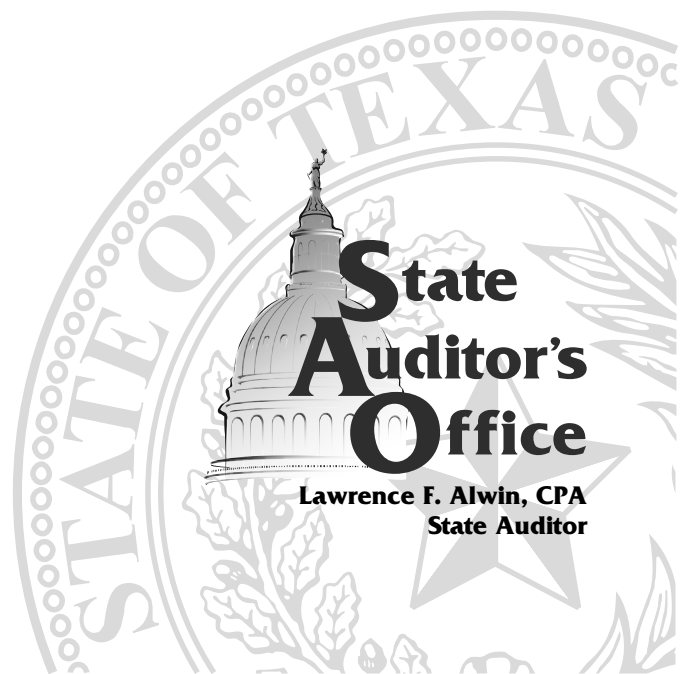


An Audit Report on
**Health Plan Cost-Reduction Measures and Contract
Management at the Employees Retirement System
and the Teacher Retirement System**

November 2004

Report No. 05-011



Health Plan Cost-Reduction Measures and Contract Management at the Employees Retirement System and the Teacher Retirement System

Overall Conclusion

The measures that the Employees Retirement System (ERS) and the Teacher Retirement System (TRS) have implemented to reduce the amount the State pays for its health care plans have generally worked as intended. These measures primarily consisted of plan design changes that shifted medical costs from the State to members.

Additional cost savings may be achieved through strengthening efforts to detect fraud, waste, and abuse and by routinely reviewing detailed claims information. A cost-benefit analysis may indicate that more robust fraud, waste, and abuse detection efforts would be appropriate.

ERS's and TRS's daily operational administration of health care and pharmacy benefits contracts is generally adequate, but both agencies should improve certain aspects of contract management. Both ERS's and TRS's contracts contain adequate provisions to hold contractors accountable.

Because health care costs continue to rise, it will be important for the State to continue to consider adjustments to its health care plans or the funding for these plans. Our research and benchmarking of industry practices and standards identified additional cost-containment and cost-shifting strategies that could be considered. To be properly considered, each strategy would need to be evaluated from an actuarial standpoint to determine the cost and benefit to the individual plans and the effect on membership.

ERS and TRS Health Care Plans

ERS's HealthSelect health care plan covers employees, retirees, and their dependents for state agencies and institutions of higher education (except for the University of Texas and Texas A&M University). In fiscal year 2003, HealthSelect had 277,000 members. Medical claims paid totaled \$927.9 million, and pharmacy claims paid totaled \$293.1 million.

The TRS-ActiveCare health care plan covers active school district employees and their dependents. In fiscal year 2003, TRS-ActiveCare had 130,000 members. Medical claims paid totaled \$318.1 million, and pharmacy claims paid totaled \$75.6 million.

The TRS-Care health care plan covers retired school district employees and their dependents. In fiscal year 2003, TRS-Care had 155,000 members. Medical claims paid totaled \$355.9 million, and pharmacy claims paid totaled \$208 million.

Key Points

ERS's and TRS's cost-reduction measures have generally worked as intended, primarily by shifting costs from the state to members.

The 78th Legislature required ERS to "reduce total health plan costs by \$485.5 million in All Funds and \$296.1 million in General Revenue" for the 2004-2005 biennium. ERS projected that it would achieve a \$621.3 million state cost reduction for the 2004-2005 biennium. Although the difference in ERS's and our cost-reduction estimates may be overcome by



savings in claims costs due to decreased utilization, our analysis of claims data indicated that ERS may not achieve \$177.8 million of its projected cost savings.

The 78th Legislature also required TRS to control the cost of its TRS-Care plan through a series of specific requirements. TRS responded by redesigning TRS-Care. TRS also implemented certain cost-reduction measures for its TRS-ActiveCare plan. TRS projected that it would achieve a \$157.1 million cost reduction for fiscal year 2004; our analysis indicated that TRS would achieve a \$166.6 million reduction in costs.

For both ERS and TRS, our analyses were based on a six-month period of actual claims data from fiscal year 2004 (because this was the claims data that was available during the time of our audit); actual claims experience for the remainder of the biennium may differ.

The cost-reduction measures that ERS and TRS implemented generally are more extensive than the measures that other states have implemented to reduce costs.

ERS and TRS should improve certain aspects of contract management.

We identified improvements that ERS should make to help ensure that it (1) objectively selects the contractor with the lowest total costs, (2) receives the proper amount of pharmacy rebates, and (3) extends contracts with proper documentation. At TRS, we identified specific enhancements to (1) provide incentives for contractors to hold claims costs down and (2) strengthen contract monitoring.

Strategies for continuing to contain health care costs could produce minimal state costs savings; continuing to shift costs could produce additional state costs savings but could also have a negative impact on members.

Implementing or enhancing cost-containment strategies such as tiered provider programs, drug formulary management, opt-out plan provisions, and wellness programs could produce minimal state costs savings when compared with cost-shift measures. In addition, cost-shift strategies such as increasing members' share of premiums, increasing member co-pays, increasing deductibles, changing coinsurance requirements, and introducing consumer-directed health plans could further reduce state costs. However, the impact of cost-shift strategies on members (for example, the impact on employee morale, recruitment, and retention) would also need to be considered.

Summary of Management's Response

ERS's and TRS's responses indicate that they generally believe their procedures over fraud, waste, and abuse; member eligibility; insurance claims audits; in-house claims reviews; and contracting are appropriate. However, both agencies agree that they will implement certain recommendations if they are cost-effective and improve current procedures or documentation.

Summary of Objectives, Scope, and Methodology

Our objectives were to:

- Determine whether the cost-containment measures taken for the self-insured ERS and TRS health care plans are achieving intended results.
- Determine whether ERS and TRS health care contracts are properly administered to ensure that the State receives health care services at the lowest cost.
- Identify additional cost-containment measures (including new plan designs) used by other state health insurance plans that could be applicable to the ERS and TRS plans.

Our scope covered ERS's and TRS's health care plans and associated contracts, as well as claims data for fiscal year 2003 and the first half of fiscal year 2004. Our audit did not include a review of information technology.

Our methodology consisted of collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating the results of the tests, and conducting interviews with ERS and TRS management and staff. We also researched and benchmarked industry practices and standards.

Recent SAO Work		
Number	Product Name	Release Date
04-025	An Audit Report on the Teacher Retirement System's Implementation of TRS-ActiveCare, the Health Care Plan for Active School District Employees	March 2004
04-017	A Report on the Teacher Retirement System's Pension and Retiree Health Insurance Plans	December 2003
02-032	A Review of Selected Controls at the Employees Retirement System	March 2002

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Detailed Results

Chapter 1

ERS Has Reduced State Health Care Plan Costs, Primarily by Shifting Costs to Members; However, It Should Strengthen Efforts to Detect Fraud and Improve Health Plan Contract Management

The measures that the Employees Retirement System (ERS) has implemented to reduce the amount the State pays for its health care plans have generally worked as intended. These measures primarily consisted of plan design changes (changes in co-pays, deductibles, and coinsurance) that shifted medical costs from the State to members. ERS offers one statewide health care plan and five regional HMOs (see text box below).

In addition, ERS may achieve further reductions to state health care costs by strengthening efforts to detect fraud and reviewing detailed claims information.

ERS's daily operational administration of health care and pharmacy benefits contracts is generally adequate, but we identified improvements that ERS should make to help ensure that it (1) objectively selects the contractor with the lowest total costs, (2) receives the proper amount of rebates, and (3) extends contracts with proper documentation.

ERS's Health Care Plan

ERS's Group Benefits Program (GBP) covers active and retired employees of state government and higher education institutions (except for the University of Texas and Texas A&M University) and their dependents.

The GBP includes health insurance coverage under one statewide plan (HealthSelect) and five regional HMOs. HealthSelect includes both medical and pharmaceutical coverage. ERS has contracted with Blue Cross and Blue Shield of Texas (BCBSTX) to maintain a network of medical providers and administer the payments for medical benefits. HealthSelect pharmacy benefits and network are administered through ERS's contract with Medco Health Solutions (Medco). BCBSTX and Medco have contracts with their network providers that include negotiated amounts for each type of service or drug provided.

In fiscal year 2004, ERS had separate contracts with each of the five HMOs to provide both medical and pharmacy coverage. The HMOs are fully insured programs. ERS pays a set monthly premium that covers both provider payments and administration. The HMOs bear all financial risk beyond the cost of the premiums.

HealthSelect is a self-insured program. ERS reimburses BCBSTX and Medco from the GBP fund for all provider claims it pays. The GBP fund is funded through monthly insurance premiums. The State pays the full amount of the premium for each employee (\$315.56 per month) and one-half of the additional premium for dependents. Dependent options for HealthSelect coverage and the additional amount the State pays are:

- Spouse - \$180.16 per month
- Child(ren) - \$120.63 per month
- Family - \$300.79 per month

The State also pays a monthly per-member fee to BCBSTX for each plan enrollee for administering the medical benefits portion of the plan. There is no monthly administration fee for Medco, which is compensated through privately negotiated rebate and discount arrangements with pharmaceutical manufacturers.

ERS's Cost-Reduction Measures Have Generally Worked as Intended, Primarily by Shifting Costs from the State to Members

The General Appropriations Act (78th Legislature) required ERS to “reduce total health plan costs by \$485.5 million in All Funds and \$296.1 million in General Revenue” for the 2004–2005 biennium.¹ As Table 1 shows, ERS projected that it would achieve a \$621.3 million state cost reduction for the 2004–2005 biennium through certain cost-reduction measures. Although the difference in ERS’s and our cost reduction estimates may be overcome by savings in claims costs due to decreased utilization, our analysis of claims data indicated that ERS may not achieve \$177.8 million of its projected cost savings. In addition, our analysis was based on a six-month period of actual claims data from fiscal year 2004 (because this was the claims data that was available during the time of our audit); actual claims experience for the remainder of the biennium may differ.

The measures that ERS implemented generally are more extensive than the measures that other states have implemented to reduce costs. Appendix 2 lists a three-year history of measures that ERS has implemented to reduce costs.

Table 1

Summary of Selected Cost Reduction Measures ERS Implemented in Fiscal Year 2003 and Fiscal Year 2004		
Cost Reduction Measure	ERS Estimate of State Cost Reduction	State Auditor’s Office Estimate of State Cost Reduction
90-day wait for coverage to begin for new employees	\$58.9 million	\$59.3 million
\$50 annual deductible for pharmacy benefits	\$21.5 million	\$28.3 million
Increase in co-pays for pharmacy benefits	\$156.1 million	\$68.6 million
Increase in coinsurance requirement and stop-loss coverage	\$105.1 million	\$132.9 million
Increase in co-pays for office visits and visits to specialists, hospitals, and emergency rooms	\$148.6 million	\$23.3 million
Subtotals	\$490.2 million	\$312.4 million
Other miscellaneous cost-reduction measures	\$131.1 million	\$131.1 million ^a
Totals	\$621.3 million	\$443.5 million
^a We did not analyze these measures because the associated cost reduction could not be determined through a review of claims data.		

For the first six months of fiscal year 2004, the total cost of medical and pharmacy claims paid through ERS’s HealthSelect health care plan was 4 percent less than the cost for the same period in fiscal year 2003. This overall reduction was the result of a 3 percent increase in the cost of HealthSelect medical claims paid (which was well

¹ See Rider 5, pages I-43 through I-44, the General Appropriations Act (78th Legislature).

below national averages), which was offset by a 24 percent decrease in the cost of HealthSelect pharmacy claims paid.

Management's Responses from ERS Regarding the State Auditor's Office's Cost-Reduction Estimates

The SAO measured changes in member copayments for pharmacy benefits and for visits to physicians, hospitals and emergency rooms. The changes in plan cost cannot be calculated simply by tabulating the increases in these amounts from 2003 to 2004. Such a methodology overlooks the impact such copayment increases have on member utilization of benefits.

The actual experience emerging under HealthSelect indicates that the actual savings resulting from the cost reduction measures will be greater, not less than the amounts projected for the 2004–2005 biennium.

Auditor's Follow-Up Comment

As we noted, differences in cost-reduction estimates may be overcome by savings in claims costs due to decreased utilization.

To reiterate, we concluded that ERS's cost-reduction measures have generally worked as intended. The 4 percent reduction in the total cost of HealthSelect medical and pharmacy claims reflects the effects of cost-reduction measures (increased co-pays and deductibles) and any decrease in utilization.

Chapter 1-B

ERS May Achieve Further Cost Reductions by Strengthening Efforts to Detect Fraud and Reviewing Detailed Claims Information

While ERS's cost-reduction measures are generally working as intended, we identified several areas within its administration of health care plans that could be strengthened to potentially achieve additional cost savings.

