Coryell, TX | 1,025 | 608 | $2,599,021 | $588,057 | $3,187,078 |
| TX | Cottle, TX | 173 | 87 | $735,171 | $113,060 | $848,231 |
| TX | Crane, TX | 49 | 25 | $101,271 | $22,970 | $124,241 |
| TX | Crockett, TX | 103 | 49 | $155,569 | $89,865 | $245,434 |
| TX | Crosby, TX | 190 | 101 | $716,204 | $157,040 | $873,244 |
| TX | Culberson, TX | 102 | 49 | $236,783 | $61,393 | $298,176 |
| TX | Dallam, TX | 435 | 249 | $906,324 | $385,421 | $1,291,745 |
| TX | Dallas, TX | 16,055 | 9,609 | $57,122,340 | $14,229,315 | $71,351,655 |
| TX | Dawson, TX | 877 | 439 | $2,468,710 | $458,316 | $2,927,026 |
| TX | Deaf Smith, TX | 232 | 109 | $720,880 | $235,107 | $955,987 |
| TX | Delta, TX | 131 | 73 | $242,002 | $132,176 | $374,178 |
| TX | Denton, TX | 14,701 | 8,954 | $47,927,929 | $13,216,418 | $61,144,347 |
| TX | DeWitt, TX | 641 | 331 | $2,530,413 | $452,820 | $2,983,233 |
| TX | Dickens, TX | 68 | 34 | $287,354 | $30,150 | $317,504 |
| TX | Dimmit, TX | 264 | 118 | $803,677 | $73,345 | $877,022 |
| TX | Donley, TX | 293 | 157 | $622,872 | $227,728 | $850,600 |
| TX | Duval, TX | 299 | 163 | $667,545 | $199,146 | $866,691 |
| TX | Eastland, TX | 808 | 448 | $2,317,362 | $676,322 | $2,993,684 |
| TX | Ector, TX | 2,479 | 1,336 | $7,388,444 | $2,135,176 | $9,523,620 |
| TX | Edwards, TX | 56 | 27 | $62,641 | $31,062 | $93,703 |
| TX | El Paso, TX | 12,383 | 6,814 | $36,165,883 | $7,519,803 | $43,685,686 |
| TX | Ellis, TX | 1,528 | 834 | $4,788,121 | $1,235,397 | $6,023,518 |
| TX | Erath, TX | 464 | 255 | $1,391,852 | $483,197 | $1,875,049 |
| TX | Falls, TX | 410 | 251 | $1,325,159 | $176,155 | $1,501,314 |
| TX | Fannin, TX | 1,049 | 560 | $3,556,243 | $792,689 | $4,348,932 |
| TX | Fayette, TX | 684 | 378 | $2,198,323 | $596,116 | $2,794,439 |
| TX | Fisher, TX | 228 | 112 | $1,039,248 | $135,696 | $1,174,944 |
| TX | Floyd, TX | 250 | 123 | $658,716 | $171,741 | $830,457 |
| TX | Foard, TX | 133 | 71 | $429,910 | $65,878 | $495,788 |
| TX | Fort Bend, TX | 9,846 | 5,231 | $29,527,750 | $6,648,082 | $36,175,832 |
| TX | Franklin, TX | 222 | 111 | $893,904 | $243,414 | $1,137,318 |
| TX | Freestone, TX | 1,310 | 780 | $4,269,870 | $1,043,418 | $5,313,288 |
| TX | Frio, TX | 665 | 328 | $1,418,135 | $370,192 | $1,788,327 |
| TX | Gaines, TX | 99 | 48 | $115,451 | $30,242 | $145,693 |
| TX | Galveston, TX | 5,281 | 3,080 | $19,392,715 | $4,280,772 | $23,673,487 |
| TX | Garza, TX | 166 | 84 | $282,564 | $120,045 | $402,609 |
| TX | Gillespie, TX | 622 | 364 | $1,660,785 | $785,609 | $2,446,394 |

| State | County | HealthSelect Participants (Employees, Retirees and Dependents) | HealthSelect Members (Employees and Retirees) | Medical Claims | Rx Claims | Total Claims |
|---|---|---|---|---|---|---|
| TX | Gonzales, TX | 442 | 245 | $1,797,912 | $472,715 | $2,270,627 |
| TX | Gray, TX | 818 | 435 | $3,098,864 | $640,377 | $3,739,241 |
| TX | Grayson, TX | 2,077 | 1,147 | $7,802,481 | $2,028,886 | $9,831,367 |
| TX | Gregg, TX | 1,886 | 1,126 | $5,537,002 | $2,012,272 | $7,549,274 |
| TX | Grimes, TX | 813 | 465 | $2,503,461 | $779,371 | $3,282,832 |
| TX | Guadalupe, TX | 1,377 | 791 | $4,153,470 | $1,435,398 | $5,588,868 |
| TX | Hale, TX | 1,307 | 650 | $4,254,556 | $888,559 | $5,143,115 |
| TX | Hall, TX | 188 | 97 | $662,353 | $237,138 | $899,491 |
| TX | Hamilton, TX | 153 | 83 | $651,213 | $190,672 | $841,885 |
| TX | Hansford, TX | 42 | 25 | $83,959 | $38,090 | $122,049 |
| TX | Hardeman, TX | 382 | 218 | $1,131,288 | $449,768 | $1,581,056 |
| TX | Hardin, TX | 1,414 | 724 | $3,957,229 | $1,578,672 | $5,535,901 |
| TX | Harris, TX | 43,434 | 25,401 | $144,737,546 | $34,370,103 | $179,107,649 |
| TX | Harrison, TX | 748 | 402 | $2,462,487 | $774,783 | $3,237,270 |
| TX | Hartley, TX | 51 | 27 | $89,307 | $33,720 | $123,027 |
| TX | Haskell, TX | 210 | 106 | $391,148 | $221,801 | $612,949 |
| TX | Hays, TX | 10,890 | 6,032 | $35,091,949 | $9,508,412 | $44,600,361 |
| TX | Hemphill, TX | 64 | 31 | $184,356 | $77,237 | $261,593 |
| TX | Henderson, TX | 2,260 | 1,243 | $7,082,225 | $2,116,042 | $9,198,267 |
| TX | Hidalgo, TX | 10,206 | 5,227 | $22,389,567 | $5,062,048 | $27,451,615 |
| TX | Hill, TX | 804 | 480 | $2,503,707 | $786,896 | $3,290,603 |
| TX | Hockley, TX | 1,335 | 650 | $4,139,970 | $1,182,449 | $5,322,419 |
| TX | Hood, TX | 605 | 350 | $2,519,244 | $1,119,146 | $3,638,390 |
| TX | Hopkins, TX | 686 | 360 | $1,906,411 | $658,014 | $2,564,425 |
| TX | Houston, TX | 2,398 | 1,291 | $6,986,777 | $1,646,100 | $8,632,877 |
| TX | Howard, TX | 2,033 | 1,194 | $6,601,056 | $1,534,937 | $8,135,993 |
| TX | Hudspeth, TX | 101 | 48 | $183,106 | $67,466 | $250,572 |
| TX | Hunt, TX | 784 | 454 | $2,390,372 | $811,628 | $3,202,000 |
| TX | Hutchinson, TX | 559 | 308 | $1,403,143 | $539,821 | $1,942,964 |
| TX | Irion, TX | 43 | 20 | $53,503 | $16,376 | $69,879 |
| TX | Jack, TX | 191 | 100 | $475,798 | $178,903 | $654,701 |
| TX | Jackson, TX | 230 | 124 | $463,102 | $206,985 | $670,087 |
| TX | Jasper, TX | 1,140 | 601 | $4,718,814 | $822,831 | $5,541,645 |
| TX | Jeff Davis, TX | 205 | 113 | $606,775 | $169,714 | $776,489 |
| TX | Jefferson, TX | 7,424 | 4,249 | $23,975,960 | $6,291,584 | $30,267,544 |
| TX | Jim Hogg, TX | 144 | 70 | $233,858 | $147,111 | $380,969 |
| TX | Jim Wells, TX | 759 | 381 | $2,308,102 | $579,554 | $2,887,656 |
| TX | Johnson, TX | 1,747 | 962 | $7,004,311 | $1,701,895 | $8,706,206 |
| TX | Jones, TX | 740 | 392 | $1,916,788 | $535,220 | $2,452,007 |
| TX | Karnes, TX | 848 | 436 | $2,206,540 | $624,970 | $2,831,510 |
| TX | Kaufman, TX | 2,596 | 1,493 | $8,565,972 | $2,170,987 | $10,736,959 |
| TX | Kendall, TX | 429 | 251 | $901,402 | $653,086 | $1,554,488 |
| TX | Kenedy, TX | 8 | 3 | $8,497 | $91 | $8,588 |

| State | County | HealthSelect Participants (Employees, Retirees and Dependents) | HealthSelect Members (Employees and Retirees) | Medical Claims | Rx Claims | Total Claims |
|---|---|---|---|---|---|---|
| TX | Kimble, TX | 233 | 116 | $844,955 | $221,587 | $1,066,542 |
| TX | King, TX | 19 | 7 | $140,759 | $21,536 | $162,295 |
| TX | Kinney, TX | 107 | 51 | $232,563 | $123,255 | $355,818 |
| TX | Kleberg, TX | 419 | 234 | $1,006,447 | $309,977 | $1,316,424 |
| TX | Knox, TX | 116 | 58 | $553,625 | $105,056 | $658,681 |
| TX | La Salle, TX | 348 | 166 | $643,225 | $202,832 | $846,057 |
| TX | Lamar, TX | 1,432 | 806 | $4,507,430 | $1,555,527 | $6,062,957 |
| TX | Lamb, TX | 302 | 143 | $771,233 | $171,564 | $942,797 |
| TX | Lampasas, TX | 280 | 162 | $791,137 | $461,550 | $1,252,686 |
| TX | Lavaca, TX | 1,022 | 512 | $2,303,929 | $929,734 | $3,233,663 |
| TX | Lee, TX | 992 | 518 | $3,080,373 | $992,939 | $4,073,312 |
| TX | Leon, TX | 974 | 525 | $3,335,248 | $930,864 | $4,266,112 |
| TX | Liberty, TX | 1,856 | 1,018 | $5,593,570 | $1,408,845 | $7,002,415 |
| TX | Limestone, TX | 2,504 | 1,625 | $10,856,659 | $2,544,513 | $13,401,172 |
| TX | Lipscomb, TX | 40 | 17 | $52,941 | $13,490 | $66,431 |
| TX | Live Oak, TX | 316 | 166 | $993,079 | $254,348 | $1,247,427 |
| TX | Llano, TX | 404 | 266 | $1,360,305 | $851,027 | $2,211,332 |
| TX | Lubbock, TX | 20,940 | 11,614 | $72,920,602 | $17,982,672 | $90,903,274 |
| TX | Lynn, TX | 201 | 106 | $660,559 | $134,290 | $794,849 |
| TX | Madison, TX | 992 | 531 | $3,570,917 | $693,449 | $4,264,366 |
| TX | Marion, TX | 137 | 76 | $231,625 | $181,421 | $413,046 |
| TX | Martin, TX | 87 | 44 | $161,530 | $49,502 | $211,032 |
| TX | Mason, TX | 120 | 64 | $248,335 | $137,114 | $385,449 |
| TX | Matagorda, TX | 527 | 296 | $1,425,132 | $429,172 | $1,854,304 |
| TX | Maverick, TX | 598 | 305 | $1,329,060 | $256,957 | $1,586,017 |
| TX | McCulloch, TX | 216 | 124 | $622,955 | $199,778 | $822,733 |
| TX | McLennan, TX | 3,488 | 2,053 | $9,964,666 | $3,276,048 | $13,240,714 |
| TX | McMullen, TX | 61 | 25 | $121,773 | $27,024 | $148,797 |
| TX | Medina, TX | 845 | 460 | $2,209,853 | $682,839 | $2,892,692 |
| TX | Menard, TX | 46 | 23 | $58,383 | $15,927 | $74,310 |
| TX | Midland, TX | 2,476 | 1,344 | $9,389,221 | $2,518,628 | $11,907,849 |
| TX | Milam, TX | 236 | 140 | $513,051 | $204,678 | $717,729 |
| TX | Mills, TX | 81 | 42 | $191,457 | $58,044 | $249,501 |
| TX | Mitchell, TX | 731 | 373 | $1,938,389 | $418,602 | $2,356,991 |
| TX | Montague, TX | 411 | 215 | $1,374,115 | $379,428 | $1,753,543 |
| TX | Montgomery, TX | 6,302 | 3,405 | $25,361,479 | $5,734,500 | $31,095,979 |
| TX | Moore, TX | 244 | 128 | $993,848 | $291,007 | $1,284,855 |
| TX | Morris, TX | 325 | 178 | $1,459,486 | $431,821 | $1,891,306 |
| TX | Motley, TX | 74 | 33 | $370,562 | $35,380 | $405,942 |
| TX | Nacogdoches, TX | 4,326 | 2,434 | $14,221,916 | $3,735,045 | $17,956,961 |
| TX | Navarro, TX | 1,719 | 948 | $5,236,783 | $1,704,764 | $6,941,547 |
| TX | Newton, TX | 207 | 119 | $346,295 | $215,084 | $561,379 |
| TX | Nolan, TX | 770 | 405 | $2,334,434 | $566,357 | $2,900,791 |

| State | County | HealthSelect Participants (Employees, Retirees and Dependents) | HealthSelect Members (Employees and Retirees) | Medical Claims | Rx Claims | Total Claims |
|---|---|---|---|---|---|---|
| TX | Nueces, TX | 6,810 | 4,063 | $20,275,675 | $5,178,308 | $25,453,983 |
| TX | Ochiltree, TX | 73 | 33 | $526,510 | $79,193 | $605,703 |
| TX | Oldham, TX | 95 | 47 | $176,104 | $156,503 | $332,607 |
| TX | Orange, TX | 1,400 | 786 | $4,736,461 | $1,429,565 | $6,166,026 |
| TX | Palo Pinto, TX | 476 | 254 | $1,630,551 | $446,357 | $2,076,908 |
| TX | Panola, TX | 468 | 279 | $1,616,125 | $613,966 | $2,230,091 |
| TX | Parker, TX | 1,594 | 887 | $5,054,033 | $1,595,550 | $6,649,583 |
| TX | Parmer, TX | 91 | 39 | $229,372 | $49,774 | $279,146 |
| TX | Pecos, TX | 949 | 485 | $1,963,368 | $438,180 | $2,401,548 |
| TX | Polk, TX | 2,086 | 1,126 | $6,439,261 | $1,470,737 | $7,909,998 |
| TX | Potter, TX | 3,389 | 1,955 | $10,067,621 | $2,767,204 | $12,834,825 |
| TX | Presidio, TX | 245 | 117 | $335,354 | $185,809 | $521,163 |
| TX | Rains, TX | 146 | 85 | $358,288 | $122,654 | $480,942 |
| TX | Randall, TX | 4,734 | 2,649 | $13,234,861 | $4,563,725 | $17,798,586 |
| TX | Reagan, TX | 18 | 11 | $22,306 | $12,031 | $34,337 |
| TX | Real, TX | 96 | 56 | $234,719 | $86,079 | $320,798 |
| TX | Red River, TX | 447 | 227 | $1,709,231 | $481,001 | $2,190,232 |
| TX | Reeves, TX | 265 | 135 | $500,790 | $188,196 | $688,986 |
| TX | Refugio, TX | 231 | 121 | $1,090,476 | $240,025 | $1,330,501 |
| TX | Roberts, TX | 34 | 12 | $28,490 | $9,038 | $37,528 |
| TX | Robertson, TX | 230 | 125 | $665,711 | $201,896 | $867,607 |
| TX | Rockwall, TX | 758 | 403 | $3,270,283 | $743,310 | $4,013,593 |
| TX | Runnels, TX | 291 | 155 | $895,474 | $216,891 | $1,112,365 |
| TX | Rusk, TX | 758 | 418 | $1,891,526 | $763,435 | $2,654,961 |
| TX | Sabine, TX | 187 | 108 | $579,424 | $175,956 | $755,380 |
| TX | San Augustine, TX | 208 | 115 | $798,149 | $218,486 | $1,016,635 |
| TX | San Jacinto, TX | 901 | 513 | $3,842,073 | $1,425,568 | $5,267,641 |
| TX | San Patricio, TX | 1,497 | 806 | $5,140,788 | $1,157,311 | $6,298,099 |
| TX | San Saba, TX | 243 | 128 | $579,932 | $201,275 | $781,207 |
| TX | Schleicher, TX | 42 | 25 | $87,451 | $27,587 | $115,038 |
| TX | Scurry, TX | 1,070 | 569 | $3,966,360 | $872,385 | $4,838,745 |
| TX | Shackelford, TX | 173 | 78 | $818,911 | $151,724 | $970,635 |
| TX | Shelby, TX | 379 | 205 | $1,019,450 | $292,865 | $1,312,315 |
| TX | Sherman, TX | 51 | 29 | $339,048 | $81,508 | $420,556 |
| TX | Smith, TX | 5,111 | 2,722 | $14,472,663 | $5,190,110 | $19,662,773 |
| TX | Somervell, TX | 141 | 77 | $357,411 | $151,356 | $508,767 |
| TX | Starr, TX | 826 | 422 | $1,725,871 | $429,830 | $2,155,701 |
| TX | Stephens, TX | 389 | 222 | $1,504,895 | $325,379 | $1,830,274 |
| TX | Sterling, TX | 40 | 23 | $105,897 | $24,634 | $130,531 |
| TX | Stonewall, TX | 68 | 32 | $262,888 | $36,462 | $299,350 |
| TX | Sutton, TX | 94 | 47 | $325,868 | $83,759 | $409,627 |
| TX | Swisher, TX | 358 | 179 | $915,236 | $219,310 | $1,134,546 |
| TX | Tarrant, TX | 15,923 | 9,324 | $58,960,562 | $15,280,422 | $74,240,984 |

