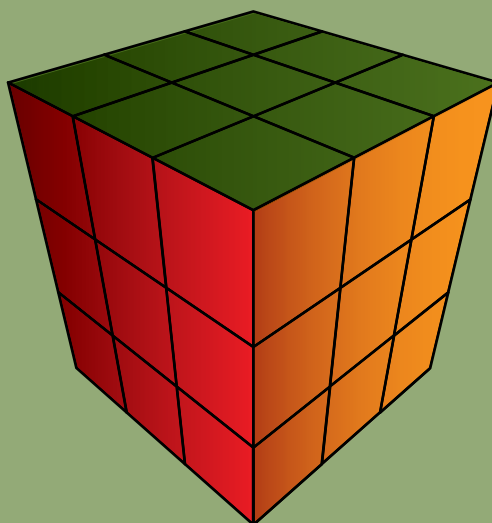


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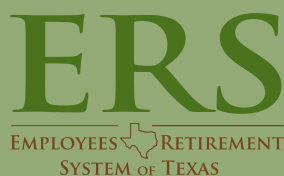


OF BENEFITS



TEXAS EMPLOYEES GROUP BENEFITS PROGRAM
INSURANCE SUMMARY

NOVEMBER 1, 2011



MISSION STATEMENT

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

TEXAS EMPLOYEES GROUP BENEFITS (GBP) INSURANCE BACKGROUND

The Employees Retirement System of Texas (ERS) professionally manages health insurance benefits for more than half a million public employees, retirees, and their families through the Texas Employees Group Benefits Program (GBP). The GBP not only covers 1 in every 48 Texans, it helps support thousands of local health providers across the state. ERS has managed health insurance benefits for the State since 1976.

For 35 years, the GBP and Texas state employees – like the rest of the nation – have felt the impact of rising health care costs. Since health insurance continues to be a significant expense, it's important for the State of Texas to get the most out of every dollar it spends on health benefits. A cost-efficient plan creates value for the State by avoiding millions of dollars in payments and lowering health care costs for the people who count on the plan.

Federal health reform under the Accountable Care Act (ACA) also brings cost control to the forefront. Much of the motivation driving health care reform is grounded in 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.

HISTORY

In 1975, the Legislature created the GBP and charged ERS with providing health insurance and other optional coverage for employees, retirees, and their eligible dependents. GBP health coverage began on September 1, 1976 as an indemnity health plan.¹

Over time, rising health care costs required annual, sometimes significant, increases in state and employee contributions for health insurance. Concerns over rising health insurance costs at the national level led most employers and insurers to implement cost containment initiatives for their health plans. The federal government also took action by enacting protective legislation to encourage the creation and growth of Health Maintenance Organizations (HMOs). An HMO is a fully-insured health insurance program that

ERS administers the GBP on behalf of the following participants:

- State agency employees, retirees, and elected officials, and their eligible dependents;
- Employees and retirees of certain institutions of higher education and their eligible dependents; and,
- Employees and retirees of certain quasi-state agencies, Community Supervision and Correction Departments, and their eligible dependents.

requires members to use a limited network of providers. The federal government also took steps to limit government spending on Medicare and Medicaid.

In the mid-1980s, the GBP health plan was amended to incorporate most of the first generation cost containment measures. Second surgical opinion, ambulatory surgery incentives, and preadmission testing methods were designed to redirect care from expensive inpatient settings to less expensive outpatient settings. Private sector employers and commercial insurance companies later adopted these changes as well. By 1984, inpatient hospital utilization began to

decline. That, combined with a general moderation in health care price inflation, led to unprecedented leveling, and even declining health insurance costs. GBP contribution rates went down by 15% on average that year, and over the next 30 months substantial fund surpluses grew.

Most other plans experienced similar results at this time, which led to unwarranted conclusions that cost containment activities were responsible for the drop in health care costs. In fact, reduced use of inpatient services was masking complex forces that continued to drive costs upward. When the shift from inpatient to outpatient care reached its limit of efficacy and safety after a few years, health benefit costs increased sharply. National trends went from a high of 25% in 1983 to near zero in 1985, then returned to 12% in 1986. The sudden increase in trend surprised the industry, resulting in significant losses for many, including the GBP indemnity plan.

With the return to double-digit health benefit cost trends in the late 80's and early 90's, there was a renewed effort nationally and within the GBP to control health care costs and ensure quality of service. Within the GBP, this effort was reflected through two major initiatives.

1. ERS implemented changes in its HMO contracting process that strengthened financial requirements, reduced adverse selection, standardized benefits and limited participation to those HMOs that saved money for the GBP.
2. On September 1, 1992, ERS implemented HealthSelectSM of Texas (HealthSelect), a self-funded, managed-care, point of service (POS) health benefits plan.

¹Tex. Ins. Code, Ch. 1551.

These efforts were immediately successful as the GBP health benefit cost trend declined sharply following the implementation of HealthSelect. 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.

The GBP has grown over the years, due in part to the addition in 1992 of all Texas institutions of higher education, except for The University of Texas and Texas A&M University Systems, which administer their own programs.

CURRENT INSURANCE OVERVIEW

ERS provides four health insurance options and a number of optional insurance coverages, such as dental, life, and disability. About 94% of GBP health insurance participants enroll in HealthSelect. The rest enroll in one of the fully-insured HMO options. 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.

Figures 1 and 2 show the funding method and current enrollment for all plans offered under the GBP. This report will focus on the health plan only, as health insurance has the largest financial impact on the state and its employees.

Figure 1
GBP HEALTH INSURANCE PLANS

Plan Type	Funding Method	Members	Participants
HealthSelect (POS)	Self-Funded	285,745	490,353
Scott & White (HMO)	Fully-Insured	12,480	21,336
Community First (HMO)	Fully-Insured	3,463	6,561
KelseyCare (MA-HMO)	Fully-Insured	42	62

Figure 2
OPTIONAL INSURANCE COVERAGE UNDER THE GROUP BENEFITS PLAN

Coverage	Plan Type	Funding	Vendor	Members	Participants/Volume
Dental Care	PPO	Self-Funded	Humana	131,546	246,842
Dental Care	HMO	Fully-Insured	Humana	80,898	151,980
Life	Life & AD&D and Dependent Life	Fully-Insured	Minnesota Life, effective Jan. 1, 2012	297,603	\$18,337,499.550
Income Replacement/Disability	Short Term	Self-Funded	Dearborn National	106,069	\$371,687,017
Income Replacement/Disability	Long Term	Self-Funded	Dearborn National	89,262	\$342,011,997

SELF-FUNDED V. FULLY-INSURED COVERAGE

According to the National Conference of State Legislatures, 92% of state employers offer a self-funded health insurance plan.² About 65% of private sector employees working for large firms are also covered by a self-funded health insurance plan.³

Self-funding means the employer—not an insurance company—assumes direct responsibility for providing health care benefits to employees. Employers and employees pay monthly contributions, which are pooled into an insurance fund. The employer holds and invests the 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 provides for greater employer cost control, flexibility in benefits design, and the ability to reduce claims through wellness and medical management.