Increase Fraud, Waste, and Abuse Detection Efforts

Medical fraud costs have increased dramatically in recent years. The BlueCross BlueShield Association (the umbrella group for BlueCross health care plans) reported that, for BlueCross plans nationwide, the costs of medical fraud had increased 66 percent in 2003 to \$162 million. Additionally, the Federal Bureau of Investigation reported that, in many of its 56 field offices, medical fraud was the number-one white-collar crime. The Texas Office of the Attorney General reports that, due to increased detection efforts, the identification of illegal overpayments to fraudulent Medicaid providers has increased by 85 percent since 2003.

We identified two ways in which ERS could strengthen its detection of fraud, waste, and abuse:

- **Contractors' efforts to detect fraud, waste, and abuse could be expanded.** ERS currently relies on the efforts of the fraud detection and special investigation units of their health plan and pharmacy benefit contractors (see Appendix 3 for

descriptions of a variety of health care plan fraud schemes). However, in most cases, the contractors' fraud detection efforts are directed to their entire lines of business rather than to specific health care plans. Based on the numbers of plan claims that the contractors reviewed and the reimbursements collected, these efforts appear to produce marginal results considering national fraud statistics. A cost-benefit analysis may indicate that more robust fraud, waste, and abuse detection efforts would be appropriate.

For example, according to BCBSTX it processed a total of 38,372,792 medical claims for all of its contracts (not just ERS) in fiscal year 2003. BCBSTX has six fraud investigators to evaluate this population of claims. Our review of claims data indicates that BCBSTX processed 4,980,034 ERS claims during that period (including both HealthSelect and HealthSelect Plus claims), for a total of approximately \$928 million. BCBSTX states that, in fiscal year 2004, it opened 13 cases that involved ERS claims. Six cases were closed in fiscal year 2004 (five were from 2003). Of these cases, two resulted in claim denials of \$1,150, one had recoveries of \$2,427, and three resulted in settlements totaling \$1,251,010. Given the national fraud statistics cited above and the volume of ERS claims, it appears that more could be done to detect fraud.

According to Medco (ERS's contracted pharmacy benefit manager), it performed 2,686 field audits and 91,550 desk audits for all of its contracts (not just its ERS contract) in 2003. Medco selects pharmacies to audit based on claims analysis of individual pharmacies (regardless of the health care plan for which the pharmacies provided drugs) and activity for all of Medco's contracts. According to Medco, the discrepancies identified in these audits may be either clerical in nature or intentional. Medco directs its audit staff to the pharmacies with the greatest potential for recovery. In calendar year 2003, 204 of Medco's field audits and 4,335 of Medco's desk audits involved ERS claimants that resulted in ERS recoveries of \$551,225. ERS pharmacy claims paid during fiscal year 2003 were \$293.1 million. As with medical claims, it appears that more could be done to detect fraud in pharmacy claims.

- Increase efforts to identify ineligible members and dependents. In 2003, ERS implemented a one-time amnesty program to allow members to voluntarily remove ineligible dependents from the health insurance eligibility roles. As a result, 4,200 ineligible dependents were removed from the ERS health care plan. ERS estimated that this saved \$3 million annually.

This is an indication that changing certain procedures to identify ineligible dependents could save ERS millions of dollars. These procedures could include (1) conducting sample audits through which documentation is requested to verify members' dependents' eligibility and (2) requiring state agencies to obtain documentation during enrollment to verify eligibility.

Conduct In-House Claims Reviews

ERS does not review the detailed claims information that the contractors administering the health care programs prepare. It does, however, contract for an annual audit of vendor claims processing. These claims audits focus on the accuracy of claims processing and can identify penalties that contractors may owe to ERS for

failure to meet performance standards. ERS collected \$2.8 million in sanctions from BCBSTX in fiscal year 2002 for failure to meet contract provisions.

However, supplementing those audits with regular in-house claims reviews could enable ERS to perform a variety of analyses to identify red flags that could indicate other potential recoupments or identify members that may be eligible for disease or case management programs.

Conducting internal reviews of detailed claims information can help verify the accuracy of contractors' invoices and provide other valuable information on a more timely basis. Performing basic data mining techniques using this information can identify issues that should be examined as a routine business practice.

Recommendations

ERS should:

- Explore requiring contractors that administer their health care plans to expand their fraud detection efforts and/or conduct health-plan-specific procedures to detect fraud, waste, and abuse.
- Continue efforts to identify ineligible members and dependents. In addition, implement additional procedures such as requiring state agencies to obtain documentation at the time of enrollment to verify eligibility.
- Routinely review detailed claims information in house to identify anomalies that should be examined in more detail.

Management's Response

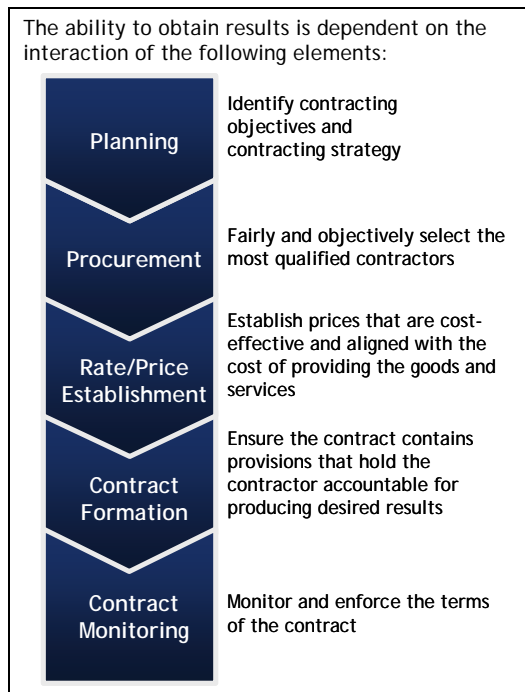
- *The Texas Employees Group Benefits Program has extensive fraud detection and prevention activities which have been set forth in ERS' annual cost containment report to the Governor's Office, the Lieutenant Governor's Office, the Speaker of the House and the Legislative Budget Board. In addition, ERS' efforts to prevent and detect fraud have been reported to the Governor's Office pursuant to Executive Order RP36. ERS requires the vendors with whom it contracts to be diligent in their efforts to detect fraud, abuse and other improprieties. Vendors are required to have in place advanced methods for detecting abuse, including, but not limited to, highly automated systems and appropriate administration to prevent improper or fraudulent activities. ERS continues to work with vendors to strengthen detection of claims abuse opportunities.*
- *Following the conclusion of the one-time eligibility amnesty period, ERS has conducted eligibility audits in which members are requested to provide documentation to support their dependents' eligibility to participate in the Group Benefits Program. To date, 93 eligibility audits have been conducted. In addition, ERS routinely performs death matches with various sources to verify we are not paying benefits to deceased members.*

- ERS relies on experts with specialized knowledge to perform the claims review function. Through its outside auditor, ERS is conducting an expanded claims audit beginning with fiscal years 2001, 2002 and 2003. Under this audit, 100% of all health claims will be electronically reviewed to identify over payments. Once identified, these claims are set-up for recovery. This process is in addition to the regular annual claims audit, which includes a review of a stratified sample of claims. ERS utilizes outlier information from the Pharmacy Benefit Manager's reporting and is integrating this process with the medical operations to identify abuses of medications, pharmacies and providers. ERS is also exploring additional data mining capabilities that will allow us to further review claims data.*

Chapter 1-C

ERS Should Make Certain Improvements in Contract Management

Figure 1 - The Five Contract Administration Elements



Source: *State of Texas Contract Management Guide - Version 1.1*, page 5

ERS's daily operational administration of health care and pharmacy benefits contracts is generally adequate. However, we identified improvements that ERS should make to help ensure that it (1) objectively selects the contractor with the lowest total costs, (2) receives the proper amount of rebates, and (3) extends contracts with proper documentation.

Figure 1 describes the five elements of good contract management; we focused on the last four elements in this process.

Table 2 summarizes the major contracts that ERS has established to administer its health care plans and pharmacy benefits.

Table 2

Summary of Major ERS Contracts to Administer Health Care Plans and Pharmacy Benefits		
Health Care Program	Contractor	Contractor Services
HealthSelect	BlueCross BlueShield of Texas (BCBSTX)	Administers the health care plan for current and retired state employees
	Medco Health Solutions (Medco)	Administers pharmacy benefits for current and retired state employees

Contract Procurement

We reviewed the processes that ERS used in fiscal year 1998 to procure contracts because these were the most recent procurements that ERS had completed. ERS is currently in the process of procuring health care and pharmacy benefits administration services and, when conducting this procurement, should address the procurement issues we identified.

The process that ERS used to select BCBSTX to administer the HealthSelect health care plan and Medco to administer HealthSelect pharmacy benefits generally resulted in the selection of qualified contractors. ERS’s legal department provided support and input into the procurement process, and ERS made a good effort to reach as many potential bidders as possible. However, we noted that the selection process used to evaluate bidders may not have ensured the objective selection of the contractor with the lowest total costs:

- ERS did not adequately compare bidders’ expected claims costs for administering the health care plan. Although ERS obtained pricing information about different medical services in different regions, it did not apply this information to its own plan’s historical utilization data to develop comparative, total claims costs for each bidder. Performing this analysis could have given ERS a more precise understanding of the potential cost of contracting with each bidder.

ERS Contract Procurements We Audited

We reviewed the processes that ERS used in fiscal year 1998 to procure the following contracts:

- ERS’s contract with BCBSTX to administer the health care plan for the HealthSelect program.
- ERS’s contract with Medco to administer pharmacy benefits for the HealthSelect program.

At the time of our audit, the procurements that ERS had conducted in fiscal year 1998 were the most recent procurements ERS had completed. Both contracts became effective in fiscal year 2000 for periods of three years, and they were subsequently extended for three additional years.

- ERS did not establish relative weights for the selection criteria in its requests for proposal (RFP) to administer the health care plan and pharmacy benefits. Establishing weights for each criterion could help ERS ensure that it objectively selects the best contractor.
- Although ERS established evaluation criteria in its RFPs, it did not have documentation indicating that it used this criteria when evaluating bidders. Although having this documentation is not required by law, ERS did not have:
 - ♦ Evaluation scoring matrices consistent with evaluation criteria specified in RFP.
 - ♦ Evaluation scoring sheets completed by the team members (including accurate tabulation of scoring results).

- ♦ Evaluation briefings ERS gave to evaluation team members before the beginning of individual bidder evaluations.
- ♦ Signed nondisclosure statement from each evaluation team member.
- ♦ Documentation demonstrating that it conducted site visits described in its RFPs.

Documenting these items in future procurements could help ERS ensure that evaluation team members use consistent criteria when evaluating bidders and maintain the confidentiality of information during the contract procurement process.

ERS also did not have a comprehensive contract manual that provided clear policies, procedures, and guidelines for the RFP process. Establishing such a manual could help to ensure that there is consistency in various procurements and that staff appropriately complete all tasks in the procurement process.

Contract Rate/Price Establishment

ERS's contract rate/price establishment processes appear reasonable. However, although ERS received \$15.2 million in drug rebates from Medco, it could not provide evidence that its actuary verified that this was the amount ERS should have received. Medco provides its pharmacy management services at no cost to ERS. One of the sources of Medco's compensation is the rebates it receives from pharmaceutical manufacturers whose drugs are in the ERS formulary. ERS receives a guaranteed rebate amount for each prescription filled, which is credited back to the health care plan. ERS relies on its actuary to verify that the amount of guaranteed drug rebate revenue received is correct.

ERS Payments to HealthSelect Contractors in Fiscal Year 2003

BCBSTX:

- ERS paid BCBSTX \$68 million in administrative fees.
- Medical claims paid totaled \$927.9 million.

Medco:

- Medco retained part of the rebates it received from pharmaceutical manufacturers for purchasing drugs. ERS does not know the total amount of the rebate that Medco retained because pharmaceutical manufacturers and pharmacy benefits managers keep this information confidential. ERS's portion of the rebate was \$15.2 million.
- Pharmacy claims paid totaled \$293.1 million.

We did not identify any issues regarding rate/price establishment processes for ERS's contract with BCBSTX. ERS received feedback from its actuary regarding industry norms for contractors' fees for administering health care plans. Based on the number of members reported by ERS, we determined that the \$68 million in total administrative fees that ERS paid to BCBSTX in fiscal year 2003 was reasonable.

Contract Formation

We concluded that the provisions in ERS's contracts with BCBSTX and Medco were generally sufficient to hold these contractors accountable. The contracts require periodic reporting by the contractor, annual performance audits, and compliance with laws and regulations. The contracts also specify definitions of allowable and unallowable expenditures and include terms regarding reimbursement of overpayments.

ERS's contract with BCBSTX also contains a health care management incentive designed to promote the efficient and cost-effective management of health care provided to in-area participants. The incentive calls for BCBSTX to receive a bonus or pay a penalty based on whether actual in-area claims costs exceed or are less than a target claims cost that ERS and BCBSTX agree upon in advance. The amount of the incentive varies depending on the amount that actual claims either exceed or are less than the target claims cost. In fiscal year 2003, BCBSTX paid ERS a penalty of \$851,121 because claims costs exceeded the target claims cost in the 2002 plan year.