| State | County | HealthSelect Participants (Employees, Retirees and Dependents) | HealthSelect Members (Employees and Retirees) | Medical Claims | Rx Claims | Total Claims |
|---|---|---|---|---|---|---|
| TX | Throckmorton, TX | 86 | 43 | $186,991 | $82,985 | $269,976 |
| TX | Titus, TX | 618 | 304 | $2,242,555 | $631,980 | $2,874,535 |
| TX | Tom Green, TX | 4,913 | 2,958 | $14,070,284 | $4,091,032 | $18,161,316 |
| TX | Travis, TX | 59,960 | 35,917 | $194,507,971 | $61,084,018 | $255,591,989 |
| TX | Trinity, TX | 1,709 | 970 | $5,775,180 | $1,483,846 | $7,259,026 |
| TX | Tyler, TX | 991 | 520 | $3,090,119 | $672,827 | $3,762,946 |
| TX | Upshur, TX | 476 | 251 | $1,556,412 | $484,819 | $2,041,231 |
| TX | Upton, TX | 56 | 29 | $134,669 | $48,597 | $183,266 |
| TX | Uvalde, TX | 1,239 | 664 | $3,044,719 | $819,999 | $3,864,718 |
| TX | Val Verde, TX | 721 | 379 | $1,166,862 | $414,874 | $1,581,736 |
| TX | Van Zandt, TX | 1,003 | 592 | $2,798,921 | $977,971 | $3,776,892 |
| TX | Victoria, TX | 2,128 | 1,167 | $5,375,936 | $1,972,660 | $7,348,596 |
| TX | Walker, TX | 11,589 | 6,664 | $43,584,559 | $9,438,708 | $53,023,267 |
| TX | Waller, TX | 412 | 238 | $1,373,302 | $289,133 | $1,662,435 |
| TX | Ward, TX | 283 | 158 | $983,951 | $199,099 | $1,183,049 |
| TX | Washington, TX | 1,777 | 1,045 | $6,201,035 | $1,454,479 | $7,655,514 |
| TX | Webb, TX | 3,617 | 1,855 | $8,530,120 | $1,895,977 | $10,426,097 |
| TX | Wharton, TX | 1,414 | 797 | $5,034,867 | $1,342,242 | $6,377,109 |
| TX | Wheeler, TX | 121 | 62 | $553,102 | $91,502 | $644,604 |
| TX | Wichita, TX | 6,545 | 3,801 | $23,459,223 | $6,699,482 | $30,158,705 |
| TX | Wilbarger, TX | 2,322 | 1,454 | $9,207,687 | $2,528,997 | $11,736,684 |
| TX | Willacy, TX | 483 | 245 | $955,932 | $399,657 | $1,355,589 |
| TX | Williamson, TX | 16,820 | 9,236 | $60,693,879 | $16,243,404 | $76,937,283 |
| TX | Wilson, TX | 678 | 393 | $2,067,136 | $600,422 | $2,667,558 |
| TX | Winkler, TX | 82 | 50 | $232,171 | $64,751 | $296,922 |
| TX | Wise, TX | 789 | 391 | $3,053,360 | $743,798 | $3,797,158 |
| TX | Wood, TX | 824 | 470 | $2,544,655 | $790,957 | $3,335,612 |
| TX | Yoakum, TX | 59 | 27 | $195,161 | $36,294 | $231,455 |
| TX | Young, TX | 376 | 189 | $798,128 | $417,948 | $1,216,076 |
| TX | Zapata, TX | 127 | 59 | $228,455 | $75,965 | $304,420 |
| TX | Zavala, TX | 297 | 144 | $683,565 | $186,725 | $870,290 |
| TX | Total | 498,361 | 283,998 | $1,607,234,040 | $434,186,445 | $2,041,420,485 |
| Non TX | Total | 6,408 | 4,433 | $21,394,674 | $16,465,642 | $37,860,317 |
| **Total** | | **504,769** | **288,431** | **$1,628,628,715** | **$450,652,087** | **$2,079,280,802** |

## APPENDIX K: ELIGIBILITY GUIDELINES FOR THE GROUP BENEFITS PROGRAM

| | SERVICE AS A STATE OR HIGHER EDUCATION EMPLOYEE | OTHER SERVICE OR ELIGIBLE GROUPS |
|---|---|---|
| **Coverage as an employee** | **Following 90 days of actual service as a:**<br>• State employees<br>• Higher education employees at public institutions and community colleges, except for the University of Texas and Texas A&M University systems;<br>• Community supervision and corrections department employees<br>• State and district and appeals court judges<br>• Elected state officials and former elected state officials and former legislative employees<br>• Employees and retired employes of the Texas Municipal Retirement System and the Texas County and District Retirement System.<br><br>Spouses and children (up to age 26) can also be added to the state insurance program. | **Survivor Benefits:**<br>Dependents of employees who have 10 years or more of service are also eligible as survivors if the employee dies. These surviving family members pay the full premium contribution for coverage.<br>**Wrongfully imprisoned:**<br>If a prisoner is found to be wrongfully imprisoned by the Texas correctional system, they are eligible to buy insurance for as many years as they were wrongfully imprisoned. Their dependents are not eligible, so they do not receive survivor benefits. |
| **Coverage as a retiree** | **Regular full-time and part-time state and higher education employees** who meet the following requirements:<br>• Age 65 + 10 years of GBP eligibility; or<br>• The Rule of 80<br><br>**Retiring from the state:**<br>• If retirement is directly from state employment, coverage is immediate;<br>• If retirement is from a non-contributing status, coverage begins after 90 days<br><br>Spouses and children (up to age 26) can also be added to the state insurance program. | **Proportionate retirees:**<br>• State employees with a combined 10 years of service credit in ERS and any other entity that participates in the proportionate retirement program:<br>o Judicial Retirement System of Texas Plans 1 & 2<br>o Teacher Retirement System of Texas<br>o Texas Municipal Retirement System<br>o Texas County and District Retirement System<br>o City of Austin Retirement System<br>o City of Austin Police Retirement System<br>o El Paso Firemen & Policeman's Pension Fund<br>o El Paso City Employees' Pension Fund<br>o Central Texas Community Health Center<br><br>*Certain retirees who retired under disability provisions of ERS, TRS or ORP may also be eligible for coverage.* |

## APPENDIX L: GBP LEGAL ISSUES

**Basis for the report**
House Bill 1, the General Appropriations Act bill for the 82nd Texas Legislature, directed the Employees Retirement System of Texas (ERS) to conduct a study of the long-term sustainability of the Texas Employees Group Benefits Program (GBP), including a review of the current plan design and funding.

**Legal control over decision making**
The Legislature has the authority to make certain decisions – such as who receives benefits (eligibility), the amount of funding for the plan (appropriations), and how cost is shared between employers and members (contribution strategy). The ERS Board of Trustees determines what the benefits will cover (plan design), oversees program operation and third-party administration (contractual arrangements and selection of vendors), and approves programs to manage costs (cost containment).

**Benefits are not guaranteed under state law.**
Since 2006, ERS has clearly and consistently communicated online and in all health-related publications that health and other insurance benefits are subject to change based upon available State funding. The Texas Legislature determines the level of GBP funding and has no obligation to provide health insurance benefits beyond each fiscal year. The State also has no legal obligation to pre-fund the outstanding cost for future retiree health care.

**Legislative intent for providing health insurance benefits.**
The Texas Insurance Code outlines legislative intent for providing health insurance benefits to the state workforce. The GBP was created to:

- Provide uniform insurance benefits for all state employees and their dependents,
- Recruit and retain competent employees with benefits at least equal to private sector benefits,
- Encourage employment and service to the state as a career profession,
- Promote and preserve the economic security and good health of employees and dependents,
- Foster and develop high standards of employee-employer relationships, and
- Recognize long and faithful service and dedication of state officers and employees.[1]

**Other Post Employment Benefits (OPEB**
ERS administers the OPEB provided under the GBP (health and basic life insurance) for state agencies, community colleges, certain quasi-state agencies and Community Supervision and Correction Departments, and higher education institutions other than the University of Texas and Texas A&M.

GBP OPEB costs are funded on a pay-as-you-go basis (PAYGO); i.e., employer funding for OPEB is limited to the amount necessary to provide for current benefits. As long as OPEB is funded on a PAYGO basis, the projected OPEB cost will continue to grow.

Under standards prescribed by the Governmental Accounting Standards Board (GASB),states are not required to contribute the ARC each year. They are only required to disclose the amount by which the state's actual contribution falls short of the ARC in its annual financial statement. In Texas, the projected OPEB cost is reported in the notes and supplementary section of the State of Texas Comprehensive Annual Financial Report.

Alternatively, the State could advance fund retiree health benefits in much the same way that it funds retirement benefits: by making annual contributions to a trust fund in amounts that are sufficient to cover both current benefits and a portion of the projected cost of future benefits. Under GASB, the State would have to contribute $1.9 billion a year (the ARC) to a trust fund in order to prevent further growth in the current projected OPEB cost of $21.5 billion.

**Affordable Care Act (ACA)**
The Texas Legislature amended the Texas Insurance Code, effective September 1, 2011, to comply with the requirements of the federal health reform package. The ACA requires GBP to implement the following plan changes during the FY12-13 biennium.

- Effective September 1, 2011, the ACA required ERS to amend the plan to cover children up to age 26, cover preventive care at no cost to the participant, eliminate the lifetime maximum for out-of-network benefits and eliminate the Evidence of Insurability (EOI) requirement for late entrants.
- Effective September 1, 2012, the plan must provide coverage for contraceptives at no cost to the member as required by the ACA.
- Also, the GBP will be required to pay fees to the Patient Centered Outcomes Research Trust (PCORT) Fund during FY13.

These ACA-required revisions are projected to cost the plan about $82.8 million during the FY12-13 Biennium. This total does not reflect the additional cost associated with elimination of the EOI requirement, which will be determined following the end of FY12.

**Early Retiree Reinsurance Program.** Additional costs due to the ACA were offset somewhat by $70.9 million in federal government subsidies in FY11-12 from the Early Retiree Reinsurance Program (ERRP), which was designed to encourage employers to continue covering retirees younger than age 65. This is a temporary measure that ended during the FY12 plan year, two years earlier than originally established because federal funding for this program was exhausted.

The state's acceptance of the federal ERRP subsidies for FY11 and FY12 required a commitment to maintain certain levels of insurance and state expenditures in the program for a period of time. Any significant changes proposed to the health insurance

program should be reconciled with the State's commitment to the federal government under ERRP.

**Value-based insurance design**. Other issues that will require attention include the development of value-based insurance design (VBID) strategies. Section 2713c of the ACA gives the Secretary of Health and Human Services authority "…to develop guidelines for group health plans and health insurance issuers offering group or individual health insurance coverage to utilize VBIDs as part of their offering of preventive services."[1]

**Alternative payment systems.** 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. 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.[2]

Medicare's experiments with Accountable Care Organizations (ACOs) have accelerated payment reform based on performance measures.[3] The ACO must include a full range of providers – from primary and specialty physicians to physician extenders (such as nurse practitioners), to hospitals. A self-funded employer can directly contract with a provider system that is forming an ACO, or they can get access to an ACO through a health insurer.

Effective January 1, 2011, ERS launched three successful Patient Centered Medical Homes in response to initiatives by the Texas Legislature.[4] The 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.

**Health Privacy Laws:**

- **Health Insurance Portability and Accountability Act (HIPAA).**
  Any time ERS needs to exchange data with or among providers or vendors, a data reporting standard must be negotiated with the third-party administrator (TPA). The state also must understand all current Personal Health Information (PHI) laws to ensure we are in compliance with any requirements regarding the use of information obtained through Health Risk Assessments (HRA) or biometric screenings. HRAs would be subject to HIPAA wellness guidelines.

- **Genetic Information Nondiscrimination Act (GINA).**
  Biometric screening information of individual participants may fall under GINA, a subset of HIPAA passed by Congress in 2008. Further research into the implications of requiring biometric screenings and use of resulting data would be required before requiring biometric screening or health risk assessments.

**Age Discrimination in Employment Act (ADEA)**
Under the ADEA administered by the Equal Opportunity Commission and the Department of Labor, employers must be careful when making benefit changes that benefit younger members at the expense of older members. (Age 40 is the cutoff). All options relating to retiree coverage must be thoroughly vetted for issues with the ADEA.

**Other legal issues:**
Substantially restricting the provider network would require legislative support to implement. Other potential legislative actions that could have a positive impact on the ERS's ability to manage costs over time are:

- enacting Certificate of Need legislation to require hospitals to get permission before building new facilities or making major expansions,
- repealing prohibitions against the Corporate Practice of Medicine to allow hospitals to hire physicians directly, which would allow for fully integrated health care practices and facilitate the creation of accountable care organizations,
- allowing self-funded insurance plans to pay providers on a capitated basis outside the HMO setting, thereby allowing the transfer of insurance risk to the provider, and
- examining the appropriateness of the scope of practice for physician extenders and pharmacists, in light of the shortage of primary care physicians in Texas.

A fully-insured HMO has approached ERS with a proposal to expand its integrated practice model, which already contains hospitals and salaried physicians. It is unclear whether state law would allow ERS to directly contract with an HMO using an alternative payment system. When ERS piloted its Patient-Centered Medical Home program, no HMOs responded to the request for proposal.

[1]Texas Insurance Code, §1551.002.

[2]Texas Insurance Code, Art. 4, Ch. 848, as enacted by SB7 (Nelson), 82nd Texas Legislature, 2011.

[3]Schneider, Eric C., et al., "Payment Reform: Analysis of Models and Performance Measure Implications, RAND Health Technical Report, 2011.

[4]HB 4586, Supplemental Appropriation Bill, 81st Texas Legislature, 2009.

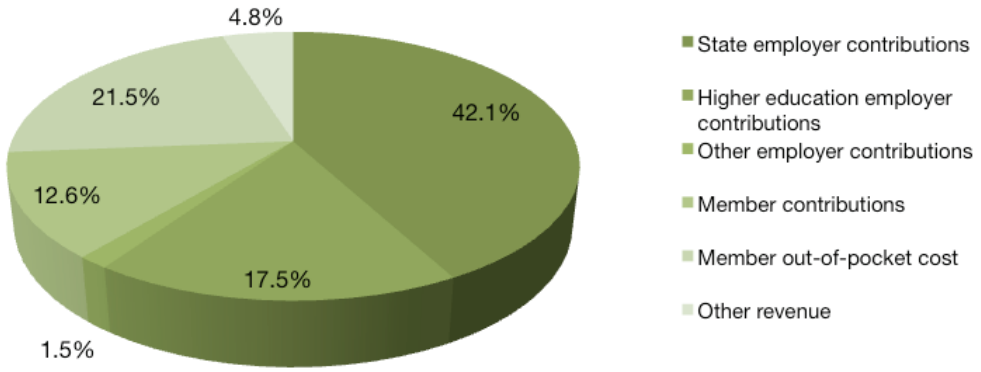
## APPENDIX M: WHAT KINDS OF EMPLOYERS USE THE GBP HEALTH INSURANCE BENEFIT?

Insurance for both active and retired employees is funded in the same manner: by state, local, or higher education sources, depending on the type of employer. Four kinds of employers pay to participate in the GBP:

1. General state agencies that pay for insurance using state appropriated funds (GR, Federal funds, Highway, and "other")
2. State agencies that do not receive a state appropriation; e.g., ERS and the Windham School District. They pay for insurance using only "local" funds.
3. Higher education institutions that receive varying levels of state appropriations depending on proportionality formulas. They pay for insurance through a combination of state and local funds with that combination varying widely by institution.
4. Other employers that are not state agencies (like Texas Municipal Retirement System, Texas County and District Retirement System, and Community Supervision and Corrections Department) that do not receive an appropriation. They pay for insurance using only "local" funds.

Due to this complex combination of funding sources, the IBS analysis generally refers to "savings to the State" as "savings to the employer."