²National Conference of State Legislatures, "States that Self Insure and Self-fund their State Employee Health Plan," January 2011

³Congressional Research Service, "Self-Insured Health Insurance Coverage," May 12, 2010

Figure 3

GROUP BENEFITS PROGRAM SELF-FUNDED V. FULLY-INSURED PROGRAMS

	Self-Funded	Fully-insured
GBP Programs	HealthSelect of Texas; Dental PPO; Income protection/disability plans; Long-term disability	HMOs; Dental HMO; Life
Risk	Borne by employer and employees who pay for the plan	Borne by insurance plan; often may be shared with network providers
Networks	Lower cost for staying in network; higher cost for going out of network	Must use in-network provider to receive services
Contract	ERS contracts with third-party administrator to set up a network and process claims	ERS contracts with outside vendor to provide an insurance option for members
Plan Design	Controlled by ERS Board of Trustees	Negotiated with insurance company; HMOs must provide coverage comparable to HealthSelect
Payments	Claims payments are made on a fee-for-service basis, and then they are reimbursed by the employer's insurance fund	Employer and/or members pay premiums. The insurance company pays for all claims

The State of Texas contracts with third-party administrators (TPAs) to administer its self-funded health benefits plans. Blue Cross Blue Shield of Texas (BCBSTX) administers the health plan, and Caremark administers the pharmacy plan. TPA contracts are bid and renegotiated on a regular basis. Their services include:

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

In contrast, HMOs are fully-insured health insurance plans. In this model, the employer contracts with an insurance company 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.

COST MANAGEMENT

Health care cost management is crucial, especially when GBP costs continue to rise faster than state revenue, employee pay and other inflation measures. Figure 4 shows that total annual GBP health expenditures have more than doubled over a 10-year period.⁴ Trend dropped temporarily in FY03 and FY11 in response to plan design changes that shifted costs to members. It is important to note that cost concerns are not unique to ERS, as they mirror cost drivers for other health plans in Texas and the United States.

Figure 4

GBP HEALTH PLAN TOTAL EXPENDITURES HAVE INCREASED 111% OVER TIME (in millions) based on data through August 2011

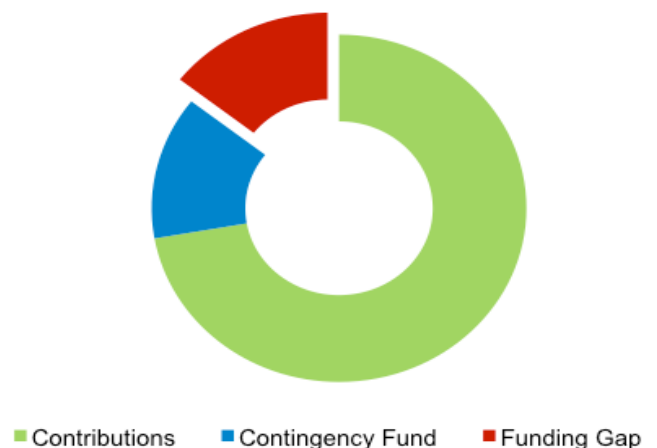


Revenue Shortfalls

Figure 5 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 – its

Figure 5

RECURRENT REVENUE SHORTFALLS LEAD TO A STRUCTURAL FUNDING DEFICIT



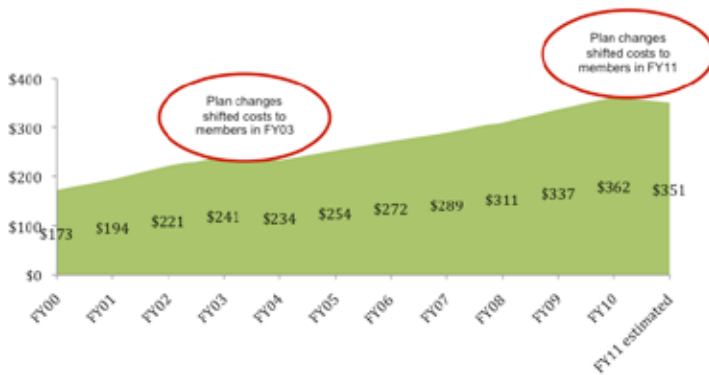
⁴Source: Rudd & Wisdom, ERS Health Plan Financial History based on data through August, 2011

“rainy day fund” – to cover revenue shortfalls. In FY09 and FY10, the GBP used \$248 million in contingency funds to cover revenue shortages.

When the contingency fund is gone, there are only two options left: cut benefits or shift costs to members. Member cost shifting can be done through plan design (raising copays, deductibles and co-insurance) or by increasing member contributions. The ERS Board of Trustees can change the plan design, but only the Legislature can change the contribution strategy. In FY11, the funding gap was closed by shifting \$140 million in costs to members.

Figure 6 shows that cost shifting to members achieved the desired effect of reducing plan costs in FY03 and in FY11, in part because members were picking up more of the total, and in part because members used fewer services.⁵ Ongoing budget pressures only increase the importance of understanding program cost drivers and implementing conservative cost management.

Figure 6
GBP HEALTH PLAN EXPENDITURES
PER PARTICIPANT PER MONTH (PPPM)
based on data through August, 2011



Primary Cost Drivers

ERS regularly analyzes program data to identify potential areas of concern and develop customized options for addressing those concerns. Some concerns highlighted in the FY10 Cost Management and Fraud Report include:

- **Pharmacy costs** continue to rise for a number of reasons. Higher prices for brand name drugs increase plan costs, although more members are using generic medications when they are available. Another issue is that too many of our members with chronic illnesses do not take their medications as prescribed.
- **Hospital costs** are another concern. Inflation is responsible for 60% of the hospital cost increase; while utilization accounts for the other 40%. Musculoskeletal complaints are the number one reason for inpatient hospital visits.
- **Demographics** also drive costs. Three out of four adults in the HealthSelect plan are now older than 40. As they age, they

Figure 7

KEY COST MANAGEMENT SAVINGS

ERS took aggressive action to create efficiency and cost savings in the HealthSelect plan by:

- **SAVING THE STATE \$6.6 BILLION** on health care payments through cost management programs in FY10.
- **CUTTING ADMINISTRATIVE OVERHEAD.** Over 97 cents of every GBP dollar is spent on health care, not administration.
- **REDUCING HEALTH PLAN COSTS 5%** by shifting \$140 million in higher copays and coinsurance to health plan members starting in FY11.
- **SAVING \$333 MILLION OVER 4 YEARS** on the Pharmacy Benefit Manager Contract.
- **HOLDING THE LINE ON PROVIDER INCREASES.** Doctor payments have increased slower than inflation for the past six years; and
- **RECEIVING \$30 MILLION** in new federal funds to offset early retiree insurance costs incurred in FY10 and FY11.

use more services. Family members also cost the plan – eight of the top 10 highest paid claims last year were for dependents. In general, the most expensive groups to insure are male spouses and retirees younger than age 65.