ERS's contract with BCBSTX also included a provision allowing for an extension of the contract, but ERS did not formally document its justification for extending its contract with BCBSTX to administer the health care plan for an additional three years. Without this documentation, it is difficult to determine how ERS considered past performance in its decision to extend the contract.

Contract Monitoring

ERS's monitoring of BCBSTX and Medco is generally adequate to ensure that ERS enforces the terms of its contracts. ERS's contract monitoring staff maintain written policies and procedures, establish monitoring plans, and document monitoring results. ERS follows up on its monitoring reviews to ensure that contractors take corrective action. When ERS external auditors identify issues, ERS's contract monitoring staff follow up on those issues until they are resolved. Through this process, ERS received \$2.8 million in performance penalties from BCBSTX in fiscal year 2002.

Recommendations

ERS should:

- In the future, consider following the guidelines set forth in the new *State of Texas Contract Management Guide* published by the Texas Building and Procurement Commission.
- More thoroughly compare bidders' expected claims costs for health care services by applying pricing information to historical utilization data.
- Establish relative weights for the individual contractor selection criteria in its RFPs.
- Document all aspects of its contract procurement process, such as evaluation team briefings, scoring matrices, completed scoring sheets, and site visits for selected finalists.
- Document policies, procedures, and guidelines for its RFP process.
- Ensure that its actuary documents the analysis it conducts to ensure that ERS receives the appropriate rebate revenue.
- Formally document its justification for extending its contracts.

Management's Response

- *ERS fully intends to follow the guidelines set forth in the recently released State of Texas Contract Management Guide. ERS was already exercising many of the techniques recommended in the guide prior to its release. ERS will further review the enhanced guidelines and adapt its policies and procedures to include appropriate guidelines based on the ERS competitive bid process.*
- *The method that we use is extremely effective and totally objective. By comparing proposed target claims costs, we are able to differentiate among the cost effectiveness of the proposers. The target claims cost that each proposer submits represents their analysis of the cost effectiveness of their management of utilization and provider reimbursement and their ability to manage the claims cost. The bonus/penalty associated with the target claims cost not only provides them with an incentive for good management, it also requires them to properly represent the cost effectiveness of their network in their proposal. The financial risk is too great for the vendor to understate this factor. As a result, it provides ERS with an excellent measure of comparison.*
- *As the auditor noted, the process reviewed took place six years ago and included a thorough review of the proposals. The procurement and monitoring process at ERS has undergone significant changes since that time.*
- *ERS currently documents all aspects of its bid process. ERS bids its HMOs every year through the Application process. The development includes timelines, bidders conferences, evaluation criteria, contract development and implementation for new HMOs. This process, along with enhanced processes from the Contract Management Guidelines, will be documented and applied to the current and future RFP evaluations.*
- *ERS currently documents all aspects of its bid process, including the guidelines for the RFP process.*
- *ERS currently verifies with its actuary that the rebate received is accurate based on the detail monthly Rx claims file. The actuary currently provides written documentation showing the results of the review.*
- *Justification for extending applicable contracts will be fully documented going forward.*

TRS Has Reduced State Health Care Plan Costs, Primarily by Shifting Costs to Members; However, It Should Strengthen Efforts to Detect Fraud and Improve Health Plan Contract Management

The measures that the Teacher Retirement System (TRS) has implemented to reduce the amount the State pays for its health care plans have generally worked as intended. These measures primarily consisted of plan design changes (changes in co-pays and coinsurance) that shifted medical costs from the State to members. TRS offers a variety of health care plans for active and retired school district employees and their dependents (see text box below).

In addition, TRS may achieve further reductions to state health care costs by strengthening efforts to detect fraud and reviewing detailed claims information.

TRS's daily operational administration of health care and pharmacy benefits contracts is generally adequate, but we identified specific enhancements that TRS needs to make to (1) provide incentives for contractors to hold claims costs down and (2) strengthen contract monitoring.

The TRS-Care Plan

TRS-Care covers school district retirees and their dependents. To be eligible, a retiree must be 65 years old with 10 years of service or meet the rule of 80. In response to changes the General Appropriations Act required, TRS-Care was entirely restructured for fiscal year 2005.

TRS-Care has three programs. TRS-Care 1 offers catastrophic coverage at no cost to the retiree but has higher out-of-pocket costs. Premiums for dependent coverage under TRS-Care 1 vary depending on Medicare eligibility of the member and/or dependent. TRS-Care 3 has the most generous benefits but the highest premium costs. Premiums vary by both Medicare eligibility and years of service. TRS-Care 2 is a new comprehensive plan with deductibles between those of the other two programs and benefit provisions nearer to those of TRS-Care 3.

TRS contracts with Aetna to administer the provider network and pay medical claims; it contracts with Caremark to administer pharmacy benefits. TRS-Care is a self-insured plan, and TRS reimburses Aetna and Caremark for claims paid. TRS-Care is funded through active employee payroll deductions and employer contributions, retiree premiums, investment returns, and supplemental appropriations. Employees contribute 0.5 percent of salary, school districts contribute 0.4 percent of covered payroll, and the State's monthly contribution is 1.0 percent of covered employee payroll. When employees retire and become eligible for coverage under TRS-Care 3, they pay a monthly premium ranging from \$90 (for member-only coverage with 30 years of service and Medicare coverage) to \$747 (for member and family coverage with less than 20 years of service and no Medicare coverage). A total of \$758.6 million was appropriated for fiscal years 2004 and 2005 for the TRS-Care Fund.

The TRS-ActiveCare Plan

TRS-ActiveCare covers active school district employees and their dependents. It is a statewide plan with three levels of coverage. There are also three regional HMOs. TRS-ActiveCare 1 is a basic plan with no premium cost to the employee but has higher out-of-pocket expenses. TRS-ActiveCare 2 is an intermediate plan. TRS-ActiveCare 3 must, by statute, provide benefits equivalent to the ERS HealthSelect plan. TRS-ActiveCare 3 has the highest premium costs.

TRS-ActiveCare is a self-insured plan that is funded entirely by member premiums and employer (school district) contributions. Each full-time school district employee receives \$500 per year (\$41.66 per month) in state appropriated supplemental compensation. Additionally, the State provides each school district employee \$900 per year (\$75 per month) for health insurance through the funding formulas in the Foundation School Program. Statute requires school districts to provide an additional \$150 per month for health insurance. Any difference in these amounts and the cost of the premium is paid by the school district employee or the school district. TRS-ActiveCare monthly premiums range from \$249 for TRS-ActiveCare 1 member-only coverage to \$1,047 for TRS-ActiveCare 3 member and family coverage.

TRS's Cost-Reduction Measures Have Generally Worked as Intended, Primarily by Shifting Costs from the State to Members

The General Appropriations Act required TRS to control the cost of its TRS-Care plan (the health insurance plan for retired school district employees) through a series of specific requirements.² TRS responded by redesigning TRS-Care for fiscal year 2005.

As Table 3 shows, TRS estimated that its new pharmacy co-pay structure for TRS-Care would reduce costs by \$130.0 million for fiscal year 2004. Our analysis of claims data indicates that this measure will save approximately \$133.4 million. Table 3 also shows that TRS implemented certain cost-reduction measures for its TRS-ActiveCare plan (the health insurance plan for active school district employees). TRS projected that those measures would achieve a \$27.1 million cost reduction for fiscal year 2004; our analysis of claims data indicated that TRS-ActiveCare would achieve a \$33.2 million reduction in costs. It is important to note that, because TRS-ActiveCare is funded through member premiums, cost reductions accrue to the health plan and not to the State. Savings for the health plan may result in lowered member premiums. Savings for the State could only occur through reduced appropriations to supplemental compensation for active school district employees or to the Foundation School Program.

Our analysis for both TRS-Care and TRS-ActiveCare was based on a six-month period of actual claims data from fiscal year 2004 (because this was the claims data that was available during the time of our audit); actual claims experience for the remainder of the biennium may differ.

The measures that TRS implemented generally are more extensive than the measures that other states have implemented to reduce costs. Appendix 2 lists a three-year history of measures that TRS has implemented to reduce costs.

² See Rider 4, pages III-37 through III-38, the General Appropriations Act (78th Legislature).

Table 3

Summary of Selected Cost-Reduction Measures TRS Implemented in Fiscal Year 2004			
Health Care Plan	Cost-Reduction Measure	TRS Estimate of Cost Reduction	State Auditor's Office (SAO) Estimate of Cost Reduction
TRS-ActiveCare	Increase in TRS-ActiveCare 3 coinsurance requirement and out-of-pocket maximum	\$13.1 million	\$14.5 million
	Increase in TRS-ActiveCare 3 and TRS-ActiveCare 2 co-pays for office visits	\$3.8 million	\$6.8 million
	Increase in TRS-ActiveCare 3 and TRS-ActiveCare 2 co-pays for pharmacy benefits	\$10.2 million	\$11.9 million
Subtotals for TRS-ActiveCare		\$27.1 million	\$33.2 million
TRS-Care	Implementation of a three-tier drug formulary based on a co-pay structure	\$30.0 million	\$33.4 million
	Other miscellaneous cost-reduction measures (\$62 million in premium increases and \$38 million in network restructure)	\$100.0 million	\$100.0 million ^a
Subtotals for TRS-Care		\$130.0 million	\$133.4 million
Totals for TRS-ActiveCare and TRS-Care		\$157.1 million	\$166.6 million

^a We did not analyze these measures because the associated cost reduction could not be determined through a review of claims data.

TRS-ActiveCare's membership increased by 17 percent in January 2004. From the last half of fiscal year 2003 to the first half of fiscal year 2004, the TRS-ActiveCare health care plan achieved.³

- A 13 percent decrease in the average cost per TRS-ActiveCare medical claim paid.
- A 1 percent decrease in the average cost per TRS-ActiveCare pharmacy claim paid.

TRS-Care's membership increased by 12 percent in 2004. In a comparison of the first half of fiscal year 2004 with the same time period in fiscal year 2003, the TRS-Care plan for retired school district employees achieved:

- An 8.5 percent decrease in the average cost per TRS-Care medical claim paid.
- An 8 percent decrease in the average cost per TRS-Care pharmacy claim paid.

Chapter 2-B

TRS May Achieve Further Cost Reductions by Strengthening Efforts to Detect Fraud and Reviewing Detailed Claims Information

While TRS's cost-reduction measures are generally working as intended, we identified several areas within its administration of health care plans that could be strengthened to potentially achieve additional cost savings.

³ We used average cost per claim for TRS's health care plans because these plans experienced large gains in membership. In addition, because TRS-ActiveCare was not implemented until fiscal year 2003, we compared the last half of fiscal year 2003 with the first half of fiscal year 2004.

Increase Fraud, Waste, and Abuse Detection Efforts

As discussed in more detail in Chapter 1-B, medical fraud costs have increased dramatically in recent years. We identified two ways in which TRS could strengthen its detection of fraud, waste, and abuse:

- Contractors' efforts to detect fraud, waste, and abuse could be expanded. TRS currently relies on the efforts of the fraud detection and special investigation units of their health plan and pharmacy benefit contractors (see Appendix 3 for descriptions of a variety of health care plan fraud schemes). In most cases, the contractors' fraud detection efforts are directed to their entire lines of business rather than to specific health care plans. Based on the numbers of plan claims that the contractors reviewed and the reimbursements collected, these efforts appear to produce marginal results considering national fraud statistics. A cost-benefit analysis may indicate that more robust fraud, waste, and abuse detection efforts would be appropriate.

For example, according to BlueCross BlueShield of Texas (BCBSTX), it processed 38 million claims in 2003, of which it estimates that TRS-ActiveCare claims represented 5 percent. BCBSTX opened eight TRS-ActiveCare claims investigation cases from July 1, 2003, through June 30, 2004. The confirmed loss due to fraudulent claims was \$6,018.59, and the recoveries from those claims were \$3,515.21. Additional claim charges of \$77,915.29 were denied prior to payment because they had undergone prepayment review. TRS-ActiveCare medical claims paid during that period were more than \$421 million. Given the national fraud statistics cited in Chapter 1-B and the volume of TRS-ActiveCare claims, it appears that more could be done to detect fraud.

- Increase efforts to identify ineligible members and dependents. Changing certain procedures to eliminate ineligible dependents could reduce costs. These procedures could include (1) conducting sample audits through which documentation is requested to verify members' dependents' eligibility and (2) requiring school districts to obtain documentation during enrollment to verify eligibility.

Under the TRS plans, the cost of premiums for family coverage is borne by the member; however, because premium costs are the same regardless of the number of dependents, members could be tempted to include ineligible individuals as dependents.

Conduct In-House Claims Reviews

TRS does not review the detailed claims information that the contractors administering the health care programs prepare. It does, however, contract for external claims audits approximately every two years. These claims audits focus on the accuracy of claims processing and can identify penalties that contractors may owe to TRS for failure to meet performance standards (see Chapter 2-C for additional details).

However, supplementing those audits with regular in-house claims reviews could enable TRS to perform a variety of analyses to identify red flags that could indicate other potential recoupments or identify members that may be eligible for disease or

case management programs. The TRS-ActiveCare program has performed some in-house analyses of certain pharmacy claims trends and data anomalies on an ad hoc basis. In addition, TRS-Care currently reviews a small sample of claims each month.

Conducting internal reviews of detailed claims information can help verify the accuracy of contractors' invoices and provide other valuable information on a more timely basis. Performing basic data mining techniques using this information can identify issues that should be examined as a routine business practice.