**Employers pay about 61 cents of every health plan dollar (FY12, source of funds for GBP health insurance benefits)**



## APPENDIX N: TEXAS EMPLOYEES GROUP BENEFITS PROGRAM

**Actual and Projected GBP fund balance**

(based on plan experience through June 2012)

| | FY2011 (Actual) | FY 2012 (Projected) | FY 2013 (Projected) |
|---|---|---|---|
| **Average Enrollment** (employees and retirees only; does not include dependents) | | | |
| HealthSelect | 288,683 | 262,171 | 253,093 |
| Medicare Advantage PPO | 0 | 24,202 | 36,571 |
| HMOs | 17,012 | 15,748 | 15,809 |
| Total | 305,695 | 302,121 | 305,473 |
| | | | |
| **GBP Revenue** | **In Millions** | | |
| Health Plans | | | |
| State Funding | $1,842.8 | $1,901.9 | $2,056.9 |
| Contribution for State Agency | 1,264.9 | 1,311.7 | 1,416.4 |
| Contribution for Higher Ed Agency | 527.9 | 543.8 | 590.3 |
| Contribution for Other Agency | 50.0 | 46.4 | 50.2 |
| Employee Funding | 394.9 | 393.7 | 416.7 |
| Total | 2,237.7 | 2,295.6 | 2,473.6 |
| Investment and Misc. Income | 13.7 | 10.0 | 8.0 |
| Total | $2,251.4 | $2,305.6 | $2,481.6 |
| | | | |
| **GBP Expenditures** | **In Millions** | | |
| HealthSelect | $2,165.0 | $2,187.4 | $2,342.8 |
| Humana MA | 0.0 | 109.5 | 172.1 |
| HMOs | 128.4 | 120.6 | 122.4 |
| Group Insurance Expenses | 12.1 | 12.7 | 13.3 |
| Subtotal | 2,305.5 | 2,430.2 | 2,650.6 |
| LESS Credit for Hospital Audit and Formulary Refunds | -145.5 | -152.3 | -100.8 |
| Total | $2,160.0 | $2,277.9 | $2,549.8 |
| | | | |
| **Net Gain (Loss)** | $91.4 | $27.7 | ($68.2) |
| | | | |
| **Contingency Fund** | | | |
| Fund Balance August 31, FY2012 | $228.0 | $92.9 | $27.8 |

## APPENDIX O

**HealthSelect**

**Cost Management Reporting**

**FY11**

| | | |
|---|---|---|
| 1. Considered Charges plus Estimated Cost Avoided | | $9,255,194,142 |
| 2. Estimated Cost Avoided | | |
| a. Medical | $42,224,965 | |
| b. Pharmacy | 14,361,389 | 56,586,354 |
| 3. Considered Charges | | $9,198,607,788 |
| 4. Less Ineligible Charges | | 1,514,982,005 |
| 5. Eligible Charges | | **$7,683,625,783** |
| 6. Reductions to Eligible Charges | | |
| a. Prescription Drug Program Charge Reductions | $499,946,203 | |
| b. Hospital Claim Reductions | 757,380,429 | |
| c. Charges Exceeding Professional Allowed Charges | 1,329,168,131 | |
| d. Other Provider Discounts & Reductions | 812,622,510 | |
| e. Rebundling | 5,888,833 | |
| f. Medical Copays and Deductibles | 150,203,322 | |
| g. Medical Coinsurance | 285,447,987 | |
| h. PDP Cost Sharing | 193,749,202 | |
| i. Coordination of Benefits - Medical - Regular | 20,165,945 | |
| j. Coordination of Benefits - Medical - Medicare | 1,524,082,528 | |
| k. Coordination of Benefits - PDP | 309,193 | 5,578,964,283 |
| 7. Gross Benefit Payments | | **$2,104,661,500** |
| 8. Refunds, Rebates and Guarantees | | |
| a. PDP Rebates | $63,340,189 | |
| b. Medicare Part D Retiree Drug Subsidy | 38,207,039 | |
| c. Early Retiree Reinsurance Program | 30,175,627 | |
| d. Subrogation | 7,239,177 | |
| e. Pharmacy Audit Refunds | 535,626 | |
| f. PBM Audit Results | 375,293 | |
| g. Hospital Audit Refunds | 1,997,976 | 141,870,927 |
| 9. Net Benefit Payments | | **$1,962,790,573** |

*Amounts taken from:
(1) Annual Statistical Review prepared by Blue Cross,
(2) Annual Experience Accounting prepared by Caremark,
(3) HealthSelect Prescription Drug Plan data, and
(4) ERS FY10 CAFR (Medicare Part D Retiree Drug Subsidy and ERRP revenue).

## APPENDIX P: COMPARING HEALTH SAVINGS ACCOUNTS, HEALTH REIMBURSEMENT ARRANGEMENTS, AND FLEXIBLE SPENDING ACCOUNTS

| | HEALTH SAVINGS ACCOUNTS | HEALTH REIMBURSEMENT ARRANGEMENTS | FLEXIBLE SPENDING ACCOUNTS |
|---|---|---|---|
| **Must it be used with a high-deductible health plan (HDHP)?** | Yes, HDHP only.<br>Minimum deductibles of $1,200 for employee only coverage; $2,400 for family coverage for 2012 | No. Employees can choose between HDHP and non-HDHP. | No. Employees can choose between HDHP and non-HDHP. |
| **Are people over 65 eligible?** | Medicare beneficiaries not eligible, but 55 to 65 year olds may contribute an extra $700 per year under a "catch-up" provision. | Only employers contribute to HRAs, so retirees are not eligible. | Since coverage is job-based, retirees are not eligible. |
| **Carry forward from year to year?** | Yes. May not roll IRA, HRA, or FSA funds into an HSA. May roll over funds from another HSA or from a Medical Savings Account. | Yes. May not roll IRA, HSA, or FSA funds into an HRA. | No, but a grace period allows employees 60-days to file claims past the end of the fiscal year. |
| **Individual owns account (keep even after leaving job)?** | Yes | Employer chooses whether an individual is allowed access to HRA after leaving the job | No. |
| **Type of coverage?** | Individual and job-based health coverage | Job-based only | Job-based only |
| **Who contributes?** | Individuals, employees, and employers. Employer contributions must be "comparable" for employees w/HDHPs. | Employer only. | Employee only. |
| **Contribution limits (for 2012) *adjusted annually for inflation** | Single coverage – Combined contribution equals the lesser of the annual deductible or $3,100<br>Family coverage – Combined contribution equals the lesser of the annual deductible or $6,250* | No statutory limit; contribution limits may be set by employer | No statutory limit; contribution limits may be set by employer. The State of Texas allows a $180 min. and $5,000 max. contribution to Tex-Flex per year. Federal law will limit this to $2,500 beginning September 1, 2013. |
| **How would it work with an FSA (i.e., Tex-Flex)?** | Expenses must be paid from the HSA or out-of pocket until the deductible is met. Only after meeting the deductible can FSA funds be used. A limited purpose FSA may be possible for items not covered by the HDHP. | Generally, expenses are paid from the HRA first, then from the FSA. | N/A |
| **Maximum out of pocket expense (for 2012)** | Single coverage -- $5,950<br>Family coverage -- $11,900<br>(not including premiums) | N/A. Depends on specifics of insurance coverage. | N/A. Depends on specifics of insurance coverage. |
| **Is prescription drug coverage carve-out allowed?** | Rx coverage must be part of the HDHP. | Rx carve-out allowed. May use HRA for Rx co-pays and deductibles. | Rx carve-out allowed. May use FSA for Rx co-pays and deductibles, and OTC drugs. |
| **Are administrative fees allowed?** | Yes. Fees may be charged to employee. | Yes. Fees may be charged to employee. | Yes. Fees may be charged to the employee. TexFlex fee is currently $1 per month. |
| **Primary legal authority and reference** | Medicare Prescription Drug, Improvement, and Modernization Act of 2003<br><br>Internal Revenue Code, sec. 223 Effective Jan. 1, 2004 | U.S. Department of Treasury Revenue Ruling 2002-41<br><br>Internal Revenue Code, sec. 105-106, Effective June 26, 2002 | Revenue Act of 1978<br><br>Internal Revenue Code, sec. 125 Effective Jan. 1, 1997 |
| **How is it taxed?** | "Above-the-line" deduction for employee, if used for qualified medical expenses. Employer contribution is not taxed as income. | Not taxed as income | Not taxed as income |

Sources: U.S. Department of the Treasury (2006), http://www.treas.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-06.pdf ; Internal Revenue Service (2004), IRS Notice 2004-2, IRS Rev. Proc. 2004-71 and IRS Publication 969; Kofman, Mila, J.D. (September 2004) "Health Savings Accounts: Issues and Implementation Decisions for States," State Coverage Issues, Vol. V, No. 3; and Saleem, Haneefa T. (December 2003), "Health Spending Accounts," U.S. Department of Labor, Bureau of Labor Statistics; IRS Rev. Proc 2012-26.

## APPENDIX Q: COMPARING STATE OF INDIANA CONSUMER-DRIVEN HEALTH PLANS

March 21, 2011

**State of Indiana offers consumer-driven health plans.** Indiana is recognized nationally for being one of the first states to offer its employees the option of a consumer-driven health plan, which is a high-deductible health plan (HDHP) attached to a tax-advantaged health savings account (HSA). As of March 2010, more than 70% of the 30,000 state employees chose one of two CDHP options.

**Indiana offers state employees a choice of plans.** The State of Indiana covers up to half the premium for two high-deductible plans and a traditional PPO. HSAs are provided for employees who enroll in an HDHP. As an incentive the first year, the state front-loaded each employee's HSA with $2,750. In 2011, the state's HSA initial contribution was reduced to $626 for CDHP 1 and $376 for CDHP 2. Non-smokers get discounted rates for all the plans.

**Medicare retirees are not eligible for the plan.** They may enroll in a Medicare complement at their own cost. Early retirees may participate in the plan, but they pay the full contribution, unlike State of Texas retirees, who continue to get full coverage after retirement.

**Indiana's annual rate increase exceeds HealthSelect**

For the most current year, the Indiana CDHP plan rates increased 8.8% to 12.3%. Their PPO rates increased 12.9%, compared to HealthSelect increase of 8%.

**The Indiana plan would cost Texas more**

If the GBP were to offer a plan like the State of Indiana, state costs for health insurance would increase significantly, while employee costs would go down.

**Considerations when comparing Indiana to Texas**

Indiana does not cover retirees,
Indiana's per member cost is much higher than HealthSelect,
Indiana contributes to the HSA; as an incentive,
Indiana rates the HDHP and PPO separately, and
PPO costs are going up at a higher rate, which also incentivizes employees to switch.

### CHANGE IN PROJECTED ANNUAL CONTRIBUTIONS IF GBP OFFERED INDIANA HEALTH INSURANCE COMPARED TO HEALTHSELECT

| | CDHP 1 | CDHP 2 | PPO | COMBINED |
|---|---|---|---|---|
| **Total Contributions** | $270.6 million ↑**11.7%** | $538.3 million ↑**23.3%** | $1.5 billion ↑**66.4%** | $743million ↑**32.2%** |
| **State Contributions** | $621 million ↑**32.3%** | $621 million ↑**32.3%** | $621 million ↑**32.3%** | $621 million ↑**32.3%** |
| **Member Contribution** | -$350.4 million ↓**91.4%** | -$82.7 million ↓**21.6%** | $912.1 million ↓**237.9%** | $122 million ↓**31.2%** |

* based on application of HealthSelect and Indiana contribution rates to FY11 total GBP Enrollment (State, Higher Education and Other). Assumed enrollment for GBP members is 35% in Plan 1, 35% in Plan 2, and 30% in the PPO.

### MONTHLY COST COMPARISON, STATE OF INDIANA EMPLOYEE HEALTH PLAN (2011) NON-TOBACCO INCENTIVE RATES; PREVENTIVE CARE COVERED BY THE EMPLOYER

| | CDHP1 Single/ Family | CDHP 2 Single/Family | PPO Single [In/Out] Family [In/Out] | FY11 HealthSelect* Single/Family |
|---|---|---|---|---|
| Annual Deductible/ Coinsurance | $2,500/ $5,000 20% coinsurance | $1,500/ $3,000 20% coinsurance | $500/ $1,000 $1,000/ $2,000 | $50 Rx deductible 20% coinsurance |
| Maximum Out of Pocket | $4,000/ $8,000 | $3,000/ $6,000 | $2,000/ $4,000 $4,000/ $8,000 | $2,000 coinsurance/ no max on copays |
| Initial Employer HSA Deposit Employer Monthly HSA Deposit | $646.36/$1292.46 $53.86/$107.71 | $388.44/$775.32 $32.37/ $64.61 | N/A | N/A |
| Monthly Employer Premium | $293.76/ $921.18 | $336.74/ $1007.37 | $401.48/ $1,136.59 | $431.56/ $685.06 |
| Monthly Employee Premium | $5.23/ $14.67 | $54.28/ $124.91 | $205.17/ $577.23 | $0/ $253.47 |
| **Total Premium (Employer + Employee)** | **$298.99/ $935.85** | **$391.02/ $1,132.28** | **$606.65/ $1,713.82** | **$431.56/ $938.53** |
| **Annual Employer Cost** | **$4,817.80/$13,639.14** | **$4,817.80/$13,639.14** | **$4,817.80/$13,639.14** | **$5,178.72/$8,220.72** |

## MERCER REPORT ON INDIANA CONSUMER-DRIVEN HEALTH PLANS

Mercer reviewed the Indiana CDHP options in May 2010 and concluded that they saved both the State of Indiana and plan members.

**Savings**

- Average PPO cost is $12,317 compared to $5462 for CDHP I and $9,444 for CDHP 2
- The two CDHPs had combined savings of 10.7% per year
- Projected savings to the State in 2010 from the CDHPs are $17-23 million
- CDHP members are projected to save $7-8 million in 2010

**Demographics**

- CDHP members are younger, but have a higher average family size that PPO members

**Actuarial value**

- CDHP plans have a lower actuarial value than PPO
  - O CDHP 1 to PPO .926 to 1.000
  - O CDHP 2 to PPO .996 to 1.000

**Utilization**

- CDHP members use fewer and less Intense services
- Mercer says there is no evidence that CDHP members are avoiding care. (determined by looking at HSA average balances. 82% of participants access their accounts but balances average $2,072 for CDHP1 and $1,196 for CDHP2.
- Reduced usage of hospital services.
  - O ER visits are 308.1 per 1,000 for PPO members, 210.4 for CDHP1 and 163 for CDHP 2
  - O Hospital admissions are 113.9 for PPO, 64.3 for CDHP 1 and 36.3 for CDHP 2
- "Sources of savings appear to come from better use of healthcare resources and more cost conscious decision making. Major cost reductions are due to:
  - O substituting generics for name brand drugs,
  - O avoiding ER Visits, and
  - O using PCP instead of specialist."

| CDHP ENROLLMENT FOR INDIANA STATE EMPLOYEES (OUT OF 30,000 STATE WORKERS) | | |
|---|---|---|
| **2006** | CDHP1 | 1,400 |
| **2007** | CDHP 1 and 2 | 6,300 |
| **2008** | CDHP 1 and 2 | 12,100 |
| **2009** | CDHP 1 and 2 | 15,500 |
| **2010** | CDHP 1 and 2 | 21,000 |

| PLAN TYPE | CDHP1 | CDHP2 | PPO |
|---|---|---|---|
| **Average net paid med + RX** | $3,339 | $7,682 | $12,317 |
| (Adjusted by pooling claimants in excess of $250k . Claims have been trended to CY09, assuming an underlying annual 8% medical trend) | | | |
| **Average HSA withdrawal** | $2,063 | $1,762 | N/A |
| **Total average state claim and HSA value** | $5,462 | $9,444 | $12,317 |
| **Difference vs. PPO** | ($6,855) | ($2,873) | N/A |
| **CATEGORIES OF DIFFERENCE IN PPO** | | | |
| **Plan Design - including account funding** | ($917) | ($51) | N/A |
| **Demographic difference (age, gender and family size)** | ($1,118) | ($89) | N/A |
| **Health Status (beyond demographic)** | ($3,058) | ($555) | N/A |
| **Consumerism (behavior change)** | ($1,535) | ($940) | N/A |
| **Unidentified difference** | ($226) | ($1,417) | N/A |
| (Actual experience varied from actuarial factors resulting in some irreconcilable differences) | | | |

## APPENDIX R: VALUE-BASED INSURANCE DESIGN—PUBLIC SECTOR INITIATIVES

ERS explored four different public sector initiatives regarding value-based insurance design (VBID).

### STATE OF MAINE [1]

In 2006, Maine's Employee Health & Benefits program adopted a VBID, a key component of which is diabetes disease management. Diabetes was targeted for this intervention because it is an expensive disease to treat, therefore, removing treatment barriers can lead to significant savings. Maine worked with one of its third party administrators (Wellpoint) to craft a diabetes disease management program that includes telephonic diabetes education and support with Certified Diabetes Educators, prescription drug and supplies co-payment waivers, access to preferred hospitals, and deductible exemptions for preventive care. Hospitals were identified as "preferred" when they achieved all of the standards identified by the Maine Health Management Coalition's Pathways to Excellence Hospital Steering Committee. Examples of preferred hospital standards include completion of safe practices survey and CMS clinical measures aggregate scores at or above the national average for selected conditions. During the second phase (initiated in 2007) primary care practices could attain "preferred" status, and members received copay and annual deductible waivers when they utilized these providers. The third phase of the value based design strategy (initiated in 2008) added waivers for copayments charged to inpatient admissions and outpatient surgeries at preferred hospitals.

Key diabetes-related findings include:

- Average cost for physician visit was $256 (up from $189) and average cost of diabetes drugs was $1,850 (up from $1,414)—both of which were expected as diabetes treatments were more easily accessed and used.
- Average cost for diabetes-related ER visit went from $199 to $183—a roughly 8% cost reduction.
- Participants in the diabetes disease management program had an average adjusted cost of $1,300 less than control group participants (over 12 month follow-up period).

