Controlling Costs and
Preventing Fraud
in the Texas Employees
Group Benefits Program

Fiscal Year 2006

The Key to Cost Containment

Prepared by
The Employees Retirement System of Texas

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Executive Director

Group Benefits Program

HealthSelect
Cost Containment and Anti-Fraud
FY06*

1.	Considered Charges plus Estimated Cost Avoided**		$5,985,771,899
2.	Estimated Cost Avoided		
	a. Case Management	1,155,918	
	b. Behavioral Health Claim Review	117,984	
	c. Utilization Management	18,750 691	20,024,593
3.	Considered Charges		5,965,747,306
4.	Less Ineligible Charges		1,379,988,378
5.	Eligible Charges		4,585,758,928
6.	Less Reductions to Eligible Charges		
	a. Prescription Drug Program Charge Reductions & Coverage Management	236,396,081	
	b. Hospital Claim Reductions	441,064,200	
	c. Charges Exceeding Professional Allowed Charges	802,346,258	
	d. Other Facility & Professional Discounts & Reductions	378,013,647	
	e. Rebundling	7,148,753	
	f. Medical Copayments & Deductibles	94,674,790	
	g. Prescription Drug Program Cost Sharing	159,139,032	
	h. Coinsurance	135,739,749	
	i. Subrogation	4,124,272	
	j. Coordination of Benefits - Medicare	888,928,233	
	k. Coordination of Benefits - Regular	14,052,302	3,161,627,314
7.	Benefit Payments		$1,424,131,614*

* Amounts taken from (1) the Annual Statistical Report prepared by BlueCross BlueShield of Texas and (2) the Prescription Drug Program Review prepared by Medco Health Solutions, Inc.

** Includes (a) those charges that the plan would have incurred if provider discounts, cost sharing or other cost containment features such as Utilization Management, Case Management or Behavioral Health Claim Review programs were not in place. An example of a reduction would be an inpatient prior authorization request for 4 days in an inpatient facility and only 3 days are preauthorized as medically necessary. The expense that was not incurred as a result of the denied day is seen as avoided costs.

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The Key to Cost Containment

Controlling Costs and Preventing Fraud in the Texas Employees Group Benefits Program

This report provides information concerning the effectiveness and efficiency of managed care cost containment and fraud detection, investigation and prevention practices in the Texas Employees Group Benefits Program (GBP), in accordance with Texas Insurance Code, sec. 1551.061. In Fiscal Year 2006 (FY06), these practices saved about $4.56 billion of the almost $6 billion in HealthSelect charges considered for GBP payment, a reduction of 76 percent.

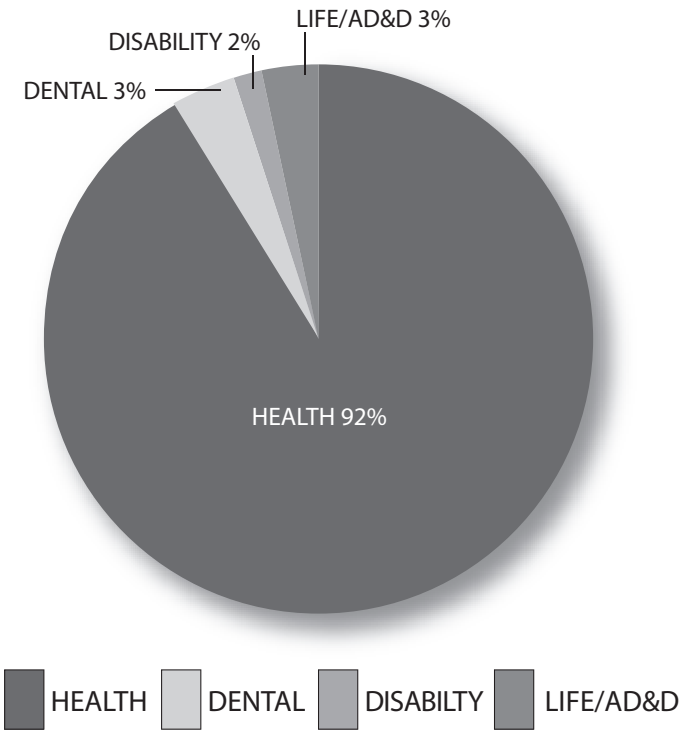
Introduction

The Employees Retirement System of Texas (ERS) administers the GBP on behalf of (a) all state agency employees, retirees, and elected officials and their eligible dependents, and (b) employees and retirees of certain institutions of higher education and their eligible dependents. The GBP offers a number of insurance programs, including health, dental, life, accidental death and dismemberment, short- and long-term disability and long-term care. The GBP also offers the option of the TexFlex Program, flexible reimbursement accounts that allow employees to save and use pre-tax dollars for health and dependent care expenses not covered by health insurance.

A significant portion of the almost $1.79 billion in total expenditures for all coverages provided under the GBP in FY06 was attributable to health coverage for members and their covered dependents. In FY06, health coverage expenditures (including Health Maintenance Organizations (HMO) premiums) totaled over $1.65 billion, or more than 92 percent of all GBP expenditures.

With such a large financial investment in the health and well being of its members, it is imperative for ERS to employ cost containment and fraud detection, investigation and prevention (anti-fraud activities) in the GBP.

GBP Expenditures, FY06



I. Executive Summary

Because employee health coverage is a significant and escalating expense for most employers, it is essential that a great deal of attention be given to minimizing and controlling health care claims cost. The programs used to control cost are collectively referred to as health care cost containment. The purpose of this report is to provide a general discussion of the development, evolution and achievements of cost containment programs included under the GBP. The report also provides actual and estimated avoided costs associated with cost containment programs under HealthSelect℠ of Texas (HealthSelect) for FY06, as well as an overview of anti-fraud efforts.

ERS and its contracted administrators engage in an ongoing process to review, revise and update cost containment programs and benefit structures. As discussed in this report, the health care charges incurred by HealthSelect participants are substantially greater than the amount for which the plan is actually liable. Cost containment programs are utilized to appropriately limit the health care charges that are actually paid by the plan by:

a) identifying the most cost effective means of delivering health care through case and claims review and utilization management;

b) eliminating charges which are not eligible for reimbursement under the plan;

c) negotiating and applying discounted provider reimbursement rates;

d) transferring liability to other payers responsible for coverage; and

e) distributing the cost between the plan and the member in accordance with the provisions of the plan.

The financial impact of cost containment on the GBP is significant, resulting in a 76 percent reduction in charges considered for payment under HealthSelect in FY06.

A. Financial Highlights

A number of strategies have been implemented to contain GBP costs.

1. Screening for Ineligible Charges

This program avoids substantial costs through initially screening out ineligible charges, a process that saved the GBP more than $1.38 billion or 23 percent of the $6 billion in charges considered for payment under HealthSelect in FY06. This process screens for items such as duplicate claims, late charges, charges for non-covered services or facilities, charges for services that are not medically necessary, and amounts in excess of benefit maximums.

2. Reductions to Eligible Charges

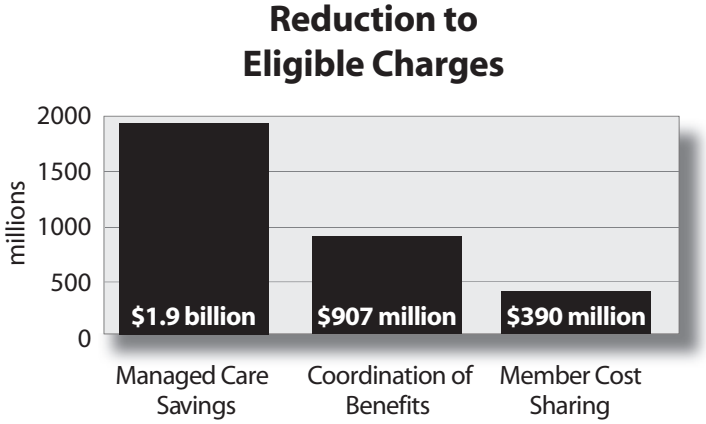
After ineligible charges are screened, a series of cost management strategies are applied to the remaining eligible charges. This process saved the GBP a total of $3.16 billion or about 69 percent of the remaining eligible charges of $4.59 billion in

30 Years of Cost Containment Experience: The beginning

1970s Cost containment efforts include benefit maximums, exclusion and limitation of ineligible charges, hospital charge audits, hospital price negotiations, provider fee profiles, fraud control and member cost-sharing (e.g., deductibles and coinsurance).

FY06. The top three cost management strategies, ranked in order of their impact on HealthSelect eligible charges, are:

- Managed care costs avoided (59 percent of the reduction to eligible charges);
- Coordination of benefits (29 percent of the reduction to eligible charges); and
- Cost sharing with members (12 percent of the reduction to eligible charges).



a. Managed Care Costs Avoided

Managed Care is a comprehensive approach to healthcare delivery that encompasses planning, educating, monitoring, coordinating, and controlling quality, access, and cost. Managed care systems consider the interests of patients, providers, and payers or use financial incentives and management controls to direct patients to providers who are responsible for giving appropriate care in cost-effective treatment settings.

More than half of the reduction to eligible charges in FY06–or about $1.9 billion in cost reductions–came from HealthSelect's managed care arrangement. The managed care arrangement avoids costs for the plan through the contract administrators' negotiation of discounted reimbursement rates with providers and administration of utilization and coverage management techniques. A large network like HealthSelect creates negotiating power in the health care marketplace and affords the state, the GBP and the members the benefit of "wholesale" prices. The $1.86 billion in avoided costs represents the discount taken off the "retail" prices that doctors, hospitals, pharmacies and other facilities would have charged the GBP and its members had they not been covered by a managed care network.

Dollars Saved	Managed Care Savings
$802 million	Charges Exceeding Professional Allowed Charges under Contract
441 million	Hospital Claim Reductions
378 million	Other Facility & Professional Discounts & Reductions
236 million	Prescription Drug Program Charge Reductions & Coverage Management
$1,857 billion	Total

b. Coordination of Benefits

The second largest reduction to eligible HealthSelect charges comes from coordination of benefits. When retired participants reach age 65 and become eligible for Medicare, GBP health benefits become secondary, which means that the state of Texas only considers paying a retiree's health claim after the Medicare program has paid on the claim. In FY06, coordination with the Medicare program saved the GBP nearly $889 million, while coordination with other insurance programs and subrogation saved another $18 million.

1980s – Pharmacy cost containment
Established discounted Retail Pharmacy Reimbursement program, Retail Pharmacy network and reimbursement levels: Maximum Allowable Cost (generics) and Average Wholesale Price (brand-name drugs).

Dollars Saved	Coordination of Benefits
$889 million	Coordination of Benefits – Medicare
14 million	Coordination of Benefits – Regular
4 million	Subrogation
$907 million	Subtotal

c. Cost Sharing

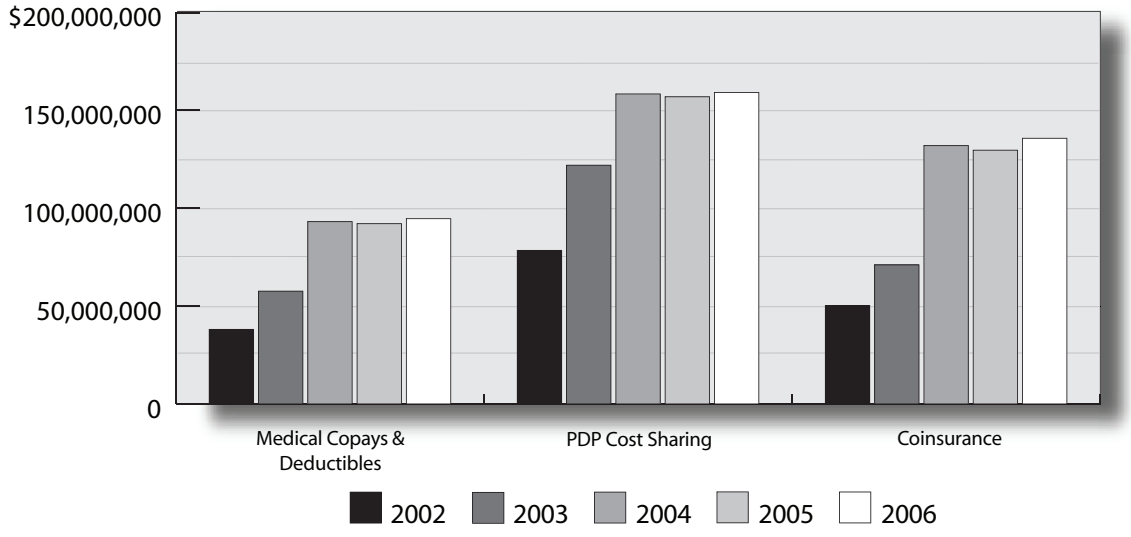
Cost sharing by members significantly reduces costs to the GBP. Roughly 8 percent or about $389 million in eligible charges were paid in FY06 by members through coinsurance, deductibles, and office visit and prescription drug copays.

Increases in member cost sharing impact the demand for health care services in two ways. First, increased cost sharing encourages members to use less expensive services. One cost containment feature of the GBP prescription drug program is the use of a "three-tier" copayment structure. The member cost is based on the tier in which the drug is placed. Under this structure, generic drugs are in the first tier, preferred name brand drugs are in the second tier and higher cost, non-preferred name-brand drugs are in the third tier. The health plan avoided costs when many allergy sufferers switched to over-the-counter medications after more expensive brand name non-sedating prescription drugs were moved to the costlier third tier of coverage.

Dollars Saved	Cost Sharing
$159 million	Prescription Drug Program Cost Sharing
136 million	Coinsurance
94 million	Medical Copayments & Deductibles
$389 million	Subtotal

Increased cost sharing also influences the total volume of health care services used. Although demand for health care services continues to rise, increased cost sharing has slowed the trend. It is important to note that as prices for health care services and supplies continue to increase, the proportion of the eligible charges covered through deductibles and copayments paid by the members will decline since those amounts are expressed as fixed dollar amounts rather than as a

Member Cost Share between FY02 and FY06



1980s – Health plan cost containment efforts increase
Implemented preadmission testing, restricted weekend admissions, and evidence of insurability requirements for late enrollers. Added second surgical opinions, outpatient surgery review and extended care benefits.

percentage of charges. As an example, consider a $50 prescription drug which is available to the member for a $25 copayment. The member and the plan share the cost on a 50%/50% basis. However, if the price for the drug increases to $55 while the copayment remains unchanged, the member's share drops to about 45% while the plan's share increases to 55%. This phenomenon, which is described as member cost share leveraging, combines with increasing prices and rising utilization to generate continuing increases in health plan costs. The adverse impact of member cost share leveraging must be offset through periodic increases in the amount of the deductibles and copayments. Alternatively, the impact of the leveraging can be minimized through use of coinsurance (which is expressed as a percentage of charges) rather than as a fixed dollar amount.

B. Contract Monitoring

ERS also has created a comprehensive monitoring and compliance program, which provides contract oversight of GBP vendors through daily contract management activities, including monthly administrative performance reports, annual claims audits and HMO operational reviews, annual site visits, ongoing policy reviews, waste and abuse identification and recovery programs, and the grievance and appeals process. (Chapter 5 provides more information on ERS contract monitoring programs.)