Recommendations

TRS should:

- Explore requiring contractors that administer their health care plans to expand their fraud detection efforts and/or conduct health-plan-specific procedures to detect fraud, waste, and abuse.
- Increase efforts to identify ineligible members and dependents by implementing additional procedures. These procedures could include requiring school districts to obtain documentation at the time of enrollment to verify eligibility.
- Routinely review detailed claims information in house to identify anomalies that should be examined in more detail.

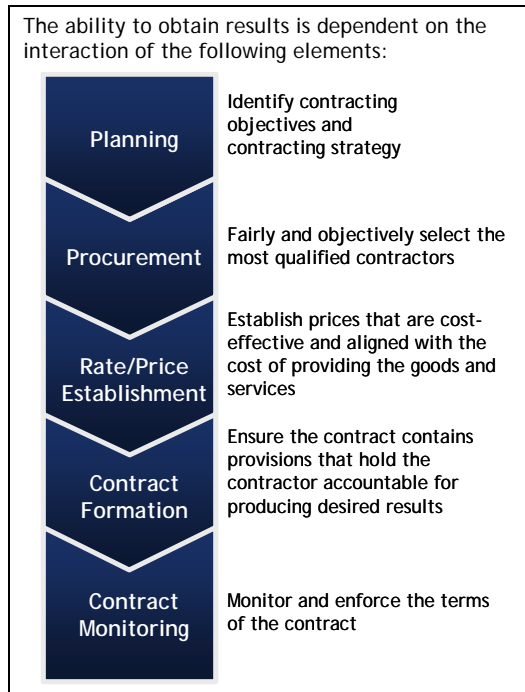
Management's Response

All TRS health care contractors have waste, fraud and abuse detection procedures in place. These vendors continually improve and enhance their detection processes. In conjunction with the quarterly review meetings held with all health care vendors TRS will address this issue to ensure that adequate procedures are in place to prevent/detect fraud.

Management believes that the current procedures in place are appropriate. TRS verifies retiree eligibility as part of the retirement process and school districts verify the eligibility of their employees. Unlike other health care plans, the TRS-administered plans have a small number of covered dependents.

On September 1, 2004 management created a new health benefits finance department for the retiree and active health care programs. During fiscal year 2005 the Director of this function will work with the TRS health care consultant and program staff to determine if additional in-house analysis will be cost effective.

Figure 2 - The Five Contract Administration Elements



Source: *State of Texas Contract Management Guide - Version 1.1*, page 5

Chapter 2-C

TRS Should Make Certain Improvements in Contract Management

TRS’s daily operational administration of health care and pharmacy benefits contracts is generally adequate. However, we identified specific enhancements that TRS needs to make to (1) provide incentives for contractors to hold claims costs down and (2) strengthen contract monitoring.

Figure 2 describes the five elements of good contract management; we focused on the last four elements in this process.

Table 4 summarizes the major contracts that TRS has established to administer its health care plans and pharmacy benefits.

Table 4

Summary of Major TRS Contracts to Administer Health Care Plans and Pharmacy Benefits		
Health Care Program	Contractor	Contractor Services
TRS-Care	Aetna US Healthcare (Aetna)	Administers the health care plan for retired school district employees
	Medco was pharmacy benefit contractor until August 31, 2004; Caremark became pharmacy benefit contractor September 1, 2004	Administers pharmacy benefits for retired school district employees
TRS-ActiveCare	BCBSTX	Administers the health care plan for active school district employees
	Medco	Administers pharmacy benefits for active school district employees

Our review of TRS’s contract management focused primarily on TRS’s contracts for TRS-Care because we previously reviewed contract management for TRS-ActiveCare contracts (see *An Audit Report on the Teacher Retirement System’s Implementation of TRS-ActiveCare, the Health Care Plan for Active School District Employees*, SAO Report No. 04-025, March 2004). During this audit, we reviewed (1) the TRS-Care contract with Aetna US Healthcare (Aetna) for procurement, rate/price establishment, contract formation, and monitoring; (2) the TRS-Care contract with Caremark for procurement and rate/price establishment; and (3) the TRS-ActiveCare contract with BCBSTX for procurement.

Contract Procurement

The process that TRS used to select Aetna to administer the TRS-Care health care plan, Caremark to administer TRS-Care pharmacy benefits, and BCBSTX to administer the TRS-ActiveCare health care plan generally resulted in the objective selection of the most qualified contractors. However, we noted that TRS did not have standard criteria for determining what to evaluate during a site visit or a written report documenting results of site visits conducted at bidders' locations. Because site visits help TRS to better understand bidders' computer capabilities and other critical operations, standardizing the site visit criteria and documenting the results could help TRS ensure that it objectively selects the best contractor.

For the procurements we audited, TRS's legal department provided support and input. In addition, TRS made a good effort to reach as many potential bidders as possible, and it compared bidders' responses by summarizing those responses in charts. In 2003, TRS also established a comprehensive contract manual for TRS-Care and TRS-ActiveCare. TRS also used weighting criteria to score bidders' responses.

Contract Rate/Price Establishment

TRS's contract rate/price establishment processes appear reasonable. Specifically:

- Rate/price establishment processes for the TRS-Care contract with Aetna. TRS obtains feedback from its actuary regarding industry norms for administrative rates. TRS verifies the accuracy of the total administrative fees Aetna charges by verifying the accuracy of the number of eligible members covered.
- Rate/price establishment processes for the TRS-Care contract with Caremark. Caremark receives compensation by retaining a portion of the rebate it receives from pharmaceutical manufacturers whose drugs are in the Caremark formulary. Caremark pays a flat rebate to TRS per prescription filled. In addition, TRS pays Caremark for other services such as prior authorization and Medicare Part B recoveries.
- Rate/price establishment processes for the TRS-ActiveCare contract with Medco. In our March 2004 audit report, we noted that TRS had begun recalculating the rebate amount it receives from Medco to ensure that it receives the proper amount of rebate. TRS determined that the \$4.5 million in rebates it received in fiscal year 2003 was the correct amount.

TRS Payments to TRS-Care and TRS-ActiveCare Contractors in Fiscal Year 2003

Aetna (TRS-Care):

- TRS paid Aetna \$18.7 million in administrative fees.
- Medical claims paid totaled \$355.9 million.

Medco (TRS-Care):

- Medco retained part of the rebates it received from pharmaceutical manufacturers for purchasing drugs. TRS does not know the total amount of the rebate that Medco retained because pharmaceutical manufacturers and pharmacy benefits managers keep this information confidential. TRS's portion of the rebate was \$9.5 million.
- Pharmacy claims paid totaled \$208 million.

BCBSTX (TRS-ActiveCare):

- TRS paid BCBSTX \$42.2 million in administrative fees.
- Medical claims paid totaled \$318.1 million.

Medco (TRS-ActiveCare):

- Medco retained part of the rebates it received from pharmaceutical manufacturers for purchasing drugs. TRS does not know the total amount of the rebate that Medco retained because pharmaceutical manufacturers and pharmacy benefits managers keep this information confidential. TRS's portion of the rebate was \$4.5 million.
- Pharmacy claims paid totaled \$75.6 million.

Contract Formation

Provisions in TRS's contract with Aetna are sufficient to hold Aetna accountable for the delivery of quality services. TRS's contract with Aetna includes provisions requiring periodic audits and financial accounting and reporting; definitions of allowable and unallowable expenditures; provisions for reimbursement of overpayments; and provisions requiring compliance with applicable laws and regulations.

However, we noted that the contract does not include incentives for the contractor to hold down the cost of future claims. As discussed in Chapter 1-C, ERS's contract with BCBSTX contains an incentive to promote the cost-effective management of health care through BCBSTX's administration of its provider network. BCBSTX receives a bonus or pays a penalty based on whether actual in-area claims costs exceed or are less than a target claims cost that ERS and BCBSTX agreed upon in advance. The amount of the incentive varies depending on the amount that actual claims either exceed or are less than the target claims cost. In fiscal year 2003, BCBSTX paid ERS a penalty of \$851,121 because claims costs exceeded the target claims cost in the 2002 plan year.

Contract Monitoring

While TRS generally monitors contracts adequately, we noted certain aspects of TRS's monitoring of Aetna that should be improved:

- External claims audits do not cover all claims. There have been three claims audits conducted in the past six years. However, the coverage period of these audits ranged from 10 to 12 months, with significant time gaps between audits. Because TRS relies heavily on the claims audits, more frequent audits that cover all claims would help enable TRS to identify and correct issues in a more timely manner. Illustrating the potential value of audits, ERS recovered \$2.8 million from BCBSTX in fiscal year 2002 when BCBSTX failed to meet performance standards.
- Although Aetna properly reported its performance guarantee results as required, TRS did not verify those results or ask Aetna for supporting documentation.
- TRS does not have a policy requiring standard monitoring site visit criteria or a written report documenting results of the site visits it conducts at Aetna.

TRS monitors Aetna's performance through reviews of member eligibility, administrative fees, and overall performance, as well as through site visits. In our March 2004 audit report, we recommended that TRS develop and implement a formal contract monitoring plan for TRS-ActiveCare contractors. TRS concurred with that recommendation and agreed to implement a formal monitoring program by August 31, 2004. Since that time, TRS has developed a monitoring plan that includes all five components of contract management and has established a monitoring team that includes representatives from several areas of the agency.

Recommendations

TRS should:

- In the future, consider following the guidelines set forth in the new *State of Texas Contract Management Guide* published by the Texas Building and Procurement Commission.
- In its contracts for the administration of health care plans, include incentives to encourage contractors to hold down future claims costs.
- Ensure that external claims audits cover all claims and are conducted with sufficient frequency to facilitate timely corrective action.
- Establish and implement procedures to verify contractors' reported performance.
- Require the use of standard site visit criteria and written reports documenting results of site visits conducted at (1) bidders and (2) entities with which it has contracted.

Management's Response

TRS is confident in its contract administration processes currently in place. Yet, we continually strive to improve in all of our operations. TRS is currently in the process of comparing the just released State of Texas Contract Management Guide, published by the Texas Building and Procurement Commission, to the TRS Contract Administration Guide. By December 31, 2004, the TRS Contract Administrator will provide TRS management with possible recommendations for revisions to our existing guide.

Management believes that current contract fees and related contract terms are appropriate and do provide the contractors with incentives to hold down claims costs while paying legitimate claims in a timely and accurate manner. Network savings are monitored on a monthly basis and reported quarterly to the Legislative Budget Board. Independent audits verify that the contractors are complying with terms and conditions of the contracts.

TRS believes the current two-year cycle for external claims audits is appropriate. If the audits indicate potential problems then TRS will re-evaluate the frequency of such audits. Future external claims audits will cover all claims data since the date of the last audit.

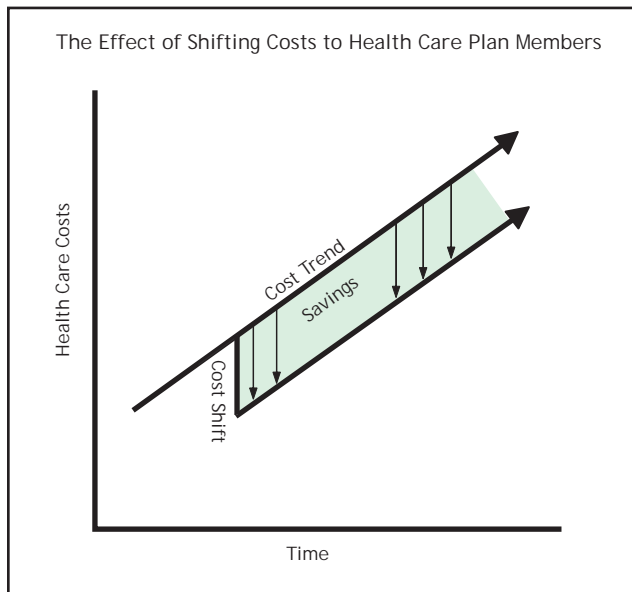
TRS relies on external audits and other information sources and procedures to verify reported performance. No additional procedures are planned at this time.

Management believes that the current procedures and documentation for evaluating health care bidders are very good and no changes will be made for this process. We do agree that we can improve our documentation of work performed at vendor site visits. The TRS-Care Director will develop a site visit report form so that work performed during the site visits will be documented. This will be developed by December 31, 2004.

Health Care Costs Continue to Increase, which Will Make Controlling Costs More Difficult for the State

Figure 3 illustrates the effect of shifting costs to health care plan members. While cost reductions can be achieved in the short run (as demonstrated by the results discussed in Chapters 1 and 2), the overall trend of increasing health care costs continues. Because health care costs continue to rise, it will be important for the State to continue to consider adjustments to its health care plans or the funding for these plans.

Figure 3



Health care costs have increased at double-digit rates for the past few years, and some analysts predict that this will continue in future years. ERS's cost data showed a 13 percent increase in total costs for HealthSelect and HealthSelect Plus between fiscal years 2002 and 2003. Industry literature indicates that an aging population, the marketing of drugs directly to consumers, the practice of defensive medicine, and the development and use of high-cost biotechnical drugs are some of the factors that have contributed to the increases in health care costs (see text box for additional details).