A more detailed accounting of cost drivers for the HealthSelect program is available in the FY10 Cost Management and Fraud Report.

Controlling costs: contracting and plan design

ERS sets and enforces high performance standards for the health plan to slow the benefit cost trend and ensure that fraud and abuse do not occur.

ERS, together with the TPAs, proactively manage plan costs to minimize the impact of cost increases on the state, employees and retirees. Cost management activities saved the plan \$6.6 billion in FY10. They include:

- negotiating provider discounts,
- monitoring costs and utilization,
- controlling fraud,
- keeping administrative costs low,
- leveraging outside sources of funds,
- developing innovative payment systems, and
- sharing costs with health plan members through plan design.

HealthSelect has low administrative costs. The Accountable Care Act requires insurers of large plans to spend 85 cents of every premium dollar on health care costs. HealthSelect far exceeds this standard with more than 97 cents of every dollar in contributions going toward health care costs.

⁵Source: Rudd & Wisdom, ERS Health Plan Financial History based on data through August, 2011

ERS aggressively negotiates TPA contracts to keep administrative costs low and ensure that members have access to a comprehensive network with the best provider discounts. In FY10, negotiated discounts for prescription drugs, hospital claims, and other providers saved the plan about \$3.2 billion. See Exhibit A for a listing of the key cost management programs implemented by ERS from FY02 to FY12.

As a state government plan, HealthSelect is not subject to the Employee Retirement Income Security Act (ERISA).

Controlling costs: 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 for three levels of coverage:

- In-network coverage 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.
- Out-of-network coverage refers to services with non-contracted providers. Members can go out of network but they pay more.
- Out-of-area coverage refers to services performed outside the TPA’s service area. Out-of-area services also cost the member more.

Network limitations save the plan money by offering financial incentives for members to use contracted providers.

Controlling Costs: 100% Dependent Eligibility Audit (DEA)

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

In February 2010, a Request for Proposal was issued to solicit bids from qualified auditing firms for a 100% dependent eligibility audit of GBP participants. ERS awarded the contract to Hewitt Associates L.L.C. (Hewitt) for a customized dependent eligibility audit, designed to deliver a fair, efficient, and accurate verification process. ERS launched the DEA in four phases between March 16 and June 24, 2011.

Based on prior audits, Hewitt estimated that members would voluntarily drop 1 to 3% of their enrolled dependents during the audit’s amnesty period. Hewitt also projected that the audit would find another 5 to 15% of dependents ineligible. As of this date, Phases II, III and IV of the audit are still underway.

Based on preliminary results, it appears that the DEA will meet its goal, as slightly more than 5% of dependents were not verified by the audit. Phase I of the DEA netted a projected savings of almost \$1.7 million.

GBP FINANCES

Funding Sources and Appropriations Process

ERS submits its Legislative Appropriations Request (LAR) for the GBP to the Legislative Budget Board (LBB) prior to each legislative session. The LAR presents the projected state contributions needed to support the GBP health plan over the next biennium. ERS projects plans costs nearly three years into the future, using actual claims experience and the health benefit cost trend.

During the FY2010-11 biennium, health plan costs exceeded revenue by about \$55 million. Even with contribution rate increases of 6% for FY12 and 7% for FY13, ERS expects health plan costs to exceed revenue by about \$82 million during the next biennium. ERS must use the GBP contingency fund to cover any shortfalls.

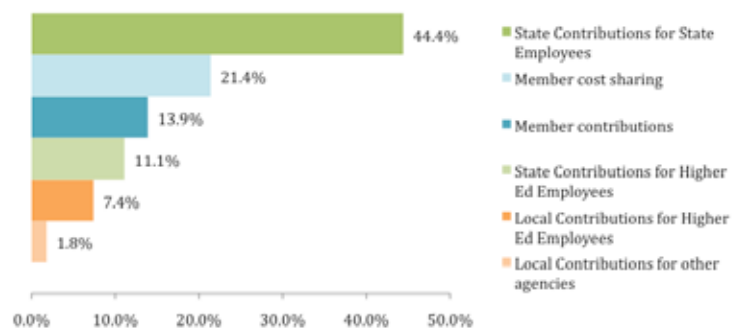
Federal Health Reform

The Legislature amended the health plan September 1, 2011, to comply with the requirements of the ACA. Implementing applicable provisions will create an array of potential gains and losses for the plan. Two federal changes will increase costs for the plan starting September 1, 2011. The most significant changes for FY12 are requirements to cover children up to age 26 and to cover preventive care at no cost to the member. On the other hand, ERS has applied and qualified for \$30 million to reimburse expenses incurred by pre-Medicare retirees. The Early Retiree Reinsurance Program provides temporary supplemental revenue for the plan starting in FY11.

Contribution Rates

The State pays 100% of the contribution rate for eligible members and 50% of the dependent contribution rates for health plan coverage. Every two years, the Legislature determines the contribution strategy. ERS staff and the consulting actuary use projected costs for the coming fiscal year to develop annual contribution rates,

**Figure 8
WHO PAYS FOR GBP HEALTH CARE BENEFITS? FY2011**



with consideration to the legislative appropriation. Critical items that affect the rates recommendation include:⁶

- revenue requirements;
- expected state funding for each fiscal year of the biennium;
- historical enrollment;
- claims experience;
- the health benefits cost trend;
- other sources of revenue; and
- the impact of participating HMOs.

In the future, ERS anticipates that contributions would have to increase by 7 - 8% each year to sustain the program at the status quo.

Figure 9
GROUP BENEFITS PROGRAM
PROJECTION OF GBP FUND BALANCE
as of August 2011

	FY2011	FY2012	FY2013
Average Number of Certificates			
HealthSelect	288,683	285,059	289,335
HMOs	17,012	15,906	16,145
Total	305,695	300,965	305,479
GBP Revenue	Amounts shown in \$millions		
Health Plans			
State Funding	\$1,843	\$1,902	\$2,066
Contribution for State Agency	1,265	1,306	1,418
Contribution for Higher Ed Agency	528	545	592
Contribution for Other Agency	50	52	56
Employee Funding	395	411	446
Total	\$2,238	\$2,313	\$2,512
Investment and Misc. Income	14	10	10
Total	\$2,251	\$2,323	\$2,522
GBP Expenditures			
HealthSelect	2,160	2,335	2,543
HMOs	128	124	136
Group Insurance Expenses	12	13	13
Credit for Hospital Audit and Formulary Refunds	141	110	114
Total	\$2,159	\$2,349	\$2,578
Net Gain (Loss)	92	(26)	(56)
Contingency Fund			
Projected Fund Balance (8/31)	\$228	\$202	\$146
<i>Note: This projection assumes an 8% annual trend and a 7% increase in funding for FY12 as provided in HB1.</i>			

New Revenue Source: Tobacco Premium Surcharge

SB 1664 (82R) added Section 1551.3075 to the Insurance Code requiring ERS to establish and enforce a monthly “Tobacco User Premium Differential” for GBP participants who use tobacco products.