C. Fraud Prevention, Detection, and Investigation (Anti-Fraud) Activities

Fraud prevention, detection and investigation are integral components of the overall ERS cost containment strategy. A few examples of ERS anti-fraud measures include:

- Annual auditing of provider claims for incorrect coding, double-billing, or falsified data;
- Conducting special waste and abuse identification and recovery audits of 100 percent of all HealthSelect medical claims;
- Working with the Pharmacy Benefit Manager (PBM) to identify and intervene in cases where abuse of certain drug categories is suspected;
- Investigating potential misrepresentation on "evidence of insurability" applications; and
- Investigating potentially ineligible dependents through routine eligibility audits. (Chapter 6 of this report provides additional information.)

D. Contract Negotiations

The GBP realized substantial cost avoidance as a result of implementation of new, improved contracts with the vendors that administer its health insurance and pharmacy benefit plans that became effective for FY06. These avoided costs will be realized throughout the life of the 3-year contract that will extend though FY08.

1. Administrative Costs Avoided

ERS will save more than $79 million for the three-year period (FY06/08) as a result of a competitive bidding process to select a third-party administrator for HealthSelect medical benefits. BlueCross BlueShield of Texas (BCBSTX) was awarded the contract for the three-year period beginning September 1, 2005.

2. Utilization Review/Disease Management

As part of the new contract negotiated with the third-party administrator, ERS was able to expand the range of disease management programs. BCBSTX now integrates utilization review, wellness

1990s – Mail service offers new way to lower pharmacy cost
Increased prescription drug copayment and implemented limitations on early prescription refills. Established Mail Service Delivery Program.

promotion, and disease management programs to coordinate benefits, services, and education across the health care continuum. Utilization review assesses the delivery of medical services to determine if the care provided is appropriate, medically necessary, and of high quality. Utilization review may include review of appropriateness of admissions, services ordered and provided, length of stay, and discharge practices, both on a concurrent and retrospective basis. Disease Management is a strategy of delivering health care services using interdisciplinary clinical teams, continuous analysis of relevant data, and cost-effective technology to improve the health outcomes of patients with specific diseases. It includes self-care management techniques, patient education, and provider training. Disease management provides individualized care plans based on clinical guidelines to manage individuals with treatable chronic diseases.

3. **Pharmacy Benefit Management**

   ERS will save almost $48 million for the three-year period (FY06/08) as a result of a competitive bidding process to select a PBM for the HealthSelect Prescription Drug Program (PDP). Medco Health Solutions, Inc. (Medco) was awarded the contract for the three-year period beginning September 1, 2005. For a more detailed discussion of PBM issues in the GBP, see Appendix 3 starting on page 57.

4. **Data Integration**

   As part of the recent contract negotiations process, both BCBSTX and Medco agreed to a greater level of data integration with one another on behalf of the GBP. The purpose of data integration is to enhance disease management and utilization review, and to prevent, detect and investigate fraud and abuse. Data integration allows predictive modeling to proactively identify and reach out to participants, based on group-specific utilization, complications and gaps in care. An assigned Registered Nurse case manager, the Blue Care Advisor (BCA), functions as a single point of contact to integrate the various aspects of medical care management. Additionally, certified diabetes educators, licensed professional counselors and masters-prepared social workers complement the clinical team. Information is gathered from various sources, including Health Risk Assessment data, pharmacy data, claim data, and information from the Personal Health Manager.

   The predictive modeling tool applies a clinically developed, severity-adjusted predictive algorithm that addresses comorbid patients as well as their uncomplicated peers and assigns participants to a single, mutually exclusive clinical risk category. Participants are categorized by several key indicators, such as degree of disease progression, number and type of conditions from healthy to catastrophic, cost of claims adjusted by age/sex and severity for a given population or individual care management index, disease progression and gaps in care to identify participants most likely to benefit from care management interventions. Through the risk stratification process, participants in the selected risk level groups receive a call from the BCA who conducts a telephonic interview to identify participant needs or gaps in care. Depending on the results of the telephonic interview, the participant may be referred to other voluntary care management programs based on identified participant needs.

1990s - Introduction of managed care networks
Implemented hospital precertification and disincentives/penalties for improper utilization.
Established managed care networks and primary care physician referral requirements.
Added Resource-Based Relative Value Scale (RBRVS).

E. Legislative Initiatives

ERS implemented the following legislative initiatives during FY06.

1. **Medicare Part D Subsidy**

   Beginning January 1, 2006, Medicare eligible individuals were allowed to enroll in a prescription drug program that is paid in part by the federal government. As an incentive for ERS to maintain retiree prescription drug coverage, Medicare will pay ERS a retiree drug subsidy (RDS) for eligible retirees who stay enrolled under GBP drug plan coverage. The legislature established the ERS appropriation for group insurance for FY06-07 in anticipation of the RDS that ERS would collect during the biennium. ERS began collecting the subsidy during FY06. Based on current projections, ERS will collect a subsidy of about $19 million for prescription drug claims incurred by Medicare eligible retirees during FY06 once all payments have been made by the federal government.

2. **Opt-Out**

   New legislation created an incentive program to encourage certain GBP members with equivalent health insurance coverage to waive GBP coverage. Members opting out of the GBP will be provided a monthly payment of up to $60 toward optional coverages (such as dental care) in lieu of the state contribution toward health coverage. This program was implemented September 1, 2006. For the first year of this program, a total of 265 new members elected to opt-out of the program resulting in avoided costs of approximately $650,000.

3. **Nurse Practitioner Pilot Project**

   Another legislative initiative directed ERS to establish a pilot on-site nurse practitioner program at the Austin headquarters of the Texas Commission on Environmental Quality. Some employers who have established on-site clinics have realized a reduction in health plan costs. The clinic opened for business on March 16, 2006. ERS will report early results for this program to the 80th Legislature by December 31, 2006. (Refer to Section II.B.5, Legislative Initiatives, for a summary of the preliminary findings.)

4. **Health Savings Account Study**

   HB 2772 directed ERS to study the long-term impact on the GBP and the feasibility of implementing a health reimbursement account or health savings account program and high deductible health plan. ERS spent much of 2006 working with Milliman, an international consulting firm that was retained to conduct the study. The findings of the study will be presented to the Governor and the 80th Legislature by December 31, 2006. (Refer to Section II.B.6, Legislative Studies, for a summary of the preliminary findings.)

F. Conclusion

During FY06, the health care cost trend moderated somewhat. However, continued increases in the cost and utilization of health care (an ongoing trend throughout the nation) will lead to further increases in the cost of HealthSelect as well as the HMOs. This, in turn, will require that ERS, in partnership with the State of Texas, maintain its ongoing in-depth analysis of GBP health plan structures and cost management programs in coming years as it works to balance the needs of the members with available revenue.

2000s - Prescription Drug Program managed separately
Carved out prescription drug program from HealthSelect and awarded contract to Medco, who administers mail order program with no dispensing fee. Added incentives for generic drug and mail order pharmacy utilization. Implemented prior authorization.

II. General Discussion of Cost Containment and Anti-Fraud Practices

A. What is Health Plan Cost Containment?

The term cost containment is used in this document to describe the extensive efforts by ERS to control the overall cost of its employee benefit plans through comprehensive administrative procedures, which ensure that only appropriate claims and expenses are paid. This is accomplished through:

- cost sharing with covered members;
- excluding ineligible charges;
- using provider discounts and reductions;
- subrogation;
- vendor audits;
- receiving pharmacy rebates;
- contracting with HMOs;
- monitoring vendor administrative results;
- preventing, detecting and investigating fraud;
- coordinating benefits with other plan sponsors and Medicare;
- integrating medical and pharmacy data to better identify and control chronic conditions;
- promoting a healthier lifestyle among plan participants; and
- working with disability income recipients to shorten their period of disability thus reducing their disability and medical costs.

ERS has developed a comprehensive cost containment strategy in conjunction with the medical benefits administrator (BCBSTX), Pharmacy Benefit Manager (Medco), and HMOs, as well as the Legislature, consulting actuaries (Rudd & Wisdom, Inc.), an independent auditor, law enforcement, other state agencies, members and the provider community. Each group plays a role in controlling the costs of the GBP.

B. Review of FY06 Cost Containment Initiatives

As a result of the selection of administrators through competitive bidding projects conducted during FY05, ERS achieved major reductions in health care administrative costs and the cost of pharmacy benefits and implemented promising new cost containment initiatives for FY06. In addition, ERS implemented several new programs and conducted studies of initiatives that may generate savings in the future.

1. Administrative Costs Avoided

During FY05, ERS conducted competitive bidding to select a third party administrator to provide administrative, network management, and utilization review services for the HealthSelect medical benefits. Two leading administrators submitted highly competitive proposals, both of which would have reduced administrative costs for HealthSelect during FY06/08.

2000s – Members pick up increased share of health plan costs
Increased deductibles, coinsurance maximums, and copayments. Changed eligibility provisions for health coverage.

ERS awarded the contract to BCBSTX after concluding that its proposal would provide the best combination of cost efficiencies and operational, network management, programmatic and system capabilities. The new contract reduced administrative costs by more than $79 million during the three-year contract term that started September 1, 2005.

2 . Utilization Review, Disease Management

In addition to the avoided administrative costs achieved through the contract negotiations with BCBSTX, ERS was able to improve utilization, wellness promotion, and disease management processes at no additional cost. The new contract with BCBSTX integrates utilization review, wellness promotion, and disease management programs into one cohesive medical care management program known as Blue Care Connection. This new initiative coordinates benefits, services, and education across the health care continuum – from wellness and prevention to disease and case management.

3. Pharmacy Benefit Management Costs Avoided

ERS also conducted competitive bidding during FY05 to select a PBM to provide pharmacy benefit management services for the HealthSelect PDP for FY06/08. This project also proved to be extremely beneficial to the program with five vendors submitting highly competitive proposals. ERS selected Medco to provide PBM services for HealthSelect, resulting in avoided costs of almost $48 million over three years. The Medco proposal was not only less expensive than the other vendors, but it also provided the best combination of cost efficiencies and operational, management, programmatic and system capabilities.

4. Medicare Part D

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) created a new Medicare prescription drug program known as Part D. Under Part D, which became effective January 1, 2006, Medicare-eligible individuals may enroll in a program that is partially paid for by the federal government. The benefits are provided through private prescription drug plans that compete based on cost and benefits. As an incentive for ERS to maintain retiree prescription drug coverage, the federal government will pay ERS a retiree drug subsidy (RDS) for eligible periods during which it provides prescription drug benefits that equal or exceed those provided under Part D. During the 2005 Legislative Session, ERS worked with the Legislative Budget Board (LBB), the Governor, and the 79th Legislature to fully consider all options available as a result of the implementation of Part D. After careful consideration, it was decided that continuation of the current prescription drug coverage for Medicare-eligible retirees was the best option for FY06/07. This approach had the multiple advantages of (a) providing coverage superior to Part D, and (b) avoiding the confusion that Part D created for many retirees, while (c) reducing the cost of prescription drug coverage for the state and the members through the RDS. Based on current projections, ERS expects to recover about $53 million during the biennium. This amount is consistent with that which was anticipated by the Legislature in setting the appropriation for the biennium.

5. Legislative Initiatives

The 79th Legislature adopted legislation designed to create new opportunities to save money under the GBP. ERS implemented several programs and is in the process of implementing others.

a. Incentive programs to waive GBP health coverage

Senate Bill 1863, House Bill 417, and Senate Bill 1 provide certain GBP mem-

bers with incentives to waive GBP health coverage. The LBB estimated that the incentive program would save approximately $8.4 million in state funds (All Funds) during FY06/07.

- **TRICARE**

  HB417 directed ERS to establish an optional TRICARE Supplement Plan (TSP) so that members who are eligible for the TRICARE Military Health System could elect to participate in such plan in lieu of participation in the GBP health coverage.

  Under the bill, the state would pay for 100 percent of the cost of the member's coverage and 50 percent of the cost of coverage for the member's dependents for each member making such an election. ERS conducted a competitive bidding project designed to select a qualified carrier to underwrite the optional TSP. The project did not generate any proposals meeting the qualifications set forth in HB417. Accordingly, implementation of the TSP was deferred pending reconsideration by the legislature. It should be noted that Congress recently passed legislation that prohibits an employer from providing incentives to encourage employees to opt out of employer health insurance coverage in favor of TRICARE.

- **Opt-Out**

  Effective September 1, 2006 ERS implemented an opt-out program under which members who are covered under another health plan providing equivalent coverage may waive GBP health coverage and receive a monthly contribution up to $60 to be applied to the purchase of GBP optional coverages. Of the 658 members who elected the Opt-Out Credit, 393 had waived coverage prior to the implementation of the opt-out program. Therefore, the program resulted in waiver of coverage by an additional 265 members. Assuming those members who newly elected the Opt-Out Credit represent average risk, the state will save approximately $650,000 during FY07.

b. Nurse Practitioner Pilot Program

House Bill 952 directed ERS to implement a pilot program to "make available a licensed advanced practice nurse to provide authorized on-site health services at a selected location to state employees who choose to make use of the services." The purpose of this pilot program is to determine if the availability of an on-site nurse can "reduce the cost of health care and increase the wellness and productivity of state employees." ERS implemented the pilot program at the Austin headquarters of the Texas Commission on Environmental Quality (TCEQ). On March 16, 2006, the clinic opened and the nurse saw her first patient. Three potential groups could have benefited from the Nurse Practitioner pilot program: TCEQ employees, the agency, and the GBP. The TCEQ employees who used the clinic came out ahead, as they saved the cost of a co-pay and gave the nurse overwhelmingly positive feedback on clinic surveys. Although absenteeism data was not collected from TCEQ, the agency benefited from productivity gains in the preliminary cost benefit analysis, based on employee time savings from using the on-site clinic rather than leaving to go to the doctor. As to whether the nurse practitioner clinic reduced the cost of health care to the GBP, a longer-term claims analysis is needed before this determination can be made. BCBSTX provides claims data as part of its contractual agreement with ERS. However, after less than nine months of data collection, it is premature to draw a conclusion on savings at this stage of the

pilot program. A full report will be provided to the 80th Legislature in December of 2006. For a copy of the report , go to **www.ers.state.tx.us** or contact ERS.

6. Legislative Studies

The 79th Legislature enacted legislation directing ERS to engage in studies to examine the cost-effectiveness of programs that could be implemented in the future.

a. Health Savings Accounts

HB 2772 directed ERS to evaluate the long-term impact of implementing a health reimbursement account (HRA) program or a health savings account (HSA) and high deductible health plan program (HDHP) as a part of the GBP on:

- future costs and benefits of all health care plans included in the GBP;
- participant access to quality health care;
- provider availability; and
- any other issue the system determines is relevant to the continued stable and efficient operation of the GBP, considering the demographic, geographic, and socioeconomic characteristics of program participants.

ERS retained a consultant, Milliman Actuaries and Consultants, to conduct the study mandated by HB 2772. A summary of the recommendations includes the following:

1. Consider introducing HSA with a HDHP on an optional basis not sooner than FY09.
2. Plan design should include the following:
   a. Provide a plan that is actuarially equivalent to HealthSelect (including account contribution)
   b. Deductible close to the allowed minimum
   c. Annual indexing of employer account contribution
3. Employee premium contributions based on composite costs of Consumer-Driven Health Plan (CDHP) and HealthSelect.
4. Enrollment goals that consider participant characteristics and final communication plan.
5. Communication Plan
   a. Enrollees in CDHP understand their choice.
   b. CDHP participants are encouraged to seek appropriate care when needed.
6. Utilize a single account administrator.

A full report will be provided to the 80th Legislature in December of 2006. For a copy of the report, go to **www.ers.state.tx.us** or contact ERS.

b. Workplace Wellness Initiative

The Texas Department of State Health Services (DSHS) worked closely with BCBSTX to develop a worksite wellness pilot program. The worksite wellness pilot program's objective was to identify risky behaviors and encourage employees to eat healthier, increase their level of physical activity, help reduce stress, lower blood pressure and cholesterol, and quit smoking. The program's aim was to focus on assisting employees with achieving and maintaining their optimal health status. ERS will carefully follow this pilot in order to determine its impact on members of the GBP.