We were able to analyze the specific effects of an aging population on ERS's health care costs (because TRS has multiple health care plans, we conducted this analysis only for ERS's

HealthSelect plan). The average age of Texas

state employees in 2004 was 43 years. Since 1999, the average age of the State's employee workforce has increased by 4.26 months per year. According to ERS, the average age of HealthSelect participants (active and retired) is 49.9 years. Figures 4 and 5 illustrate that the effects of an aging population are likely to be a significant driver for state health care costs.

Factors Leading to Increases in Health Care Costs

- **Direct-to-consumer marketing:** Advertising directly to the patient rather than the doctor to create demand for a new drug.
- **Defensive medicine:** Providers performing excessive or unnecessary procedures to protect themselves from negligence lawsuits.
- **Biotechnical drugs:** New drugs developed to attack specific diseases through the use of DNA and cell-fusion technology. These drugs may cost thousands of dollars per dose.
- **Aging population:** The effect of increasing medical needs as members grow older.

Figure 4

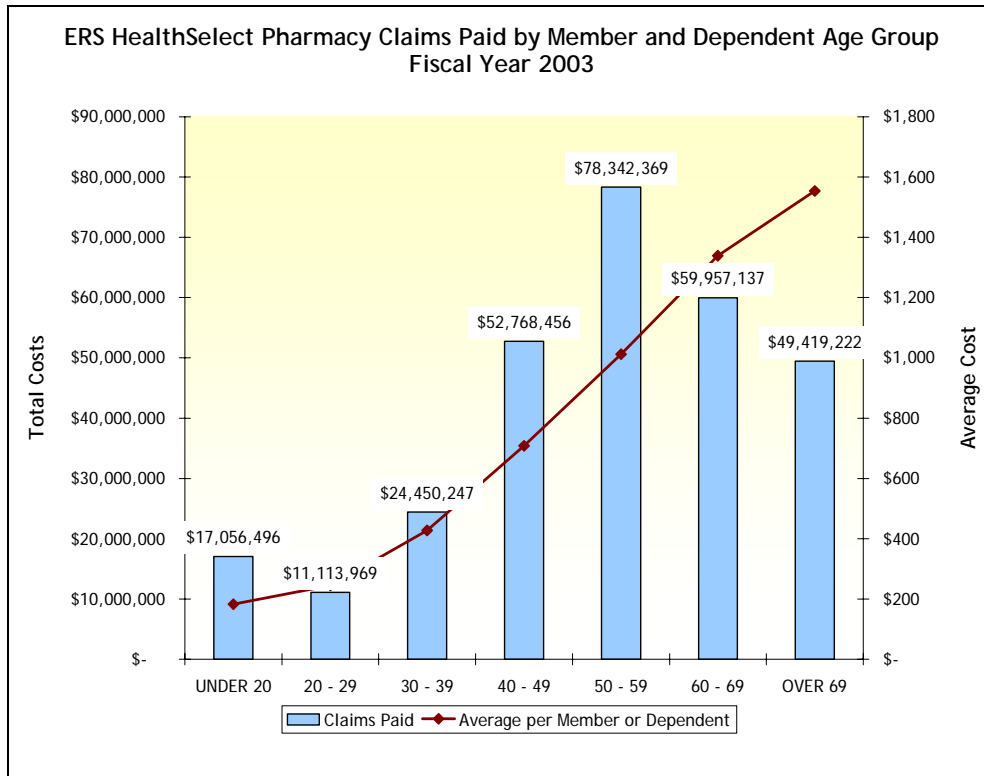
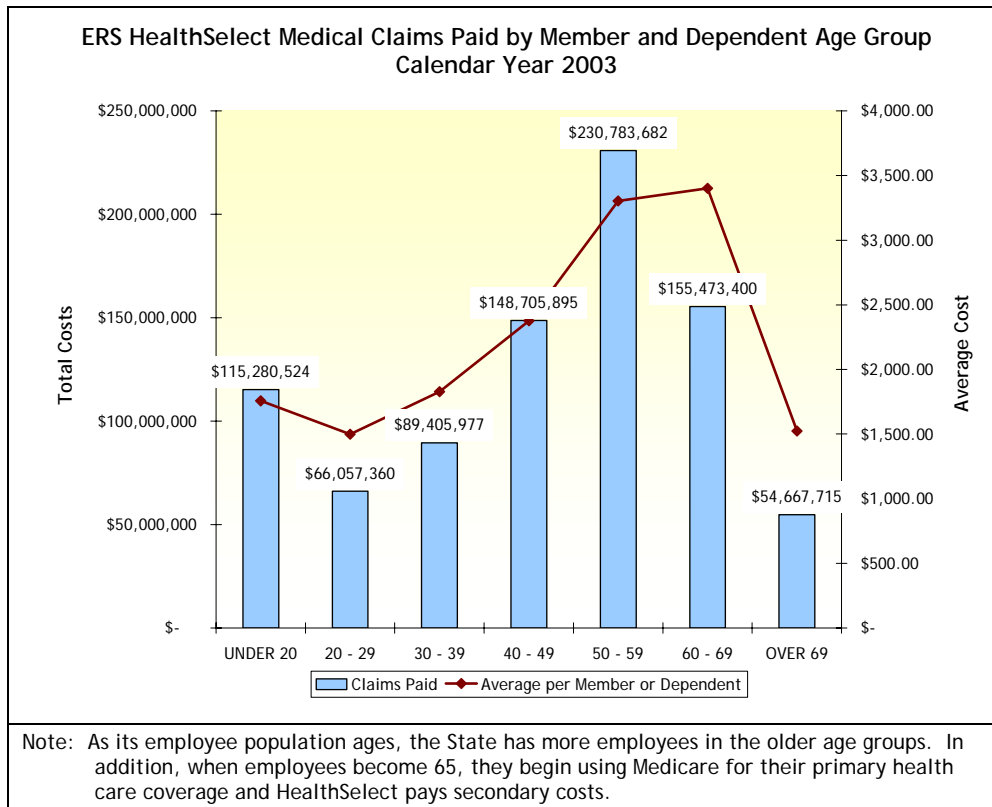


Figure 5



Strategies for Continuing to Contain Health Care Costs Could Produce Minimal State Costs Savings When Compared with Cost-Shift Strategies

Our research and benchmarking of industry practices and standards identified cost-containment strategies that could be implemented or enhanced. However, to be properly considered, each strategy would need to be evaluated from an actuarial standpoint to determine the cost and benefit to the individual plans and the effect on membership. Some health care plans report that they have achieved additional cost savings through these measures.

Tiered Provider Programs

Tiered provider programs compare providers (such as physicians, hospitals, and clinics) and arrange them in tiers by cost. The high-cost providers are expected to bring their costs in line or risk being dropped from the network. Alternatively, a high-cost provider may stay in the network and a member must pay a higher share of the costs to use that provider.

This type of program was adopted by the California Public Employees' Retirement System (CalPERS) in May 2004. CalPERS subsequently informed 38 high-cost hospitals that they would be dropped from the CalPERS network beginning in 2005. Members were not covered at the excluded hospitals unless they switched to a different health insurance plan with higher deductibles and other out-of-pocket costs. Under this program, CalPERS expects to save \$36 million in 2005 and \$50 million per year thereafter.

Drug Formulary Management

Currently, ERS and TRS health care plans have open drug formularies under which all drug tiers (generic, preferred, and nonpreferred) are covered. Adjusting the approach toward drug formularies could achieve additional state cost savings. However, such adjustments could necessitate changes to compensation arrangements with pharmacy benefit managers. For example, under ERS's and TRS's current formularies, the pharmacy benefit managers' compensation comes in the form of rebates from drug manufacturers. Under different formulary arrangements, the availability of rebates might be reduced, which could require ERS and TRS to pay their pharmacy benefit managers an administrative fee.

Some formulary management measures include:

- **Category exclusions to disallow certain drugs.** Some health care plans have excluded certain high-cost drugs from their formularies when less expensive but clinically equivalent alternatives exist. One example is the drug Zyprexa, an atypical antipsychotic drug used to treat schizophrenia and bipolar disorder. For their Medicaid programs, the states of Texas, Kentucky, and West Virginia have excluded that drug from their preferred drug lists because a less expensive alternative that is clinically equivalent exists and is covered. Zyprexa accounted for 46 percent of all spending on antipsychotic drugs for Medicaid in these states.
- **Fourth-tier drug designation to move members toward less expensive treatments.** The designation of fourth-tier drugs is a mechanism through which extremely

high-cost drugs are moved to a tier that requires coinsurance or a cost percentage co-pay. Under the current open system for ERS's HealthSelect plan and TRS-ActiveCare 3, a member would pay only a \$40 mail order co-pay or a \$55 retail co-pay for a biotech (non-preferred tier) maintenance drug that costs \$5,000 per month. In a fourth tier that required the member to pay 20 percent coinsurance, the cost to the member for the same drug would be \$1,000 per month until the maximum out-of-pocket limit is reached.

As an example of the use of a high-cost drug, we identified one member of TRS-ActiveCare who received more than \$1 million in pharmacy benefits while paying co-pays totaling \$900.

- **Fail-first policies to encourage use of cheaper formulary drugs.** This policy requires that the physician prescribe drugs from the formulary (older and cheaper drugs) first and show that these drugs fail to treat the condition before prescribing newer and more expensive drugs that are not in the formulary. To be effective, this policy is usually used in conjunction with strong prior approval rules. This policy also could limit the effects of direct-to-consumer marketing techniques. Some medical groups oppose this policy because they believe it is not in the best interest of the patient. This policy is currently an option used by some states in the Medicaid program.
- **Pill-splitting to take advantage of differences in ingredient pricing.** Although pill-splitting must be done on a voluntary basis and relies on members' ability to dispense the correct dosage, this technique could save costs. Many drugs have similar ingredient costs regardless of drug strength (dosage). For example, ERS pharmacies' claims-paid data indicates that Lipitor (the most expensive drug in terms of total claims paid for both the ERS and TRS plans) had an average retail 30-day cost of \$60.84 for a 10 milligram dosage and \$92.91 for 20, 40, and 80 milligram dosages. Under a pill-splitting arrangement, costs could be cut in half if a member taking the 40 milligram dosage was prescribed the 80 milligram dosage and split the pill in half. In fiscal year 2003, ERS and TRS paid claims for Lipitor that totaled \$26.7 million.

A study conducted by the Stanford Center for Research in Disease Prevention identified eleven drugs that are highly amenable to pill-splitting. We applied that study's method of analysis to the ERS and TRS health care plans and determined that pill-splitting for these eleven drugs could potentially save up to \$18 million per year. The actual savings would be less than this because not all members would participate.

However, the Stanford study also cautioned that pill-splitting must be clinically appropriate for the member. Some restrictions on pill-splitting include poor eyesight, physical inability, and poor memory on the part of the member. In addition, pills with enteric coatings (coatings that do not break down easily), time-release features, or short duration of absorption should not be split. There is also some risk of drug content loss due to powdering.

The State of North Dakota informed pharmacists that it would pay them an extra 15 cents a pill to split pills in half, as long as the pill had scoring that would allow the pharmacist to safely split it. In contrast, the State of Kentucky's Board of Pharmacy rejected a mandatory pill-splitting initiative, arguing that it

compromises the pharmaceutical profession. Kentucky now has a voluntary program.

- Drug reimportation to take advantage of lower drug costs in other countries. Advocates of drug reimportation claim that this may save patients up to 40 percent on drug costs. Critics say that fears over the safety of imported drugs are legitimate reasons to enforce the U.S. Food and Drug Administration's ban on reimporting drugs. Others claim that the expense of storing, testing, and distributing reimported drugs will consume much of the savings for most plans. Still others say that large increases in the use of reimported drugs would cause drug manufacturers to limit or cap the drugs they sell abroad, thereby closing the source or causing prices to increase.

Some state and local governments, mostly in states bordering Canada, are experimenting with methods to make these lower-cost drugs available to their members. The State of Illinois, in a program called I-SaveRX, has contracted with a Canadian pharmacy supplier to establish a clearinghouse for residents to directly contact 45 foreign pharmacies that have been approved by Illinois health inspectors. The clearinghouse claims to save up to 50 percent of the cost of the 100 most commonly used drugs.

Opt-Out Plan Provisions

ERS could implement a win-win, opt-out cash incentive for members who have duplicate health care coverage or access to other health insurance. Currently, industry insurance and ERS plan rules require the health care coverage provided by the active employer to be the primary coverage for a member with dual insurance coverage. Members who have or can obtain low-cost coverage from a spouse's health plan or have retiree health insurance from another employer currently have no incentive to decline the state coverage because the other coverage will be considered secondary and will pay for the coinsurance costs that ERS's plan does not pay.

It is difficult to estimate what the participation rate would be if an opt-out provision were offered. If 10 percent of members opted out and the opt-out payment was one-third of the full plan premium costs, the estimated savings to the State for ERS's health care plan would be approximately \$135 million during the 2004–2005 biennium.

Opt-out provisions also could have an overall negative effect on health plans because of the "adverse selection" that could occur if healthy members opt out of the plan, thereby increasing costs for the members who remain in the plan.

In the case of TRS, opt-out provisions may not be as effective because members of TRS's health care plans already pay a significant portion of their premiums and, therefore, already have an incentive to opt out of these plans.