### STATE OF CONNECTICUT

This year, the State of Connecticut (represented by Governor Malloy) and the State Employees Bargaining Agent Coalition (unions that represent state employees) created a labor agreement that includes VBID. Union members approved the agreement in August, the legislature ratified it in early September, and state employees had until September 15 to decide if they wanted to participate in the VBID program.[2] The Comptroller reports that "more than 95 percent of employees have chosen to enroll in the VBID plan."[3] Diabetes is one of the five chronic conditions included in the agreement. Copayments are waived or reduced ($0/$5/$12.50) for Type I and Type II diabetes medications.[4] Copayments for office visits for diabetes treatment and monitoring are also waived. 5 VBID plan enrollees with diabetes must commit to yearly physical exams, regular preventive screenings, disease counseling, and education program participation.[6] If enrollees do not comply with these measures, then the incentives can be revoked and the individual is subject to higher premiums and deductibles.[7] Program costs are expected to be offset by new copayments for emergency room visits and pre-authorization requirements for high cost diagnostics.[8]

### POLK COUNTY, FLORIDA [9]

Due to high rates of diabetes and hypertension in Polk County employees, these diseases were targeted for a 2005 VBID. Polk County collaborated with CVS Caremark to roll out a Contract for Care program. A member enrolled in this program first signs a care contract—participants are responsible for showing up for scheduled appointments and following medication adherence guidelines. The individual is assessed and categorized by severity of disease, then works with a Clinical Care Advisor to develop and implement a personalized plan of care. Participants can meet with the Clinical Care Advisor up to six times. During these meetings, patients and advisors review lab results and current medications, and discuss disease-related education topics. Copays are eliminated for diabetes medications and supplies—which can be as much as 10-20% of the patent's monthly income. Financial incentives apply to employees and family members who have enrolled in the program.

Key diabetes-related findings include:

- Lower levels of HBA1C (blood glucose measurement)—67% of individuals with severe diabetes had an average reduction of HBA1C of 1.51 mg/dl.
- The number of Polk County employees identified as high-risk for diabetes dropped by 22%.
- Reduced hospitalizations and ER visits for individuals with diabetes and hypertension resulted in net savings of $213,000. For participants with diabetes, ER visits were reduced by 7% and hospitalizations were reduced by 22% from 2004 to 2006.

### SPRINGFIELD, OREGON [10]

In 2005, the City of Springfield rolled out a VBID for diabetes management. Enrolled employees with Type I and Type II diabetes were put into control and intervention test groups—25 participants for each group. Data was collected twice over the period of about two years. Copayment waivers for medications and diabetes related medical visits (including lab tests and physician visits) were given to both groups. The control group received educational materials and the intervention group got face-to-face pharmacist consultations. The pharmacists worked with intervention group members

"…to determine behavioral changes, create problem solving skills, learn risk reduction measures, plus consult…with the person's physician."[11] Financial incentives seemed to cause reductions in both groups, but the treatment effects were stronger in the intervention group.

Key diabetes-related findings include:[12]

- The control group saw a 30% drop in HA1c. However, a more striking decrease was found in the intervention group—HA1c dropped 50%.
- LDL cholesterol also decreased more in the intervention group (5.8 mg/dL) than control group (1.6 mg/dL).
- Average sick leave for intervention group decreased by 15.3 hours, 2.7 hours in the control group.

[1]Value-Based Design in Action. Umich.edu. Center for Health Value Innovation, Aug. 2009. Web. 2 Dec. 2011.
[2]"CT State Reform: V-BID in Connecticut: More than 95% of State Employees Enrolled." University of Michigan. Center for Value-Based Insurance Design, n.d. Web. 2 Dec. 2011. <http://www.sph.umich.edu/vbidcenter/ctstatereform.html>.
[3]Ibid
[4]"Revised SEBAC 2011 Agreement between State of Connecticut and State Employees Bargaining Agent Coalition (SEBAC)." N.p., n.d. Web. 2 Dec. 2011. <http://inthistogetherct.org/wp-content/uploads/2011/07/ Revised_SEBAC_2011_TA.pdf>.
[5]Ibid
[6]Ibid
[7]Ibid
[8]"CT State Reform: V-BID in Connecticut: More than 95% of State Employees Enrolled." University of Michigan. Center for Value-Based Insurance Design, n.d. Web. 2 Dec. 2011. <http://www.sph.umich.edu/vbidcenter/ctstatereform.html>.
[9]Value-Based Design in Action. Umich.edu. Center for Health Value Innovation, Aug. 2009. Web. 2 Dec. 2011.
[10]Ibid
[11]Ibid
[12]Ibid

## APPENDIX S: PRIVATE SECTOR METHODOLOGY

All of the information below is taken directly from the survey document. No changes were made to the original material.

### AON HEWITT—2011 HEALTH CARE SURVEY

"A total of 1,028 individuals participated in Aon Hewitt's 2011 Health Care Survey. The confidence interval is 95% +/- 2%-6%. Numbers in this document are rounded to the nearest whole."
The participant profile is as follows:

**Number of World Wide Employees**
Below 1,000—18%
1,000- 5,000—24%
5,001- 25,000—35%
Over 25,000—23%

**Number of U.S. Benefit-Eligible Employees**
Below 1,000—33%
1,000- 5,000—34%
5,001- 25,000—24%
Over 25,000—10%

**Which industry classification best describes your organization?**
Banking/ Finance—5%
Construction/ Engineering—4%
Energy—5%
Food/ Beverage Manufacturing and Services—3%
Government (State/Local)—4%
Health Care—10%
Higher Education—6%
Insurance—6%
Manufacturing—14%
Professional/ Business Services—4%
Retail—8%
Technology—5%
Transportation and Warehousing—3%
Other—24%

### KAISER FAMILY FOUNDATION AND HEALTH RESEARCH & EDUCATIONAL TRUST—EMPLOYER HEALTH BENEFITS 2011 ANNUAL SURVEY

"The Kaiser Family Foundation/Health Research & Educational Trust 2011 Annual Employer Health Benefits Survey (Kaiser/HRET) reports findings from a telephone survey of 2,088 randomly selected public and private employers with three or more workers. Researchers at the Health Research & Educational Trust, NORC at the University of Chicago, and the Kaiser Family Foundation designed and analyzed the survey. National Research, LLC conducted the fieldwork between January and May 2011. In 2011 our overall response rate is 47%, which includes firms that offer and do not offer health benefits. Among firms that offer health benefits, the survey's response rate is 47%.

From previous years' experience, we learned that firms that decline to participate in the study are less likely to offer health coverage. Therefore, we asked one question to all firms with which we made phone contact, but the firm declined to participate. The question was, "Does your company offer a health insurance program as a benefit to any of your employees?" A total of 3,184 firms responded to this question (including 2,088 who responded to the full survey and 1,096 who responded to this one question). Their responses are included in our estimates of the percentage of firms offering health coverage. The response rate for this question was 71%. Since firms are selected randomly, it is possible to extrapolate from the sample to national, regional, industry, and firm size estimates using statistical weights. In calculating weights, we first determined the basic weight, then applied a nonresponse adjustment, and finally applied a post-stratification adjustment. We used the U.S. Census Bureau's Statistics of U.S. Businesses as the basis for the stratification and the post-stratification adjustment for firms in the private sector, and we used the Census of Governments as the basis for post-stratification for firms in the public sector. This year, we modified the method used to calculate firm-based weights resulting in small changes to some current and past results. For more information on the change consult the Survey Design and Methods section of the 2011 report. Some exhibits in the report do not sum up to totals due to rounding effects and, in a few cases, numbers from distribution exhibits referenced in the text may not add due to rounding effects. Unless otherwise noted, differences referred to in the text use the 0.05 confidence level as the threshold for significance.

| | Selected Characteristics of Firms in the Survey Sample, 2011 Sample Size | Sample Distribution After Weighting | Percentage of Total for Weighted Sample |
|---|---|---|---|
| **FIRM SIZE** | | | |
| 3–9 Workers | 130 | 1,996,357 | 60.6% |
| 10–24 Workers | 205 | 777,413 | 23.6 |
| 25–49 Workers | 157 | 271,908 | 8.3 |
| 50–199 Workers | 296 | 193,136 | 5.9 |
| 200–999 Workers | 511 | 43,392 | 1.3 |
| 1,000–4,999 Workers | 466 | 7,944 | 0.2 |
| 5,000 or More Workers | 323 | 2,098 | 0.1 |
| **ALL FIRM SIZES** | **2,088** | **3,292,248** | **100%** |
| **REGION** | | | |
| Northeast | 415 | 645,447 | 19.6% |
| Midwest | 590 | 746,566 | 22.7 |
| South | 697 | 1,123,265 | 34.1 |
| West | 386 | 776,971 | 23.6 |
| **ALL REGIONS** | **2,088** | **3,292,248** | **100%** |
| **INDUSTRY** | | | |
| Agriculture/ Mining/ Construction | 125 | 397,852 | 12.1% |
| Manufacturing | 203 | 203,885 | 6.2 |
| Transportation/ Communications/Utilities | 113 | 122,441 | 3.7 |
| Wholesale | 115 | 183,297 | 5.6 |
| Retail | 149 | 407,711 | 12.4 |
| Finance | 137 | 218,163 | 6.6 |
| Service | 883 | 1,303,665 | 39.6 |
| State/Local Government | 131 | 50,587 | 1.5 |
| Health Care | 232 | 404,647 | 12.3 |
| **ALL INDUSTRIES** | **2,088** | **3,292,248** | **100%** |

## MERCER—2011 NATIONAL SURVEY OF EMPLOYER SPONSORED HEALTH PLANS

"The survey report is representative of all US employers that have 10 or more employees and that offer health insurance. In the Overview, we present general findings for the entire surveyed population. Because health benefits vary greatly on the basis of employer size, we also examine results separately for large and small employers. We divide the two groups at 500 employees because our survey shows that plan characteristics change most dramatically at this point. The balance of the report looks at results for large employers only.

The survey was established in 1986 (by Foster Higgins, which later merged with Mercer). We used a stratified random sample in 1993 for the first time. This report is comparable to surveys from 1993 to 2010, but should not be compared to earlier surveys…

…The random sample used for the National Survey of Employer-Sponsored Health Plans includes private employers and government agencies that have 10 or more employees.

For private employers, we used the D&B database, drawing a sample stratified in eight size categories. The survey is an enterprise survey, meaning that only one response per employer is accepted even if the employer has multiple work sites or establishments. For government agencies, we used the Census of Governments, drawing random samples of state, county, and local governments.

A weighting scheme was used to combine the results and create one database. Results may be projected to all employer health plan sponsors with 10 or more employees.

The sample was composed and weighted to permit projectable data breakouts for the four geographic regions shows below (graphic shows West, Midwest, Northeast, and South). The larger size groups were oversampled but weighted to reflect the proportions of firms nationally. Although we discuss some findings based on industry group in the analysis, the sample was not stratified by industry, and readers are advised to use industry data judiciously.

In addition, we collected data from a convenience sample of clients and prospects. The weights for these participants were set at zero in calculating projectable results, but the data is available to supplement the random sample for special tabulations.

Questionnaires were mailed to large employers in the random sample in July 2011 along with instructions for accessing a web-based version of the survey instrument, another option for participation. Employers with fewer than 500 employees, which historically have been less likely to respond using a paper questionnaire, were contacted by ICR, a survey research organization based in Media,

## APPENDIX T: PUBLIC ENTITY SURVEY QUESTIONS

| ELIGIBILITY |
|---|
| Total Enrollment (tot #) |
| Employees (#) |
| Retirees (#) |
| Dependents (#) |
| Other (#) |
| Waiting period (# of days) |
| |
| **RETIREES** |
| Medicare retirees covered (Y/N) |
| Employer contribution (%) |
| Early retirees covered (Y/N) |
| Employer contribution (%) |
| Separate plan for retirees? (Y/N) |
| Separate rating for retirees? (Y/N) |
| Rx Approach (EGWP, RDS, etc) |
| Eligibility (describe -- e.g. years of service) |
| |
| **FUNDING** |
| Self-funded? |
| How many coverage tiers? eg. member only, member + family (#) |
| Single risk pool? (Y/N) |
| |
| **CONTRIBUTIONS/PREMIUMS** |
| Single coverage employer (%) |
| Single coverage employee (%) |
| Family coverage employer (%) |
| Family coverage employee (%) |
| |
| **PLAN CHOICE** |
| How many plan choices? (tot #) |
| PPO (#) |
| POS (#) |
| HMO (#) |
| HDHP (#) |
| CDHP (HDHP + HSA) (#) |
| Indemnity (#) |
| Med-Advantage PPO (#) |
| Med-Advantage HMO (#) |
| Other (Specify) |
| |
| |
| |

| FOR PPO/POS ONLY |
|---|
| Single Deductible ($) |
| Family Deductible ($) |
| Primary Care Copay ($) |
| Specialty Care Copay ($) |
| ER Copay ($) |
| Outpatient Copay ($) |
| Inpatient Copay ($) |
| Generic Copay ($) |
| Preferred Brand Copay ($) |
| Non-preferred Brand Copay ($) |
| Specialty Drug Copay ($) |
| Incentive for Mail Order? (Y/N) |
| Coinsurance OOP maximum ($) |
| |
| **FOR CDHP ONLY** |
| Single Deductible ($) |
| Single Out of Pocket Max ($) |
| Employer Deposit to HSA for single coverage (Annual $) |
| Family Deductible ($) |
| Family Out of Pocket Max ($) |
| Employer Deposit to HSA for family coverage (Annual $) |
| |
| **PROGRAMS OFFERED (DESCRIBE)** |
| Disease management |
| Health Risk Assessment |
| Biometric Screening |
| Tobacco |
| Obesity |
| Generic Drugs |
| Step therapy |
| Other (Specify) |
| |
| **INCENTIVES (DESCRIBE)** |
| Disease management |
| Health Risk Assessment |
| Biometric Screening |
| Tobacco |
| Obesity |
| Emergency Room Care |
| Generic Drugs |
| Value based benefit design |
| Other (Specify) |

# Common Appendix I: INTERIM BENEFIT STUDY PARTICIPANTS

*Figure CA.1 – Insurance Forum Participants*

| Insurance Forum Presentations | |
|---|---|
| **Group or Topic** | **Persons Involved** |
| **Legislation Requiring the Interim Benefits Study** | Porter Wilson, Chief of Staff representing Senator Robert Duncan, Chairman Senate Committee on State Affairs |
| **The Road Ahead – Health Care Strategies in an Era of Reform** | Craig Dolezal, South Region Health & Benefits Practice Leader, Aon Hewitt, Atlanta, Georgia |
| **Managing Health Plan Costs - What the "Thought Leaders" are Thinking** | Mark E. Chronister, Principal, Mercer Health & Benefits LLC |
| **Strategies for Sustaining the Employees Retirement System of Texas Medical Plan** | Peter J. Maillet , Area Vice President, Gallagher Benefit Services |
| **The State of the Market and the Future of Health Care** | Eric Bassett, Senior Partner and Thought Leader for Mercer Health & Benefits LLC |
| **Legislative Budget Board Activities** | Deborah Hujar, Senior Policy Analyst, LBB, Texas Performance Review |

*Figure CA.2 – Retirement Forum Participants*

| Retirement Forum Presentations | |
|---|---|
| **Group or Topic** | **Persons Involved** |
| **Legislative View of the Interim Benefits Study** | Merita Zoga, Committee Clerk, House Committee on Pensions, Investments and Financial Services Representing Committee Chair State Representative Vicki Truitt |
| **LBB Recommendation to the 82nd Texas Legislature on Maintaining Solvency of ERS** | Jennifer Jones, Analyst, Legislative Budget Board |
| **The Fadeout or the Future of the Defined Benefit Plan** | Gary B. Lawson, J.D.,LL.M., Partner, Strasburger & Price LLP |
| **Current Status, Issues & Trends Impacting Public Pension Plans** | Keith Brainard, Research Director, National Association of State Retirement Administrators |
| **Legislative Perspective and History** | The Honorable Sherri Greenberg, Interim Director at the Center for Politics and Governance at the LBJ School, Former State Representative and Chair, House Committee on Pensions and Investments |
| **Defined Contribution Plans in the Public Sector** | Greg Seller, Senior Vice President Government Markets, Great-West Retirement Services, Founding member of National Association of Government Defined Contribution Administrators |

*Figure CA.3 – Workforce Forum Participants*

| Workforce Forum Presentations | |
|---|---|
| **Group or Topic** | **Persons Involved** |
| **Recent State Auditor's Office Reports Related to State Workforce Issues** | John Keel, Texas State Auditor |
| **Population Change in Texas: Implications for Education of the Labor Force and Economic Development** | Steve Murdock, PhD., Founding Director of The Hobby Center for the Study of Texas |
| **Pressures and Impacts of Changing Public Sector Benefits** | Linda Kegerreis, Chief Workforce Officer for CPS HR Consulting |

| Workforce Forum Presentations | |
|---|---|
| **Group or Topic** | **Persons Involved** |
| **Panel Representing Higher Education Employers** | Rey Garcia, Ph.D, President and CEO representing Texas Association of Community Colleges<br>Jim Brunjes, Chief Financial Officer representing Texas Tech University System<br>Katherine Justice, Executive Director of Human Resources representing University of Houston System |
| **Panel Representing Employee Advocates** | Sgt. Gary Chandler, President, and Senior Trooper Mark Proveaux, District 7/Capitol Headquarters, representing Texas Department of Public Safety Officers Association<br>Andy Homer, Director of Public Relations for Texas Public Employee Association<br>Mike Gross, Vice President representing Texas State Employees Union |
| **Panel Representing State Agency Employers** | George Ebart, Director of Human Resources for Texas Department of Transportation representing the State Agency Coordinating Committee (Large agencies)<br>Brian White, Deputy Public Counsel/Chief of Staff for Office of Injured Employee Counsel representing Mid-Sized Agency Coordinating Council<br>John Monk, Administrative Officer of Heaqlth Professions Council representing the Small State Agency Taskforce |