7 . Data Integration

Pursuant to the new contracts effective September 1, 2005, both BCBSTX and Medco have agreed to a greater level of data integration with one another on behalf of the GBP. The programs being used to accomplish the integration and to

contain costs within the GBP, including preventing potential fraud or abuse, will be the following:

a. Blue CareLink

This program is an innovative integration of the medical and disability management programs. Initiated at ERS' request, the program philosophy is based upon early identification and outreach to injured or ill participants in order to optimize health benefits and minimize or possibly prevent disability; and

b. Blue Care Connection

The program is designed to identify and contact participants proactively based on specific utilization and disease parameters. The program combines predictive modeling tools with the traditional elements of medical care management (case management, utilization management, and disease management) and health advocacy components to create a care management strategy that is sensitive to the needs of the individual participant. **Refer to Section IV for a more detailed description of the Blue Care Connection program.**

III. Financial Results of Cost Containment and Anti-Fraud Practices for FY06

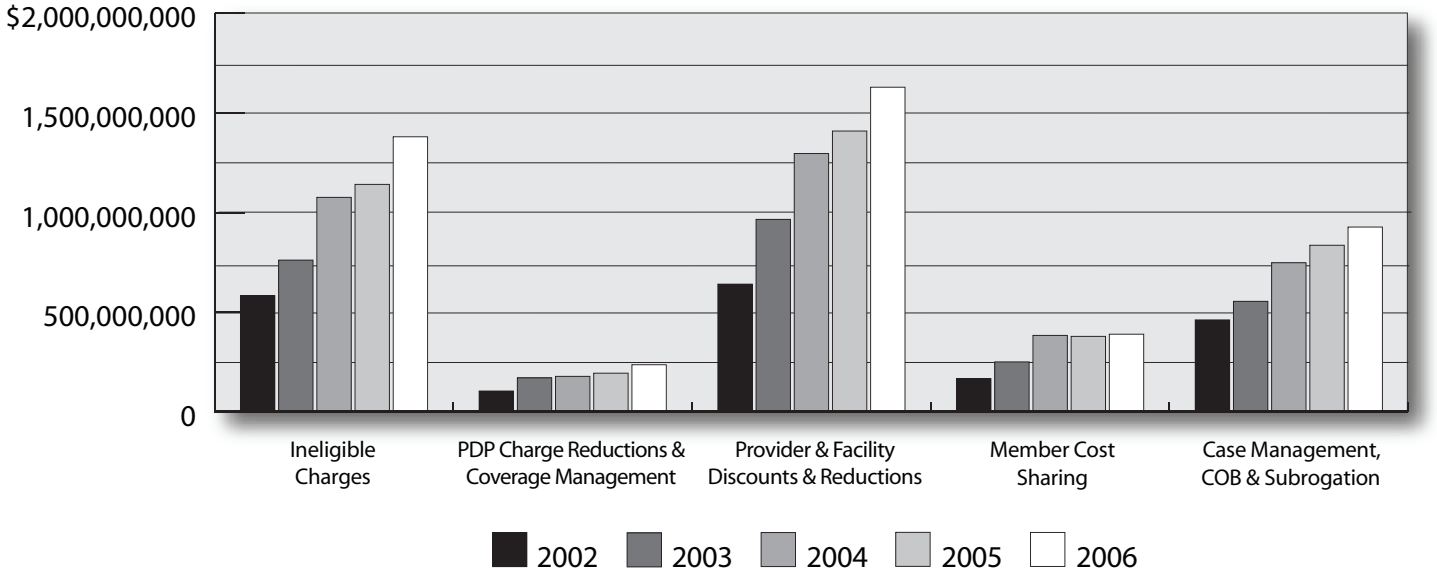
Under HealthSelect, almost $6 billion of charges were considered for payment during FY06. Due to cost containment and anti-fraud features, about $4.56 billion of considered charges were not paid under the plan. The $1.42 billion of benefits paid represents approximately 24 percent of the considered charges, or avoided costs of more than 76 percent.

Based on the actual results for FY04, FY05 and FY06, the benefit revisions implemented in FY03 avoided more than was expected. This is an extremely favorable development, given the complex interaction of the changes and the volatile health care cost environment.

The greater-than-expected cost avoidance allowed the health program to complete FY06 in a strong financial condition. These changes, together with further cost containment steps and contractual improvements discussed elsewhere in this report, are expected to result in lower than expected cost to the state and the members for the FY06/07 biennium.

This section presents and discusses the actual and estimated reductions in charges resulting from ERS' cost containment and anti-fraud practices under HealthSelect for FY06. The financial information discussed in this section of the report was developed based on information prepared by BCBSTX and Medco and presented in the chart on page 18 and on the inside of the front cover. It should be noted that the financial information presented herein includes data with respect to all state agency and higher education members enrolled in HealthSelect.

HealthSelect Cost Containment
Five Year History



Group Benefits Program

HealthSelect
Cost Containment and Anti-Fraud
FY06*

1.	Considered Charges plus Estimated Cost Avoided**		$5,985,771,899
2.	Estimated Cost Avoided		
	a. Case Management	1,155,918	
	b. Behavioral Health Claim Review	117,984	
	c. Utilization Management	18,750 691	20,024,593
3.	Considered Charges		5,965,747,306
4.	Less Ineligible Charges		1,379,988,378
5.	Eligible Charges		4,585,758,928
6.	Less Reductions to Eligible Charges		
	a. Prescription Drug Program Charge Reductions & Coverage Management	236,396,081	
	b. Hospital Claim Reductions	441,064,200	
	c. Charges Exceeding Professional Allowed Charges	802,346,258	
	d. Other Facility & Professional Discounts & Reductions	378,013,647	
	e. Rebundling	7,148,753	
	f. Medical Copayments & Deductibles	94,674,790	
	g. Prescription Drug Program Cost Sharing	159,139,032	
	h. Coinsurance	135,739,749	
	i. Subrogation	4,124,272	
	j. Coordination of Benefits - Medicare	888,928,233	
	k. Coordination of Benefits - Regular	14,052,302	3,161,627,314
7.	Benefit Payments		$1,424,131,614*

* Amounts taken from (1) the Annual Statistical Report prepared by BlueCross BlueShield of Texas and (2) the Prescription Drug Program Review prepared by Medco Health Solutions, Inc.

** Includes (a) those charges that the plan would have incurred if provider discounts, cost sharing or other cost containment features such as Utilization Management, Case Management or Behavioral Health Claim Review programs were not in place. An example of a reduction would be an inpatient prior authorization request for 4 days in an inpatient facility and only 3 days are preauthorized as medically necessary. The expense that was not incurred as a result of the denied day is seen as avoided costs.

Reductions to "Charges Considered"

Included among the cost containment processes are certain steps that reduce the total charges considered, described below:

1. **Estimated Cost Avoided**

   Cost management programs enabled the plan to avoid approximately $20 million in estimated charges. The costs avoided associated with these programs resulted in a reduction in charges considered under the plan.

   Reductions to charges considered are as follows:

Programs	Costs Avoided
Case management	$ 1,155,918
Behavioral health claim review	117,984
Utilization management	18,750,691
Total	$ 20,024,593

- **Case Management:** In 1993, the case management program was upgraded to accept referrals from a variety of medical sources, not just the pre-certification program, as was previously the case. Case management services were broadened to include oncology, high-risk obstetrics, diabetes and rehabilitation, in addition to traditional large case management for catastrophic head and spinal cord injuries.

  Also, the criteria for case management have been redeveloped, and case managers have received more specialized training to promote increased effectiveness.

- **Behavioral Health Claim Review:** The behavioral health claim review program is a retrospective activity that reduces or rejects charges for hospital days or entire admissions that are not precertified or subsequently found to be medically necessary. As a percentage of total charges, the reductions associated with this program declined as the managed care network expanded and the associated cost reduction programs matured. Behavioral health claim review is declining as a percentage of total charges because increased management of psychiatric and substance abuse claims is producing fewer inappropriate admissions.

- **Utilization Management:** The utilization management program includes preauthorization and prospective review for elective inpatient hospital admissions, extended care services, and transplant predeterminations. Cases failing the initial review criteria are referred to physicians for peer review before final determination. The utilization management program also includes:

  - referral management;
  - concurrent review;
  - voluntary second surgical opinions;
  - discharge planning and retrospective review to confirm medical necessity; and
  - physician compliance with program requirements.

2. **Screening for Ineligible Charges**

   The charges under consideration for payment are first screened for any ineligible charges that may be included. Ineligible charges include such items as duplicate claims, late charges, and charges for non-covered services, charges for which there is incomplete documentation, charges incurred when coverage was not in effect, charges incurred in facilities not under contract, charges for services which were not medically necessary, and amounts in excess of benefit maximums. In FY06, considered charges included $1.38 billion of ineligible charges. The following summarizes the aggregate results of this step of the process:

Charges Reviewed	Costs Avoided
Charges considered	$5,985,771,899
Ineligible charges	(1,379,988,378)
Total eligible charges	$4,585758,899

3. **Determination of Benefit Payments for Eligible Charges**

Once claims have been screened for ineligible charges, the eligible charges are then paid under the provisions of the plan. In determining benefit payments, eligible charges are subjected to reductions based on contracted fee arrangements with providers, rebundling protocol, copayments, deductibles, and coinsurance. The eligible charges also are processed against the provider fee profile, and payments are further adjusted to reflect coordination of benefits when participants are covered under Medicare or other health insurance plans.

Reductions to Eligible Charges
HealthSelect FY06

Eligible charges		**$4,585,758,899**
Less Reductions to Eligible Charges		
Prescription Drug Program Charge Reductions & Coverage Management	$236,396,081	
Hospital Claim Reductions	441,064,200	
Charges Exceeding Professional Allowed Charges	802,346,258	
Other Facility & Professional Discounts & Reductions	378,013,647	
Rebundling	7,148,753	
Medical Copayments & Deductibles	94,674,790	
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Coordination of Benefits - Regular	14,052,302	3,161,727,314
Benefit Payments		**$1,424,131,614**

For an explanation of the terms used in this table, see page 21.

What follows are descriptions of the reductions applied against eligible charges, as outlined in the table on page 20:

Prescription Drug Program (PDP) Charge Reductions and Coverage Management – PDP charge reductions represent the costs avoided from retail and mail price discounts. PDP coverage management includes concurrent and retrospective utilization review, point-of-sale edits, prior authorization of certain drugs, dose optimization and quantity limitation programs and pharmacy audits.

Hospital Claim Reductions – Hospital claim reductions represent the total costs avoided associated with Diagnosis Related Groups (DRGs), per diem and negotiated fee arrangements. The interactive effect between DRGs and precertification and concurrent review also is reflected in this reduction.

Charges Exceeding Professional Allowed Charges – The part of the professional charges by physicians or facilities presented for payment that are above the contractually agreed upon level.

Other Facility and Professional Discounts and Reductions – These discounts and reductions are attributable to additional contractually agreed upon reductions to the original billed amount.

Rebundling – Rebundling is a method by which a number of related procedures which were originally billed separately are combined to be paid in the most cost-effective manner.

Medical Copayments – Copayments represent the member's share of the cost of an office visit.

Prescription Drug Program (PDP) Copayments – The PDP cost sharing includes prescription drug copayments, deductibles and payments required when a member opts for a brand drug when a generic is available.

Deductibles – The deductible is a set dollar amount which must be paid by the member before the health plan begins making payments on claims.

Coinsurance – Coinsurance is the percentage the member is responsible for paying on a given claim.

Subrogation – The subrogation program allows the plan to recover certain amounts paid on behalf of a participant who has rights of recovery against a third party for negligence or any willful act resulting in injury or illness to the participant. Typically, such recoveries occur in connection with automobile accidents for which a third party is found liable.

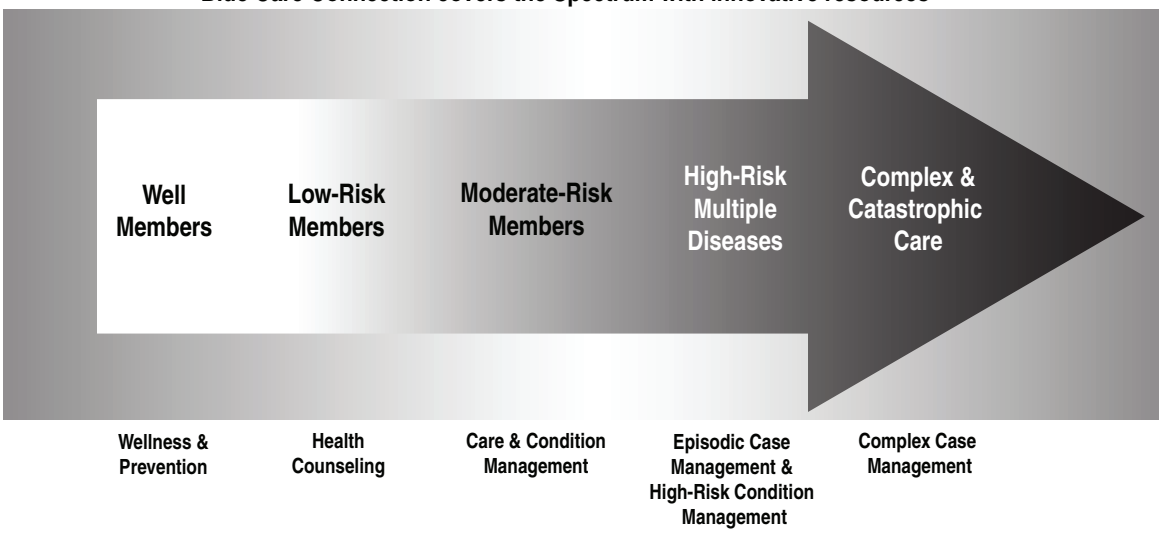
Coordination of Benefits-Medicare – Medicare Coordination of Benefits (COB) is the process by which the health plan reviews claims and assigns a portion of the required claim cost to Medicare according to the member's coverage under that plan.

Coordination of Benefits-Regular – Regular COB is the process by which the health plan reviews claims and assigns a portion of the required claim cost to one or more other insurance plans according to the member's coverage under the other plan(s).

IV. Blue Care Connection

The Wellness Spectrum

Blue Care Connection covers the Spectrum with innovative resources



Wellness programs increase awareness and personal accountability in members to support healthy lifestyle choices.
Health Counseling includes user-friendly online tools and telephone-based services to assist members in identifying and tracking their health.
Care Management ensures that members with acute care medical situations receive coordinated care.
Episodic & High-Risk Condition Management Program targets specific medical conditions for which a Condition Management program exists.
Complex Case Coordination supports members experiencing acute, late-stage and catastrophic events. The collaborative process includes evaluating, coordinating and monitoring services to meet the individual's health care needs to promote quality.

A. Program Description

Blue Care® Connection (BCC) is a voluntary program that integrates all of BlueCross BlueShield of Texas' medical care management components into one care management program. BCC coordinates benefits, services and education across the health care continuum – from wellness and preventive care to disease management and case management. The BCC program transitioned the original medical care management program to an integrated, participant-centric model in FY06. BCC combines the traditional elements of medical care management with health advocacy to create a care management strategy that is sensitive to the needs of the individual participant. The program is designed to proactively identify and reach out to participants, based on HealthSelect utilization patterns, complications, and gaps in care.