Wellness Programs

These programs attempt to reduce employee health care needs. The results are usually long-term and difficult to evaluate on a cost-benefit basis. Typical program objectives are smoking cessation, weight control, nutrition and fitness improvement, and safety awareness. These programs also include employee screening for diseases

in the early stages when they are easier and less expensive to treat. Wellness programs are currently authorized by Chapter 664 of the Texas Government Code if funds are available, with approvals from the Governor and the Department of State Health Services. TRS-ActiveCare currently offers some features of wellness programs.

Management's Responses from ERS Regarding Opt-Out Plan Provisions

The savings estimated by SAO are overstated. The percentage of University of Texas System and Texas A&M System employees opting out is less than 5%. This low level of participation in the opt-out is attained even though the employee has access to 50% of the state contribution. In addition, although SAO mentions the potential for adverse selection and indicates that it could increase cost for those remaining in the plan, it fails to note that adverse selection would also deplete savings for the state.

Chapter 3-B

Continuing to Shift Costs Could Produce Additional State Costs Savings but Could Also Have a Negative Impact on Members

Our research and benchmarking of industry practices and standards also identified additional cost-shift strategies that could be considered. However, to be properly considered, each strategy would need to be evaluated from an actuarial standpoint to determine the cost and benefit to the individual plans and the effect on membership. While some health care plans report that they have achieved cost savings through these measures, the impact on members (for example, the impact on employee morale, recruitment, and retention) would also need to be considered.

Increasing Members' Share of Premiums

Under current ERS health care plan enrollment and premium cost, shifting 10 percent of the premium cost to the member would reduce the State's cost by approximately \$202 million for the 2006–2007 biennium. The fiscal year 2005 monthly premium for member-only coverage in ERS's HealthSelect plan is \$315 per member, which is covered entirely by the State's contribution.

In contrast, TRS's health care plans already require members to make premium contributions that exceed the national average of premiums paid by members. Under the prevalent TRS active employee plan (TRS-ActiveCare 2), the member's maximum monthly premium contribution is \$64. Under the prevalent TRS retiree plan (TRS-Care 3), the premiums for Medicare-eligible retirees range from \$90 to \$110 per month, depending on years of service; the non-Medicare-eligible premiums range from \$280 to \$310 per month, depending on years of service.

A 2003 survey of state health benefits conducted by the Segal Company (a private company providing employee benefit consulting and actuarial services) found that, on average, state employers nationwide pay 90 percent of the premium for member-only coverage, while the member pays the remaining 10 percent. The average includes 12 states (36 percent of respondents) that do not require the member to pay a portion of the premium for member-only coverage. Another study of health insurance trends and indicators conducted by the Kaiser Family Foundation (a non-profit health care research foundation) found that, on average, members paid 16

percent (\$42) of the average member-only premium. These studies did not compare member premium contributions with average salaries to assess whether members who are required to pay a portion of their premiums also receive higher salaries.

Although requiring ERS members to make premium contributions could save costs, this shift could have a substantial impact on employee morale, recruitment, and retention. This may also cause some healthy members to decline health coverage (adverse selection). In addition, the results of the state employee exit surveys given to employees when they terminate state employment show that dissatisfaction with pay and benefits is the second leading reason for employees' leaving state employment (retirement was first). The annual employment turnover rate for state employees was 17 percent in fiscal year 2003.

Increasing Member Co-pays

Both ERS and TRS require health plan members to share the costs of health care by making co-payments for medical and pharmacy benefits, and continuing to increase these co-pays could save the State additional costs. However, it should be noted that additional increases in co-pays could lead to decreased utilization which, in turn, could ultimately lead to higher medical costs in the future because members may delay getting health care or avoid getting regular, preventative screenings. After increasing co-pays and implementing deductibles in fiscal year 2003, ERS pharmaceutical utilization dropped by 17 percent for the first half of fiscal year 2004. Appendix 2 details the increases in co-pays that ERS and TRS implemented in fiscal year 2003.

The Kaiser Family Foundation's *Study of State Plans* shows that 24 percent of states required members to pay a \$20 office visit co-pay in fiscal year 2003. The co-pay for an office visit to a primary care physician through ERS's HealthSelect plan is \$20. Only 10 percent of states required members to pay co-pays that were higher than \$20, while 66 percent of states required members to pay lower co-pays.

Increasing Deductibles

ERS's and TRS's plans currently require deductibles only under certain circumstances. Increasing these deductibles or implementing them where they are not currently in place could save the State additional costs. Current plan requirements for deductibles are as follows:

- ERS's HealthSelect plan requires a \$50 annual deductible for pharmacy benefits and a \$500 deductible for medical benefits that applies only to out-of-network claims. There is also a \$200 out-of-area deductible for medical benefits.
- TRS-ActiveCare 2 and 3 do not have a pharmacy benefit deductible.
- TRS-ActiveCare 3 has a \$500 deductible for medical benefits for out-of-network claims.
- TRS-ActiveCare 1 and 2 have in-network deductibles of \$1,000 and \$500, respectively, for medical benefits.
- TRS-Care 1 has a deductible ranging from \$1,800 to \$4,000 for medical benefits and pharmacy benefits, depending on Medicare coverage.

- TRS-Care 2 has a deductible of \$1,000 for medical benefits and pharmacy benefits.
- TRS-Care 3 has a deductible of \$300 for medical benefits and pharmacy benefits.

The Kaiser study found that only 8 percent of state plans have a separate deductible for pharmacy benefits, while 79 percent have a plan deductible for medical benefits.

Changes to Coinsurance

Under a coinsurance arrangement, the member pays a portion of the medical claim. The current coinsurance rate is 80 percent paid by the plan and 20 percent paid by the member for ERS's HealthSelect plan, TRS-ActiveCare plans 1 and 2, and all TRS-Care plans. The current coinsurance rate for TRS-ActiveCare 3 is 85 percent paid by the plan and 15 percent paid by the member. According to the Segal Company survey, only 6 percent of states have member coinsurance requirements of more than 20 percent.

The maximum in-network coinsurance out-of-pocket amounts for members are \$1,000 plus copays for HealthSelect and TRS-ActiveCare 3, and \$2,000 plus deductibles and co-pays for TRS-ActiveCare 1 and 2. For the TRS-Care 1, 2, and 3 plans, the coinsurance cap plus deductibles and co-pays are \$9,000, \$6,000, and \$5,300, respectively.

Consumer-Directed Health Plans

To contend with rising health care costs, some employers have implemented consumer-directed health plans (CDHP). Still untested in state government, these plans center on the creation of an account with funds the employee can access to purchase his or her health care at any provider. While proponents of CDHPs contend that these plans offer more choice and flexibility, opponents assert that CDHPs are a temporary fix to a more permanent problem. Experts warn that there is not enough data or experience to draw definite conclusions about the effects of CDHPs. Appendix 4 provides additional details on CDHPs.

Management's Responses from ERS Regarding Increasing Member Share of Premiums

The Segal Company survey also indicates that state employers nationwide pay 78% of the premium for member and dependent coverage. Currently under the GBP, the State pays 67% of member and family coverage. Under the change discussed by SAO, the state would pay only 64% of member and family coverage.

Statewide Changes Could Also Be Considered

Potential Benefits of Combining State Health Care Contracts

BCBSTX already negotiates payment amounts with health care providers based on the total number of members and dependents in *all* of BCBSTX's Texas health care contracts (including all of its public sector contracts and all of its contracts with private sector entities). While combining multiple state health care contracts into a single contract would not achieve economies of scale with providers, it could lead to reduced administrative costs for state agencies that administer health care contracts.

According to BCBSTX, as of October 2004, the total number of members and dependents in all of its Texas health care contracts was 3,707,289. Of that number, 831,715 (22.4 percent) were members of ERS, TRS, and University of Texas health care plans.

Unlike BCBSTX, Medco negotiates pharmacy payments separately for individual health care plans. Therefore, combining multiple state pharmacy benefit contracts into a single contract and negotiating only one set of drug prices may achieve economies of scale that could reduce state costs. (This assumes that all health care plans would provide the same pharmacy benefits.) This could also lead to reduced administrative costs for state agencies that administer pharmacy benefit contracts.

According to Medco, as of October 2004, the total number of members and dependents in all of its Texas health care contracts was 4,200,000. Of that number, 979,417 (23.3 percent) were members of ERS, TRS, and University of Texas health care plans.

As adjustments to the State's health plans are considered, regular communication and coordination among all agencies and higher education institutions involved in health care administration might help to achieve the most favorable results, particularly in the area of contracting. For example:

- It could be beneficial to study whether combining state health care contracts across agencies and universities could reduce costs (see text box). Considerations could include the risks associated with contracting with a single contractor and the risks associated with having multiple contracts.
- If contracts remain separate, it could still be beneficial for agencies that administer health care plans to regularly coordinate on the results of their contract negotiations. This could help them to become knowledgeable about the arrangements other agencies have made with contractors that administer health care and pharmacy benefits.
- Whether state health care contracts are combined or remain separate, it could be beneficial to study the costs and benefits of reprocurring health care contracts more frequently than every six years (having three-year contracts with three-year extensions).

Management's Responses from ERS Regarding Combining State Health Care Contracts

It is important to note the administrative costs associated with the health care contracts represent 5% or less of total cost. Since each of the state programs is large enough on its own to obtain near maximum economies of scale, administrative costs could not be reduced to any significant degree through combination.

Management's Responses from ERS Regarding Combining Pharmacy Contracts

Since retail pharmacy reimbursement rates drive the cost of retail pharmacy benefits, combination would not produce economies of scale unless pharmacies were willing to accept lower rates of reimbursement. Historically, retail pharmacies have refused to accept lower rates than are presently in place. They have been a vocal force both at the agency level and at the legislative level. Economies of scale could be achieved by all plans only through a sharp reduction in the size of the pharmacy network, i.e., by eliminating some independent pharmacies and one or more of the chains from the

retail networks. ERS and most other state agencies that administer pharmacy benefit contracts do not pay administrative fees to their pharmacy benefit managers. Therefore, combination could not reduce the administrative costs.

Appendices

Appendix 1

Objectives, Scope, and Methodology

Objectives

Our objectives were to:

- Determine whether the cost-containment measures taken for the self-insured Employees Retirement System (ERS) and Teacher Retirement System (TRS) health plans are achieving intended results.
- Determine whether ERS and TRS health care contracts are properly administered to ensure that the State receives health care services at the lowest cost.
- Identify additional cost-containment measures (including new plan designs) used by other state health insurance plans that could be applicable to the ERS and TRS plans.

Scope

The scope of the audit covered ERS's and TRS's health care plans and both agencies' contract management functions. The scope also covered tests and analyses of health care claims for the period from 1998 to 2004. Our audit did not include a review of information technology.

Methodology

The audit methodology consisted of collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating the results of the tests, and conducting interviews with ERS and TRS management and staff. We also researched and benchmarked industry practices and standards.

Procedures, tests, and analyses conducted for both ERS and TRS, unless indicated otherwise, included the following:

- Reviewed the State Auditor's Office (SAO) report and the agency internal audit report covering contracting and health insurance
- Identified enabling legislation, laws, regulations, and statutory requirements related to health care contracting
- Reviewed contracts between the agencies and the pharmacy benefits manager (PBM)
- Reviewed contracts between the agencies and the third-party administrator (TPA)
- Developed a system process map for ERS illustrating the relationships between the member, agency, PBM, and pharmacist

- Reviewed health insurance operations and agency-established cost-containment measures
- Interviewed health insurance program directors and staff, including legal departments
- Compared existing health plan features, benefits, and cost-control measures to the federal government health plans for BlueCross standard and basic options
- Reviewed the fiscal year 2003 and year-to-date PBM and TPA savings statements
- Conducted data mining techniques for PBM and TPA savings statements to identify erroneous or fraudulent payments
- Identified key agency health plan cost-containment measures recently implemented for PBM and TPA
- Conducted Internet research related to consumer directed health plans
- Conducted Internet research related to cost-containment benchmarking
- Reviewed and documented articles and journals concerning health care cost-containment issues
- Estimated the overall aggregate impact of identified health care cost-containment measures for PBM and TPA
- Reviewed pharmacy and medical claims data bases
- Reviewed criteria used to evaluate potential contractors
- Evaluated adequacy of health insurance contract provisions
- Tested the agency contractor procurement and selection activities performed in the request for proposal (RFP) process for inclusion of adequate contracting elements
- Analyzed the manner in which the agency calculates the amount of vendor payments, administrative fees, and drug rebates
- Examined financial and non-financial agency monitoring efforts regarding significant contract provisions
- Tested agency monitoring activities prescribed by state guidelines and agency policies and procedures, and as described by health insurance program directors and staff for indicators of monitoring weaknesses
- Examined the current record maintenance procedures in place for contract management documents
- Evaluated agency efforts to detect and prevent contractor fraud

Criteria used for both ERS and TRS, unless indicated otherwise, included the following:

- Texas Insurance Code
- General Appropriations Act (77th and 78th Legislatures)
- Legislative Appropriations Requests for fiscal years 2004 and 2005
- Agency Strategic Plans for fiscal years 2003 to 2007
- Texas Building and Procurement Commission Request for Proposal (RFP) Guidelines for State Agencies and Procurement Manual
- ERS's PBM RFP for HealthSelect of Texas for fiscal year 1998
- ERS's Medical TPA RFP for HealthSelect of Texas for fiscal year 2000
- TRS-Care's Administrative Service Organization RFP for fiscal year 1998
- TRS-Care's PBM RFP for fiscal year 2004
- TRS-ActiveCare's Administrative Service Organization RFP for fiscal year 2002
- ERS's Contract Monitoring Plan
- TRS's Contract Administration Manual
- State of Texas Contract Management Guide

Other Information

We conducted fieldwork from May 2004 to September 2004. This audit was conducted in accordance with generally accepted government auditing standards. The following members of the State Auditor's staff performed this review:

- Dave Gerber, MBA (Project Manager)
- Ron Zinsitz, CPA (Assistant Project Manager)
- Jodi Edgar
- Joe Fralin, MBA
- Dorvin Handrick, CISA, CDP
- Lorey Helford
- Willie Hicks, MBA
- Terry Nickel, CFE
- Hugh Ohn, CFA, CPA, CIA
- Worth Ferguson, CPA (Quality Control Reviewer)
- Carol Smith, CPA, CIA (Audit Manager)

Detailed Information on ERS's and TRS's Health Care Plans

Tables 5 through 9 provide detailed information regarding ERS's and TRS's health care plans. Because these tables provide information for plan years 2003 through 2005, they illustrate the specific cost-reduction measures (for example, increases in co-pays and deductibles) that ERS and TRS have implemented.

