PUBLIC AGENDA ITEM - #5

5. Review and Discussion of Recent Changes Impacting Benefits Offered Under the Texas Employees Group Benefits Program

August 25, 2009

BACKGROUND

Senate Bill 1, the General Appropriation Act for fiscal years 2010-2011, provided funding for state employee and retiree health insurance based on current benefits. The funding requested by ERS anticipated spending all but $50 million of the insurance contingency reserve fund; however, based on the actual appropriation for insurance, it is projected that all of the contingency reserve fund will be expended leaving a deficit of $50 million.

It is difficult to predict how much of the contingency reserve fund will need to be spent over the biennium. Original predictions were for an expected cost growth trend of 8 percent. Since employee and state contribution rates are capped for the biennium there is a possibility that the contingency reserve fund will be depleted by the end of fiscal year 2011. On August 13, staff met with Rudd & Wisdom, ERS' consulting actuary for insurance, to discuss the financial status of the health plan. There has been an increase in the underlying trend particularly on payments to hospitals. The health plan's cost trend appears to be running at 9 percent. This will mean that the contingency fund will begin fiscal year 2010 with $10 million less than predicted. This, coupled with a 9 percent trend over fiscal year 2010 and fiscal year 2011, means that as much as a 10 percent benefit reduction may be required beginning in fiscal year 2011.

An additional stress on the contingency fund is the nine bills that passed during the 81st Legislative Session which will impact HealthSelect of Texas℠ (HealthSelect) and/or health maintenance organization coverage. ERS staff reviewed each bill to determine the impact on ERS, the GBP and its related contracts. If the bill was determined to have a financial impact to the GBP, ERS prepared a cost estimate and submitted it to the Legislative Budget Board. Cost estimates are included with the bill documents when lawmakers considered bills in committee hearings and on the floor of their respective chambers. The LBB can accept the ERS cost estimate, or submit a different cost estimate based on its own analysis.

Although the nine bills become effective on September 1, 2009, most of the mandates do not apply to the state health plan until September 1, 2010. The following table includes further information on the legislation and its expected impact on the GBP:

Coverage for routine patient care costs for participating in certain clinical trials (SB 39)
Background: Sponsors of this bill felt that people would not participate in clinical trials for fear of a financial burden. Testimony during committee hearings indicated that some benefit plans were excluding the cost of routine patient care when a person was participating in clinical trial.
Impact: HealthSelect already covers "routine" patient costs incurred concurrently with a clinical trial. However, there are some additional costs that could be incurred as a result of this legislation since some organizations that sponsor clinical trials do not cover all the costs associated with the trial, thereby requiring the research institution to absorb a loss or pass it on to the patient.

By mandating insurance coverage, this legislation could encourage sponsoring organizations and/or research facilities to pass costs to the patient that are currently absorbed by such organizations and/or facilities.

Cost: Staff expects that the additional cost that would result from this bill to be relatively small. Nevertheless, the additional cost and estimated impact in FY 2011 is $1.0 million.

PBM contract provisions, 90-day supply of maintenance drugs at retail pharmacies, and study on PBM usage of certain drug information– SB 704

Background: This bill requires that ERS, Teacher Retirement System, University of Texas and Texas A&M University disclose the financial terms of their respective Prescription Benefits Management (PBM) contracts to any agency who requests the information. The information, however, must remain confidential and cannot be shared outside the requesting agency. Also, certain auditing rights must be contained in PBM contracts.

The bill also provides a way for GBP participants to obtain a 90-day supply of a prescription drug at a retail pharmacy if the plan is not charged more than what is required for a 90-day supply at mail service. Retail pharmacies must be allowed to dispense those drugs under the same terms and conditions as a mail service pharmacy.

Impact: This affects PBM contracts which are effective or amended after September 1, 2009. Since the ERS/Caremark contract does not expire until August 31, 2012 this bill will not impact the HealthSelect plan until FY 2013, unless ERS makes changes to the contract. ERS has requested that Caremark evaluate the impact of allowing 90-day prescriptions to be filled at retail pharmacies. Should Caremark's review show that such a provision has little or no impact on our current financial terms, ERS staff may recommend allowing this as early as September 1, 2010.