1. **Blue Care Advisor** - An assigned Registered Nurse case manager, the Blue Care Advisor (BCA), functions as a single point of contact at BCBSTX to integrate the various aspects of medical care management. Additionally, certified diabetic educators, licensed professional counselors and masters-prepared social workers complement the clinical team.
2. **Data Mining Tools** - Some of the other data mining tools include:
   - Health Risk Assessment data;
   - Medical Claims data;

- Pharmacy data;
- Laboratory data;
- the Care Management System; and
- the Personal Health Manager.

3. **Data Mining Capabilities** - The extensive data mining capabilities focus on:
   - HealthSelect specific case-mix distribution;
   - comparative analyses with multiple populations;
   - individual profiles; and
   - identification of gaps in care/treatment opportunities.
4. **Predictive Modeling Tools** - Potential program participants are primarily identified via the predictive modeling tool using research-based logic, which provides an analysis of claims data and predicts which participants may benefit from outreach.

B. Components of Blue Care Connection

1. **Wellness Initiative Tools** - Wellness and preventive care initiatives include targeted participant mailings and outreach calls regarding key preventive screenings and disease specific services, such as:
   - *Newborn Packet*: Distributed to parents of newborns to encourage immunization compliance and well-child visits.
   - *12- and 18-Month Immunization Birthday Cards*: Distributed to parents at their children's one year birthday and at 18 months to encourage immunization compliance and well-child visits.
   - *12-Year Immunization Birthday Card and Letters*: Birthday cards are distributed to parents and the participant in the month of the child's 12 year birthday to encourage immunization compliance.
   - *Women's Birthday Card*: Distributed to females 40 and older in their birthday month to encourage preventive screenings and immunizations.
   - *Men's Birthday Card*: Distributed to males 50 and older in their birthday month to encourage preventive screenings and immunizations.
   - *Breast and Cervical Cancer Mailing*: Distributed to female participants 20-64 years of age who have not had a Pap smear within the previous three years, and to participants 51-69 years of age who have not had a mammogram within the previous two years.
   - *Outbound Calling Program*: Female participants ages 20-64 who have not had a Pap smear within the previous three years and participants ages 51-69 who have not had a mammogram within the previous two years are contacted to encourage preventive screenings.
   - *Pneumonia Brochure*: Distributed to all participants age 65 and older and participants ages two to 64 with a chronic disease, such as asthma, diabetes and/or congestive heart failure, to encourage pneumococcal and influenza vaccinations.
   - *Colon Cancer Brochure*: Distributed to participants age 50 and older who have not had a colon cancer screening within the previous 12 months, to encourage preventive screenings.

Blue Care Connection
Preventive Care Interventions
Cumulative PY06
9/1/05 – 8/31/06

91,910	**Birthday Cards to Women Age 40+** • Breast and Cervical Cancer Screening • Clinical and Self Breast Exam • Thyroid Exam • Bone Density Test
49,449	**Birthday Cards to Men Age 50+** • Clinical Prostate Exam
3,337	**Childhood/Adolescent Immunization Reminders**
5,127	**Newborn Packets**
149,823	**Total**

2. **Health Counseling** - Health counseling services designed to promote and enhance self-care, such as:
   - 24/7 NurseLine
   - Health Risk Assessment
   - Personal Health Manager

Blue Care Connection
Cumulative PY06
9/1/05 – 8/31/06

Health Risk Assessments (HRA)

- **417 Total HRAs taken in PY06**

Nurseline

- **1,173 calls were received during the plan year**
- **67% of all calls were handled by a registered nurse**
- **93% seeking emergency room care were redirected to more appropriate care**

3. **Care Management** - Care management efforts designed to reduce inpatient admissions and readmissions consisting of:
   - Episodic Case Management;
   - BCA calls for preadmission and post-discharge counseling; and
   - Focused inpatient review conducted during concurrent review for selected diagnoses.
4. **Disease Management Programs** - Disease management programs targeting major chronic conditions and specific diagnoses such as:
   - Asthma
   - Chronic Obstructive Pulmonary Disease
   - Congestive Heart Failure
   - Coronary Artery Disease
   - Diabetes
   - End State Renal Disease
   - High Cholesterol
   - Hypertension
   - Low Back Pain
   - Metabolic Syndrome
   - Cancer
   - Rare conditions
5. **Complex Case Management** – A collaborative process that includes assessing, planning, implementing, coordinating, monitoring and evaluating options and services to meet the individual's health care needs through communication and available resources to promote quality, cost-effective outcomes.

1,799 cases managed resulting in avoided costs of $1,154,138 for PY05/06. These avoided costs were attributed to negotiated rates for visiting nurses, durable medical equipment purchase/ rental and prescription drugs.

6. **Special Beginnings® Program** – integrates high-risk pregnancy identification and the case management program. The success of the program is facilitated through frequent contact with the patient. The case manager will assess health and lifestyle factors, discuss prenatal care, educate and encourage use of other resources, as appropriate. The relationship built during the prenatal phase enhances communication regarding well-baby care following delivery. The program goals include improving clinical outcomes and potentially reducing the costs associated with pre-term and low-birth-weight infants.

The Importance of Prenatal Care - Prenatal care is extremely important not only from a healthy baby standpoint, but also from a cost containment standpoint. The approximate cost of a normal delivery (vaginal or C-Section) for HealthSelect participants ranges from $1,000 to $3,000. The average cost of a premature baby is approximately $60,000.

V. Contract Monitoring

The ERS contract monitoring program combines a number of strategies to provide oversight for contracts within the GBP to ensure that administrators and insurers that work for the GBP are executing their duties in accordance with their contractual obligations. The monitoring program is an important part of organizing and evaluating the success of the overall cost containment program. The contract monitoring program includes:

A. Annual Claims Audits and HMO Operational Reviews

ERS retains an independent claims auditor to perform audits of the HealthSelect medical and prescription drug plan administrators. Annually, statistically valid, random samples of claims are selected from electronic data files provided by each of the administrators for the GBP claims processed during the previous fiscal year. Each claim in the sample is tested for payment and processing accuracy, adherence to plan benefits, and timeliness of payment. The annual audits confirm eligibility, test claims data, review fraud controls and reconcile claim payments and accounting statements.

An independent outside audit recovered $7.1 million in billing errors in a four year period.

Financial accuracy rates for FY05 were found to be over 99 percent for medical claims and 100 percent for pharmacy claims. These rates exceed the industry standard of 99 percent. These audits result in recovery of overpayments and identify areas of administrative improvement, which are then monitored in subsequent audits.

Similar audits also are performed for the group term life, disability, accidental death and dismemberment, dental and flexible spending plans.

The independent auditor also performs an annual operational review of one or more HMOs. The nature of the operational review is such that it is required periodically rather than annually. The auditor examines medical claim administration for accuracy and timeliness of payment, internal controls, process edits for fraud and abuse, complaint and appeal procedures and employee training.

B. Waste and Abuse Identification and Recovery Audit Program

ERS engaged an independent auditor to identify and recover overpayments resulting from billing errors. This project examined all medical claims incurred between September, 2000, and August 31, 2004, and has resulted in the net recovery of $7.1 million for the program. This program helps ERS confirm that claim processing procedures are consistent with ERS policy and expectations. The information gathered through this program continues to be useful in revising current and developing new performance requirements for vendors. The audit for FY 2005 is presently underway.

C. Annual Site Visits

The ERS staff conducts annual on-site operational reviews with all GBP vendors to evaluate their facilities and staff, as well as to verify that proper procedures are followed in administering benefits for members enrolled in their plans. Site visits provide the opportunity to evaluate adherence to stated policies and procedures. The visits also allow ERS staff to meet and establish contacts with vendor operations staff so that future administrative issues can be resolved in a timely manner.

D. Monthly Administrative Performance Reports

ERS requires each vendor to provide monthly data on customer service results, claims processing timeliness, complaints, network stability, timeliness of document delivery and fraud/abuse detection.

E. Ongoing Policy Review

On a periodic basis, ERS and its consulting actuaries investigate suspected excess utilization and high cost services and supplies that are identified as potentially problematic. An example of a program improvement that has been achieved through this process is the more cost effective manner in which the program now reimburses physicians for specialty drugs dispensed in the physician's office. As a result of the identification of potentially excessive billing for such drugs, ERS worked with the medical plan administrator to implement a new reimbursement formula and new procedures to avoid over-billing by providers.

F. Nationwide and Worldwide Network Discounts

HealthSelect members receive the benefit of network discounts throughout the country and throughout the world when they utilize services outside of Texas. With the BCBSTX's Blue Card and BlueCard Worldwide, HealthSelect members receive the discounts that have already been negotiated with providers worldwide by the local Blue Cross plans. Members may call a toll free number or search online and obtain the location of a Blue Cross contracted provider anywhere in the world. This service protects our members from the fear of being billed for excessive charges and insures that the health plan receives the best available price.

G. Grievances and Appeals

The GBP statute provides for a formal grievance and appeals process for the insurance program. This process not only gives participants a valuable means of addressing concerns, but it also gives ERS another effective mechanism for contract monitoring. The process has the potential to bring to light contractual issues that may not be working as intended, which ERS then can correct. See Appendix 5 on page 61 for additional detail.

V. Fraud Prevention, Detection and Investigation (Anti-Fraud) Practices

A comprehensive anti-fraud program is an integral component of the overall cost containment strategy implemented by ERS. ERS requires vendors to be diligent in their efforts to prevent, detect and investigate fraud, abuse and other improprieties. In fact, ERS has developed various monthly, quarterly or ad hoc reporting requirements for all GBP vendors and holds ongoing bi-weekly operations meetings with the GBP's primary vendors, BCBSTX and Medco, to discuss issues, trends, or new opportunities for improving the administration of the GBP. ERS has taken the necessary steps to ensure that fraud and abuse of the program are prevented or reduced, and that violators are dealt with appropriately.

ABUSE means provider practices that are inconsistent with sound fiscal, business or medical practice, and result in an unnecessary cost to the program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes participant practices that result in unnecessary cost to the program.

This section discusses the anti-fraud practices of ERS and the primary vendors through the GBP: BCBSTX, Medco and six regional HMOs. Under the terms of their contracts, vendors must have advanced methods for preventing, detecting and investigating fraud and abuse, including but not limited to, highly automated systems and appropriate administration and oversight to prevent improper or fraudulent activities. This section also discusses ERS' internal anti-fraud processes.

FRAUD means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. 42 CFR 455.2

A. Joint ERS/Vendor Efforts

ERS has increased the emphasis on anti-fraud practices in the GBP by doing the following:

- Requiring an enhanced monthly narrative report on anti-fraud efforts to include information specific to the GBP;
- Having a Certified Fraud Examiner on ERS staff; and
- Establishing dedicated meetings for the purpose of discussing cost containment and anti-fraud activities. The meeting includes the ERS' Internal Auditor and representatives from the ERS Benefit Contracts, and Cost & Risk Management Divisions. Representatives from BCBSTX's Network Management, Special Investigations Department (SID) and staff from the BCBSTX Full Service Unit attend these meetings. (Refer to Appendix 4 for a complete description of the Special Investigations Department.)

  In response to requests from ERS for additional coordination of cost containment and anti-fraud efforts, both BCBSTX and Medco have applied additional resources to the GBP contract.

BCBSTX has:

- Initiated bi-monthly meetings concerning this topic. One is a cross-departmental anti-

fraud meeting on a corporate basis. The other meeting is a SID Advisory meeting internal to BCBSTX, which includes directors of various departments involved in administering the HealthSelect program.

- Assigned a dedicated data analyst to the GBP. The analyst evaluates our data, such as reviewing Emergency Room claims for indications of overutilization and analyzing pharmaceutical claims paid using medication administration codes. The analyst also includes the quarterly Pharmacy Benefit Manager High Utilization data in his analysis and any investigations.

Medco has:

- At ERS' request, initiated a High Utilization Intervention Program for GBP members designed to identify potential areas of fraud and abuse of prescription drugs.
- Provided quarterly data on GBP specific pharmacy utilization to BCBSTX.

B. ERS Processes

The contract provisions for each administrator or vendor establish requirements for anti-fraud programs. ERS conducts monthly meetings with BCBSTX to analyze the results of anti-fraud efforts, and to review and discuss trends, ongoing investigations and new developments that may affect the GBP.

All contract administration activities focus on minimizing fraud, waste and abuse, which are an ongoing priority in ERS' contract administration. Examples of specific measures include:

- BCBSTX Cost Containment meeting with SID as standing agenda item;
- Waste and Abuse Identification Audit;
- Annual audit;
- Grievance process;
- Evidence of Insurability Misrepresentation discovery program;
- Authorizing Medco to implement High Utilization Intervention; and
- Increased member education.

1. **Independent Auditor**

   ERS contracts on an annual basis with an independent auditor to review and examine the administrative activities of the HealthSelect third-party administrator and the HealthSelect pharmacy benefits manager. The auditor also reviews the operations of selected HMOs. ERS reserves the right to request further review of any audit finding, including any delays in patient referrals or terminations of coverage.

2. **Internal Grievance Process**

   ERS also has an internal grievance process for HealthSelect participants to appeal adverse decisions regarding claims adjudication, and other matters. In administering this function, ERS sometimes finds cases that appear to be questionable where the administrator is asked to investigate and resolve the matter.

3. **Evidence of Insurability Misrepresentation for Health Coverage**

   In June 2005, in response to a request from ERS, BCBSTX implemented the Evidence of Insurability (EOI) Misrepresentation Program for HealthSelect. The purpose of this program is to minimize GBP benefit payments for certain situations subject to exclusion. Under the provisions of the program BCBSTX works closely with ERS and Fort Dearborn Life Insurance Company (FDL), which administers the EOI process for HealthSelect, to identify potential misrepresentation on the EOI application. For those participants approved for coverage through the EOI process, BCBSTX monitors health claim activity during the first 18 months of coverage and shares claims files with FDL to use in their investigation process.

   The investigation process considers:

   - the potential that a claim could be the result of conditions that existed before the application was approved; and/or
   - the potential that a known material condition existed that may not have been disclosed at the time of application.

C. Medical Plan Processes

All of the processes involved in any vendor's administration include elements for anti-fraud practices by the vendor itself, providers and members. Due to the large percentage of GBP members enrolled in HealthSelect, anti-fraud practices within HealthSelect are the main focus of ERS. ERS requires BCBSTX to monitor plan expenditures and to be vigilant for any instance of fraud or other improprieties. BCBSTX uses a variety of systems, departments, and procedures to detect and prevent overcharges, unnecessary or extensive hospital confinements, unnecessary medical treatment or other health care provider abuses. In FY06, they included:

- Prepayment Claims Edits
- Health Care Management Division
- Special Investigations Department
- Prescription Drug High Utilization Analysis
- Post Payment Audits

The potential for fraud and abuse is not limited to healthcare providers but also may be attempted by GBP participants. ERS, under Section 1551.351, Texas Insurance Code, has the authority to employ a variety of disciplinary actions up to and including the expulsion of a participant who submits a fraudulent claim or who has defrauded or attempted to defraud any health plan offered under the GBP.