Table 5

Comparison of Co-pays for HealthSelect, TRS-ActiveCare, and TRS-Care Plans									
	Plan Year 2003			Plan Year 2004			Plan Year 2005		
Network/ Non- Network	Health Care Co-Pays								
	Per PPO Visit	Specialist	Emergency Room	Per PPO Visit	Specialist	Emergency Room	Per PPO Visit	Specialist	Emergency Room
HealthSelect									
Network	\$15 changed 05/01/03 to \$20	\$15 changed 05/01/03 to \$30	\$50 ^a + 10% changed 05/01/03 to \$100 ^a + 20%	\$20	\$30	\$100 ^a + 20%	\$20	\$30	\$100 ^a + 20%
Non- Network	30% ^b	30% ^b	\$50 + 10% ^a changed 05/01/03 to \$100 ^a + 20%	40% ^b	40% ^b	40% ^b	40% ^b	40% ^b	40% ^b
TRS-ActiveCare 3									
Network	\$15	\$15	\$50 ^a + 10%	\$20	\$30	\$50 ^a + 15%	\$20	\$30	\$50 ^a + 15%
Non- Network	30% ^b	30% ^b	30% ^b	35% ^b	35% ^b	\$50 ^a + 15%	35% ^b	35% ^b	35% ^b
TRS-ActiveCare 2									
Network	\$25	\$25	20% ^b	\$25	\$35	20% ^b	\$25	\$35	20% ^b
Non- Network	40% ^b	40% ^b	40% ^b	40% ^b	40% ^b	20% ^b	40% ^b	40% ^b	40% ^b
TRS-ActiveCare 1									
Network	\$15	\$15	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b
Non- Network	40% ^b	40% ^b	40% ^b	40% ^b	40% ^b	20% ^b	40% ^b	40% ^b	40% ^b
TRS-Care 3									
Network	\$15	\$15	20% ^b	\$25	\$25	20% ^b	\$25	\$25	20% ^b
Non- Network	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	40% ^b	40% ^b	40% ^b

Comparison of Co-pays for HealthSelect, TRS-ActiveCare, and TRS-Care Plans									
	Plan Year 2003			Plan Year 2004			Plan Year 2005		
Network/ Non- Network	Health Care Co-Pays								
	Per PPO Visit	Specialist	Emergency Room	Per PPO Visit	Specialist	Emergency Room	Per PPO Visit	Specialist	Emergency Room
TRC-Care 2									
Network	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	\$35	\$35	20% ^b
Non- Network	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	40% ^b	40% ^b	40% ^b
TRC-Care 1									
Network	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b
Non- Network	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	20% ^b	40% ^b	40% ^b	40% ^b
^a Co-pay waived if patient is admitted to hospital ^b After deductible									

Table 6

Comparison of Deductibles for HealthSelect, TRS-ActiveCare, and TRS-Care Plans						
	Plan Year 2003		Plan Year 2004		Plan Year 2005	
Network/ Non- Network	Health Care Deductibles					
	Individual	Family	Individual	Family	Individual	Family
HealthSelect						
Network	None	None	None	None	None	None
Non- Network	\$500	\$1,500	\$500	\$1,500	\$500	\$1,500
TRC-ActiveCare 3						
Network	None	None	None	None	None	None
Non- Network	\$500	\$1,500	\$500	\$1,500	\$500	\$1,500
TRC-ActiveCare 2						
Network	\$500	\$1,500	\$500	\$1,500	\$500	\$1,500
Non- Network	\$500	\$1,500	\$500	\$1,500	\$500	\$1,500
TRC-ActiveCare 1						
Network	\$1,000	\$3,000	\$1,000	\$3,000	\$1,000	\$3,000
Non- Network	\$1,000	\$3,000	\$1,000	\$3,000	\$1,000	\$3,000
TRC-Care 3						
Network	None	None	None	None	\$300	\$600
Non- Network	\$240	\$480	\$240	\$480	\$300	\$600

Comparison of Deductibles for HealthSelect, TRS-ActiveCare, and TRS-Care Plans						
	Plan Year 2003		Plan Year 2004		Plan Year 2005	
Network/ Non-Network	Health Care Deductibles					
	Individual	Family	Individual	Family	Individual	Family
TRC-Care 2						
Network	\$1,800	\$3,600	\$1,800	\$3,600	\$1,000	\$2,000
Non-Network	\$1,800	\$3,600	\$1,800	\$3,600	\$1,000	\$2,000
TRC-Care 1						
Network	\$4,500	\$9,000	\$4,500	\$9,000	\$4,000	\$9,000
Non-Network	\$4,500	\$9,000	\$4,500	\$9,000	\$4,000	\$9,000

Table 7

Comparison of Out-of-Pocket Maximums for HealthSelect, TRS-ActiveCare, and TRS-Care Plans						
	Plan Year 2003		Plan Year 2004		Plan Year 2005	
Network/ Non-Network	Health Care Out-of-Pocket Maximums					
	Individual	Family	Individual	Family	Individual	Family
HealthSelect						
Network	\$500 ^C	None	\$1,000 ^C	None	\$1,000 ^C	None
Non-Network	\$1,500 ^C	None	\$3,000 ^C	None	\$3,000 ^C	None
TRC-ActiveCare 3						
Network	\$500 ^C	None	\$1,000 ^C	None	\$1,000 ^C	None
Non-Network	\$1,500 ^C	None	\$3,000 ^C	None	\$3,000 ^C	None
TRC-ActiveCare 2						
Network	\$2,000 ^C	\$6,000 ^C	\$2,000 ^C	\$6,000 ^C	\$2,000 ^C	\$6,000 ^C
Non-Network	\$2,000 ^C	\$6,000 ^C	\$2,000 ^C	\$6,000 ^C	\$2,000 ^C	\$6,000 ^C
TRC-ActiveCare 1						
Network	\$2,000 ^C	\$6,000 ^C	\$2,000 ^C	\$6,000 ^C	\$2,000 ^C	\$6,000 ^C
Non-Network	\$2,000 ^C	\$6,000 ^C	\$2,000 ^C	\$6,000 ^C	\$2,000 ^C	\$6,000 ^C
TRC-Care 3						
Network	\$5,240 ^C	\$10,480 ^C	\$5,240 ^C	\$10,480 ^C	\$5,300 ^C	\$10,600 ^C
Non-Network	\$5,240 ^C	\$10,480 ^C	\$5,240 ^C	\$10,480 ^C	\$5,300 ^C	\$10,600 ^C
TRC-Care 2						
Network	\$6,800 ^C	\$13,600 ^C	\$6,800 ^C	\$13,600 ^C	\$6,000 ^C	\$12,000 ^C
Non-Network	\$6,800 ^C	\$13,600 ^C	\$6,800 ^C	\$13,600 ^C	\$6,000 ^C	\$12,000 ^C

Comparison of Out-of-Pocket Maximums for HealthSelect, TRS-ActiveCare, and TRS-Care Plans						
	Plan Year 2003		Plan Year 2004		Plan Year 2005	
Network/ Non-Network	Health Care Out-of-Pocket Maximums					
	Individual	Family	Individual	Family	Individual	Family
TRC-Care 1						
Network	\$9,500 ^C	\$19,000 ^C	\$9,500 ^C	\$19,000 ^C	\$9,000 ^C	\$18,000 ^C
Non-Network	\$9,500 ^C	\$19,000 ^C	\$9,500 ^C	\$19,000 ^C	\$9,000 ^C	\$18,000 ^C

^C Plus co-pays and deductibles

Table 8

Comparison of Coinsurance for HealthSelect, TRS-ActiveCare, and TRS-Care Plans						
	Plan Year 2003		Plan Year 2004		Plan Year 2005	
Network/ Non-Network	Health Care Coinsurance					
	Plan Pays	Participant Pays	Plan Pays	Participant Pays	Plan Pays	Participant Pays
HealthSelect						
Network	90% 80% ^d	10% 20% ^d	80%	20%	80%	20%
Non-Network	60% ^d	40% ^d	60%	40%	60%	40%
TRC-ActiveCare 3						
Network	90%	10%	85%	15%	85%	15%
Non-Network	70%	30%	65%	35%	65%	35%
TRC-ActiveCare 2						
Network	80%	20%	80%	20%	80%	20%
Non-Network	60%	40%	60%	40%	60%	40%
TRC-ActiveCare 1						
Network	80%	20%	80%	20%	80%	20%
Non-Network	60%	40%	60%	40%	60%	40%
TRC-Care 3						
Network	80%	20%	80%	20%	80%	20%
Non-Network	80%	20%	80%	20%	60%	40%
TRC-Care 2						
Network	80%	20%	80%	20%	80%	20%
Non-Network	80%	20%	80%	20%	60%	40%
TRC-Care 1						
Network	80%	20%	80%	20%	80%	20%
Non-Network	80%	20%	80%	20%	60%	40%

^d Increased on 05/01/2003

Table 9

Comparison of Pharmacy Co-Pays for HealthSelect, TRS-ActiveCare, and TRS-Care Plans									
	Plan Year 2003			Plan Year 2004			Plan Year 2005		
Network/ Non- Network	Health Care Pharmacy Co-pays								
	Retail / Non-maintenance (30 day supply)	Retail Maintenance (30 day supply)	Mail Order (90 day supply)	Retail / Non-maintenance (30 day supply)	Retail Maintenance (30 day supply)	Mail Order (90 day supply)	Retail / Non-maintenance (30 day supply)	Retail Maintenance (30 day supply)	Mail Order (90 day supply)
HealthSelect									
Preferred	\$5/\$20 ^f \$10/\$25 ^d	\$5/\$20 ^f \$15/\$35 ^d	\$10/\$40 ^f	\$10/\$25 ^e	\$15/\$35 ^e	\$30/\$75 ^e	\$10/\$25 ^{ef}	\$15/\$35 ^{ef}	\$30/\$75 ^{ef}
Non-Preferred	\$35 \$40 ^d	\$35 \$55 ^d	\$70 ^e \$120 ^d	\$40 ^e	\$55 ^e	\$120 ^e	\$40 ^e	\$55 ^e	\$120 ^e
TRS-ActiveCare 3									
Preferred	\$5/\$20 ^f	\$5/\$20 ^f	\$10/\$40 ^f	\$25	\$25	\$50	\$10/\$25 ^f	\$15/\$35 ^f	\$20/\$62.50 ^f
Non-Preferred	\$35	\$35	\$70	\$40	\$40	\$80	\$40 ^g	\$55 ^g	\$100 ^g
TRS-ActiveCare 2									
Preferred	\$5/\$25 ^f	\$5/\$25 ^f	\$10/\$50 ^f	\$25	\$25	\$50	\$10/\$25 ^f	\$15/\$35 ^f	\$20/\$62.50 ^f
Non-Preferred	\$45	\$45	\$90	\$45	\$45	\$90	\$45 ^g	\$60 ^g	\$112.50 ^g
TRS-ActiveCare 1									
Preferred	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h
Non-Preferred	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h
TRS-Care 3									
Preferred	\$8/\$16 ^f	\$8/\$16 ^f	\$12/\$24 ^f	\$10/\$25 ^f	\$10/\$25 ^f	\$20/\$50 ^f	\$10/\$25 ^{fg}	\$10/\$25 ^{fg}	\$20/\$50 ^{fg}
Non-Preferred	\$8/\$16 ^f	\$8/\$16 ^f	\$12/\$24 ^f	\$40	\$40	\$80	\$40	\$40	\$80
TRS-Care 2									
Preferred	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	\$10/\$30 ^{fg}	\$10/\$30 ^{fg}	\$20/\$75 ^{fg}
Non-Preferred	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	\$50	\$50	\$125
TRS-Care 1									
Preferred	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h
Non-Preferred	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h	20% ^h
^d Increased on 05/01/2003 ^e After \$50 deductible									