The tobacco cessation program promotes wellness through lower health premiums for people who lead a tobacco-free lifestyle. Participants who report tobacco use will pay a higher premium, based on the legally required monthly premium differential. To support members and their families who are trying to quit, the GBP offers tobacco cessation programs and covers prescription drugs like Chantix and Zyban.

Starting January 1, 2012 tobacco users will pay more. Tobacco users must certify if they or any of their covered dependents use tobacco during a coverage review period of Nov. 7 to Dec. 9, 2011. If a member or a covered family member uses tobacco, they will pay \$30 per user up to a maximum of \$90 more each month for their health insurance. (See Figure 12.) The contribution surcharge will be deducted from monthly paychecks on a pre-tax basis.

Figure 12
TOBACCO MONTHLY CONTRIBUTION
EFFECTIVE JANUARY 1, 2012

Tobacco User(s)	Monthly Premium
1 Covered Person [Member, Spouse, or Child]	\$30
2 Covered Persons [Member + Spouse, Member + Child(ren), Spouse + Child(ren)]	\$60
3 Covered Persons [Member + Spouse + Child(ren)]	\$90

⁶82(R), SB 1664 by Duncan

NEW PLAN INITIATIVES

In addition to ongoing cost containment activities, ERS seeks new and innovative ways to cut costs, improve plan design, or offer its members new choices. Two such changes for FY11 and FY12 include pilot programs to better coordinate care and Medicare Advantage programs for Medicare-enrolled retirees and dependents.

Medical Home/Accountable Practice Model Effective January 1, 2011

Most insurance plans pay for health care on a fee-for-service (FFS) basis; i.e. one payment for each service provided. Critics say that FFS creates financial incentives for providers to order more services, results in poor coordination of care, and leads to duplicative or conflicting treatments. In contrast, integrated care systems create an environment where primary care doctors, specialists, and hospitals work together to manage the overall care of their patients.

Accountable Care Organizations (ACOs) are one recent example of integrated patient care. Under this model, ERS holds the ACO accountable by assessing whether appropriate amounts of high quality care are being provided to their usual patient population. ERS financially rewards the ACO as efficiency and quality improve, which motivates further improvement and progress towards fully coordinated care.

Beginning January 2011, ERS launched pilot programs in three cities (Austin, Houston and Tyler) to increase clinical quality and efficiency, improve the patient and provider care experience, and coordinate and integrate care within and among the participating practices.

The pilot programs reimburse providers based on clinical quality and cost targets. The target is to cut the health plan benefit cost trend by half. Should a physician group reduce the benefit cost trend by more than half; ERS will share the savings on a 50/50 basis. Savings are determined on an annual basis. Early indications from the pilot programs are mixed.

Figure 13

PILOT PROGRAM RESULTS

Pilot	Number of Participants	Early Results from Pilot
ARC	25,000	ERS anticipates savings will result in a shared savings payment with ARC
Kelsey	10,000	ERS anticipates savings will result in a shared savings payment with Kelsey
Trinity	5,000	With a small population, savings are not yet substantial enough to generate a shared savings payment with Trinity

ERS is examining programs to build upon the pilot projects. Models under consideration could combine one or more of these strategies:

- ACOs or groups of providers that would formally accept responsibility for care of all or a portion of GBP participants;
- “Episode of care payment systems,” which bundle all payments to a provider group, per patient, per defined episode of illness;
- Global payment systems that make an up-front fixed payment per participant for a specified range of services over a set period of time;
- Payments for coordinating the care of people with complex or chronic conditions, with the goal of preventing complications and reducing costs; or
- Performance-based incentives for health care providers who meet specific performance targets.

Medicare Advantage Plans, effective in FY12

On September 1, 2011, ERS provided a Medicare Advantage HMO option called KelseyCare in the Houston area. KelseyCare will provide health coverage and prescription drug benefits to Medicare retirees and their spouses age 65 and over in Harris, Fort Bend, Montgomery, and Galveston Counties.

On August 23, 2011, the ERS Board of Trustees approved the selection of Humana Insurance Company to provide a Medicare Advantage plan with statewide Preferred Provider Organization (PPO) services.

The Humana Medicare Advantage Plan (Humana MA Plan) will provide medical benefits starting January 1, 2012 for a four-year term, subject to the terms of the contract. On that date, ERS will transfer all Medicare-enrolled GBP retirees, surviving spouses and dependents from HealthSelect and the HMOs to the Humana MA Plan. The new plan will provide benefits to retirees who are eligible for primary coverage under Medicare Part A and Part B.

- The Humana MA Plan provides fully-insured health benefits in return for a lower monthly premium;
- The retiree will not be required to contribute toward the cost of coverage in the Humana MA Plan;
- The retiree will contribute 50% of the cost of spousal coverage. The new member contribution for spousal coverage will be \$113.00 per month, compared to a \$250.74 contribution for spousal coverage under HealthSelect;
- The Humana MA Plan will provide medical benefits that are at least as good as those provided under HealthSelect;
- There will be no copay or coinsurance for medical coverage under the Humana MA Plan;
- The Humana MA Plan participants can use any physician who accepts Medicare. The benefit level for in-network and out-of-network providers is the same;
- Humana MA Plan participants will continue to receive the HealthSelect prescription drug benefits; and
- Eligible members and their dependents have the option to remain in HealthSelect or an HMO and can change back to their original medical plan throughout the 2012 calendar year. The election changes will be effective on the 1st of the following month.

The GBP health plan costs could be reduced by as much as \$42.5 million as a result of implementation of the Humana MA Plan.

POTENTIAL STRATEGIES UNDER CONSIDERATION

The following strategies have been considered by ERS and others over the past several years.

Rating Actives Separately from Retirees

Since the introduction of Medicare Advantage plans will significantly reduce the cost of covering Medicare-primary retirees, ERS is considering rating retirees separately from pre-65 retirees and active employees.

It should be emphasized rating retirees separately will not change the total cost of the health care plan; it will just change how contributions are calculated and collected.

High Deductible Health Plans with HSA options

A High Deductible Health Plan (HDHP) offers deductibles of \$1,200 to \$2,400 and a maximum level of out-of-pocket expenses. Deductibles are adjusted annually for inflation. This is quite different than the current HealthSelect plan, which currently has a \$0 deductible. Under an HDHP plan, medical expenses are generally not covered until the annual deductible is reached, whereas HealthSelect participants get first dollar coverage. Because the

HDHP member takes on a greater amount of risk and up-front cost through the deductible, the premiums are generally lower.