Examples of Fraud and Abuse

PROVIDER ISSUES

Falsifying Claims / Encounters

Alteration of a Claim

Incorrect Coding

Double Billing

False Data Submitted

Falsifying Services

Billing for Services / Supplies Not Provided

Misrepresentation of Services / Supplies

Substitution of Services

Other Issues

Kickbacks

Falsifying Credentials

Fraudulent Enrollment Practices

Fraudulent Third Party Liability (TPL) Reporting

Fraudulent Recoupment Practices

MEMBER ISSUES

(Fraud) Eligibility Determination Issues

Residency

Household Composition

Citizenship Status

Misrepresentation of Medical Condition

Failure to Report Third Party Liability (TPL)

In addition, a number of other measures are in place to prevent improper payment of claims, including, but not limited to, case management, utilization management, medical/surgical claim review, behavioral health and chemical dependency claim review, extensive eligibility edits, post-payment hospital reviews, reporting audits, pharmacy rebates, coordination of benefits and provider discounts. The various audits, edits and reviews applied to the medical and pharmacy claims greatly reduce the volume of claims that are evaluated for potentially fraudulent activity.

The measures described throughout this report reduce overall plan costs and enhance the ability of ERS and its vendors to detect potentially fraudulent activity.

1. Prepayment Edits

The current fraud, waste and abuse program begins with the numerous edits that are part of the BCBSTX claims processing system. Claim payments are subject to review based on the benefit payment allocated to the claim. Each processed claim is finalized with an explanation of benefits (EOB) that is mailed to the member and, if required, a provider summary that is included with the payment issued to the service provider. The provider summary will include reasons for the denial of benefits.

Within the claims processing system, numerous edits are designed to prevent payment of potentially fraudulent or abusive claims. The system checks that:

- The patient data matches the eligibility record.
- The diagnosis is reasonable in light of the patient's sex and age.
- The charges are reasonable for the services as described and coded on the claim.
- The payment amount does not exceed the billed amount.
- The payment amount does not exceed the contracted or allowable amount.
- Multiple service pricing and unbundled charges are processed in accordance with the TPA and industry standards.
- Global fees are applied to the services described on the claim.
- The claim is not a duplicate of a previous claim.

When the claim data fails to meet the requirements of these and other edits, the claims are pended or held for individual review by claims processing personnel, the medical review unit and/or the SID. The independent auditor tests the above mentioned prepayment edits as part of the annual claims audit and verifies that the edits are applied appropriately.

ERS Costs Avoided from Prepayment Claims Edits, FY06

Duplicate Charges	$988,545,118
Late Charges	155,667,441
Non-Covered Charges	103,939,563
Ineligible members[1]	6,261,309
Incomplete claim documentation[2]	125,242,468
Other	332,479
Total ERS Costs Avoided as a result of all Prepayment Claims Edits	$1,379,988,378

[1] *Members whose coverage has been terminated or who have never been covered on the policy.*

[2] *Includes late charges, insufficient claims information, etc.*

2. Health Care Management Division

BCBSTX's Health Care Management Division, through its medical staff, assists the SID with programs that are designed to identify providers who have treatment and billing patterns that indicate potential fraud and/or abuse. Such programs include detailed computer analysis, on-site audits, provider education programs, and scrutiny of providers subject to pre-payment review. The Health Care Management division reviews claims for coding, pricing (overcharging), and medical necessity issues.

A medical director routinely provides input to the SID regarding current practice patterns and best practice standards, and reviews issues concerning medical necessity, approved medical interventions and compliance with current medical policy. The medical director often assists the SID with on-site reviews of medical

records and interviews with suspect health care providers.

3. Special Investigations Department

ERS, through its contract with BCBSTX, has access to sophisticated research and fraud prevention tools. BCBSTX has a multi-layered anti-fraud program in place that is administratively monitored for effectiveness. Anti-fraud objectives are included in BCBSTX's operational and support programs. The Special Investigations Department identifies and investigates health care fraud, refers cases to law enforcement for criminal prosecution, recovers losses due to fraud, protects the assets of its customers, and creates a deterrence effect. The overall goal is to eliminate the source of the fraud (providers) rather than settling for a fraction of the loss and allowing the providers to remain in business.

a. Special Investigations Department (SID)

The SID is comprised of health insurance experts, data analysts, medically trained staff including registered nurses (RNs), a Medical Director, a former prosecutor and former law enforcement agents. An Investigative group and a Data Intelligence group are located in Texas. The SID intelligence group uses sophisticated data mining tools to identify leads regarding health care fraud schemes. If during the course of the investigation, fraud is not substantiated, the matter is referred to the Professional or Facility Provider Network Department to conduct additional provider training and guidance. The SID investigative groups use all available resources to develop leads into cases that can be referred to law enforcement for criminal prosecution. Not all cases investigated by the SID result in criminal prosecution. However, those cases not referred to law enforcement often involve issues of abuse for which there is high recovery potential. The SID works with the BCBSTX Legal and Provider Relations Departments to coordinate such matters as civil litigation and provider training/education.

b. ERS Dedicated Statistical Analyst

The Texas SID added a statistical analyst in FY06. The role of the dedicated analyst is to mine for data anomalies, identify potentially fraudulent schemes, and uncover abusive practices within the ERS account. Once anomalies, schemes, or possible abuses are identified, they are reviewed and researched to help explain their outlier status. Outliers that do not have reasonable explanations are referred to the Texas SID to be worked by the investigative staff to determine if fraud is occurring within the ERS program. The lead referrals are not clear cut evidence of fraud, but they do serve as an early indication that potentially fraudulent activity exists within a provider's/subscriber's practice. In other words, lead referrals are the beginning of an investigative trail, which may or may not end in fraudulent activity.

c. Predictive Modeling/Regression Analyses

Outliers are identified through predictive modeling. The predictive models use specialty based regression analyses, which predict what a provider should get paid based on individual billing practices compared to the billing practices of the specialty as a whole. The predictive models explain and model normal provider behavior, but also show those providers who are billing much more than the predicted amount. These providers are then researched as potential data leads.

In FY06, predictive models were created for the following specialties:

- Allergy;
- Cardiovascular Disease;
- Oncology;
- Physical Therapy; and
- Rheumatology.

These five models have generated eight lead referrals and have uncovered double billing and unbundling schemes.

d. Projects/Activity

Aside from predictive modeling, several other projects were started in FY06.

The Oncology J-Code Project looked at oncologists excessively billing for expensive injections. It focused on the top five highest paid J-Codes with at least a 20 percent increase in paid amount. The dosages are often complex, which could result in a higher risk of overpayment. J-Codes are codes used to report injectable drugs that are usually administered by a doctor and ordinarily cannot be self-administered. In many cases, these are very expensive specialty drugs used to treat cancer or rare diseases.

- The project identified 26 oncologists whose J-Code utilizations were excessive. All 26 were referred to the TX SID for investigation.
- Of these 26, eight providers were selected because they ranked as the top provider associated with certain J-Code billings. Claims histories for the top five ERS patients who received J-Code services from the top provider were extracted for medical review. These records were received and currently are being reviewed.

The Emergency Room **(ER) Hoppers Project** was created to address the abuse of emergency room benefits to obtain narcotics prescriptions. It focused on those members who have five or more visits to the ER over a 12-month span. Patients with visits to the ER for injury and poisoning, neoplasms, and diseases of the circulatory system were excluded from the analysis. Based on the analysis, those members with five or more ER visits were split into two categories; ER Hoppers and ER Abusers.

- ER Hoppers are those members who have visited three or more different ER facilities.
- An ER Abuser is a member who visits the ER five or more times, but generally goes to the same ER facility for each visit.

Both sets of members are being reviewed and researched to determine for lead referral. Those not chosen for lead referral will be referred to Blue Care Connection for counseling.

The **Foreign Claims Project** was started to identify ERS members who have received some form of non-covered plastic surgery abroad and billed the surgery under a covered service. Complete medical history was merged with the foreign claim to identify those patients who have no previous history and/or no follow up care to support the foreign claim diagnosis. Those patients with injury and poisoning diagnoses, birthing diagnoses, heart failure, and ER visits were excluded from the analysis.

In FY06, 40 members were identified as not having the proper medical history to support the foreign claim diagnosis. These members have been referred to the TX SID foreign claims specialist for investigation.

Data Intelligence/Claim Accuracy Audits

Claim accuracy audit programs are performed on a monthly or quarterly basis. These programs are supplemented by quality reviews of the claims processing personnel's work product by more senior personnel and supervisory staff. Potential fraud and abuse are often identified through these programs and reviews. As mentioned above, the SID intelligence group uses sophisticated data mining tools to identify leads regarding health care fraud schemes. The software programs used are IBM's Fraud and Abuse Management System (FAMS) and Statistical Analytical Software (SAS). The SID has an agreement with IBM and SAS to integrate these soft ware applications to produce a first-of-its-kind fraud detection platform. The new

platform enables the SID to detect emerging fraud patterns more quickly, across larger volumes of data, and with greater ability to filter out false positives so that investigative resources can be better allocated.

4. **Fraud Prevention Case Studies**

High Profile Case Activity

In October 2005, the owner of a medical facility in Houston, Texas was indicted by a Federal Grand Jury on 46 counts of mail fraud, insurance fraud, health care fraud and false claims for billings to insurance companies that totaled $16 million over six years. This individual is accused of claiming that he administered injections of costly drugs for the treatment of hepatitis C to patients who were self-administering the injections at home. He is also charged with unbundling the drugs Interferon and Ribavirin which are routinely sold and priced together in a kit. He has entered a Not Guilty plea and the trial date is pending. Four counts in the indictment involve ERS claims. The trial was scheduled for late October 2006.

While the SID mainly investigates provider fraud, there are occasions when member fraud is addressed. Such is the case with an ERS member who submitted falsified medical records to support fraudulent medical claims in order to claim more than $10,000 in reimbursement to which he was not entitled. SID went through great efforts in their investigation to include locating and contacting the alleged provider in Africa in order to prove that the claims were falsified. SID has worked with ERS Legal staff in an effort to remove the member from the health benefit roles of ERS. Additionally, SID is working with the Texas Department of Insurance, and the Dallas County District Attorney's Office is bringing criminal charges against the ERS member. By aggressively pursuing cases of health care fraud, SID's goals are to achieve a deterrent effect for others as well as protect the assets of BCBSTX and its customers.

5. **Providers on Review**

BCBSTX's Health Care Management Division, through its medical staff, assists the SID with programs that are designed to identify providers who have treatment and billing patterns that indicate potential fraud and/or abuse. Such programs include detailed computer analysis, on-site audits, provider education programs and the providers on prepayment review program. Health Care Management reviews claims for coding, pricing (overcharging) and medical necessity issues.

6. **Radiology Quality Initiative**

Outpatient Diagnostic Imaging Services

BCBSTX implemented a Radiology Quality Initiative (RQI) program October 1, 2004 to control high-tech diagnostic imaging utilization and costs through physician education and direction of services to the most appropriate and cost-effective setting.

The program manages utilization through education, providing regular mailing and doctor-to-doctor interaction regarding advances and standards in diagnostic imaging identifies utilization and cost trends associated with imaging and provides BCBSTX and ERS with detailed reporting. Compliance with RQI is required for the following outpatient diagnostic imaging services when performed in a physician's office, the outpatient department of a hospital, or a freestanding imaging center:

- Computer tomography (CT) scans
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiogram (MRA)
- Nuclear cardiology studies
- Positron emission tomography (PET) scans

When a physician wishes to order one of these tests, he/she must obtain an RQI number. Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient

surgery (hospital and freestanding surgery centers), or 23-hour observation are excluded from this requirement.

7. Prescription Drug High Utilization Analysis

The SID reviews prescription drug data from Medco to identify members with high utilization patterns in their prescription drug use such as:

- Employee drug addiction or abuse
- Doctor/pharmacy shopping schemes
- Script stacking/embedded scripts (multiple and/or overlapping prescriptions for narcotics)
- Drug diversion schemes
- Black market drug sales schemes
- Duplicate billing schemes
- Identity theft schemes
- Prescription forgery

This initiative is important not only in terms of identifying, investigating and preventing fraud, waste and abuse, but also in terms of helping to identify employees who may be addicted to narcotics and who, therefore, may pose a potential danger and/or liability to the group, their employees and the public in general.

8. Post-Payment Audits

In addition to the corporate, divisional, and local audits performed as a part of the quality assurance program, detailed audits are routinely performed on various claim types. Under the direction of the BCBSTX Hospital Review and Reporting Department, vendors are used to perform the following detailed claim audits and to recover any owed funds. In any case where abuse or intentional upcoding is suspected, data is forwarded to the SID for investigation and appropriate action.

Total Recoveries from Post Payment Vendor Audits, FY06

Concentra Audit[1]	$1,011,430
AIM Audit[2]	1,572,002
Total recoveries	$2,583,432

[1] Concentra audit includes DRG coding, appropriate billing, Home Infusion Therapy claims, Durable Medical Equipment claims, outpatient laboratory claims, other payor liability, etc.

[2] AIM Audit includes hospital credit balance audits

D. Prescription Drug Program Processes

Medco currently serves as the pharmacy benefit manager (PBM) for HealthSelect. Medco's responsibilities include detection and prevention of fraud in connection with HealthSelect pharmacy benefits. ERS requires Medco to monitor plan expenditures and to be vigilant for any instance of fraud or other improprieties. Medco uses a variety of systems, departments, and procedures to prevent, detect and investigate overcharges, including:

- Concurrent Detection/Prevention of Potential Fraud and Abuse;
- Retrospective Detection/Prevention of Potential Fraud and Abuse; and
- Pharmacy Audit Program.

Clinical rules are used to identify aberrant patterns of care and are applied both concurrently and retrospectively across patterns of patient care.

1. Concurrent Detection/Prevention of Potential Fraud and Abuse

Potentially fraudulent and abusive use of pharmacy benefits can be detected and avoided at the same time, using advanced point-of-sale and concurrent utilization review capabilities. Specifically, the point-of-sale system can be set up so that certain fields, such as member date of birth, are required for claims adjudication. Eligibility

checks and plan prescription limits (e.g., quantities, days supply, duplicate claim checks, etc.) further detect and preclude fraud and abuse.

Finally, as part of Medco's Coverage Management Program (formerly Managed Prior Authorization and Managed Rx Coverage), the advanced capabilities of the system can be used to leverage an "excessive utilization" rule category to detect and preclude fraud and abuse. "Excessive utilization" rules also are applicable and detect excessive use by drug and across drug categories. These rules consider numerous variables including the amount of drug, number of prescriptions, number of pharmacies, and/or number of prescribers over time.

2. Retrospective Detection/Prevention of Potential Fraud and Abuse

Under the terms of its ERS contract, Medco also uses its High-Utilization Management Program and the Pharmacy Audit Program to detect and prevent fraud and abuse.

- **High-Utilization Management Program**
  Fraud and abuse are detected retrospectively (after-the-fact) through the High Utilization Management Program. The High-Utilization Management Program operates under utilization-based clinical rules specifically designed to identify, document, and correct or deter cases of potentially excessive use or abuse.

  The High-Utilization Management Program is designed to identify patients who meet criteria indicative of excessive use or, in some cases, abuse. For example:

  - Patients' drug spending within a specified time period for all therapeutic drug categories;
  - Number of claims a patient incurred within a specified time period for all therapeutic drug categories;
  - Number of physicians a patient used within a specified time period for all therapeutic drug categories;
  - Number of pharmacies a patient used within a specified time period for all therapeutic drug categories; and
  - A query that examines a combination of claims, physicians, pharmacies and daily supply for a quarterly period within specific therapeutic categories with the potential for high abuse (e.g. narcotics, tranquilizers, etc.). Patients with cancer or AIDS drug markers are excluded.

3. Pharmacy Audit Program

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

a. Criteria for Auditing Retail Pharmacies
All pharmacies that participate in the PBM's networks are evaluated on a quarterly basis by the Fraud Detection System. The pharmacies identified for audit are prioritized according to potential recovery, and additional audits are scheduled as appropriate. This constant evaluation process provides the latest available profile for each provider pharmacy, allowing for timely and accurate analysis of dispensing patterns.