***Figure CA.4 – Stakeholder Meeting Participants***

| Stakeholder Meetings | |
|---|---|
| **Group or Topic** | Persons Involved |
| Center for Public Policy Priorities | F. Scott McCown and Chandra Villanueva |
| Independent | Bill King – Founder and Former Chair of Texans for Public Pension Reform |
| Texas Conservative Coalition | John Colyandro and Tom Aldred |
| Texas Department of Aging and Disability Services | Chris Traylor-Commissioner, Tom Phillips-COO, and Gordon Taylor-CFO |
| Texas Department of Assistive and Rehabilitative Services | Debra Wanser-Commissioner, Alvin Miller-COO, Mary Wright-CFO, and Glenn Neal-Deputy Commissioner |
| Texas Department of Criminal Justice | Brad Livingston-Executive Director |
| Texas Department of Family and Protective Services | Howard Baldwin-Commissioner, Jennifer Sims-Deputy Commissioner, and Terri Ware-COO |
| Texas Department of Public Safety | Cheryl MacBride-Deputy Director, David Baker-Deputy Director, and Steve McCraw-Director |
| Texas Department of Transportation | Dee Porter- Chief Human Resources and Administrative Services Officer |
| Texas Health and Human Services Commission | Morris Arnold, HR Director |
| Texas Hospital Association. | Dan Stultz and Jack Hawkins |
| Texas Juvenile Justice Department | Cheryl Townsend-Executive Director |
| Texas Lottery Commission | Janine Mays, Director |

| Stakeholder Meetings | |
|---|---|
| **Group or Topic** | Persons Involved |
| Texas Medical Association | C. Bruce Malone, MD, Lou Goodman, PhD, Larry Stein, Lee Spangler, Darren Whitehurst, and Patricia Kolodzey |
| Texas Pension Review Board | Christopher Hanson, Executive Director and Emily Brandt, Research Specialist |
| Texas Pharmacy Association | Joe Da Silva, Sandra Nelson, Michael Wright, and Kim Roberson |
| Texas Public Policy Foundation | Talmadge Helfin and Arlene Wohlgelmoth |

***Figure CA.5 – Solution Session Participants***

| Solution Sessions | |
|---|---|
| **Group or Topic** | **Persons Involved** |
| Cerner | Doug Ervin, Grady Cusan, Robert Peeler, and Mike Heckman |
| Alere Wellbeing | Michele Rakoczy |
| National Teachers Associates Life Insurance Company | Ray Eliason and Jim Cothron |
| Aflac | Adam Bradshaw, Harold McKeever, and Kip Havel |
| Johnson & Johnson Ethicon | Richard Ponder, Frederic Pupprecht, Brady Berry, and Peter Hayes |
| ExtendHealth | Jon Andrews and Richard Wheeler |
| Humana | Tim Snyder, Laura Mansow, Tiffany Claderen, B. Walt, and C. Cude |
| Texas State Employees Union | Mike Gross |
| Alliance Work Partners | Rick Dielman, Ann Starr, and Barbara Wilson |
| MedeAnalytics | Dan West, Jim Maikranz |
| AON Hewitt | Brian Septon, Joe Grieco, Phil Peterson, Frank Easley, and John Adrian |
| AmWins | Donald Sheehan, Michael Hajdun, Bob Mitchell, and Philip Moroneso |
| Scott & White | Davidica Blum and Allan Einbodan |
| Part D Advisors | Pat Coleman, Eric Singer, Andrew Madonna, and Mike Tehan |
| Careington | Stuart Sweda and B. Williams |
| Texas Public Employees Association | Andy Homer, Ray Hymel, Gary Anderson, and Jan Thomas |

***Figure CA.6 – Higher Education Employer Survey Participants***

| Higher Education Employer Survey Respondents | |
|---|---|
| **Group or Topic** | Persons Involved |
| Angelina College | Dr. Larry Phillips |
| Angelo State University | Kurtis Neal |
| Blinn College | Karla Roper |

| Higher Education Employer Survey Respondents | |
|---|---|
| **Group or Topic** | Persons Involved |
| Central Texas College District | Holly Jordan |
| Clarendon College | Annette Ferguson |
| Del Mar College | Dr. Lee Sloan |
| Galveston College | Myles Shelton |
| Grayson College | Alan Scheibmeir |
| Houston Comminity College | Willie Williams Jr. |
| Kilgore College | William Holda |
| Lamar State College-Orange | Alicia Gray |
| Laredo Community College | Lee Spain |
| McLennan Community College | Lisa Wilhelmi |
| Northeast Texas Community College | Diana Hall |
| South Plains College | Anthony Riley |
| Southwest Texas Junior College | Anne H Tarski |
| Stephen F. Austin State University | Glenda F. Herrington |
| Sul Ross State University | Judy Perry |
| Temple College | Glenda O. Barron |
| Texarkana College | Jeffery D Teague |
| Texas State Technical College | Angela Ball |
| Texas State University | Michelle Moritz |
| Texas Tech University System | Martha Brown |
| Texas Woman's University | Lewis Benavides |
| Trinity Valley Community College | Jennifer Robertson |
| University of Houston Downtown | Betty Powell |
| University of Houston-Clear Lake | Michelle Dotter |
| Victoria College | Terri Kurtz |
| Wharton County Junior College | Judy J. Jones |

***Figure CA.7 – Agency Employer Survey Participants***

| State Agency Employer Online Survey Respondents | |
|---|---|
| **Group or Topic** | **Persons Involved** |
| Adjutant General's Department | Denice Wicks |
| Commission on State Emergency Communications | Brian Millington |
| Court of Appeals - 10th District | Tom Gray |

| State Agency Employer Online Survey Respondents | |
|---|---|
| **Group or Topic** | **Persons Involved** |
| Court of Appeals - 14th District | Christopher Prine |
| Court of Appeals - 1st District | Sherry Radack |
| Court of Appeals - 2nd District | Debra Spisak |
| Court of Appeals - 3rd District | Jeffrey D. Kyle |
| Court of Appeals - 6th District | Josh Morriss |
| Court of Appeals - 8th | Ann Crawford McClure |
| Court of Criminal Appeals | Sharon Keller |
| Credit Union Department | Harold Feeney |
| Executive Council of Physical Therapy & Occupational Therapy Examiners | John Maline |
| Fire Fighters' Pension Commission | Sherri Walker |
| Health and Human Services Commission | Morris Arnold |
| Ninth Court of Appeals | Steve McKeithen |
| Office of Court Administration | Kate Oehlers |
| Office of Injured Employee Counsel | Erick Dunaway |
| Office of Public Insurance Counsel | Deeia Beck |
| Office of the Attorney General | John Poole |
| Office of the Fire Fighters' Pension Commissioner | Aslynn Rose |
| Railroad Commission of Texas | Mark Bogan |
| Securities Board | Carla James |
| State Commission on Judicial Conduct | John Brown |
| State Office of Administrative Hearings | Cathleen Parsley |
| State Office of Risk Management | Gail McAtee |
| Supreme Court of Texas | Jennifer Cafferty |
| Texas Animal Health Commission | Larissa Schmidt and Dr. Dee Ellis |
| Texas Board of Chiropractic Examiners | Yvette Yarbrough |
| Texas Board of Veterinary Medical Examiners | Nicole Oria |
| Texas Commission on Environmental Quality | Melissa Applegate |
| Texas Commission on Fire Protection | Don Wilson |
| Texas Commission on Jail Standards | Adan Munoz, Jr |
| Texas Commission on the Arts | Mary Lopez |
| Texas Comptroller of Public Accounts | Janet L. Bray |
| Texas Department of Agriculture | Cynthia Mendoza |

| State Agency Employer Online Survey Respondents | |
|---|---|
| **Group or Topic** | **Persons Involved** |
| Texas Department of Banking | Executive Team of the DOB |
| Texas Department of Housing and Community Affairs | Gina Esteves |
| Texas Department of Motor Vehicles | Sharon Brewer |
| Texas Department of Public Safety | (see stakeholder meeting) |
| Texas Education Agency | Harvester Pope |
| Texas Ethics Commission | David Reisman |
| Texas General Land Office | Terri Loeffler |
| Texas Historical Commission | Terry Colley |
| Texas Juvenile Justice Department | (see stakeholder meeting) |
| Texas Medical Board | Maria Moreno |
| Texas Parks and Wildlife Department | Al Bingham |
| Texas Pension Review Board | John Perryman |
| Texas School for the Blind & Visually Impaired | Charlotte Miller |
| Texas State Board of Examiners of Psychologists | Sherry Lee |
| Texas State Board of Pharmacy | Gay Dodson |
| Texas State Board of Plumbing Examiners | Lisa Hill |
| Texas Workforce Commission | Susanna Holt Cutrone |

***Figure CA.8 – Benchmarking Survey Participants***

| Benchmarking Survey Participants | |
|---|---|
| **Group or Topic** | **Persons Involved** |
| University of Texas at Austin | Claire Moore |
| State of Florida | Michael Talbot and Stephanie Leeds |
| City of Austin | Sheri Altes |
| City of Houston | Margaret Baptiste, Gerri Walker, and Jocelyn Wright |
| Travis County | Cindy Purinton |
| State of Pennsylvania | Christy Leo |
| State of Georgia | Pam Keene, Jean Giles, Trudie Nacin, and Peggy Woodruff |
| Texas A&M University | Ellen Gerescher |
| State of California | Elaine Smith |
| State of Ohio | James Knight, Harry Colson, and Brian Pack |
| State of Illinois | Pam Kogler |
| State of Michigan | Julie Creemers |
| State of North Carolina | Rita Jacobs Sandoval |

# Common Appendix II: EMPLOYER SURVEY

## PARTICIPATION

All state employers were surveyed regarding the role of benefits in recruiting and retaining a qualified state workforce. There were different surveys for agency employers and higher education employers because higher education does not participate in the ERS retirement plans. Below are the responses from the participants.

## Agency Employers that Responded

66 of 120 AGENCIES RESPONDED TO THE SURVEY (55%)

***Figure CB.1 – Agency Survey Participant List***

| | |
|---|---|
| Adjutant General's Department | Commission on State Emergency Communications |
| Court of Appeals - 10th District | Court of Appeals - 14th District |
| Court of Appeals - 1st District | Court of Appeals - 2nd District |
| Court of Appeals - 3rd District | Court of Appeals - 6th District |
| Court of Appeals – 8th District | Court of Criminal Appeals |
| Credit Union Department | Department of Disability Services |
| Department of Family Protective Services | Department of Rehabilitative Services |
| Executive Council of Physical Therapy & Occupational Therapy Examiners | Fire Fighters' Pension Commission |
| Health and Human Services Commission | Lottery Commission |
| Ninth Court of Appeals | Office of Court Administration |
| Office of Injured Employee Counsel | Office of Public Insurance Counsel |
| Office of the Attorney General | Office of the Fire Fighters' Pension Commissioner |
| Railroad Commission of Texas | Securities Board |
| State Commission on Judicial Conduct | State Office of Administrative Hearings |
| State Office of Risk Management | Supreme Court of Texas |
| Texas Animal Health Commission | Texas Board of Chiropractic Examiners |
| Texas Board of Veterinary Medical Examiners | Texas Commission on Environmental Quality |
| Texas Commission on Fire Protection | Texas Commission on Jail Standards |
| Texas Commission on the Arts | Texas Comptroller of Public Accounts |
| Texas Department of Agriculture | Texas Department of Banking |
| Texas Department of Criminal Justice | Texas Department of Housing and Community Affairs |
| Texas Department of Motor Vehicles | Texas Department of Public Safety |
| Texas Department of Transportation | Texas Education Agency |
| Texas Ethics Commission | Texas General Land Office |
| Texas Historical Commission | Texas Juvenile Justice Department |
| Texas Medical Board | Texas Parks and Wildlife Department |
| Texas Pension Review Board | Texas School for the Blind & Visually Impaired |
| Texas State Board of Examiners of Psychologists | Texas State Board of Pharmacy |
| Texas State Board of Plumbing Examiners | Texas Workforce Commission |
| **8 responses did not identify the agency** | |

## Higher Education Employers that Responded

31 of 77 HIGHER EDUCATION INSTITUTIONS RESPONDED (40%)

***Figure CB.2 – Higher Education Survey Participant List***

| | |
|---|---|
| Angelina College | Angelo State University |
| Blinn College | Central Texas College District |
| Clarendon College | Del Mar College |
| Galveston College | Grayson College |
| Houston Community College | Kilgore College |
| Lamar State College-Orange | Laredo Community College |
| McLennan Community College | Northeast Texas Community College |
| South Plains College | Southwest Texas Junior College |
| Stephen F. Austin State University | Sul Ross State University |
| Temple College | Texarkana College |
| Texas State Technical College | Texas State University |
| Texas Tech University System | Texas Woman's University |
| Trinity Valley Community College | University of Houston-Downtown |
| University of Houston-Clear Lake | Victoria College |
| Wharton County Junior College | **2 responses did not identify the institution** |

## COMMON SURVEY QUESTIONS

The following questions were asked on both surveys.

| **What role do state benefits play in recruiting and/or retaining qualified employees for your institution?** |
|---|
| **Agency Employer Responses** |
| **Common Feedback**<br>• State benefits play a large role in recruiting and retaining qualified employees, particularly at the lower end of the salary ranges and for all employees with a spouse and/or children.<br>• State benefits are the major tool in attracting and retaining employees. Because there is a significant salary differential for many positions with similar private sector or even federal or local government positions, the benefit package is sometimes the only competitive advantage offered by state employment.<br>• Employees consistently advise that salary and benefits play a significant role in job satisfaction. |

| **What role do state benefits play in recruiting and/or retaining qualified employees for your institution?** |
|---|
| **Agency Employer Responses** |
| **Agency Specific**<br>**DPS** - Some local law enforcement entities allow their officers to retire at an earlier age and have higher pay--DPS is competing against these employers for commissioned officers. We currently have over 400 vacant commissioned positions. Turnover in the entry level of Schedule C is very high--over 30%. Diluting benefits will only make this turnover rate increase.<br>**Parks and Wildlife** - The state benefits package is absolutely critical to our ability to attract and retain highly qualified employees. Although Texas Parks and Wildlife Department's average salary is higher than the state average, comparable market-level salaries are typically 5-15% higher. So we rely heavily on the state's benefit package to boost our competitiveness, especially for professional level positions. |

**What role do state benefits play in recruiting and/or retaining qualified employees for your institution?**

**Higher Education Responses**

**Common Feedback**

- State benefits are critical in recruiting and retaining employees.
- State benefits are an offset to low state salaries.
- State paid benefits are very important to recruiting.
- State benefits are often stated as the decision point for accepting employment and reason for not leaving.

**Institution Specific**

**Lamar State College** – Orange - The importance of state benefits can be shown in the fact that only 3.8% of our employees have waived or opted out of the state health insurance.

**Texas State Technical College** - For retention, benefits are the single biggest factor that employees list as a reason they stay other than job satisfaction.

**What are your challenges in recruiting employees?**
(What are your issues with filling vacancies?)

**Agency Employer Responses**

**Common Feedback**

- Finding minority applicants with degrees and experience in the needed fields is difficult.
- Finding people with the right credentials at the salaries we offer is difficult. Sometimes benefits will fill the gap but often not for highly competitive positions where the salary differential is wide,
- We cannot offer help with moving expenses if needed in another geography.
- Applicants find higher pay at other agencies (same benefits), city or federal government for same type position.
- We cannot indicate when there might be a salary increase – many private sector positions have a starting salary and 6-month or first year bump after probation.

**What are your challenges in recruiting employees?**
(What are your issues with filling vacancies?)

**Agency Employer Responses**

**Specific Jobs or Agencies**

**Attorneys** - The main challenge in hiring attorneys is the level of compensation. According to national statistics published by the Bureau of Labor Statistics, attorneys in state government are paid less than other industry sectors, including local and federal government. In FY 2009, the annual mean wage for attorneys in state government was $82,750 compared to $91,040 for local government and $127,550 for federal government. Currently, Texas courts of appeals have a rider that limits the pay of newly hired or promoted attorneys to $79,750.

**Rural District Positions** – The main challenges with staffing or retaining rural positions are low salary combined with moving away from nuclear family support for things like child care and lack of employment for the spouse.

**HHSC** - The greatest challenge in effective recruiting is attracting qualified applicants with related work experience. Compensation and benefits pay a large part in effective recruiting.

**TCEQ** - Our recruitment challenges include attracting the skill sets necessary to fulfill the agency's mission, as well as our objective to attract and retain a workforce representative of the state's labor force in terms of ethnicity and gender. We find ourselves competing with other entities who are also seeking qualified minorities, especially Hispanic candidates, for technical and professional jobs. These organizations can often offer higher salaries.

**What are your challenges in recruiting employees?**
(What are your issues with filling vacancies?)

**Higher Education Responses**

**Common Feedback**

- The inability to offer a salary compensation that is competitive with private industry.
- A lack of local credentialed personnel in applicant pool in rural areas – its very difficult to attract highly qualified specialty staff to areas far from a large city when pay is low, and pay is not competitive with larger neighboring colleges.

**Specific Jobs or Institutions**

**Angelina College -** Our challenge is hiring master's degree faculty at salaries that are $5,000-$8,000 below starting salaries for bachelor's degree teachers at the elementary and secondary levels in the metropolitan areas and asking hourly classified staff to start at hourly rates $1.00-$1.50 below comparable jobs in local industry and business. We are able to compete only because of the benefits.