With an HDHP, some members will have a larger out-of-pocket expense while others will have less. Health Spending Accounts (HSAs) give HDHP participants a tax-free way to save for expected health care costs. Funds that are not withdrawn in a year can be rolled over and used in future years. Once the HSA is exhausted however, there are no further tax advantages to help defray additional out-of-pocket expense.

Value-Based Benefit Designs

A long-term approach to saving health care costs is by implementing a Value-Based Benefit (VBB) plan design. This kind of plan creates incentives to encourage the use of generic drugs and preventive services, motivate healthy lifestyles, and steer members toward high quality providers who follow evidence-based treatment guidelines. Incentives can include rewards, reduced premium share, or adjusted deductibles and/or co-pays. Overall, VBBs are designed to pay a greater portion of the cost of more efficient, higher-outcome treatments.

Starting in FY12, all GBP insurance plans provide 100% coverage for certain services coded as preventive care, such as periodic health evaluations, immunizations, well-baby/well-child care, tobacco cessation and weight loss programs, and certain screening devices.

ERS incorporated some value-based benefit design changes into the HealthSelect plan effective September 1, 2010. For example, a \$50 urgent-care copay was enacted at the same time the ER copay increased to \$150. This change and others – such as a new high-tech radiology copay – were made in an effort to steer members toward choosing more appropriate levels of care.

If a more aggressive value-based plan design were implemented, plan costs would increase in the short run; however an investment in VBB is intended to focus plan design on achieving long-term results and driving cost-saving, informed behaviors. Since the GBP is a pay-as-you-go plan, reducing member costs for some services would have to be offset by increasing member costs for other services.

High Efficiency or Restrictive Networks

One proposed cost savings approach is to establish high efficiency, restrictive networks. These networks can take various forms, from eliminating high cost providers (hospitals and physicians) to creating a network of cost-effective specialists. Overall, the objective of high efficiency or restrictive networks is to create a quality network based on lowest total health care costs (cost and quality).

To steer members toward higher-value care, the plan design would include a higher level of benefit for participants who chose higher efficiency providers.

Defined Contribution HealthCare Model

The premise of defined-contribution (DC) health plans is that a certain amount of money is made available to each participant for healthcare needs. In turn, each participant can purchase individual health insurance according to his/her needs, using the money the employer has allocated.

A defined-contribution plan has one major goal: shifting risk and responsibility from the employer to the employee or participant. Under a defined contribution plan, the participant bears much more responsibility for how to spend the fixed amount of money given by their employer. Some say this type of ownership will cut down on waste and foster a healthy competition among health-care providers. Others say it will discourage members from getting needed care.

Inspired by the defined contribution approach, leading insurers have developed products that are being marketed as Consumer-Driven Health Plans. CDHPs incorporate either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) with a high deductible or catastrophic plan option. The HRAs are generally funded by the employer and are meant to cover the deductible and other small claims.

Health Care Collaborative

Senate Bill 8 (8IR) sought to improve health care quality, accountability, and cost containment in Texas by encouraging health care provider collaboration, effective health care delivery models, and coordination of health care services.

SB 8 defined a health care collaborative as a group of physicians and other health care providers legally structured and organized to provide health care services. These collaboratives would be able to receive and distribute payments to participating physicians or health care providers. The Texas Department of Insurance and the Office of the Attorney General would have regulatory authority over them. The bill stated that the intent of the Legislature was to exempt and provide immunity from federal antitrust laws through the state action doctrine for certified health care collaboratives.

In the coming year, ERS will review the establishment of healthcare collaboratives in the marketplace and how they would interact with the GBP structure.

Offer Regional Third-Party Administrators

The regional Third-Party Administrator (TPA) model would divide the state into a number of geographic areas. The advantage to this approach would be to select the best TPA for that limited geographic area so that the overall program has a collection of the best TPA providers to provide a higher level of service than a single, state-wide TPA that may have gaps in hospital or physician coverages/participation.

It should be noted that the implementation of a regional TPA model could potentially offset or eliminate the benefits of a statewide network model. Currently, the statewide network model provides for the following benefits:

- Simplifies healthcare access for the membership;
- Promotes member understanding of the plan benefits;
- Assures uniform benefit administration;
- Minimizes internal and/or external administrative costs;
- Competes with regional HMOs;
- Promotes access to specialty providers throughout the state;
- Minimizes adverse selection; and
- Allows for consistency in provider reimbursement.

EXHIBIT A

HISTORY OF COST MANAGEMENT PROGRAMS

FY 2002 - FY 2011

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

EXHIBIT A (CON'T)

HISTORY OF COST MANAGEMENT PROGRAMS

FY 2002 - FY 2011

FY2007	<ul style="list-style-type: none"> • Personal Health Manager • Opt-Out Credit • Continue to participate in Medicare Part D subsidy
FY2008	<ul style="list-style-type: none"> • 100% PBM claims audit • Wellness committee established • Continue to participate in Medicare part D subsidy
FY2009	<ul style="list-style-type: none"> • New pharmacy benefit manager transparency contract for HealthSelect saves \$288 million in prescription drug costs over the next four years • Continue to participate in Medicare part D subsidy
FY2010	<ul style="list-style-type: none"> • Coordination of benefits with Medicare Part B prescription drugs • Pharmacy re-contracting regarding average wholesale price modification • Unclaimed funds process established • Continue to participate in Medicare part D subsidy • AWP lawsuit saves \$49 million over 3 years
FY2011	<ul style="list-style-type: none"> • Dependent eligibility audit to save \$15 million • 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 • Ability to fill extended day prescriptions at retail participating pharmacies • 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 • 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 • Increase emergency room copay from \$100 to \$150; new urgent care copay of \$50 • Implement \$100 a day copay for high tech radiology (MRI, Nuclear Medicine, CT scan) • Limit annual visits and lower allowable charges for chiropractic care
FY2012	<ul style="list-style-type: none"> • Implement tobacco use contribution differential effective January 1, 2011 • Continue and potentially expand medical home/accountable care practice model pilot programs • Implement Medicare Advantage (MA) Programs for Retirees and Medicare-Enrolled dependents with same benefits as HealthSelect. The MA HMO was effective 9/1/11 and the MA-PPO will be effective January 1, 2012 • Cost Savings of \$20 million annually from Most Favored Nations (MFN) clause for the PBM contract • Received \$30 million from Early Retiree Reinsurance Program (ERRP) • Evaluate the use of an Employer Group Waiver Plan (EGWP) plus Wrap to replace the Retiree Drug Subsidy Program (RDS)