Pharmacies are selected for audit based on several criteria:

- **Deviant Pharmacies Identified by the Fraud Detection System** – Medco's proprietary system produces a dispensing profile for each participating pharmacy on a quarterly basis and benchmarks the profile against other participating pharmacies in the same area. This allows a comparison of the provider against their peers in order to identify outliers with the greatest potential recovery. Some of the major dispensing profile performance measures evaluated by the detection system are:
  - Average Ingredient Cost;
  - Drug Enforcement Administration submission;
  - Drug Mix (includes controls, compounds, targeted medications, etc.);
  - Generic Dispensing;
  - Package Size;
  - Reversal Rate;
  - Time/Date;
  - Usual and Customary Contribution; and
  - Utilization of Dispense As Written Codes.
- **High Volume Pharmacies** – Auditing pharmacies with a high claims volume allows a review of providers that represent a significant portion of ERS reimbursement dollars.
- **Professional Selection Audits** – These audits can result from a follow-up to a previous audit, an anonymous complaint, or information from a member. The audit investigators are encouraged to identify candidates based on their professional knowledge, experience, and insights.
- **Networking** – To meet the requirements of its ERS contract, Medco also identifies additional audit contacts through relationships established with state and federal regulatory and law enforcement agencies. They have worked with the Drug Enforcement Administration, the Federal Bureau of Investigation, and state and federal Attorneys' General offices to identify fraud. Information through the account team improves overall communication and can be a key tool in the identification of audit candidates, as well as providing additional information.

  The majority of audits are identified by the advanced Fraud Detection System. The Fraud Detection System utilizes sophisticated triggers or groups of triggers that lead to the initiation of both on-site field and desk audits. This complex system analyzes multiple deviant parameters to identify audit candidates, and the best method of approach is then determined.

b. Desk Audits

Many discrepancy types can be uncovered without conducting an on-site claims review. For example, key discrepancy types conducive to a desk audit include patient receipt of medications, physician authorization of medications billed, and inaccurate metric quantity submissions. Field audits are initiated when the potential issues cannot be resolved through the desk audit process or when a larger potential issue is identified.

The desk audit program complements the field audit process, allowing for proactive, concurrent, and retrospective claim review. A key component of the desk audit process includes a daily, targeted review of point-of-sale claims for accuracy. When inaccurate claims submissions are identified, the Pharmacy Audit group works with the participating provider to correct the claim prior to payment. The advantage to the daily claims review process is that the claim is corrected prior to

payment. As a result, when the claims cycle closes, the pharmacy receives the correct reimbursement and ERS is invoiced correctly.

c. Field Audits

Field audits integrate the overall performance management initiatives, reviewing many of the pharmacy's credentials, procedures, and compliance with the terms of the provider's agreement. The Field Audit Investigator conducts an in-depth analysis of claims reimbursed against the pharmacy's dispensed prescriptions and associated records.

At the conclusion of the audit, an exit interview is conducted with the pharmacist to ensure awareness of the issues identified during the audit. The audit investigator takes advantage of the one-on-one interaction with the pharmacist to provide direction and guidance to the provider, proactively addressing the discrepancies identified to prevent future inaccurate claim submissions.

A combination of field audits with targeted patient and physician confirmation letters allows independent verification of all three aspects of the prescription process: physician, patient and pharmacy. Patients and physicians are asked to review the accuracy of the medications reimbursed to the audited pharmacy, including drug names, strengths, quantities and dates dispensed or prescribed. Not only are these letters an important source of audit recovery, but they serve as a strong audit control that will help maintain the integrity of the prescription drug program by ensuring that reimbursed prescriptions are authorized by physicians and received by ERS participants.

Note about retail pharmacy audits: Plan sponsors generally require their PBM to conduct audits of retail pharmacies in order to guard against fraud. Retail pharmacies consider PBM audits to be intrusive, time-consuming and potentially unfair. They are particularly concerned with an auditing concept they refer to as "extrapolation." Audits are conducted based on statistically valid random sampling, with results "extrapolated" based on the findings of the audit. The results of the audit are extrapolated to all the pharmacy's business.

The ERS PBM, Medco Health, does not utilize the extrapolation method. Medco Audit Department performs analysis of claims data along predefined audit criteria in order to identify outlier pharmacies. Medco's audit approach is to use this type of analysis to identify the pharmacies with the greatest potential of inappropriate claim submissions. When discrepancies are identified, 100% of those recovered funds are returned to ERS. During FY06, a total of $663,851 dollars was returned to the GBP as a result of pharmacy audits.

Refer to Appendix 3 for additional information and recent developments regarding the GBP Pharmacy Benefit Program.

VI. Preview of Cost Containment Initiatives for FY07

A. Coordination of Benefits (COB) for Retail Prescription Drugs

Starting in November 2006, ERS implemented a new COB program. The purpose of this program is to identify those HealthSelect members who have other prescription drug coverage in addition to HealthSelect so that COB can be arranged. For example, a member may have coverage through a previous employer or as a retiree whose coverage should pay benefits prior to his or her GBP coverage. The PBM identifies this coverage to the network pharmacy, which asks the member for the prescription drug card for the other coverage. Once the other card is provided by the customer, the pharmacy adjudicates the claim and allocates the charges appropriately.

B. Promotion of Blue Care Connection (BCC)

ERS will work with the HealthSelect administrator to promote the various components of the Blue Care Connection program, including the Personal Health Manager, Health Risk Assessments (HRA), and the Blue Care Advisors. This effort will include statewide presentations on wellness and the importance of a healthy lifestyle. Many employers have been successful in reducing health care costs with similar efforts. For instance, HRAs identify medical conditions in the early stages when treatment is most effective.

C. Random Eligibility Audits

ERS will increase the number of audits conducted on health plan members to ensure only eligible participants are enrolled in the health plan. These audits will include Dependent Eligibility Audits, Qualifying Life Event Audits, and Evidence of Insurability Audits.

Appendices

Appendix 1

Glossary of Terms

24/7 Nurse Line – Confidential toll free number which members can call 24 hours a day/7 days a week to speak with a Registered Nurse, request or listen to one of 1,200 recorded messages regarding a specific health concern.

Blue Care Advisor – A clinician (i.e., Registered Nurse (RN), social worker (LMSW) or counselor (LPC) working within the Blue Care Connection program to promote healthy lifestyles through disease/condition management and behavioral modification coaching and education (i.e., rare diseases, impact conditions, excessive emergency room utilization for diagnoses which could be managed in a less intense setting, lacking recommended preventive care screenings, etc.). Serves as a single point of contact helping members navigate through the health care system.

Coinsurance – The participant's share of a covered medical expense, in addition to the deductible. The coinsurance is expressed as a percentage of the allowed charge. Under HealthSelect, a variety of coinsurance arrangements apply depending upon whether a participant is eligible for in-area or out-of-area benefits and whether he/she utilizes network providers.

Concurrent Review – Monitoring a patient's care while he/she is in the hospital. Concurrent review is designed to ensure that the patient remains in the hospital no longer than is necessary for the safe treatment of the medical condition.

Coordination of Benefits Provisions (COB) – A cost control mechanism by which two or more health plans (including Medicare) covering the same participant limit the aggregate benefits provided by all coverages to an amount which does not exceed 100 percent of the eligible expenses.

Deductible – The amount of eligible expenses that must be incurred by a participant before benefits become payable under the plan. Under HealthSelect, a variety of deductibles apply depending upon whether a participant is eligible for in-area or out-of-area benefits and whether he/she utilizes network providers. Effective September 1, 2003, a $50 deductible was applied to the PDP.

Diagnosis Related Groups (DRGs) – A method of hospital reimbursement under which the hospital is paid a specified fee (a DRG) based on the patient's diagnosis. The DRG is the only reimbursement to the hospital unless the case exceeds a certain length of stay or cost thresholds designed to recognize catastrophic cases. Under this arrangement, the hospital has a significant incentive for cost effective treatment.

Discharge Planning – A cost containment process that may be used to ensure that the patient stays in the hospital only as long as necessary and, once the patient is discharged, that ongoing care is rendered in an appropriate manner. This process may include a recommendation that the patient leave the hospital for home health care, skilled nursing care, hospice care, rehabilitation services or other treatment.

Extended Care Benefits – A cost containment technique to encourage substitution of skilled nursing facility care, home health care or hospice care for more expensive inpatient hospital care.

Fraud Control – A process utilized by a plan administrator to detect fraud in the submission of health benefit claims. Under HealthSelect, the plan administrator's claim processing personnel look for alteration of documents and verify the validity and accuracy of claims submissions. Computer edits are designed to detect duplicate claims. Situations involving a large dollar volume of claims for individual participants are reviewed for potential fraud.

Health Risk Assessment (HRA) – A questionnaire designed to elicit health history and lifestyle information from members in order to identify the need for outreach. The questionnaire is recommended for all members on an annual basis; but especially for new members with little or no claims history.

Hospital Charge Audits – Audits of hospital bills performed by the plan administrator to detect any overpayments. If overpayments are discovered, they are recouped from the hospital by collecting them directly or by netting them against future benefit payments.

J-Codes - Codes used to report injectable drugs that ordinarily cannot be self-administered and must be administered by a doctor. In many cases, these are very expensive specialty drugs used to treat cancer or rare diseases.

Office Visit Copayment – Amount participant pays for each office visit. Under HealthSelect, a participant is required to pay a $20 copayment for each office visit to a network primary care physician and a $30 copayment for each office visit to a network specialist. There is no other charge if other services are not performed on the participant for such visits.

Outpatient Surgery – A cost containment program designed to encourage utilization of outpatient treatment for certain surgical procedures in lieu of more expensive inpatient care.

PDP Copayment – Amount participants pay for each prescription under the Prescription Drug Program (PDP), the participant is required to pay a copayment for each prescription that is filled. The retail copayments were increased effective May 1, 2003, to $10 for Tier I drugs, $25 for Tier II drugs and $40 for Tier III drugs. An additional "retail maintenance charge" of $5 for Tier I drugs, $10 for Tier II drugs and $15 for Tier III drugs is applied to maintenance medications filled at a retail pharmacy, so that maintenance drugs filled at retail pharmacies cost a total of $15 for Tier I drugs, $35 for Tier II drugs and $55 for Tier III drugs. Mail service copayments were increased effective May 1, 2003, to $30 for Tier I drugs, $75 for Tier II drugs and $120 for Tier III drugs for a 90-day supply.

Per Diem – Arrangement for reimbursing hospitals that provides a specified daily rate according to broad types of admissions.

Prescription Price Discounts – Administrator reimbursement to pharmacies for name brand drugs on the basis of a discounted average wholesale price. Under the Mail Service Delivery Program (MSDP), larger discounts are provided. Pharmacies are reimbursed for generic drugs on the basis of maximum allowable cost (MAC). In addition, pharmacies receive a dispensing fee for each prescription. There is no dispensing fee for the MSDP.

Preadmission Certification – A cost containment program under which a participant or his physician must contact the administrator prior to a non-emergency hospital admission. The administrator will confirm the need for the admission; suggest an alternative setting, such as an outpatient facility; or suggest that the surgery or treatment is inappropriate, and that an alternative be explored. A second surgical opinion may be requested. Also, the length of stay is certified. Similar procedures are required in the case of an emergency admission, although the participant and his physician are allowed a certain period following the admission to make the contact.

Preadmission Testing – A cost containment program designed to reduce inpatient hospital confinements by encouraging outpatient diagnostic and lab testing to be completed prior to the hospital admission.

Personal Health Manager – A component of the Blue Care Connection program which empowers members to increase their involvement in their wellness by providing easy access to highly

personalized health information and programs through a secure web-based solution. The PHM enables members to manage their health by facilitating the exchange of specific personal health information (PHI) without compromising privacy. Members may communicate securely with the Ask A Nurse, Ask A Trainer, Ask A Dietician, and Ask A Life Coach involved in their care, track medical information through monitoring tools and graphs and/or take the Health Risk Assessment (HRA) to be aware of strengths and risks.

- **Ask A Nurse** – The confidential feature in the Personal Health Manager (PHM) that allows for members to communicate securely with nurses about health and wellness topics.
- **Ask A Trainer** – The confidential feature in the Personal Health Manager (PHM) that allows for members to communicate securely with physical therapists about fitness and exercise topics.
- **Ask A Life Coach** – The confidential feature in the Personal Health Manager (PHM) that allows for members to communicate securely with healthcare professionals about life issues.
- **Ask A Dietician** – The confidential feature in the Personal Health Manager (PHM) that allows for members to communicate securely with certified dieticians/nutritionists about nutritional and weight loss topics.

Predictive Modeling – Extensive data mining capability for identification of at-risk members. From the predictive modeling data, group-specific results are compared to the aggregate BCBSTX population. This demonstrates a small percentage of the membership consumes a large percentage of the health care costs. The predictive model tool stratifies the population using 3M's Clinical Risk Group (CRG) algorithm. There are 1,075 CRGs and a member is assigned to a mutually exclusive group. The application uses demographic, claim and pharmacy data to group the population into nine case mix status levels ranging from Healthy to Catastrophic Conditions. The predictive model is currently updated every other month.

Primary Care Physician (PCP) – The physician selected by the participant who assumes responsibility for management of that participant's health care. All network health care must be obtained through and directed by the PCP.

Rebundling – A tool employed in claims processing to avoid the additional charges which might otherwise occur when a provider assesses separate charges for each of a number of related procedures that more appropriately should have been billed under one global procedure code. The process of rebundling combines related procedures into a single procedure subject to a single fee.

Second Surgical Opinion – A cost containment program that encourages or requires individuals to have a second (or third) evaluation of the medical condition for which certain surgical procedures have been recommended to avoid unnecessary surgery.

Appendix 2

Cost Containment History in the Group Benefits Program

A. Pre-Cost Containment

In the early years, health insurance plans included a variety of features designed to control costs. These early features primarily included a wide range of limitations on benefits, such as limited days of hospital care, surgical schedules that limited amounts paid to professionals and relatively low benefit maximums.

As the population became more health and benefit conscious, these limitations became increasingly less acceptable. As a result, health insurance plans throughout the nation entered a long period of benefit liberalization. First, major medical plans were added to existing basic hospitalization and surgical coverages. Then comprehensive medical plans replaced major medical plans.

The Texas Employees Group Benefits Program's (GBP) (formerly the Texas Employees Uniform Group Insurance Program) basic plan has been a comprehensive medical plan since its inception in 1976. As such, it is consistent with the coverage provided to most employees throughout the country.

Even before cost containment gained the importance that it now has, the GBP basic plan and other comprehensive medical plans included a variety of features designed to control or manage costs. These features include:

- Exclusion of certain ineligible expenses (including expenses that are not considered to be medically necessary);
- Coordination of benefits provisions;
- Deductibles;
- Coinsurance;
- Benefit maximums, both overall and with respect to certain types of expenses;
- Fraud control;
- Hospital charge audits; and
- Provider fee profiles.

B. First Generation Cost Containment

For FY85, the GBP adopted its first cost containment program. This program, which remained in effect through August 31, 1989, included the following:

- **Second Surgical Opinion**: Participants were required to obtain a confirming second surgical opinion for certain procedures. Failure to obtain a confirming opinion resulted in a reduction in benefits.
- **Outpatient Surgery:** Participants received enhanced benefits if certain procedures were performed on an outpatient basis.
- **Extended Care Benefits**: Certain incentives were included in the plan to encourage the use of extended care facilities, including skilled nursing facilities, home health care and hospice care. These benefits, along with certain private duty nursing services, also required precertification by the insurer.