**University of Houston Downtown -** State budget cuts have created some challenges in recruiting employees. There are fewer funds available for advertising, participating in job fairs, and training. Our major challenge is in the recruitment of faculty, where salaries are not at the level they should be to compete with larger more established universities. Our physical location also presents a challenge in recruiting qualified and experienced staff employees. UHD must compete with other major employers in the Downtown Houston area for the best employees.

**What are your challenges in retaining employees?**
(What are the factors contributing to your high turnover positions?)

**Agency Employer Responses**

**Common Feedback**

- Low salary and the lack of regular cost of living salary increases are challenges.
- The lack of pay for performance programs – even modest one-time merits.
- Workload increases, especially after mandatory reductions in force.
- Staff have limited career advancement opportunities.
- Some agencies pay higher than others for same job positions, which causes internal agency job hopping to get more money.
- The lack of money or time for training employees.
- We are in competition with oil field wages.

Private sector competition in certain positions.

**What are your challenges in retaining employees?**
(What are the factors contributing to your high turnover positions?)

**Agency Employer Responses**

**Agency Specific**

**Commission on State Emergency Communications** - Agency has a very low turnover rate. An improving Austin economy could change that quickly. Wages and the low public appreciation/perceptions given to state employees are the main challenges.

**Court of Appeals – 8th District** - Surprisingly, the greatest challenge is work ethic among young attorneys. Generally speaking, state employees work 40-hour weeks. The case load of this court has increased due to the creation of new lower courts and docket equalization. We are a three-judge court, meaning that there is only one panel unless recusal issues arise. Our attorneys do not have the luxury of off-panel months, and this court has traditionally granted oral argument upon request. To meet our legislatively imposed performance measures, our attorneys often work many more hours per week as well as some weekends and holidays. They are exempt employees and do not receive overtime pay. We offer comp time, of course, but many begin to feel that if they are going to be working as many hours as those in the private sector, they might as well receive the salary benefits that the private sector can offer.

**Credit Union** - We have the highest turnover in the financial examiner positions. Generally, they leave for higher pay or because of the extensive travel.

**DPS** - Low salaries. Better pay with similar or better benefits at other employers. Many of our employees have to work second jobs to make ends meet. This can often affect performance on the primary job. Many of our Driver License employees make about $5,000 per year less than McDonald's first line supervisors.

**Department of Banking** - Historically, employees choose to leave employment with the agency for two main reasons: higher compensation and reduced travel. Due to the nature of the profession (financial institution examiners), it is very difficult for the agency to reduce the level of travel. Compensation and other benefits, like flexible work schedules, are offered to help compensate for the stress of travel. To the extent that benefit packages are reduced, retaining employees will become increasingly more difficult.

**Parks and Wildlife** - In the past, employees perceived that state employment offered greater long-term security than private sector employment.

**What are your challenges in retaining employees?** (What are the factors contributing to your high turnover positions?)

**Agency Employer Responses**

Recent state agency budget reductions and funding shortages, coupled with rising out-of-pocket expenses for health coverage and potential changes to the retirement plan, may cause many to re-think their options. This is especially true for employees in lower salaried/hourly positions or those with highly marketable skills.

**Texas Workforce Commission** - The Consumer Price Index has increased 11.4% since 2007, but state budget constraints have led to fewer merit or promotion increases. As reported in December 2011 by the SAO, state agencies awarded 55.3% fewer merits in 2011 than they did in 2007. Added to this (or from the employee's point view, deducted) were increases to the employee costs for retirement and insurance coverage. This has produced a situation where employees see it is easier to increase their salary by changing jobs (within the agency, with other agencies, or in the private sector) than to progress in their current one.

**What are your challenges in retaining employees?** (What are the factors contributing to your high turnover positions?)

**Higher Education Responses**

**Common Feedback**

- Turnover is mostly due to salary.
- Reduction in benefits is moving away from benefits being a motivator to stay.
- One edge is the State continues benefits in retirement.
- Salary increases have not only been behind the public sector bur also below the CPI.
- The high costs for dependent premiums.

**Specific Job or Institution**

**Stephen F. Austin University -** Our challenges include a lack of promotional opportunities, low salaries, and to some extent our geographic location.

**When talking with potential hires, are there specific benefits they ask about or that are offered by the competition that the State does not offer?**

**Agency Employer Responses**

**Aggregate of all agency feedback**

- Optical Plan
- Benefits for elderly parents as dependents
- Better dental choices – too expensive
- Help with moving expenses
- Signing bonuses
- After Probation Salary increase
- High level positions expect some amount of starting vacation time reflecting their level of position
- Flexible working environments –remote working
- Matching 401K – this is offset by current retirement offering
- Increasing interest in coverage for preventive treatments
- Transportation benefits - bus, rail reimbursements, or free passes
- Employee wellness facilities —a gym facility, running track, showers, etc. or assistance with joining a facility
- Lasik surgery coverage
- Worksite day care
- Lower copays
- Tuition reimbursement

**When talking with potential hires, are there specific benefits they ask about or that are offered by the competition that the State does not offer?**

**Higher Education Responses**

**Aggregate of all institution feedback**

- Work/life balance options
- Supplemental insurance
- Bonuses
- Vision plan
- Day care allowance
- Better dental coverage – lots of complaints – same with vision
- Option to purchase additional life insurance on spouse and children
- Want ability to tailor plans so they don't pay for what they don't need
- Free tuition at any state institution (realize this is beyond ERS)
- Relocation expenses
- Employer subsidized day care
- PTO – paid time off
- Remove 3 month wait

**Is the 90-DAY wait for benefits a deterrent to your ability to attract employees?**

**Agency Employer Responses**

**Common Feedback**

- Responses were mixed – problem at some agencies but not others.
- COBRA is expensive – suggestions were to reduce the wait to 30 days and/or to allow use of the pre-tax flexible spending account to help offset the high expense.
- Persons with pre-existing conditions deterred from accepting employment.

**Agency Specific**

**DPS** - We have 50 or more recruits going through recruit school without health insurance. These employees are working and living in close quarters in extremely challenging conditions and, although their injuries are considered workers compensation, they would not be covered for other health issues and their families are of major concern. Asking these men and women who are currently covered by insurance to go without coverage or pay COBRA prices results in losing good candidates.

**TDCJ** – We want a wait period to continue for protection of the employer against recruits only applying to get the insurance then immediately go on sick leave.

**Is the 90-DAY wait for benefits a deterrent to your ability to attract employees?**

**Higher Education Responses**

**Common Feedback**

- Respones range from definitely detrimental to disappointing but it doesn't change decision for employment.
- Mainly detrimental on non-local recruitment – especially if coming from private business that do not have a wait.

**What impact would changes to the current health insurance program have on your workforce?**
Consider the following: A – higher premiums or out-of-pocket costs for same coverage. B – changing to a high deductible/health savings account style plan. C – offering a lower base level of state-provided benefits with member-paid options for additional insurance choices.

**Agency Employer Responses**

**Common Feedback**

- Of the options, employers feel their staff want to pay less for a lower base level of state provided benefits with member options for additional insurance choices.

**What impact would changes to the current health insurance program have on your workforce?**
Consider the following: A – higher premiums or out-of-pocket costs for same coverage. B – changing to a high deductible/health savings account style plan. C – offering a lower base level of state-provided benefits with member-paid options for additional insurance choices.

**Agency Employer Responses**

- To the extent employees' share of insurance costs must go up, the structure should also be adjusted so everyone shares in those increases fairly and those who want more benefits, pay more, e.g. employees would like a plan where you could choose co-pay levels versus premium levels--in other words, the flexibility to choose the plan that works best for the employee and the employee only pays for what is needed.
- Fear is if the State moves to a lower level of benefits and the market place moves back up with its benefits, the state workforce will be left with only those applicants that cannot get jobs in the private sector.
- Implementation of any of the listed factors would create hardships for those employees making smaller salaries. Without any additional compensation in their salaries they could not afford the increases. Many do not carry family insurance and are not seeking medical attention they need due to the cost of current insurance.
- Cost shifting changes are essentially pay cuts – particularly bad since no merits or raises in years.
- Higher cost changes will cause a rush to retire.

**What impact would changes to the current health insurance program have on your workforce?**
Consider the following: A – higher premiums or out-of-pocket costs for same coverage. B – changing to a high deductible/health savings account style plan. C – offering a lower base level of state-provided benefits with member-paid options for additional insurance choices.

**Higher Education Responses**

**Common Feedback**

- Any of the options would cripple the community colleges which are already underfunded – especially harmful to the rural areas.
- These options would create a financial hardship for the majority of the employees impacting lower paid employees the most.
- It would be more difficult to retain employees – colleges would lose critical staff.

**What impact would changes to the current health insurance program have on your workforce?**
Consider the following: A – higher premiums or out-of-pocket costs for same coverage. B – changing to a high deductible/health savings account style plan. C – offering a lower base level of state-provided benefits with member-paid options for additional insurance choices.

**Higher Education Responses**

- Instead of incentivizing wellness - would foster more illness since staff would not go to the doctor when needed due to higher cost of deductibles or dropping insurance coverage altogether.

**Job or Institution Specific:**

**Central Texas College District -** Employees would complain about any change to benefits, and, if the change is a reduction in benefits, it would decrease morale. Reduced health benefits would create a financial hardship for the majority of our employees. Some employees might even terminate and apply for Medicaid. Other employees might drop coverage and hope they didn't get sick/ill. Higher premiums/out of pocket costs with the same coverage will impact the lower paid employees more. For example, many of our facilities employees make $8.30/hour. This is $1,400 gross per month. Right now the employee and family health premium takes up almost 1/2 of their take home pay. I have concerns about the high-deductible or HSA. Concern is if the plan would cover employees 65 years and older and would depend heavily on how high the deductibles are. Providing lower base level coverage all depends on how reduced the benefit share.

**Any other ideas or issues that you would like documented as part of the study?**

**Agency Employer Responses**

**Aggregate of Agency Suggestions**

- Provide an Optical Plan option.
- Allow the TexFlex account balance to roll over for the next plan year rather than taking a loss.
- Offer options of better health and dental coverage with more carriers from which to choose.
- State contributes to cost of retirement and insurance products that the individual purchases on their own, and owns themselves, not dependent on state employment.
- Give individuals the option to get the products they want based on their needs.
- Need to focus on providing some level of secure benefits and not continuous flux. If we lose the element of security and things within state employment, like benefits, start bouncing around

**Any other ideas or issues that you would like documented as part of the study?**

**Agency Employer Responses**

annually like the private sector, then we lose a significant non-tangible benefit. Thus, a commitment to a base level of benefits is more important than fluctuating benefits, even if they are going up in value, if there is some assurance of not going down, or if they do go down in a tough economy, they will be restored when the economy picks back up before other increases in spending are considered.

- Consider a larger contribution by employees, but maintain benefits.
- Employee benefits are the sole real factor differentiating us from employers in the private sector. Without them, or with lesser benefits or more costs to employees, that sole advantage is eliminated or minimized. Bad can only result.
- Our return-to-work retiree program works very well and benefits everyone involved. It is much more fair and cost-effective to the State than paying full salaries, it gives us the benefit of experienced employees, and our employees are very happy with it and appreciative of it.
- If these changes were made to the state employee benefits package during "good times," you would see a much higher than average turnover throughout the workforce. If these changes are made right now, there would not be a significant change to the turnover rate; but once economic conditions changed for the better; there would be a significant increase in employee turnover. I saw this in the later 2000s. The potential qualified employee pool also shrinks, resulting in hiring average vs. good to excellent employees. You get what you pay for.
- The State of Texas has always had the reputation of being a prestigious employer and one served their job with pride. Anyone who held a state job was considered lucky because the State rewarded their employees with much deserved benefits. These benefits were in lieu of loftier salaries that could be obtained in the public sector. A person that takes a state job does it out of service; a dedication to the greater good. Today there is substantial discontent and poor morale because benefits have continued to be slashed and taken away. The state worker feels devalued. Pride has been replaced by anger and resentment. Being told

| Any other ideas or issues that you would like documented as part of the study? |
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| Agency Employer Responses |
| to be grateful to have a job does not endear an employee to his job. Something needs to be done to make the State the prideful place to work again. The way we are going is not working.<br>• The job itself, pay, benefits, promotion opportunities, supervision, and coworkers are all important to an individual's overall job satisfaction.<br>• Consider converting to a PTO system. Under the present system, employees not nearing retirement have an incentive to abuse sick leave.<br>• For years state employees have countered lower pay in comparison to the private sector with stable, valuable benefits (retirement and insurance). If these benefits were diminished, there would be very little motivation to work for the State, as many employees could make significantly more money in the private sector.<br>• ERS has a difficult task before it, and SOAH appreciates the thoughtful approach ERS is taking with this study, and the opportunity to provide input. SOAH's employees want a stable, strong, and actuarially sound employee retirement system, and no one disputes that the issues ERS is currently facing will have to be addressed. At the risk of being repetitive, it is important to say again that while the agency's employees understand that state salaries are lower than those in the private sector, the bargain they have made in exchange is that the State will provide good health care insurance and a stable retirement plan. Changes to the retirement and health plans that hit employees directly in the already-stretched-thin pocketbook are going to be difficult, especially if salary increases are not on the horizon to help them recoup increased health care costs and/or costs or losses resulting from a market-based retirement plan.<br>• Develop a long term, employee oriented pay and benefit system that is outside of the normal legislative activities.<br>• Legislative action that restricts agency mission makes it hard to manage budget and accomplish goals.<br>• If retirement eligibility rules change, including the inability to use sick leave and vacation leave accruals towards the retirement eligibility, current employees would need to be grandfathered because having so many employees trying to use |

| Any other ideas or issues that you would like documented as part of the study? |
|---|
| Agency Employer Responses |
| up their hours would be detrimental to our agency.<br>• Any reduction to longevity and vacation/sick leave monthly accruals would negatively impact both current employees and our ability to recruit quality applicants without other flexibility or incentives that could attract employees.<br>• State employment benefits may be the biggest selling point for recruitment and retention. Reducing those benefits should be weighed very carefully.<br>• Wages and all state benefits should be viewed not only as expenses but also as investments for the State. Offering the best benefits can help reduce turnover. Staffing levels also impact the equation. FTE caps mean in many instances that state employees are actually required to do far more than is widely known or contemplated.<br>• A qualified and stable state workforce is needed to meet demands for quality service delivery to a growing state population. The State's value proposition as an employer is its benefit and pension plan.<br>• There seems to be a misperception coming through the media that the State's benefit programs are overly generous and unduly expensive to the State. The pension program has been managed conservatively. We have no automatic cost of living increases, we don't allow spiking, there have not been contribution holidays, and investment policy has been conservative yet diversified. It doesn't seem fair to lump the State's benefit programs in with other retirement programs that are not managed as well. State employees have invested their lives in state service with the expectation that these benefits will be available to support them at retirement.<br>• Do not reduce or eliminate state benefits. They are vital to our recruiting and retention programs due to low state salaries.<br>• To help minimize the impact of benefit changes on agencies' ability to recruit and hire talent, consideration should be given to leaving the employee-only benefits as intact as possible. This is the benefit all employees receive, so it should be maintained as high as possible. While family benefits are important features of the State's total compensation package, care should be taken to make sure to these additional benefit costs are fair |

| Any other ideas or issues that you would like documented as part of the study? |
| --- |
| Agency Employer Responses |
| and reduced as far as is reasonable before cutting the employee-only benefits. For example, consider having tiered insurance premiums based on the number of family members covered and not covering spouses of employees who have access to other health insurance. |
| • Bringing HMO health like options into the Austin area service coverage would be an improvement. |
| • For potential benefit design change options, we prefer options that would have the minimum impact on our ability to attract new hires or retain current employees. |
| • I believe that ERS' implementation of Roth 401(k)s and 457s was an excellent addition to the benefits program and another resource to recruit qualified employees. |
| • Despite the lack of pay raises and the difficulties that that causes, the high quality of state benefits in the past has allowed most state agencies to continue to hire qualified and competent staff. As those benefits continue to erode, we believe that the likelihood of being able to secure that type of new employee in the future will diminish accordingly. |
| • Some of these ideas may be feasible for new hires or even those not yet tenured. However, many of the benefits offered by the State make it possible to get some of the best of the best for employees. Knowledge, experience, and loyalty are the tradeoff. |
| • In an improving economy it will become much more difficult for state agencies to hold onto employees without being able to offer benefits beyond salary. The theory of reshaping state benefits to be comparable with private industry will necessitate restructuring salary and bonuses to be similarly comparable to the private industry. Given the current fiscal environment, this is anticipated to be difficult, at best. |
| • It is flat out unfair to change the retirement rules on folks who have already worked for the State for several years. If they must be changed prospectively, that will hurt hiring, but at least it is fair. I know that it is easier to hire right now, but the economy is improving. Once we are past this bump in the road people will leave for better jobs with better pay and benefits in the private sector. |

| Any other ideas or issues that you would like documented as part of the study? |
| --- |
| Agency Employer Responses |
| • I would be interested in the impact of a demoralized workforce on productivity. I believe we already expect a tremendous amount of commitment from staff - to further reduce benefits is frightening. |
| • Use-it-or-lose-it annual time. Prevent abuse of sick leave that by awarding comp time for employees who do not use any sick leave in a calendar year. This encourages employees to use their vacation time, instead of sick time. |
| • Texas state government does not pay competitive salaries for professional staff. Cutting benefits will only make recruitment more difficult. The State should be doing what it can to recruit the best and the brightest into public service because the need is great and getting more acute with the turbulent financial times ahead of Texas. Cutting retirement and/or health benefits will not only negatively impact the quality of the state work force it will also have a negative impact on the State's economy as a whole. |
| • The business of the government must be competitive with the private sector, not just in its ability to recruit and retain employees, but also to ensure that its employees have the skills and resources necessary to participate in a global workforce. Regulatory agencies must have employees who have access to the same technology, training, and tools that the private sector they regulate does. Agencies that provide services to the public must have employees who have access to the same training, technology, and tools that allow the private sector service industry to work smarter and to reach the individuals they serve. Agencies that provide services to other agencies must have access to the same training, technology, and tools that allow private sector business to business providers to offer innovative and effective solutions. Reductions that eliminate access to training and to current professional resources make it extremely difficult for staff to stay abreast of changes and innovations in their fields. Changes in benefits to classes of employees who have made career decisions based on current benefit promises will gut an aging workforce and when coupled with low salaries and few training dollars, government will not have a skilled workforce capable of providing services or |

**Any other ideas or issues that you would like documented as part of the study?**

**Agency Employer Responses**

regulating industries. If the state decides to change its benefits, changes will have to address the salary disparities among the public and private sector. One-time merit payments are a good idea, if there is money to fund them.