EXHIBIT B

HEALTHSELECT PAYMENTS BY COUNTY, FY11

COUNTY	HEALTHSELECT PARTICIPANTS	HEALTHSELECT PLAN PAYMENTS	PHARMACY PLAN PAYMENTS	TOTAL HEALTH PAYMENTS IN COUNTY
ANDERSON	5,408	\$18,319,068	\$4,821,391	\$23,140,459
ANDREWS	128	\$325,479	\$89,075	\$414,553
ANGELINA	4,331	\$13,879,156	\$3,407,133	\$17,286,289
ARANSAS	408	\$826,700	\$552,862	\$1,379,563
ARCHER	291	\$1,073,207	\$253,894	\$1,327,100
ARMSTRONG	132	\$359,251	\$119,826	\$479,077
ATASCOSA	553	\$1,746,074	\$552,751	\$2,298,826
AUSTIN	822	\$2,069,999	\$832,327	\$2,902,326
BAILEY	78	\$375,923	\$85,275	\$461,198
BANDERA	318	\$1,324,727	\$362,672	\$1,687,399
BASTROP	4,837	\$21,400,570	\$5,201,308	\$26,601,879
BAYLOR	192	\$365,053	\$201,951	\$567,004
BEE	3,338	\$11,829,277	\$1,900,386	\$13,729,663
BELL	1,228	\$2,750,749	\$672,424	\$3,423,173
BEXAR	13,591	\$38,173,885	\$13,181,183	\$51,355,067
BLANCO	334	\$984,343	\$386,155	\$1,370,498
BORDEN	26	\$128,196	\$10,528	\$138,724
BOSQUE	231	\$423,544	\$168,113	\$591,657
BOWIE	2,230	\$5,678,314	\$1,413,036	\$7,091,350
BRAZORIA	7,082	\$25,313,250	\$6,134,824	\$31,448,074
BRAZOS	1,516	\$3,385,684	\$1,018,010	\$4,403,695
BREWSTER	1,046	\$2,608,615	\$705,763	\$3,314,378
BRISCOE	154	\$1,111,463	\$69,563	\$1,181,026
BROOKS	143	\$447,403	\$93,343	\$540,746
BROWN	1,834	\$6,540,705	\$1,787,846	\$8,328,551
BURLESON	250	\$827,104	\$264,107	\$1,091,211
BURNET	771	\$3,321,978	\$1,078,314	\$4,400,292
CALDWELL	1,991	\$7,371,177	\$1,566,985	\$8,938,162
CALHOUN	205	\$350,458	\$196,766	\$547,225
CALLAHAN	754	\$2,333,448	\$585,081	\$2,918,529
CAMERON	5,724	\$11,764,547	\$3,173,395	\$14,937,943
CAMP	210	\$660,174	\$177,274	\$837,448
CARSON	260	\$1,155,064	\$208,659	\$1,363,724
CASS	1,039	\$2,333,434	\$785,767	\$3,119,200
CASTRO	139	\$574,477	\$95,571	\$670,047
CHAMBERS	267	\$715,104	\$220,406	\$935,509
CHEROKEE	4,187	\$14,672,635	\$4,323,069	\$18,995,704
CHILDRESS	844	\$2,398,852	\$622,295	\$3,021,147
CLAY	391	\$1,662,917	\$401,946	\$2,064,863
COCHRAN	76	\$429,731	\$51,801	\$481,532
COKE	110	\$409,307	\$76,848	\$486,155

COUNTY	HEALTHSELECT PARTICIPANTS	HEALTHSELECT PLAN PAYMENTS	PHARMACY PLAN PAYMENTS	TOTAL HEALTH PAYMENTS IN COUNTY
COLEMAN	258	\$1,595,499	\$292,305	\$1,887,804
COLLIN	4,717	\$16,765,817	\$4,956,905	\$21,722,722
COLLINGSWORTH	165	\$916,351	\$135,811	\$1,052,162
COLORADO	454	\$1,682,808	\$379,578	\$2,062,386
COMAL	2,076	\$5,731,244	\$2,050,711	\$7,781,955
COMANCHE	237	\$692,298	\$183,275	\$875,573
CONCHO	97	\$612,159	\$83,503	\$695,662
COOKE	1,325	\$5,020,732	\$1,115,262	\$6,135,994
CORYELL	1,031	\$2,413,560	\$608,350	\$3,021,909
COTTLE	173	\$699,554	\$113,681	\$813,236
CRANE	49	\$98,787	\$23,838	\$122,624
CROCKETT	103	\$170,465	\$92,271	\$262,736
CROSBY	189	\$768,736	\$158,872	\$927,607
CULBERSON	102	\$193,689	\$61,630	\$255,318
DALLAM	434	\$947,321	\$389,773	\$1,337,093
DALLAS	16,040	\$57,961,602	\$14,454,962	\$72,416,564
DAWSON	886	\$2,288,771	\$472,839	\$2,761,610
DEAF SMITH	232	\$612,709	\$239,229	\$851,938
DELTA	131	\$248,135	\$130,960	\$379,095
DENTON	14,700	\$49,687,685	\$13,326,882	\$63,014,567
DE WITT	642	\$2,594,112	\$458,466	\$3,052,578
DICKENS	68	\$299,190	\$30,038	\$329,228
DIMMIT	263	\$476,547	\$74,485	\$551,032
DONLEY	293	\$613,524	\$305,892	\$919,416
DUVAL	299	\$655,526	\$201,717	\$857,243
EASTLAND	809	\$2,164,845	\$694,968	\$2,859,813
ECTOR	2,480	\$7,676,880	\$2,187,828	\$9,864,708
EDWARDS	56	\$66,349	\$31,062	\$97,411
ELLIS	1,528	\$4,637,582	\$1,264,229	\$5,901,811
EL PASO	12,385	\$36,223,527	\$7,596,295	\$43,819,822
ERATH	464	\$1,436,969	\$482,746	\$1,919,715
FALLS	410	\$1,416,794	\$181,778	\$1,598,572
FANNIN	1,049	\$3,599,675	\$798,914	\$4,398,589
FAYETTE	684	\$2,262,360	\$631,470	\$2,893,830
FISHER	229	\$1,072,070	\$137,683	\$1,209,752
FLOYD	246	\$615,389	\$172,476	\$787,865
FOARD	133	\$388,480	\$67,576	\$456,056
FORT BEND	9,850	\$29,513,684	\$6,729,075	\$36,242,758
FRANKLIN	222	\$821,907	\$253,955	\$1,075,861
FREESTONE	1,310	\$4,650,191	\$1,056,256	\$5,706,447
FRIO	662	\$1,379,683	\$413,994	\$1,793,676
GAINES	99	\$136,313	\$30,672	\$166,985
GALVESTON	5,279	\$19,912,377	\$4,341,884	\$24,254,261
GARZA	166	\$298,969	\$119,864	\$418,833
GILLESPIE	622	\$1,703,986	\$786,894	\$2,490,880