- **Preadmission Testing**: Incentives were provided to encourage participants to obtain outpatient diagnostic and lab testing prior to admission to the hospital.
- **Weekend Admissions**: Disincentives were incorporated into the plan to discourage admission to hospitals on the weekend.

For FY85, the Board of Trustees (Board) also adopted major modifications in the program's underwriting practices. These modifications are not generally considered cost containment features; rather, they are considered sound underwriting practices, designed to preserve the financial viability of the program by avoiding adverse selection.

They are as follows: (a) consolidation of multiple plans into one plan of health benefits, (b) elimination of open enrollment and establishment of evidence of insurability requirements for late entrants, and (c) strengthening of preexisting condition limitations. (Limits on preexisting conditions were eliminated effective September 1, 1997, in response to the Health Insurance Portability and Accountability Act.)

1. **Case Management**

   In 1987, the Board adopted case management, a special form of utilization management employed with catastrophic cases. Under case management, the insurer or administrator becomes involved in an attempt to direct the patient to the most cost-effective form of treatment. As such, registered nurses with discharge planning and specialized clinical experience monitor catastrophic claims involving inpatient hospitalization. They work with the attending physician, the patient and his/her family to develop a long-term treatment plan that makes the most efficient use of medical resources and achieves the best patient outcome. Reviewers may recommend alternatives to lengthy hospitalization, such as home care, hospice care, rehabilitative services, skilled nursing facilities, etc. Occasionally, case management may involve extra contractual consideration in order to achieve the most cost-effective outcome.

2. **Medical Necessity**

   The GBP does not cover services or supplies unless they are medically necessary (as defined under the plan) for the diagnosis or treatment of an illness, injury or bodily malfunction. Medical necessity determinations generally are made at the time the claim is submitted; however, in FY88, ERS adopted a voluntary preauthorization program for psychiatric care. The purpose of this voluntary program was to allow a provider to request prior review of a proposed psychiatric treatment plan, to determine if any charges would be denied later on the grounds that services were not medically necessary. When the plan administrator is able to notify a provider in advance that certain services will not be considered medically necessary, providers can adjust treatment patterns and avoid charges.

C. Second Generation Cost Containment

Effective September 1, 1989, ERS replaced the first generation cost containment program with a second generation program that includes the following:

- Preadmission certification;
- Concurrent review;
- Discharge planning; and
- Case management.

This program includes all of the features of the previous program (e.g., second surgical opinion, outpatient surgery, weekend admission, etc.), but it improved the coordination of these features by placing them under a single mechanism.

1. **Hospital Admissions**

   The program includes preadmission certification and concurrent length-of-stay review for each hospital admission, including inpatient psychiatric care and

substance abuse admissions. It includes the following features:

- All non-emergency hospitalizations, including psychiatric and substance abuse admissions, must be pre-certified in advance.
- All recommended inpatient surgery must be pre-certified, and determinations will be made concerning the necessity for a second surgical opinion and the appropriate health care setting.
- All emergency hospital admissions must be certified within 48 hours of the admission.
- Each hospital admission is subject to a $200 deductible. If proper certification is obtained, the $200 deductible is waived, and all charges are paid according to the provisions of the contract. The certification process includes approval of each admission and the assignment of an approved length of stay for each admission. Failure to certify an admission results in: (a) payment of the $200 deductible by the participant, and (b) no payment for eligible room charges that are determined not to be medically necessary based upon a review of the hospital admission by the administrator.
- If a hospital stay extends beyond the initially certified length of stay, prior approval must be obtained before the extension, or the extra days will not be covered unless determined to be medically necessary by the administrator.
- Expenses incurred in connection with preadmission testing and outpatient surgery determinations are reimbursed on the same basis as any other illness, compared to the 100 percent reimbursement in effect prior to September 1, 1989.

2. Rebundling Medical Claims

Effective January 1990, ERS adopted a "rebundling" program that had been designed by BlueCross BlueShield of Texas (BCBSTX). Rebundling is a method of adjusting a provider's bill, which identifies and regroups individual charges for a number of related procedures that should be included under one global code at a lower rate. For example, a provider may charge separately for each step of a hysterectomy, such as exploratory laparotomy, subsequent hospital care, etc., for a total charge of $3,600, when one all-inclusive code with a single fee of $2,000 is applicable. Similarly, when running a series of blood tests, a laboratory may fail to use the appropriate, less expensive global procedure code and will instead list each component separately at its full rate. The intent of the program is to encourage providers to bill correctly and lower the costs of health care to participants.

D. Third Generation Cost Containment

Effective September 1, 1992, ERS implemented a point-of-service (POS) managed health care plan, HealthSelect of Texas. For FY93, HealthSelect included managed care networks in four metropolitan areas: Austin, Dallas, Houston and San Antonio. As seen in the table below, HealthSelect continued to expand its managed care networks, until effective September 1, 1999, all Texas counties were served by HealthSelect managed care networks.

The Expansion of HealthSelect POS Managed Care

Fiscal Year	HealthSelect Territory
FY93	Austin, Dallas, Houston, San Antonio
FY94	All of the above, plus Amarillo, Lubbock, El Paso, Corpus Christi, Waco
FY95	All of the above, plus Abilene, Beaumont, Big Spring, Del Rio, Midland/Odessa, San Angelo, Victoria, Wichita Falls, the Valley, large areas of East Texas
FY99	All Texas Counties

Network providers have agreed to provide health care for GBP participants according to contracts with BCBSTX, the administrator of HealthSelect. These contracts specify fee arrangements, medical treatment protocols, and utilization controls for the providers. The intent of this arrangement is to provide high quality health care while maintaining control over cost and utilization.

1. **Primary Care Physician**

   HealthSelect participants residing in areas served by the managed care networks are provided with benefit incentives that encourage them to obtain health care through the network. Health care provided through the network is managed by a primary care physician (PCP), who is responsible for the participant's primary treatment and diagnosis. The PCP refers patient to specialists when necessary, arranges outpatient testing as appropriate, participates in hospital admissions and monitors hospital care rendered by specialists to whom the patient has been referred. HealthSelect participants who access care through a PCP are not responsible for initiating the utilization review procedures and are not required to file claims. Except for collection of copayments coinsurance, providers accessed through the PCP are not allowed to bill the participant.

   HealthSelect participants residing in areas served by provider networks may access outside the network, although benefits are less extensive and the participants are responsible for satisfaction of utilization review procedures and the submission of claims. Participants who reside outside HealthSelect network areas continue to access the health care system in the same manner as they did prior to the implementation of HealthSelect. The second generation cost containment features described above remain applicable to out-of-area participants.

   The HealthSelect administrator compared HealthSelect utilization with that of a similar plan without the PCP requirement and found that the annual per capita rates of utilization of professional services and hospital admissions under HealthSelect were about 6 percent lower than the same indices under the comparable plan.

2. **Provider Reimbursement Methodologies**

   During FY92, BCBSTX began using a Diagnosis Related Group (DRG) methodology to reimburse hospitals. Under this methodology, a flat fee, known as DRG, is paid for each hospital admission based on the diagnosis assigned to that admission. This arrangement provides the hospital with the incentive for the cost-effective treatment of the patient.

   Although the DRG reimbursement basis is now applicable to the bulk of hospital charges under HealthSelect, other reimbursement mechanisms are used:

   - Per diems, which pay specified amounts for each day of confinement, are used with substance abuse and psychiatric admissions.
   - Some hospitals are reimbursed according to a negotiated fee arrangement, which specifies a contractual fee for each service.

   During FY97, BCBSTX implemented a Resource Based Relative Value Scale (RBRVS) methodology for reimbursing professionals. This methodology, modeled after one originally implemented in connection with the Medicare Program, is designed to enhance the effectiveness of primary care by increasing reimbursement for primary care while reducing reimbursement for more expensive surgical procedures. HealthSelect experienced immediate cost avoidance from implementing RBRVS.

3. **Health Maintenance Organization (HMO)**

   Fully insured HMOs have participated in

the GBP since the late 1970s. GBP member enrollment in fully insured HMOs and HealthSelect Plus, a self-funded HMO, grew significantly through the 1980s and 1990s, peaking in FY98 at more than 47 percent.

After dropping slightly in FY99, HMO enrollment decreased steadily until it was less than eight percent during FY04. HMO enrollment has grown slightly since FY04, reaching almost 10 percent of total enrollment during FY06. HMO enrollment has declined due to the consolidation of HMOs, the increase in HMO costs across the state and, as discussed below, the termination of HealthSelect Plus.

ERS has developed significant experience in dealing with HMOs, which allows it to utilize HMOs in a cost efficient manner that also provides additional health care choices for members.

4. HealthSelect Plus

Effective September 1, 1996, ERS began offering a self-funded HMO-type plan to GBP participants. HMO Blue, a subsidiary of BCBSTX (the HealthSelect administrator), functioned as the HealthSelect Plus administrator. HealthSelect Plus provided benefits and provider networks similar to those provided through the fully insured HMOs and employed HMO-like utilization management and provider contracting.

Through FY02, the plan was offered in the following areas of Texas: Abilene, Alpine, Amarillo, Austin, Beaumont, Corpus Christi, El Paso, Dallas/Fort Worth, Houston, Lubbock, Midland/Odessa, San Angelo, San Antonio and Tyler. The number of participants in HealthSelect Plus grew to more than 80,000 in FY02, before rising costs and reductions in provider networks required ERS to reduce its service area and restrict new enrollment for FY03. Enrollment declined to approximately 57,000 for FY03.

HealthSelect Plus, originally intended to provide experience with self-funding of HMOs, became the largest provider of HMO benefits under the GBP due to the combined effect of its popularity and the declining number and viability of commercial HMOs. Unfortunately, HealthSelect Plus suffered from rising costs like most HMOs and eventually became unaffordable for the program. In May, 2003, in response to the Legislature's request for cost reductions, HealthSelect Plus was terminated, and members enrolled in HealthSelect Plus were transferred to HealthSelect.

5. Recent Benefit and Eligibility Revisions

Since FY98, health care costs in the GBP have accelerated significantly. This, coupled with a state budgetary crisis, led the Legislature to reduce GBP funding effective May 1, 2003, and provide less funding for the FY04/05 biennium than was provided for the FY02/03 biennium. As a result, significant benefit and eligibility changes were required to balance expenditures with available revenue. Member cost sharing increased (e.g., the addition of a $50 deductible per participant/per plan year for pharmacy benefits), and new cost containment initiatives were implemented, such as the generic drug program and the retail maintenance copay, which encourages the use of the more cost effective Mail Service Delivery Program (MSDP).

a. Revised Eligibility

Revised eligibility provisions reduced the number of plan members for which the state pays the cost of health coverage. These changes, implemented in May and September of 2003, were the most significant in the history of the GBP. A 90-day waiting period was imposed on new employees, and some or all of the cost of coverage was shifted to certain members; for example, state funding for graduate students was reduced to 50 percent of the cost of coverage.

b. Increased Member Cost Sharing

By increasing the member's out-of-pocket expense at the time that health care services are used, revised cost-sharing provisions not only transfer a portion of the cost to the member, but also encourage members to be more cost conscious when making health care choices. The financial disincentives associated with increased cost sharing were expected to reduce the potential for any overutilization of health care benefits. In other words, as member cost sharing went up, demand for health care services was expected to go down.

The changes to the health plan effective May 1, 2003, led to substantially increased costs for health plan members. Between FY03 and FY04, per capita cost sharing increased by an average of about 61 percent. Compared to FY02, FY04 per capita cost sharing increased by an average of more 100 percent.

c. Radiology Management Service

Use of a radiology management service provided by BCBSTX to reduce unnecessary radiological services and to direct radiological services to more cost effective providers. (See description on page 35.)

d. Reduced Reimbursement for Specialty Drugs

Reduced reimbursement for specialty drugs administered in the physician's office. BCBSTX has entered into an agreement with a vendor that manages specialty drug programs for high cost injectables and other drugs administered in the physician's office.

e. PDP Revisions

Revisions to the PDP to meet the requirements of SB 1173, concerning prior authorization for coverage of certain categories of drugs.

f. Recent Changes to the PDP

In response to the Legislature's request for reductions in cost, ERS implemented the following changes to the PDP effective May 1, 2003.

1. Mail Service Copayments

The MSDP was revised to require a copayment equivalent to the retail copayment for each 30-day supply by mail. Members now pay three 30-day copays for a 90-day supply of drugs through the MSDP, instead of receiving a discounted price of two 30-day copays for a 90-day supply. This allows the plan to receive the full benefit from the MSDP's reduced ingredient cost and dispensing fee and increased generic substitution.

2. Retail Maintenance Fee

A "retail maintenance fee" was created to encourage members to obtain maintenance medications through mail service. In effect, this charge for filling maintenance prescriptions at retail pharmacies allows the plan to achieve the same cost efficiencies that would have occurred had the prescription been filled through the mail.

3. Rural Pharmacy Reimbursement Rates

ERS directed Medco to negotiate lower reimbursement rates for independent pharmacies located in rural areas.

4. Generic Incentives

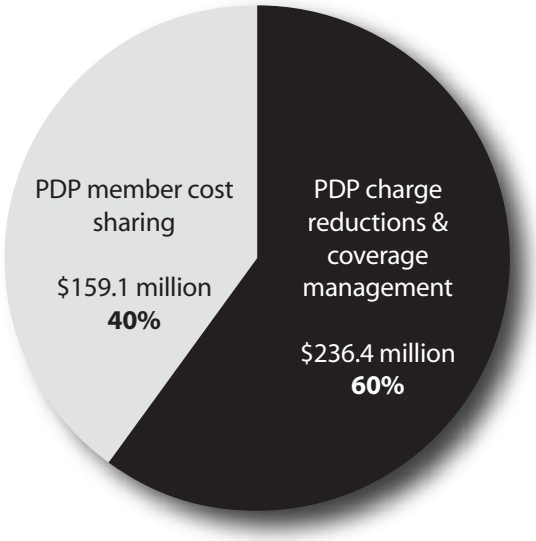
Members were required to pay the generic copay plus the difference between the cost of a brand name drug and its generic equivalent whenever a generic was available but they chose the brand name drug instead.

g. PDP Member Cost Sharing

As a result of the PDP changes, 40 percent of the FY06 avoided costs on

PDP expenses were attributable to GBP member cost sharing. Cost shifting to members resulted in a 102 percent increase in PDP copays and deductibles between FY02 and FY04, some portion of which may be attributed to growth. Member cost sharing declined slightly during FY05 due to a reduction in HealthSelect membership and increased utilization of less expensive generic medications.

40 percent of the FY06 savings on PDP expenses were attributable to GBP member cost sharing



During FY06, the PDP and MSDP discounted reimbursement arrangements and coverage management programs produced average avoided costs of about 34 percent. The coverage management programs include concurrent and retrospective utilization review, point-of-sale edits, prior authorization of certain drugs, dose optimization programs, quantity limitations for certain drugs and pharmacy audits.

E. Prescription Drug Program

- **Discounted retail pharmacy reimbursement**

  Effective September 1, 1988, ERS and BCBSTX developed a discounted reimbursement arrangement with a network of retail pharmacies under the Prescription Drug Program (PDP). Pharmacies are reimbursed based on ingredient cost plus a dispensing fee. Name brand ingredient cost is reimbursed based on a percentage of average wholesale price (AWP), while generic ingredient cost is reimbursed using a maximum allowable cost (MAC) basis. The PDP began using a revised reimbursement arrangement in February 1996. Under the 1996 arrangement, chain pharmacies and independent pharmacies located in urban areas agreed to reduced prescription drug reimbursement rates.