Cost: To be determined

Coverage for certain prosthetic devices, orthotic devices, and related services (HB 806)

Background: Based on testimony in the committee hearings, some insurance plans limit, and even exclude, from coverage, charges in connection with prosthetic devices such as artificial limbs.

Impact: ERS adjusted the HealthSelect plan over two years ago and removed any limitations on the coverage for new or replacement prosthesis. Coverage for orthotics will be new to HealthSelect beginning Plan Year 2011.

Cost: Review of the financial impact of this bill on the HealthSelect program, with the addition of coverage for orthotics, is minimal and will be significantly less than $1.0 million.

Classification of dispensing prescriptions issued for certain controlled substances (SB 904)

Background: This legislation authorizes a prescribing practitioner to issue multiple prescriptions authorizing up to a 90-day supply of Schedule II controlled substance drugs and one Schedule IV drug, Carisoprodol, effective September 1, 2009.

Impact: Currently, these types of drugs can only be dispensed for a 30 day supply. This bill is

directed at the prescribing physician.

Cost: Review of the financial impact of this bill found no additional cost.

Certain information required on pharmacy benefit cards (HB 1138)

Background: Certain data describing the Rx benefit is required on the front of the ID card, including:

- The company providing the benefits
- The group number
- Member ID number (NOT the members social security number)
- Bank identification number for electronic billing
- The effective date of coverage
- The co-payments and deductibles
- Telephone number of the customer service area of the vendor (on the back of the card)

Currently, ERS' prescription drug coverage card contains all the information listed above except for the copayments and deductible. ERS removed copayment and deductible information after consulting with pharmacists who said the information was confusing to members.

Impact: Effective September 1, 2010, ERS will issue new ID cards.

Cost: The cost is $1.00 per member, increasing FY 2010 administrative expense by approximately $250,000.

Coverage for certain tests for the early detection of cardiovascular disease (HB 1290)

Background: This bill was designed to provide coverage for the screening of cardiac conditions for males older than 45 and younger than 76; females older than 55, and younger than 76; diabetics; or, those at risk of developing coronary heart disease based on a score derived from the Framingham Heart Study coronary prediction algorithm.

The coverage must include up to $200 for one of the following:

1) Computed Tomography (CT) scanning measuring coronary artery calcification; or
2) Ultrasonography measuring carotid intima-media thickness and plaque.

Impact: The bill does not reference Chapter 1551 and therefore would not impact HealthSelect but will require the coverage through an HMO.

Cost: HMOs may require a rate increase to cover this cost beginning FY 2011

Health benefit plan coverage for amino acid-based elemental formulas (HB 2000)

Background: Requires coverage of amino acid-based elemental formula (AABEF) provided the treating physician issues a written order specifying it is medically necessary for treatment of certain diagnosed conditions specified in the bills. The coverage must be provided without regard to the formula delivery method.

Information provided by BCBSTX indicates that use of AABEF is rare, impacting only one ten-thousandth of the population. The annual cost of AABEF is a minimum of $5,000 per patient.

Impact: There are presently about 525,000 participants in the GBP. Based on the information provided by BCBSTX, ERS expects that about 52 would use AABEF during a given year and would be eligible for the coverage required under the bill at a cost to the plan of $5,000 per year.

Cost: The estimated fiscal impact to the HealthSelect program beginning September 1, 2010 is $260,000

Requirements for mediation of contracts between physicians, hospitals, and health benefit plans (HB 2256)

Background: Requires HealthSelect to make available to a member, under specified circumstances, a mandatory mediation process for settlement of a health benefit claim dispute related to medical services provided by an out-of-network facility-based physician in a network hospital. This includes anesthesiologists, radiologists, pathologists, emergency department physicians and neonatologists. The GBP HMOs would not be subject to the requirements of the bill. The requirements of the bill would become effective no later than September 1, 2010.