**Any other ideas or issues that you would like documented as part of the study?**

**Higher Education Responses**

**Aggregate of all institution feedback**

- There are fewer and fewer physicians and dentists in network in rural areas.
- Discrimination against community colleges is apparent in the latest funding provided for benefits by the last Legislature.
- Give consideration to adding a vision plan, improving disability coverage, and reducing waiting periods.
- DHMO providers are lacking – expand providers or do away with the plan.
- Minimize the negative impact caused by reduction in state funding.
- Continuing cuts in community college funding places an ever-increasing burden on taxpayers and students that cannot be sustained.
- Get rid of the 90-day wait.
- If we have to cut somewhere – charging retirees based on years of service is perceived to be equitable.
- Need to significantly expand the UnitedHealthcare network in West Texas to avoid cost increases for out of network coverage.
- Consider offering agencies incentives or rebates for lower claims and/or expenditures. There is no incentive for employers to develop programs to help people change lifestyle or engage in wellness programs.
- Community colleges need to be able to offer the same salaries and benefits as 4 year institutions – more students are having to attend community college due to lack of skills or enter and/or stay in 4 year institutions.

## RETIREMENT BENEFIT QUESTIONS FOR AGENCY EMPLOYEES

The following questions were only on the agency employer survey because higher education does not participate in the main ERS Retirement Plan.

**What impact would changes to the current pension program have on your workforce?**
Consider the following: A – changing to a 401(k) style plan. B – offering a hybrid 401(k) and defined benefit option. C – delaying retirement eligibility. D – lowering existing benefits.

**Agency Employer Responses**

**Common Feedback**

- Of all options, moving away from a defined benefit plan is identified as the most detrimental
- Will increase loss of much needed skilled resources in areas where private sector competes
- Will promote rush to retire which negatively impacts the plan
- Will reduce ability to recruit
- Devastating to morale
- Most of workforce not educated in how to invest a DC plan resulting in inadequate funds to retire further taxing state services to support a higher level of aging poverty

**How would your agency be affected if you were not able to hire return to work retirees?**

**Agency Employer Responses**

**Common Feedback**

- Most agencies only hire return-to-work retirees for jobs needing expertise that requires a lot of experience or training
- Sometimes only option to get institutional knowledge
- Provides a way to deal with resource shortages for critical staffing
- In many cases, use as a cost savings since they hire back at a lower salary

**Agency Specific**

**Court of Criminal Appeals** - We hire return-to-work retirees at 65% of their old salary, after giving them a one-time 25% bonus. We modeled our procedure on the legislative retirement-incentive program from a few years ago. If we were not allowed to hire back

**How would your agency be affected if you were not able to hire return to work retirees?**

**Agency Employer Responses**

retirees, we would have less-experienced staff. Also, with our plan, the Court saves 35% of the salary expense for as long as that employee stays. Our plan benefits the Court and the retiree, and it saves money for the State.

**Office of Administrative Hearings -** A number of employees in both the ALJ and staff ranks have many years of experience with SOAH and a thorough knowledge of the agency's mission and its operations. If we were barred from bringing them back in appropriate circumstances, we would be unable to take advantage of irreplaceable institutional knowledge and experience, as well as invaluable knowledge of administrative law.

**DPS -** DPS rehires retired officers in hardship locations and will expand it to other locations to address critical shortfalls in staffing. This will help to fill commissioned vacancies. Additionally, strategic positions have benefitted from hiring employees for non-commissioned positions. Having this option is still beneficial to the agency. DPS is trying to be prudent about rehires and not abuse the privilege.

**A number of agencies – typically smaller ones** – indicated they do not hire return-to-work retirees and there would be no impact.

**How would your workforce react if annual and sick leave were no longer counted towards retirement eligibility?**

**Agency Employer Responses**

**Common Opinion – Multiple Agencies**

- Significant impact if not grandfathered
- Would result in staff 'burning' sick leave causing resource shortages and difficulty providing some services.
- No incentive to work more than 40 hours or skeleton crew days, reducing ability to meet service needs.
- Some positions have had mandated layoffs or are staffed below FTE caps due to budget or lack of available resources, which results in remaining staff having to work instead of take vacation to meet needs. The only reason they agree is that their vacation and sick time will be retained to count towards retirement – if this is taken away, staff will not forgo vacation to provide critical services which increases the FTE count required to meet needs.

# Common Appendix III: THE STATE WORKFORCE

## Key Findings

The Texas workforce as a whole is challenged by skill shortages for critical occupations. The challenge to the public sector workforce, and to the State, is even higher. Robust benefit packages have the potential of at least partially counteracting the effect of low wages and encouraging highly educated employees to seek and retain work in the public sector. Wages and benefits are not only expenses, but investments for the State — investments that can help reduce turnover and ensure the State has the skilled workforce it needs to provide the essential services so many Texans rely on.

Policymakers will need to address the competing interests and philosophies for how best to provide retirement plans and health care benefits for employees and retirees that are in line with employer and employee resources. Whether the State maintains or modifies its current benefit structures, a broad-based perspective will ensure that sustainable, competitive benefits are provided at a reasonable cost for all concerned — without compromising the quality of the state workforce.

## Ensuring a Qualified Workforce

The state public sector is a significant percentage of the overall job market in Texas and instrumental in ensuring the safety and care of our citizens. It's these 151,779 Texans working for publicly funded organizations — 15% of the state's total workforce[1] — who deliver varied and integral services, as authorized and funded by the Texas Legislature, which Texas citizens rely on. As the State Legislature evaluates the role of pensions and level of health care offered to our state workers, the weight these benefits carry in ensuring a qualified workforce should be considered.

**State employees:**

- Build and maintain highways
- Collect tax revenue
- Guard prisoners
- Patrol the highways
- Protect vulnerable children and adults
- Regulate environmental resources to ensure clean air, water and responsible waste
- Support the health and safety of children
- Care for the deaf, visually impaired, mentally handicapped

Over the next decade, the State faces a number of challenges that are common throughout public sector (federal, state, and local) organizations. The economic downturn has resulted in budget cuts and reduced staffing levels at a time when the demand, especially for health, public safety, and correctional services, is increasing. Higher-level professional and specialized occupations require skilled, educated, and well-trained workers, but lower wage structures are likely to make it increasingly difficult for the public sector to recruit and retain these workers.[2]

According to national research, all public workers earn less than the private sector, and state employee salary levels are about 10% below market. In Texas, the State Auditor's Office* (SAO) found that most general state employees within benchmark positions had wages well below those of comparable jobs in the overall labor market. Almost one-fifth — 17,342 — are paid salaries that are more than 20% behind market rates.[3]

Overall, the highest-paid public sector workers earn 12% less than their private sector counterparts, while the lowest paid workers make 3.4% more.[4] This pay discrepancy is explained by the number of professional positions the state workforce requires. State government positions often require specific expertise and more training than those in the private sector. The two workforces also have inherent differences, making direct comparisons difficult. For example, manufacturing and sales account for a large part of private industry work and typically require a lower skill set. These same jobs are rare in the State, where professional and administrative support occupations (including teachers) account for two-thirds of the state and local government workforce, compared with one-half of private industry.[5]

**Benchmark Positions: Comparison of Salary Ranges with Average Market Pay**

The State Classification Team conducted market analysis to determine the "going rate" for positions in the market. This analysis used benchmarks, which are jobs in the private and public sector that strongly match corresponding state jobs in terms of duties, scope, and responsibility. For the referenced report, the State Classification Team compared the midpoints of state salary ranges for job classifications with the average market pay for corresponding benchmark or comparable positions to determine whether salary ranges for state positions were competitive with the market. In analyzing the competiveness of salary ranges, a job classification series' salary range was generally considered competitive if within 10% of the market average.

The State Auditor's 2010 market analysis shows that almost 40% of state jobs do not have a close equivalent in the rest of the job market. It's because of lower wages and the State's inability to offer the compensation and retention tools comparable to the private sector — bonuses, stock options, expense accounts — that the public sector relies heavily on competitive benefit packages to attract and retain its workforce.

This appendix focuses on general state agencies whose employees receive retirement benefits managed through the Employees Retirement System of Texas (ERS) — and does not include employees in higher education. The State also has directed the ERS to study group benefit programs in an interim legislative study. The goal here, however, is to provide insight into employers' ability to hire and retain valued workers.

*Information from the SAO is based on the FY2011 reports, which are periodically reissued based on current information.

## Understanding the State Workforce

The State Auditor analyzes the workforce by considering full time equivalent (FTE) positions.Different from headcount, an FTE is any combination of employees whose hours total 40 per week. For example, two employees who each work 20-hours per week equal one FTE.

More than half of the state's FTE positions are in higher education while the remaining are in 116 general state agencies. About 70% of state agency employees work for health and human services or public safety and criminal justice agencies — agencies supporting countless citizens throughout our state. It's these employees who provide health care and immunizations to those living in poverty, help children and seniors escape abuse and neglect, give those with disabilities and developmental delays opportunities for independence, preserve our natural resources to ensure clean air and water, and protect our safety on the roads, in the wake of a natural disaster, and from criminal activity at every level. While demands on these agencies increase, state agency employment dropped by 0.9%, or -1,441.9 FTEs, between FY2010 (September 1, 2009 – August 31, 2010) and FY2011.[6]

*Different from headcount, an FTE is any combination of employees whose hours total 40 per week. For example, two employees who each work 20-hours per week equal one FTE.*

***Figure CC.1 - Distribution of State FTEs – FY2011***

| General Appropriation Act Article | Number of FTEs | Percentage of Total State Govt.Workforce | Percentage of State Agency Workforce |
|---|---|---|---|
| Higher Education | 159,746 | 51.30% | N/A |
| Health and Human Services | 55,685 | 17.90% | 36.70% |
| Public Safety and Criminal Justice | 52,393 | 16.80% | 34.50% |
| Business and Economic Development | 15,960 | 5.10% | 10.50% |
| General Government | 9,460 | 3.00% | 6.20% |
| Natural Resources | 8,388 | 2.70% | 5.50% |
| Regulatory | 3,466 | 1.10% | 2.30% |
| Public Education | 2,404 | 0.80% | 1.60% |
| Legislature | 2,332 | 0.70% | 1.50% |
| The Judiciary | 1,691 | 0.50% | 1.10% |
| **Total – Institutions of Higher Education** | **159,746** | **51.3%** | **N/A** |
| **Total – General State Agencies** | **151,779** | **48.7%** | **100%** |
| **Grand Total** | **311,525** | **100%** | **N/A** |

*Source: State Auditor's Office of Texas*
*Note: Numbers and percentages do not add up exactly due to rounding errors.*

## Lagging State Wages

Policymakers in Texas had the foresight to designate a legislative agency to advise the State Legislature on compensation issues. The Classification Team, located within the SAO, is responsible for maintaining the State's compensation and classification system, analyzing state workforce issues, and providing information on employee compensation issues to the Legislature.

Because of the economic downturn, increased attention has been focused on public sector costs, including wages and their levels relative to the private sector. Most recent studies on wage levels agree that in a head-to-head comparison between like positions, public sector wages are lower, especially when education, demographics, and other factors are the same. The Center for Retirement Research found that public sector wages nationally are 9.5% lower than the private sector.[7] While the National Institute on Retirement Security (NIRS) found public sector wages in Texas to be 15% lower than those for similar workers doing similar work in the private sector.[8]

In its FY2011 workforce study, the State Auditor found that more than two-thirds of state employees made less than $40,000 per year, while less than one-fifth made more than $50,000.[9]

**Balancing Act: Public Sector Wages Consistently Lower at the National Level**

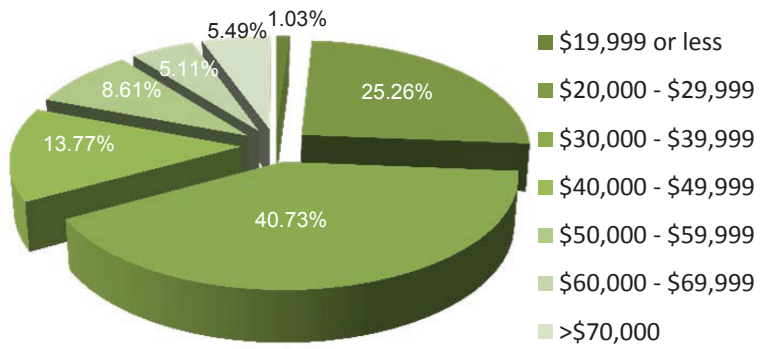
Economists and compensation specialists generally use private sector comparisons to judge whether public sector wages are at the right level. Excessive pay in the public sector may overburden taxpayers, while lower pay makes it difficult, if not impossible, to attract workers of the quality needed to provide the services demanded by citizens. In the last 20 years, earnings for state and local employees nationally have, in general, declined relative to comparable private sector employees.[1]

## Catching Up: The Cost of Wage Alignment

In a separate study, the SAO compared the salaries and benefits of classified law enforcement officers with those of seven large local law enforcement agencies in Texas. State-level peace officers are licensed by the Texas Commission on Law Enforcement Officers Standards and Education and are employed by the Department of Public Safety; the Parks and Wildlife Department; the Alcoholic Beverage Commission; and the Department of Criminal Justice. The SAO found that it would cost $27.7 million in additional state funds to align the wages of 4,420 underpaid peace officers with the market mid-range pay of these local law enforcement agencies.

Unfortunately, these pay differentials could get worse, especially in light of the economic downturn. According to a national survey by the International Public Management Association for Human Resources, 91% of state governments report suspensions of pay increases and 73% report suspensions of pay-structure adjustments. Although Texas-specific data is not available in this survey, it's likely that Texas, along with other states, will find it increasingly difficult to compete successfully with other public and private sector organizations for skilled workers. To that point, the state employers survey indicated that the main recruiting challenge state agencies face is low salary.[1]

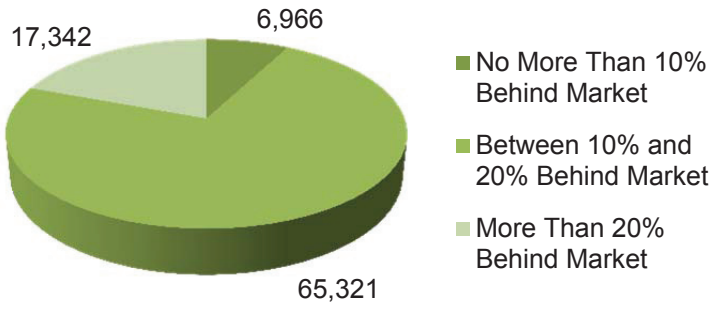
***Figure CC.2 - Salary Distribution for Full-time Classified Employees – FY2011***




Source: State Auditor's Office of Texas, includes employees in Salary Schedules A and B.[10]

The SAO also evaluated general state agency compensation against other government organizations and the private sector. The 2010 market analysis identified 421 state classification titles out of 856 that could be compared to similar positions in the private sector or other public organizations. (However, as mentioned earlier, the private sector includes certain work that is not part of state employment, such as manufacturing and sales.) Of full-time classified employees, 60.2% worked in these 421 titles, called "benchmark positions," each of which corresponds to a salary group that provides the minimum, midpoint, and maximum salary rates.[11]

***Figure CC.3 - Number and Percentage of State Employees Paid Below Market Rates Average of First and Second Quarters – FY2010***




*Source: State Auditor's Office of Texas (2010)*

## Decreasing State Employment

Across the U.S., state governments are reducing the size of their workforce through layoffs, furloughs and early retirement incentives. Other personnel decisions also affect the size of state government, including hiring freezes, pay freezes, and pay cuts.[12] The 82nd Texas Legislature (2011) reduced the State's budget by 8.1% for the 2012-2013 biennium,[13] which will support fewer workers and could impact the State's ability to deliver services.