- **Mail Service Delivery Program**

  Effective September 1, 1996, ERS implemented an optional mail service drug plan, under which participants can obtain larger supplies of maintenance drugs. Mail service and retail copays were the same until September 1, 2000 when three copay levels were put in place (generic, preferred and non-preferred). From September 1, 2000 until May 1, 2003, participants could order up to a 90-day supply for a copayment that was approximately two-thirds the cost of an equivalent supply at a retail pharmacy. Effective May 1, 2003, a 90-day supply of medication requires three 30-day copayments.

Appendix 3
Pharmacy Benefit Management Issues

The 79th Legislature considered numerous bills that addressed perceived weaknesses in the manner in which state agencies contract with Pharmacy Benefit Managers (PBMs). Those bills primarily addressed (a) retail pharmacy reimbursement, (b) the relative cost effectiveness of retail and mail service, (c) PBM pricing transparency and (d) a variety of miscellaneous issues. ERS worked extensively with the Legislature to clarify the manner in which ERS contracts with its PBM. As the Legislature gained a better understanding of ERS contracting methodology, its concerns were alleviated. The following summarizes the manner in which ERS has addressed the issues included in the proposed legislation.

A. Retail Pharmacy Reimbursement

Retail pharmacies have complained that the PBMs charge their clients more than they reimburse the pharmacies, collect from their clients weeks in advance of paying the pharmacies and fail to disclose the pharmacy reimbursement arrangements to their clients. ERS successfully avoids these problems by: (a) requiring its PBM to bill ERS for the exact amount that it pays the pharmacy; (b) paying the PBM only after it has paid the pharmacy; and (c) reimbursing the pharmacies based on a formula that ERS specifies. These payments are audited on an annual basis.

B. Mail Service vs. the Retail Pharmacy

Retail pharmacies have alleged that mail service is more costly than the retail pharmacy because PBMs overcharge for generics, charge members more than if the drug had been obtained at retail and require members to pay the copay even if the drug costs less than the copay. Through competitive bidding, ERS has structured its contract to save more than $40 million per year from mail service. The ERS PBM contract contains customized provisions that specifically address and prevent the PBM from charging a member more than he/she would have paid if the drug had been obtained at retail and require the mail service facility to charge the lesser of the formula price or the copay. During FY06, approximately one-third of the GBP expenditure for maintenance drugs went to Medco and two-thirds went to retail pharmacies. This benefit design has been in place since FY03. Mail service is projected to generate cost avoidance of $103 million for the FY08 – 09 biennium.

C. PBM Pricing Transparency

Critics of PBMs allege that plan sponsors are overcharged for drugs obtained at retail, do not receive a fair share of rebates and are victims of mail service overpricing. ERS has

addressed each of these issues through a vigorous competitive bidding process previously described and through rigorous contracting specifically designed to prevent the practices alleged by the critics.

D. Pharmacy Rebates

Manufacturers pay significant rebates to promote the use of their drugs. PBMs share the rebates with their customers in two ways: (a) reduced charges for services, particularly administration (e.g., ERS does not pay an administrative charge) and (b) payment of rebates based on actual utilization. The controversy arises over whether the plan sponsor receives its "fair share." Rebate formulas are generally expressed either as a percentage of the total rebates received by the PBM in connection with the plan sponsor's program or through a specified amount per claim. The "fair share" issue is complicated by the difficulty of auditing the total amount of rebates received in connection with a given block of business given that the amount that a manufacturer pays a PBM is based on (a) aggregate business conducted by the PBM and (b) factors that cannot be easily tied to a given block of business. ERS has addressed the issue through competitive bidding, i.e., through tight bid specifications which require each competing vendor to bid on the same basis. ERS requires rebates to be paid on the basis of each formulary claim, a standard that allows for competition that can be objectively quantified, evaluated and easily audited.

E. Miscellaneous Issues

Therapeutic substitution: Therapeutic substitution is an administrative process by which the PBM attempts to influence a participant to change a script to a therapeutically equivalent drug, or a specific brand in lieu of another more expensive brand. This can be a controversial process since the availability of rebates raises questions regarding objectivity and runs the risk of interfering with the physician/patient relationship. Because of these concerns, ERS has always forbidden this practice in its PBM contract.

Formulary: The formulary drugs are selected by an independent pharmacy and therapeutic (P&T) committee based on both efficacy and cost. Cost analysis includes both the price of the drug as well as available rebates. PBMs have been accused of manipulating the formulary to maximize rebate revenue, some of which they retain. ERS uses an open formulary (i.e., most drugs are on the HealthSelect formulary). This mitigates concerns that the formulary may have been manipulated for the benefit of the PBM.

Generic Drugs: Encouraging the use of generics is a commonly accepted means of cost management in a prescription drug plan. In HealthSelect during FY06, the average cost of a day of therapy was $0.85 when a generic was used as compared to $1.40 (65% greater) when a multi-source brand drug was used. (A multi-source brand drug is one for which there is a generic equivalent available.) Generics save money for the plan and the members. Encouraging the use of generics is an important cost management strategy in HealthSelect.

Appendix 4

Structure and Operation of BlueCross BlueShield's SID

To facilitate a three-stage approach to reducing health care fraud (identify, investigate and refer for criminal prosecution), the Special Investigations Department (SID) is organized to include an intelligence group and four investigative groups. The mission and responsibilities of each group are as follows:

A. Intelligence Group (IG)

The mission of the IG is to proactively and reactively identify providers, subscribers and others suspected of fraud. The IG's personnel are located in Texas and Illinois, but function as a single entity by sharing expertise, experience, resources and data. The IG uses all available internal and external resources, including:

1. **Proactive Computer Analysis**

   The IG uses data mining tools to identify leads regarding health care fraud schemes. The software programs used are IBM's Fraud and Abuse Management System (FAMS) and Statistical Analytical Software (SAS). The SID has an agreement with IBM and SAS to integrate these software applications to produce a first-of-its-kind fraud detection platform. The new platform enables the SID to detect emerging fraud patterns more quickly, across larger volumes of data, and with greater ability to filter out false positives so that investigative resources can be better allocated. Implementation of the new platform occurred in June 2005.

2. **Databases**

   The IG utilizes several databases such as LexisNexis, ChoicePoint and others, which have been specifically tailored for health care fraud utilization. These databases are used to research court records, media articles, fraudulent Social Security numbers, state licensing information, asset ownership and backgrounds on individuals and businesses.

3. **Information from the BlueCross BlueShield of Texas (BCBSTX) Customer Service Unit (CSU)**

   The CSU processes health care claims, and its personnel are trained and experienced in identifying suspicious claims and unusual billing patterns. Suspicious claims are electronically routed to the IG for further review and analysis.

4. **Law Enforcement Contacts**

   The IG and SID have established valuable contacts with state and federal law enforcement and prosecutorial agencies that provide intelligence regarding current health care fraud schemes and trends, and facilitate the SID's referral of cases for investigation and criminal prosecution.

5. **Calls to the Fraud Hotline**

   Customers also provide valuable information through the fraud hotline. Dedicated staff members at BCBSTX carefully analyze and evaluate the information received via the fraud hotline. This information is further developed by the IG and referred to the SID's Executive Director as warranted.

6. **Contacts with Other Health Care Organizations**

   Through its membership in various organizations and associations, the IG has established excellent contacts throughout the health care industry. Some of the associations maintain databases and issue bulletins and newsletters that alert members to fraudulent health care schemes. The IG uses the information from these organizations and associations to query the third party administrator's databases for similar situations.

   After sufficient information is developed and verified to demonstrate that a reasonable suspicion of fraud exists, the IG prepares a summary report that includes background information, details of the suspected fraud and the parties involved and a recommendation for further investigation. The report is then forwarded to the SID's Executive Director for review and possible assignment to one of the SID's three investigative groups. The Medical Director assigned to the SID also reviews the report to identify any fraudulent conduct regarding medical necessity issues.

7. **Investigative Groups**

   The SID has four investigative groups: two in Illinois, one in New Mexico and one in Texas. Each investigative group is comprised of highly trained personnel with extensive backgrounds in the medical profession, the health insurance industry and federal law enforcement. Many of the SID's investigators are former, recognized agents of the Federal Bureau of Investigation and the Internal Revenue Service. The investigative group in Texas consists of eight investigators and four analysts. The investigators have a diverse background of experience ranging from medical, law enforcement, nursing, and insurance, while the analysts all have advanced degrees. These individuals use their diverse backgrounds to work as a team to investigate complex health care fraud schemes.

   The SID is dedicated to working as a team with BCBSTX's Provider Affairs Department, Medical Review Department, Full Service Units and Legal Department to identify, investigate and refer for criminal prosecution any person or company that defrauds or attempts to defraud ERS.

   The SID has strong working relationships with the SIDs of other Blue Cross plans. The SID also works very closely with its Provider Affairs Department to maintain the integrity of the provider network. The SID subdivides its approach to combating health care fraud into categories based on medical discipline (such as oncology, dentistry, podiatry, etc.), and by the fraudulent schemes employed against each discipline.

   Cases are assigned to the investigative groups based on the geographical location of the person or company that is defrauding or attempting to defraud ERS. After a case has been assigned to an investigative group, the senior manager responsible for that group will contact ERS to advise of the alleged fraud, secure ERS' written direction regarding the future payment of all suspect claims, and make arrangements to interview employees who are directly or indirectly involved in the alleged fraud. Through such contact, ERS obtains a clear understanding of the alleged fraud and the actions the SID will be taking to resolve the matter.

After this initial contact with ERS, the investigative group will conduct interviews, field audits and use other investigative techniques to obtain evidence that confirms or refutes the allegations of fraud. If evidence exists to support a probable cause finding that a crime was committed, the investigator responsible for the case will prepare a detailed case summary for the SID's Executive Director. If the Executive Director agrees there is probable cause to believe that a crime was committed, ERS will be notified, and the case will be referred to law enforcement for criminal prosecution.

B. Fraud Detection

Possible fraud is detected in a variety of ways. Claims processors, customer service representatives and medical staff are trained to identify fraud indicators during the adjudication process. Employees are trained to watch for and report the following circumstances:

- Claims that appear altered, as indicated by different type sets used in entering claims data; different handwriting in the handwritten material; or presence of erasures or white outs;
- Claims or receipts without letterhead;
- Different receipts from the same provider;
- Receipts are numbered consecutively, but the dates of service are not;
- Provider and the patient have the same address;
- Spelling mistakes, especially with medical terms; and/or
- Claims from foreign countries with foreign currency.

Medical and Utilization Management staff also play a key role in detecting fraud and abuse. The employees are trained to watch for and report the following activities:

- Providers who fail to provide the services indicated by the member's condition;
- Providers whose care appears to fail medical or other professional standards;
- Care provided outside the provider's specialty; and/or
- Providers with high utilization of certain procedures, relative to peer practices.

Possible fraud and abuse also is detected through:

- Post-payment reviews of claims data;
- System edits performed to ensure the integrity of the claims; and
- Participant inquiries to customer service.

Post-payment review is performed using utilization data compiled by two commercial software tools, FAMS and Codman software.

- **FAMS:** The FAMS developed by IBM is a sophisticated fraud and abuse detection tool. FAMS uses leading edge modeling and decision support techniques to support the detection, investigation settlement and prevention of health care fraud and abuse. A suite of investigative tools supports the analysis of provider profile scores and detailed claims data. These include the ability to analyze each behavior pattern individually or in selected combinations, the capability of drilling down to the actual claims that support the profile, the access to standard graphic and statistical reports and the capability of developing and generating ad hoc reports. Analytical reports and graphics detailing peer group behavior and claims activities are used to support litigation and referral of cases to law enforcement. The reports also are used as part of negotiations, settlement options, and criminal prosecutions. One key to preventing losses from health care fraud and abuse is modifying provider behavior. The system supports ongoing monitoring of providers and offers new tools to evaluate and educate them. The FAMS software is used by the Medical Division as well as by the SID.
- **Codman Software:** The data analysis from the Codman software enables the third-

party administrator to focus on problematic practice patterns in populations with a common medical variable, such as diabetes. Fraud Investigators have access to the Codman data-mining tool and use it to research fraud case targets.

Once possible fraud has been reported, the SID works closely with the appropriate divisions (Medical, Legal, Local Medical Directors, etc.) to investigate fraudulent activities. If quality of care issues are discovered during the fraud investigation, the SID notifies the Medical Division and the State Board of Medical Examiners. Confirmed provider fraud is reported to the Texas Department of Insurance Fraud Unit as well as to the appropriate federal law enforcement agencies. If the case is accepted for criminal prosecution, BCBSTX provides the appropriate witnesses to introduce claims and other evidence to the court.

C. Credentialing Services

As part of its contract with ERS, BCBSTX has an ongoing process to credential new providers and to recredential established providers every three years. Many items are considered in this process including, but not limited to: status of license, current and past malpractice cases, amount of liability insurance, status of Medicare/Medicaid sanctions, information from the National Practitioner Data Bank (NPDB), staff privileges at participating hospitals, and utilization data if available. Providers with identified problems or issues are brought to one of two statewide peer review committees, Texas Medical Advisory Committee (TMAC) or Texas Peer Review Committee (TPRC), for evaluation and recommendations.

At recredentialing, the utilization data program is used to compare provider utilization to a pertinent peer provider group. Potential actions that might be recommended by the peer review committee when problems are identified include: an educational letter with scheduled re-review; obtaining medical records for like specialist review; recoupment of money based on aberrant billing practices; referral to SID for potential fraud; placement on pre-payment review; and termination from the provider networks.

Appendix 5

Grievances and Appeals

ERS Board Rules provide that any person participating in the insurance program who is denied payment of insurance benefits may request the carrier's reconsideration of the disputed claim. If denied, the participant then may submit the disputed claim to the ERS executive director for review. Trustee Rule, 34 TAC § 81.9, Grievance Procedure.

HealthSelect, term life and accidental death and dismemberment, short and long-term disability, evidence of insurability for coverage, and dental indemnity claims all may be appealed. Claims and coverage issues relating to a health maintenance organization (HMO) are not covered under the GBP statute and 34 TAC § 81.9. Such claims are instead first reviewed by the appropriate HMO and, if necessary, appealed to the Texas Department of Insurance. This includes claims submitted by participants of the dental HMO administered under the GBP.

ERS has established a five-step appeals process wherein participants receive instructions on the procedure to be followed:

1. Appeal to the benefit administrator (BCBSTX or Medco).
2. Appeal to the ERS grievance administrator.
3. If appeal rights granted, referral to the State Office of Administrative Hearings (SOAH).
4. Presentation of SOAH decision to the ERS Board of Trustees.
5. Appeal of the Board's decision to district court.

Upon receipt of an appeal to the benefit administrator's denial, the ERS grievance administrator (a registered nurse) requests information from BCBSTX or Medco, reviews information received, and prepares a file for review by the ERS Grievance Review Committee (GRC). The GRC determines if the claim or application for coverage was denied in accordance with plan rules and contract provisions and renders its concurrence or rejection of the benefit administrator's decision. The GRC does not make medical determinations. The GRC's recommendation then undergoes a review by the Director of Benefit Contracts, the Legal Division, and the Director of Governmental Relations. Decisions resulting in denials are mailed to participants by certified mail. If appeal rights are granted, the letter will inform them of the right to appeal ERS' decision within 30 calendar days from the date that the certified letter is issued. Failure to file an appeal within a timely manner results in the loss of the participant's right to appeal.