Impact: HealthSelect participants will be able to request mediation if the unpaid amount after deductible, copayments and coinsurance is greater than $1,000 when the hospital, where the services were performed by a non-contracting, facility-based physician, is in the PPO network and has a contract.

The process for mediation is laid out in the bill. The major provisions include:

- If mediation is requested, the physician or their representative and carrier (TPA) shall participate.
- A requirement that facility-based physicians (except in an emergency) must disclose, if requested by the enrollee, contracting status, expected costs and circumstances in which the enrollee is responsible for those costs. Mediation is not allowed if the enrollee acknowledges the disclosure.
- Research by ERS staff found that the cost of the mediator, which is split evenly between the physician and administrator, is estimated at $2,000.
- A mediator may not impose judgment on a party about an issue.
- The evaluation of fees has 3 criteria:
  - The amount charged by the facility-based physician is excessive.
  - The amount paid by the administrator represents the usual and customary rate.
  - The amount due from the enrollee after copayments, deductible and coinsurance.

COST: Based on information supplied by BCBSTX regarding the number of times a patient is balanced billed for more than $1,000 on services by a facility-based physician, ERS estimates that the cost to the HealthSelect program will be $10.4 million per year

Bariatric surgery coverage for state employees on a cost-neutral or cost-positive basis, as soon as practical, but no later than 9/1/2010 (SB 2577)

Background: Requires that the ERS Board of Trustees (Board) develop a cost-neutral or cost-positive plan for providing bariatric surgery coverage for employees eligible to participate in the program.

ERS can design and implement a plan to cover bariatric surgery that is different from other coverage in order to lower the cost to the plan. No additional funding was provided for the coverage. ERS expects that this coverage will have very specific requirements for this benefit, including higher deductibles and mandatory participation in certain programs prior to the surgery. ERS is currently reviewing the best way to implement this coverage.

Impact: At a minimum, in order to meet the requirements of being cost-neutral or cost-positive, benefits would have the following limitations and exclusions:

- Only employees who have been covered under the HealthSelect portion of the GBP continuously for the 5 years prior to the surgery; and
- adhere to the guidelines established by HealthSelect's Third Party Administrator (TPA) may qualify. Those guidelines may include:
    - A Body Mass Index (BMI) of 40 or more or a BMI of 35 or more with at least one co-morbidity.
    - Participation in a medically supervised weight loss program for one year prior to the surgery.
- Services would be required to be performed at a "Center of Distinction" as defined by the TPA.
- Benefits would be subject to a separate deductible and coinsurance rate. This is estimated to be no less than $3,000 deductible and a 20 percent coinsurance payment by the member. Expenses would not be applied against the employee's annual out-of-pocket limit.
- Benefits would be limited to "in-network only". No coverage would be available out-of-network, or services by a non-contracted facility or physician.
- Surgery would only be allowed once in the lifetime of a member, as defined by Chapter 1551.101.

Cost: Based on our initial review, if coverage applies only to employees (not dependents) with 5 or more years of continuous coverage under the HealthSelect plan, the estimated eligible participants are 110,052. ERS has received information indicating the incident rate can range from 1.9 per 1,000 to as high as 15 per 1,000 eligible. Therefore the cost to the HealthSelect plan can range from $2.1 million to $16.2 million per year.

While no action is required of the Board, ERS will be working with Rudd & Wisdom to price the cost of these changes to the HealthSelect and HMO rates effective 9/1/2010.

With the potential for added costs as a result of the legislation outlined in this agenda item, along with the estimated shortfall in contributions in SB1, ERS staff and the consulting actuary will be closely monitoring GBP expenditures, claims experience and the contingency reserve fund balance throughout the next fiscal year. Any concerns will be promptly brought to the attention of the Board.

This agenda item is provided for informational purposes only.

STAFF RECOMMENDATION:

No action is required on this item.