COUNTY	HEALTHSELECT PARTICIPANTS	HEALTHSELECT PLAN PAYMENTS	PHARMACY PLAN PAYMENTS	TOTAL HEALTH PAYMENTS IN COUNTY
GLASSCOCK	9	\$70,048	\$11,875	\$81,923
GOLIAD	307	\$1,169,285	\$272,354	\$1,441,639
GONZALES	442	\$2,090,809	\$474,778	\$2,565,587
GRAY	818	\$3,172,987	\$650,225	\$3,823,212
GRAYSON	2,076	\$7,626,907	\$2,050,350	\$9,677,257
GREGG	1,885	\$6,027,348	\$2,017,825	\$8,045,173
GRIMES	814	\$2,627,622	\$788,916	\$3,416,538
GUADALUPE	1,377	\$4,071,296	\$1,442,230	\$5,513,527
HALE	1,305	\$4,240,801	\$901,864	\$5,142,665
HALL	188	\$626,717	\$239,808	\$866,525
HAMILTON	153	\$645,200	\$191,881	\$837,081
HANSFORD	43	\$89,955	\$37,354	\$127,308
HARDEMAN	384	\$1,272,528	\$457,554	\$1,730,082
HARDIN	1,415	\$4,072,912	\$1,614,127	\$5,687,039
HARRIS	43,438	\$147,851,202	\$34,770,396	\$182,621,597
HARRISON	749	\$1,992,698	\$788,516	\$2,781,214
HARTLEY	51	\$146,157	\$33,718	\$179,875
HASKELL	210	\$390,018	\$226,443	\$616,461
HAYS	10,890	\$35,651,557	\$9,609,042	\$45,260,599
HEMPHILL	64	\$222,910	\$77,239	\$300,149
HENDERSON	2,261	\$6,835,000	\$2,170,956	\$9,005,956
HIDALGO	10,199	\$22,412,930	\$5,178,362	\$27,591,292
HILL	804	\$2,461,396	\$797,641	\$3,259,036
HOCKLEY	1,338	\$4,430,043	\$1,216,888	\$5,646,931
HOOD	606	\$2,567,018	\$1,135,355	\$3,702,373
HOPKINS	686	\$1,858,134	\$667,308	\$2,525,442
HOUSTON	2,400	\$7,482,350	\$1,682,746	\$9,165,096
HOWARD	2,039	\$6,616,520	\$1,646,097	\$8,262,617
HUDSPETH	101	\$169,804	\$69,291	\$239,096
HUNT	784	\$2,485,051	\$822,190	\$3,307,241
HUTCHINSON	559	\$1,492,368	\$545,451	\$2,037,819
IRION	43	\$55,329	\$17,803	\$73,131
JACK	191	\$642,135	\$179,950	\$822,085
JACKSON	229	\$462,308	\$208,266	\$670,573
JASPER	1,140	\$4,244,746	\$823,949	\$5,068,695
JEFF DAVIS	204	\$652,300	\$171,281	\$823,581
JEFFERSON	7,425	\$24,819,322	\$6,391,894	\$31,211,215
JIM HOGG	144	\$397,103	\$147,726	\$544,828
JIM WELLS	760	\$2,121,754	\$583,419	\$2,705,173
JOHNSON	1,744	\$6,939,074	\$1,758,949	\$8,698,023
JONES	741	\$2,027,924	\$534,256	\$2,562,180
KARNES	848	\$2,096,789	\$634,053	\$2,730,841
KAUFMAN	2,600	\$8,559,746	\$2,187,632	\$10,747,379
KENDALL	429	\$878,507	\$654,498	\$1,533,005
KENEDY	8	\$8,063	\$91	\$8,154

COUNTY	HEALTHSELECT PARTICIPANTS	HEALTHSELECT PLAN PAYMENTS	PHARMACY PLAN PAYMENTS	TOTAL HEALTH PAYMENTS IN COUNTY
KENT	26	\$32,754	\$17,382	\$50,136
KERR	1,780	\$5,270,777	\$1,895,157	\$7,165,933
KIMBLE	229	\$943,750	\$221,505	\$1,165,255
KING	19	\$139,002	\$21,536	\$160,538
KINNEY	107	\$244,463	\$123,160	\$367,623
KLEBERG	419	\$1,025,898	\$314,144	\$1,340,042
KNOX	117	\$353,163	\$105,588	\$458,751
LAMAR	1,433	\$5,186,643	\$1,555,836	\$6,742,479
LAMB	302	\$756,231	\$176,602	\$932,833
LAMPASAS	281	\$839,814	\$462,736	\$1,302,550
LASALLE	349	\$611,786	\$209,262	\$821,049
LAVACA	1,023	\$2,162,427	\$941,025	\$3,103,453
LEE	992	\$3,307,730	\$1,009,651	\$4,317,380
LEON	976	\$3,499,804	\$947,241	\$4,447,045
LIBERTY	1,860	\$6,141,119	\$1,439,916	\$7,581,036
LIMESTONE	2,506	\$11,628,657	\$2,578,527	\$14,207,184
LIPSCOMB	40	\$62,512	\$13,664	\$76,176
LIVE OAK	316	\$986,483	\$279,874	\$1,266,357
LLANO	405	\$1,180,013	\$851,812	\$2,031,825
LUBBOCK	20,938	\$73,952,265	\$18,278,523	\$92,230,787
LYNN	201	\$715,117	\$136,279	\$851,396
MADISON	216	\$626,224	\$200,254	\$826,479
MARION	3,484	\$9,988,002	\$3,300,841	\$13,288,843
MARTIN	61	\$120,513	\$27,069	\$147,582
MASON	994	\$3,672,684	\$710,771	\$4,383,456
MATAGORDA	137	\$230,845	\$181,638	\$412,482
MAVERICK	87	\$162,766	\$53,703	\$216,469
MCCULLOCH	120	\$270,030	\$138,898	\$408,928
MCLENNAN	527	\$3,131,595	\$430,216	\$3,561,811
MCMULLEN	599	\$1,124,805	\$259,421	\$1,384,226
MEDINA	846	\$2,326,873	\$689,979	\$3,016,853
MENARD	46	\$78,904	\$16,557	\$95,461
MIDLAND	2,471	\$8,912,533	\$2,666,624	\$11,579,157
MILAM	236	\$644,333	\$207,499	\$851,832
MILLS	79	\$185,662	\$57,919	\$243,581
MITCHELL	731	\$2,044,987	\$423,431	\$2,468,418
MONTAGUE	412	\$1,502,733	\$384,890	\$1,887,623
MONTGOMERY	6,315	\$25,292,661	\$5,805,132	\$31,097,793
MOORE	244	\$969,387	\$298,614	\$1,268,001
MORRIS	325	\$1,546,371	\$433,445	\$1,979,816
MOTLEY	74	\$397,239	\$34,926	\$432,165
NACOGDOCHES	4,328	\$14,659,375	\$3,774,781	\$18,434,156
NAVARRO	1,717	\$5,162,812	\$1,754,233	\$6,917,045
NEWTON	208	\$401,634	\$216,082	\$617,716
NOLAN	771	\$2,340,799	\$579,248	\$2,920,047