*The state agency workforce is already lean, having grown by only 2% over the past decade, even as Texas' population grew ten times*

The state agency workforce is already lean, having grown by only 2% over the past decade, even as Texas' population grew ten times faster.[14] Between 2011 and 2012, the headcount of full-time employees dropped from 152,657 to 147,600 (number of actual employees, which is a higher number than FTE positions).[15]

***Figure CC.4 - Full-Time Staffing Levels for State Agencies by Occupational Category: FY2012 Compared to FY2011***

| Occupational Category | Average Headcount 2011 | Average Headcount 2012 | Change from 2011 to 2012 | % Change |
|---|---|---|---|---|
| Accounting, Auditing, and Finance | 5,630.50 | 5,465.00 | -165.50 | -2.94% |
| Administrative Support | 17,306.50 | 16,548.50 | -758.00 | -4.38% |
| Criminal Justice | 34,496.75 | 33,050.00 | -1,446.75 | -4.19% |
| Custodial | 3,932.25 | 3,850.50 | -81.75 | -2.08% |
| Education | 147.00 | 122.00 | -25.00 | -17.01% |
| Employment | 923.75 | 907.50 | -16.25 | -1.76% |
| Engineering and Design | 7,934.25 | 7,747.00 | -187.25 | -2.36% |
| Human Resources | 1,382.25 | 1,331.00 | -51.25 | -3.71% |
| Information Technology | 4,643.00 | 4,430.50 | -212.50 | -4.58% |
| Inspectors and Investigators | 2,968.50 | 2,880.00 | -88.50 | -2.98% |
| Insurance | 1,099.25 | 1,049.00 | -50.25 | -4.57% |
| Land Surveying, Appraising, and Utilities | 267.75 | 259.50 | -8.25 | -3.08% |
| Law Enforcement | 4,513.50 | 4,405.00 | -108.50 | -2.40% |
| Legal | 3,065.50 | 2,993.00 | -72.50 | -2.37% |
| Library and Records | 201.75 | 185.50 | -16.25 | -8.05% |
| Maintenance | 3,532.25 | 3,769.00 | 236.75 | 6.70% |
| Medical and Health | 6,281.50 | 6,141.00 | -140.50 | -2.24% |
| Natural Resources | 2,748.00 | 2,343.50 | -404.50 | -14.72% |
| Office Services | 201.00 | 154.50 | -46.50 | -23.13% |
| Planning, Research, and Statistics | 540.50 | 529.00 | -11.50 | -2.13% |
| Procedures and Information | 723.00 | 695.00 | -28.00 | -3.87% |
| Program Management | 13,609.75 | 12,473.00 | -1,136.75 | -8.35% |
| Property Management and Purchasing | 2,154.75 | 2,134.00 | -20.75 | -0.96% |
| Public Safety | 1,138.00 | 1,169.00 | 31.00 | 2.72% |
| Safety | 252.50 | 250.50 | -2.00 | -0.79% |
| Social Services | 32,963.75 | 32,717.50 | -246.25 | -0.75% |
| **TOTAL EMPLOYEES** | **152,657.50** | **147,600.00** | **-5,057.50** | **-3.31%** |

*Source: State Auditor's Office of Texas*

## Recognizing the Positive and Negative Impact of Turnover

When employees leave, or positions turn over, the implications can be costly. The department loses training, in terms of dollars and time, and often invaluable institutional knowledge walks out the door. Both losses can negatively impact the agency's productivity. The overall and voluntary turnover rates as well as voluntary separations were on the rise in FY2011.

The State Auditor cited several possible reasons for this increase in turnover rates. Exit surveys pointed to a perceived lack of employment stability due to budget cuts, and the key reason for voluntary separations and turnover, aside from retirement, was better pay and benefits. For example, in the Texas Department of Criminal Justice (TDCJ), correctional officer positions are turning over the fastest. Most vacancies are within 10-12 of the more than 100 units, and these officers are leaving for higher paying oil field work — salaries the State cannot offer. In addition, there were a reduced number of salary actions for state employees — with 7,161 fewer merits and 4,142 fewer one-time merit increases in FY2011 compared to FY2010.[16] Turnover rates rise when merits and pay increases aren't offered for several years. According to the employer survey, this is true for parole officers, who particularly tend to have high turnover during this time. With vacancies reaching the 2,000 mark for this position, it's becoming difficult to provide needed services.[17]

***Figure CC.5 - Voluntary Employee Separations for FY2010 and FY2011***

| Separation Type | FY2010 | FY2011 | Percent Change |
|---|---|---|---|
| Retirement | 3,696 | 4,411 | 19.3% |
| Voluntary Separation from Agency | 12,535 | 13,909 | 11.0% |
| Total Voluntary Separations | 16,231 | 18,320 | 12.9% |

*Source: State Auditor's Office of Texas using data from Uniform Statewide Payroll/Personnel System, Human Resources Information System, and Standardized Payroll/Personnel Reporting System.*

The state workforce is older than that of the private sector (median age of 44.0 compared to 40.3), and its median tenure level is higher (7.1 years compared to 4.5 years). The average tenure is six years with an agency and 10 years with the State.

State employees between 40 and 49 years of age were the largest group, at 27.8% of the state's workforce, but only represented 16.5% of the state's turnover. In contrast, the turnover rate was highest (32.5%) among employees who were under 30 years of age; this group comprised only 15.7% of state employees, but represented 30.2% of the state's turnover.[18]

***Figure CC.6 - Turnover by Age Group for FY2011***

| Age Group | Average Headcount | Percentage of Headcount | Separations | Percentage of Separations | Turnover Rate |
|---|---|---|---|---|---|
| 16 to 29 | 24,183.00 | 15.7% | 7,868 | 30.2% | 32.5% |
| 30 to 39 | 33,144.25 | 21.4% | 5,315 | 20.5% | 16.0% |
| 40 to 49 | 42,895.75 | 27.8% | 4,282 | 16.5% | 10.0% |
| 50 to 59 | 39,785.75 | 25.8% | 5,194 | 20.0% | 13.1% |
| 60 to 69 | 13,512.50 | 8.7% | 3,100 | 11.9% | 22.9% |
| 70 or older | 965.00 | 0.6% | 269 | 1.0% | 27.9% |
| **Totals** | **154,486.50** | **100.0%** | **26,028** | **100.0%** | **16.8%** |

*Source: State Auditor's Office of Texas using data from Uniform Statewide Payroll/Personnel System, Human Resources Information System, and Standardized Payroll/Personnel Reporting System.*

Many state jobs with high turnover rates have high education and training requirements, making those positions hard to fill and retain under the best circumstances. This is especially true in Texas, where there is competition for skilled workers in an overall market that is experiencing skill shortages in such occupations as public safety, health care, law enforcement, and other professional and technical positions.[19] Such circumstances, according to the state employer survey, put a strain on the affected agencies and could reduce their ability over time to deliver consistent, effective services to citizens.[20]

***Figure CC.7 - Hard-to-fill Positions in the Public Sector***

| Job Class Title | Average Headcount | Terminations | Turnover Rate |
|---|---|---|---|
| Correctional Officer I | 677.25 | 405 | 60% |
| Correctional Officer II | 1862.75 | 1055 | 57% |
| Mental Retardation Assistant I | 5436.25 | 2809 | 52% |
| Licensed Vocational Nurse III | 462 | 179 | 39% |
| Psychiatric Nursing Assistant I | 1860.25 | 717 | 39% |
| Juvenile Correctional Officer IV | 1104 | 398 | 36% |
| Human Services Specialist I | 400.5 | 142 | 36% |
| Child Protective Services Specialist II | 2531.75 | 862 | 34% |
| Correctional Officer III | 7487.25 | 2541 | 34% |
| Licensed Vocational Nurse II | 786 | 251 | 32% |
| Human Services Specialist II | 1376.5 | 422 | 31% |
| Food Service Worker I | 659 | 198 | 30% |
| Mental Retardation Assistant II | 1421.75 | 418 | 29% |
| Nurse II | 793.5 | 211 | 27% |
| Nurse III | 1019 | 251 | 25% |
| Clerk III | 2405.25 | 515 | 21% |
| Mental Retardation Assistant III | 704.75 | 149 | 21% |
| Custodian I | 608 | 128 | 21% |
| Child Protective Services Specialist III | 1231.75 | 257 | 21% |
| Food Service Manager II | 445 | 93 | 21% |
| Clerk II | 2147.75 | 426 | 20% |
| Psychiatric Nursing Assistant II | 570 | 111 | 20% |

Source: State Auditor's Office of Texas Workforce data for FY2011, considering positions with more than 400 staff statewide and a turnover rate of more than 20%.

According to the SAO, if skill-shortage trends continue, the State should expect significant competition in recruiting and retaining employees. Competition will be especially difficult in the following State jobs, which are already experiencing turnover rates that exceed 20%.[21]

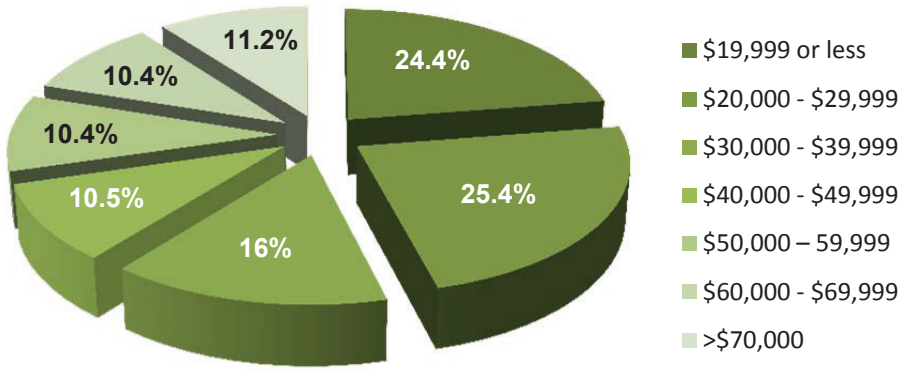
***Figure CC.8 - Selected State Jobs with High Turnover for FY2011***

| Job Titles | Average Headcount FY2011 | Overall Turnover Rate Including Retirement. | Percentage of Headcount |
|---|---|---|---|
| Mental Retardation Assistant | **7,884.0** | **42.2%** | **5.1%** |
| Juvenile Correctional Officer | **1,887.75** | **39.6%** | **1.2%** |
| Licensed Vocational Nurse | **1,253.25** | **33.5%** | **0.8%** |
| Psychiatric Nursing Assistant | **3,075.75** | **28.9%** | **2.0%** |
| Child Protective Services Specialist | **5,309.75** | **23.5%** | **3.4%** |
| Trooper Trainee/Probationary Trooper | **240.25** | **23.3%** | **0.2%** |
| Correctional Officer | **27,296.5** | **22.3%** | **17.7%** |

*Source: State Auditor's Office of Texas using data from Uniform Statewide Payroll/Personnel System, Human Resources Information System, and Standardized Payroll/Personnel Reporting System.*

Employees paid less than $30,000 annually left state employment at a much higher rate than those earning above this level.[22]

***Figure CC.9 - Turnover Rates among State Employee by Salary Breakdown for FY2011***




*Source: State Auditor's Office of Texas using data from Uniform Statewide Payroll/Personnel System, Human Resources Information System, and Standardized Payroll/Personnel Reporting System.*

The cost to an organization for each position that is turned over has been estimated at anywhere from 100-300% of the departing employee's annual salary. The estimate varies depending on the type of position being filled and the departing employee's performance level.[23] The general guideline for turnover cost is one-third of an employee's salary, with the potential of increased costs related to orienting and training new employees. This is particularly true for jobs that require new hires to undergo extensive training, such as peace officers and public safety personnel. For example, according to the Department of Public Safety, it costs $30,186 to train each new recruit, and this is in addition to the officer's salary. If that officer leaves after several months, the State loses that investment when the officer walks out the door. What makes the issue more difficult is that many of the hard-to-fill jobs described earlier are in higher demand during economic downturns.[24]

Turnover can have both positive and negative effects on an organization. For example, it can replace low-performing employees with high-performing ones. There can also be a financial benefit as a result of the difference between the salary paid to an experienced employee who leaves an agency with the lower salary paid to a new employee. However, when agencies lose highly skilled, experienced employees, turnover may negatively affect their business operations — productivity could be lowered while key positions are vacant and new employees are trained.[25]

Some agencies are able to hire return-to-work (RTW) retirees at a reduced salary. Without this option, these agencies would lose the institutional knowledge and training these candidates bring (back) to the table. According to employer survey feedback, the RTW program gives employers access to an experienced candidate pool at a competitive salary rate, especially in times of critical staffing shortfalls. The feedback also indicated that it would be counterproductive in providing quality services to prevent an agency from hiring the most qualified candidate simply because they had previously retired from the State.[26] The RTW program offers a cost-effective alternative to training a new candidate, fills the gap for critical staffing, and saves the State some salary expense. In addition, employers continue to contribute to the retirement fund of RTW employees. Therefore, the RTW program exists without any negative impact to the fund.

## Acknowledging the Value of Retirement Benefits

The U.S. employee benefit system is a shared responsibility among businesses, individuals and the government. Employee benefits are a competitive incentive used by businesses and public sector organizations to attract and retain qualified employees. Benefits also increase an employee's economic security and improve morale. Certain benefits, including Social Security, unemployment insurance, workers' compensation, and family and medical leave, are mandatory for certain types and size employers. General categories of benefits include retirement; health insurance; vacation, sick, and holiday pay; longevity pay; life and disability insurance; and education, among others.[27]

Employer-sponsored retirement plans are just one tool for attracting and retaining the most qualified employees to meet the goals and business needs of an organization. These plans provide individual financial security through pensions, individual retirement accounts, disability benefits, and/or tax-free death benefits. Such plans are protected and regulated by state and federal law, managed as trust funds, and overseen by boards of trustees.[28]

For large private companies (500-plus employees), 76% of the workforce participates in retirement programs — 43% in defined benefit (DB) and 60% in defined contribution (DC) plans. In the public sector, 88% of the workforce participates in retirement plans — 82% in DB and 17% in DC plans. These numbers compare participation rates; however, when comparing access to retirement programs versus participation in the public sector, only about half of those with access to a DC plan participate.[29] Texas, as with most states, provides their employees with DB pension plans with lifetime payments to eligible retirees based on salary, years of service, and a funding formula. Texas also offers an optional DC plan.

According to state employers surveyed, retirement benefits play a significant role in recruiting and retaining the workforce needed to provide state government services. Employees and potential employees view such benefits as an incentive, while also helping ensure retirement security. Any changes to the retirement benefits are expected to increase the turnover rate, and many employers mentioned that grandfathering long-serving employees would reduce the risk of losing a trained workforce.[30] With several plan structures, their impact on the workforce varies and appeals to different employers and employees depending on the goals of each.

If the employer's workforce is highly mobile, a plan design that quickly gives employees a right to their benefits and allows them to take the benefits with them when they change employers will be attractive to such workers. Rapid vesting and broad portability are key advantages of the DC plan. While this design may attract workers, it's less likely to retain them.

If the employer wants to encourage long-term service to retain a workforce that has the unique skills and experience required to provide goods and services, then a better retirement plan design would reward long-term service. This is the key advantage of the DB plan. This design provides an incentive for longer-term service, which can both reduce turnover rates and increase the return-on-investment of employer training costs, especially those associated with new employees.

The American Academy of Actuaries has found that for employees, the most beneficial plan largely depends on age and the projected length of service with the State. Changing to a DC or hybrid plan would be most beneficial for younger employees with shorter state employment who leave before retirement eligibility. This change would be least beneficial for employees at mid-career with approximately 15 years of service.[31]

Texas taxpayers get a highly efficient workforce for significantly less cost than most other employers.

## Offsetting Lower Wages

Total compensation (or total rewards) describes the complete reward and recognition package that an employee receives. Use of the total compensation package allows employers to leverage multiple factors to attract, motivate, and retain employees. This package includes an employee's base salary, benefits, and other rewards — the largest component, by far, being salary. While enhanced retirement and health benefits cost more relative to wages for state-local workers than for those in the private sector, they are not high enough to offset lower overall wages. With research showing that state-level salaries are, on average, 15-20% lower than wages paid in comparable private sector jobs in Texas, the SAO found that state health and retirement benefits are not disproportionately more expensive. This means total compensation costs for state employees are, on average, lower than what other employers pay. Texas taxpayers get a highly efficient workforce for significantly less cost than most other employers.[32]

The SAO identified the value of an average, classified regular FTE's total compensation package in FY2011.[33]

***Figure CC.10 - Total Compensation Components and Percentages in FY2011***

| Component | Includes | Percentage of Total Compensation | Percentage of Total State Budget |
|---|---|---|---|
| Base Salary | Compensation | 67.7% | 7.03% |
| Paid time off | Holidays, sick leave, and annual leave | 10.4% | 1.08% |
| Health Insurance | | 10.4% | 1.08% |
| Employer payroll expenses | Social Security and Medicare taxes, unemployment compensation, and worker's compensation | 5.7% | 0.59% |
| Retirement Contributions | | 4.1% | 0.43% |
| Longevity Pay | | 1.7% | 0.18% |
| **Total** | | **100%** | **10.39%** |

*Source: State Auditor's Office of Texas (FY2011).*

The State offers other benefits excluded from the SAO assessment of the compensation package and the above figures, such as: state compensatory time; military leave; emergency leave; parent-teacher conference leave; volunteer firefighters and emergency medical services training leave; court-appointed special advocates volunteer leave; and extended sick leave. Some agencies also are able to budget for state-paid or -sponsored professional development and training, but many agencies no longer have the budget for it.

Since the slight public-sector advantage in benefit percentages does not counterbalance much lower wages paid to state workers in Texas, as described earlier, it's important that policymakers avoid reducing public sector benefits in isolation of wage considerations.[34] Any reduction in benefits is viewed by state employers as a direct pay cut, according to employer survey feedback. Should public sector benefits deteriorate without wage increases, hard-to-fill positions will likely remain vacant longer, or remain unfilled, creating a risk for citizens requiring the services authorized by the Texas Legislature. Survey feedback also indicates that more state workers would likely move to higher-paying positions in other governmental entities or the private sector, increasing turnover costs, and lowering the quality of services the State can deliver.[35]

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