COUNTY	HEALTHSELECT PARTICIPANTS	HEALTHSELECT PLAN PAYMENTS	PHARMACY PLAN PAYMENTS	TOTAL HEALTH PAYMENTS IN COUNTY
NUECES	6,810	\$20,979,403	\$5,239,254	\$26,218,657
OCHILTREE	73	\$544,058	\$79,892	\$623,951
OLDHAM	95	\$161,112	\$157,021	\$318,133
ORANGE	1,401	\$4,841,445	\$1,443,846	\$6,285,291
PALOPINTO	476	\$1,642,600	\$448,273	\$2,090,872
PANOLA	465	\$1,520,133	\$638,470	\$2,158,603
PARKER	1,594	\$5,294,193	\$1,611,100	\$6,905,293
PARMER	92	\$219,998	\$50,080	\$270,078
PECOS	950	\$1,811,356	\$446,238	\$2,257,594
POLK	2,085	\$7,070,881	\$1,494,615	\$8,565,496
POTTER	3,389	\$10,040,611	\$2,793,213	\$12,833,824
PRESIDIO	244	\$335,590	\$187,020	\$522,610
RAINS	146	\$375,853	\$123,621	\$499,474
RANDALL	4,739	\$13,544,331	\$4,657,698	\$18,202,029
REAGAN	18	\$21,572	\$12,031	\$33,603
REAL	96	\$204,545	\$85,930	\$290,475
RED RIVER	447	\$1,728,835	\$489,680	\$2,218,515
REEVES	265	\$496,862	\$190,804	\$687,665
REFUGIO	231	\$1,105,448	\$240,032	\$1,345,479
ROBERTS	34	\$28,757	\$9,084	\$37,841
ROBERTSON	231	\$607,734	\$202,433	\$810,166
ROCKWALL	760	\$3,081,019	\$756,534	\$3,837,552
RUNELS	292	\$970,830	\$218,298	\$1,189,128
RUSK	757	\$1,804,555	\$764,886	\$2,569,441
SABINE	187	\$565,675	\$176,238	\$741,914
SAN AUGUSTINE	207	\$817,206	\$218,789	\$1,035,994
SAN JACINTO	892	\$3,861,579	\$1,430,437	\$5,292,015
SAN PATRICIO	1,498	\$5,068,901	\$1,160,569	\$6,229,470
SAN SABA	244	\$591,539	\$201,201	\$792,741
SCHLEICHER	42	\$93,135	\$27,651	\$120,786
SCURRY	1,072	\$4,248,571	\$883,043	\$5,131,614
SHACKELFORD	173	\$751,444	\$192,077	\$943,521
SHELBY	379	\$1,033,926	\$296,335	\$1,330,261
SHERMAN	51	\$366,296	\$92,715	\$459,011
SMITH	5,104	\$14,495,592	\$5,244,900	\$19,740,492
SOMERVELL	141	\$364,791	\$151,307	\$516,098
STARR	826	\$1,656,398	\$433,856	\$2,090,254
STEPHENS	389	\$1,757,706	\$329,912	\$2,087,618
STERLING	40	\$100,982	\$28,192	\$129,174
STONEWALL	68	\$180,436	\$36,462	\$216,898
SUTTON	94	\$307,675	\$83,666	\$391,341
SWISHER	359	\$1,208,470	\$220,503	\$1,428,973
TARRANT	15,910	\$57,588,535	\$15,401,538	\$72,990,073
TAYLOR	6,675	\$21,997,531	\$5,926,981	\$27,924,513
TERRELL	57	\$130,564	\$41,398	\$171,962

COUNTY	HEALTHSELECT PARTICIPANTS	HEALTHSELECT PLAN PAYMENTS	PHARMACY PLAN PAYMENTS	TOTAL HEALTH PAYMENTS IN COUNTY
TERRY	406	\$1,553,705	\$296,972	\$1,850,677
THROCKMORTON	86	\$198,750	\$83,562	\$282,311
TITUS	612	\$2,088,662	\$629,859	\$2,718,521
TOM GREEN	4,913	\$14,647,907	\$4,158,313	\$18,806,220
TRAVIS	59,746	\$198,215,789	\$61,687,787	\$259,903,576
TRINITY	1,713	\$6,604,474	\$1,515,851	\$8,120,325
TYLER	989	\$3,099,931	\$683,415	\$3,783,345
UPSHUR	476	\$1,340,835	\$487,984	\$1,828,819
UPTON	56	\$94,247	\$49,123	\$143,370
UVALDE	1,241	\$3,240,909	\$824,593	\$4,065,502
VALVERDE	719	\$1,220,643	\$417,421	\$1,638,064
VANZANDT	1,004	\$2,915,180	\$982,412	\$3,897,592
VICTORIA	2,125	\$5,448,057	\$1,997,588	\$7,445,645
WALKER	11,588	\$45,816,647	\$9,602,096	\$55,418,743
WALLER	411	\$1,518,988	\$294,740	\$1,813,728
WARD	283	\$927,111	\$203,168	\$1,130,279
WASHINGTON	1,776	\$6,280,359	\$1,469,198	\$7,749,558
WEBB	3,615	\$8,986,908	\$1,924,087	\$10,910,995
WHARTON	1,415	\$5,303,356	\$1,357,200	\$6,660,555
WHEELER	121	\$536,280	\$93,848	\$630,128
WHICITA	6,538	\$23,884,930	\$6,817,630	\$30,702,560
WILBARGER	2,321	\$9,454,563	\$2,574,241	\$12,028,805
WILLACY	483	\$861,326	\$403,306	\$1,264,632
WILLIAMSON	16,804	\$60,777,563	\$16,383,265	\$77,160,827
WILSON	678	\$2,099,964	\$617,878	\$2,717,842
WINKLER	82	\$216,711	\$67,438	\$284,149
WISE	789	\$3,240,388	\$745,398	\$3,985,786
WOOD	823	\$2,640,218	\$778,238	\$3,418,457
YOAKUM	59	\$196,823	\$36,294	\$233,118
YOUNG	376	\$734,337	\$420,444	\$1,154,780
ZAPATA	127	\$302,951	\$75,873	\$378,824
ZAVALA	297	\$701,853	\$187,543	\$889,396
GRAND TOTAL FOR TEXAS	498,124	\$1,638,523,776	\$440,063,493	\$2,078,587,270



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