Comparison of Pharmacy Co-Pays for HealthSelect, TRS-ActiveCare, and TRS-Care Plans									
	Plan Year 2003			Plan Year 2004			Plan Year 2005		
Network/ Non- Network	Health Care Pharmacy Co-pays								
	Retail / Non-main-tenance (30 day supply)	Retail Main-tenance (30 day supply)	Mail Order (90 day supply)	Retail / Non-main-tenance (30 day supply)	Retail Main-tenance (30 day supply)	Mail Order (90 day supply)	Retail / Non-Main-tenance (30 day supply)	Retail Main-tenance (30 day supply)	Mail Order (90 day supply)
<p>^f Price is co-payment per generic medication/co-payment per preferred brand-name medication</p> <p>^g If a member obtains a brand-name drug when a generic equivalent is available, the member is responsible for the general co-pay plus the cost difference between the brand-name drug and the generic drug</p> <p>^h Employee will pay 100% of discounted cost at the time of purchase; 80% will be reimbursed after the deductible</p>									

The sources of the information in Tables 5 through 9 included:

- *ERS OnLine Benefits Information, 2002–2003*
[https://auth.ers.state.tx.us/profile_ersbis/cgi-bin/athcgi.exe]
- *TRS-ActiveCare: Plan Highlights, 2002–2003*
[http://www.trs.state.tx.us/TRS-ActiveCare/highlight_0203planoptions.pdf]
- *TRS-Care: Highlights of the Plan, 2002–2003*
[<http://www.trs.state.tx.us/Publications/TRSCareHighlightsSEPT2002.pdf>]
- *TRS-Care: Your Group Plan Booklet, 2002–2003*
[<http://www.trs.state.tx.us/Publications/TRSCareGroupPlanBooklet2002.pdf>]
- *An Audit Report on the Teacher Retirement System’s Implementation of TRS-ActiveCare, the Health Care Plan for Active School District Employees, SAO Report 04-025, March 2004*
- *TRS-Care: Highlights of the Plan, 2003–2004*
- *TRS-Care: Group Plan Booklet, 2003–2004*
- *ERS OnLine Benefits Information, 2004–2005*
[https://auth.ers.state.tx.us/profile_ersbis/cgi-bin/athcgi.exe]
- *Employees and Retirees Under 65: Good News for HealthSelect, 2004–2005*
[http://www.bcbstx.com/hs/pdf/ERSunder65factfinal_070104.pdf]
- *For HealthSelect Members: Information About Your Prescription Drug Program, 2004–2005* [http://www.ers.state.tx.us/Insurance/PDFs/MedcoTierAnnouncement_091004.pdf]
- *TRS-ActiveCare: Plan Highlights, 2004–2005* [http://www.trs.state.tx.us/TRS-ActiveCare/ac_highlightsfy05.pdf]
- *TRS-Care: Highlights of the Plan, 2004–2005*
[http://www.trs.state.tx.us/Publications/trs_carehighlights0405.pdf]
- *TRS-Care: Your Group Plan Booklet, 2004–2005*
[http://www.trs.state.tx.us/TRS-Care/trscare_groupplan2004.pdf]

Description of Health Care Plan Fraud Schemes

BlueCross BlueShield of Texas prepared and provided the following information regarding various health care plan fraud schemes to both ERS and TRS.

Black Market Drug Sales. In this scheme, the subscriber obtains prescription drugs for a pharmacy at a cost of only his or her copayment. Thereafter, these very expensive drugs are resold on the black market at a tremendous profit to the subscriber. To obtain these drugs from the pharmacy, the subscriber uses prescriptions that he or she obtained from a corrupt physician or that were stolen and forged. The subscriber's health plan pays the pharmacy for the cost of the drugs on the mistaken belief that the subscriber needed the drugs for his or her medical care and treatment.

Doctor Shopping. This scheme involves a subscriber "bouncing" from one doctor to another for purposes of getting multiple prescriptions for controlled substances or other pharmaceutical drugs. The subscriber is either addicted to the drugs or is reselling the drugs for profit on the black market.

Durable Medical Equipment/Supplies. Durable medical equipment (DME) companies use a variety of schemes to overcharge health plans for the cost of equipment and supplies that are rented or sold to subscribers. If a piece of equipment is rented to a subscriber, the total rental cost should never be more than the purchase price of the equipment. Similarly, if a piece of equipment is purchased by the health plan, the health plan should not be charged a monthly fee to rent the same piece of equipment. However, in some cases, the DME company will use different provider numbers or business names to bill a health plan for both the rental cost and the purchase price of the same piece of equipment. In other cases, the DME company will bill the health plan for equipment that was never provided to the subscriber, that the subscriber no longer has possession of, or for a more expensive model than what the subscriber actually received.

"Free" Services. In this scheme, health care providers market certain tests, such as allergy screening or hearing, as being "free." Providers do this as a pretext or ploy to obtain the subscriber's health insurance information. Once the information is obtained, the cost of the "free" test and other services that the subscribers did not want or receive are billed to the subscriber's health plan.

Identity Swapping. Identity swapping occurs when a subscriber "lends" his or her health plan and/or pharmacy card to an individual (imposter) who does not have health coverage. The cost of the medical services and/or prescription drugs received by the imposter is billed to the subscriber's health plan as if the services and/or drugs were actually provided to the subscriber.

Identity Theft. A person's identity, including his or her Social Security number, is stolen and resold to a different person (buyer) for use in obtaining employment in the United States. Through such employment, the buyer is able to get health coverage. Individuals who purchase false identification are more likely to "lend" their insurance cards to others who do not have health coverage or to participate in other forms of health care fraud.

Kickbacks. In this scheme, a sham rental or service agreement, such as a lease for equipment, office space or personnel, is used to validate the relationship between two health care providers who specialize in different areas of the medical profession (for example, neurology versus podiatry). The purpose of the relationship is to cause an increase in the number of patients referred by and between the two health care providers and the revenue each provider can generate for his or her medical practice. In some cases, the patients are referred for tests that have no medically recognized value. Yet, the health care providers bill the patient's health plan for the testing and their services, i.e., the professional component and the technical component (or facilities fee).

Misrepresenting Services. Certain medical procedures, such as cosmetic surgery, are not normally covered by a subscriber's health coverage. In such cases, the subscriber and physician may conspire to defraud the health plan by billing the procedure under the name and CPT code of a procedure that is covered by the subscriber's health coverage. Because the physician and subscriber are working together to defraud the health plan, this scheme is one of the most difficult to identify.

Patient Renting/Unnecessary Services. In this scheme, subscribers are paid by recruiters and physicians to submit to surgeries and other medical procedures that are not medically necessary. Payment is made in the form of cash, free trips and/or cosmetic surgeries. The surgeries and other medical procedures are usually done on the weekend and out of state. The cost of these surgeries and medical procedures is billed to the subscriber's health plans at excessive dollar amounts. In some cases, the cosmetic surgeries are billed under the name and CPT code of a procedure unrelated to cosmetic surgeries, but covered by the subscriber's health plan. More importantly, however, is that these unnecessary surgeries and procedures pose a substantial risk of harm to the subscribers' mental and physical health.

Phantom Billing. In this scheme, the health care provider bills the subscriber's health plan for equipment, supplies and/or services that were never provided.

Studies/Free Samples. To determine the effectiveness of a drug, studies are conducted by physicians with the assistance of patients who suffer from a particular illness or disease. Because the physicians get the drugs from the manufacturer for free, the physicians are not supposed to charge the patient's health plan for the drugs. In this scheme, the physicians will bill the patient's health plan for the "market value" of the drugs even though the providers got the drugs for free. This scheme also occurs with respect to "fee samples" of the drug to physicians. The physicians provide the "free samples" to their patients and then bill the patients' health plan for the "market value" of the drugs.

Unbundling. In this scheme, the health care provider bills the health plan separately for procedures and supplies that are considered to be part of a single procedure or included as part of a global fee. The provider does this because it is more lucrative to bill the procedures and supplies separately than as part of a single procedure or a global fee.

Up-coding. In this scheme, the health care provider will bill the subscriber's health plan for a more expensive service than what was actually provided. For example, if a mental health professional provided 50 minutes of group therapy to 30 individuals, the mental health professional would be up-coding if he or she billed each patient's

health plan for a 50 minute individual therapy session since individual therapy is much more expensive than group therapy.

Unlicensed Providers. Periodically, the licenses of unethical or incompetent physicians and other members of the health care community will be suspended or revoked by regulatory agencies such as the Texas Board of Medical Examiners. When this happens, these individuals can no longer practice their profession in that particular state. However, some individuals will continue to see patients and to bill for the cost of their services by using the name of another health care professional or will bill his or her services as if the services were provided to the subscriber in a different state.

Consumer-Directed Health Plans

Appendix 4-A

How Do Consumer-Directed Health Plans Work?

Most consumer-directed health plans (CDHP) have a three-tiered structure. These tiers include the following:

- **Account Contributions.** The first tier consists of an employer contribution into a tax-exempt account on behalf of an employee. The employee is then free to use these funds for qualified medical expenses throughout the year. If funds are left in the account at year end, they can be rolled over into the account the next year (except in the case of flexible spending accounts).
- **Out-of-Pocket Expenses.** The second tier includes an employee's out-of pocket expenses. Specifically, if an employee's medical expenses exceed the amount of funds the employer contributed to the tax-exempt account, the employee must personally pay for his or her medical expenses up to a certain threshold or deductible amount.
- **Insurance.** The third tier includes a more traditional insurance plan that is activated when medical expenses exceed the specified deductible. Depending on the details of the insurance plan, the employee may be required to pay co-pays or coinsurance.

Typically, CDHPs have a provision for free preventative screening and care. In addition, they typically incorporate a Web-based information component that allows employees to manage and track their medical bills and receive information on provider quality.

Appendix 4-B

Arguments for Consumer-Directed Health Plans

Some common arguments for CDHPs include:

- **Utilization.** Proponents contend that CDHPs will change consumer behavior in a positive way which, in turn, will reduce health care costs. They assert that, because consumers are in charge of making their own purchasing decisions, this can significantly decrease consumer utilization of doctors and prescription drugs. Lower utilization leads to lower demand, which then leads to lower prices. Supporters of CDHPs also argue that consumers will make more cost-effective choices, such as purchasing a generic drug over a brand name drug or seeing a doctor who provides services for prices that are lower than competitors'. According to Conning Research & Consulting Inc., employees in a CDHP use 11 percent fewer health care services.
- **True costs of health care will become more apparent.** Some employers believe that employees have been desensitized to the true costs of health care. In traditional managed care plans, employees pay fixed co-pays for doctor visits or prescription drugs. Therefore, most employees are not aware of the true costs of health care. In addition, CDHP proponents assert that most employees view

access to health care as a right rather than a benefit. Proponents contend that CDHPs will change employees' perception of health care by making them realize that health care is, in fact, a benefit provided by the employer.

- **Industry effects.** Another argument in support of CDHPs relates to the industry as a whole. In addition to creating a lower cost environment due to CDHPs' open market structure, supporters contend that this will also lead to increases in health care quality. Because consumers would be free to see any doctor they choose, providers would be forced to add value and provide better quality health care to attract patients.
- **Lower out-of-pocket expenses.** Supporters also assert that CDHPs will result in lower out-of-pocket expenses for most individuals, even for individuals who are older and less healthy. They argue that, if an individual needs access to expensive health care procedures, the maximum out-of-pocket threshold will prevent even the sickest patient from experiencing excessive out-of-pocket expenses.

Appendix 4-C

Arguments Against Consumer-Directed Health Plans

Some common arguments against CDHPs include the following:

- **Adverse selection.** One argument against CDHPs is the phenomenon of adverse selection. Specifically, if a CDHP is offered in conjunction with a traditional health plan, healthy individuals are more likely to choose the CDHP, leaving the older, less healthy individuals in the traditional plan. As a result of this adverse selection away from the traditional plan, the cost of health care in the traditional plan, as well as the risks to the traditional plan, will increase. This, in effect, leaves the employer with relatively higher medical expenses.
- **Lack of historical results.** CDHP opponents argue that there are too many unknowns at this point to devise a sound CDHP. For example, it is difficult to determine whether a given amount of annual employer contribution is reasonable. In addition, CDHP critics argue that consumers are not ready to take total responsibility over their health care purchasing. Critics also note that CDHPs are a way for the employer to become less involved in health care and shift the responsibility to the employee.
- **Decisions may adversely affect health.** Another argument against CDHPs is that they will cause consumers to make decisions that may adversely affect their health. Because the funds in their accounts can be rolled over to future years, consumers will have an incentive to spend as few of these funds as possible. Critics suggest that consumers may make cost-related decisions rather than health-related decisions. For example, a consumer may ignore signs of an illness to avoid the cost of going to a doctor. In the meantime, an existing condition may worsen because the consumer has an incentive not to seek treatment.
- **Loss of bargaining power.** Some benefit managers argue that CDHPs will not save money and that the cost of medical care may actually increase under CDHPs. In traditional plans, benefit managers enjoy a great deal of bargaining power with

health care providers. Under CDHPs, benefit managers would lose their bargaining power and the cost of health care could actually rise.

- Plans may not be demographically equitable. Some critics believe that CDHPs favor certain demographic groups and sacrifice equity and fairness. Critics contend that CDHPs favor young, healthy individuals. Because individuals in this demographic group typically spend less on health care, their out-of-pocket expenses will be minimal. On the other hand, older, less healthy individuals with pre-existing conditions may experience significant out-of-pocket expenses depending on the deductibles and structure of the CDHP.

The sources of information in this appendix included:

- “Consumer Driven Health Care,” Consumer Driven Health Care.us, 2003, <<http://www.consumerdrivenhealthcare.us/>>, April 13, 2004.
- “Heal Thyself: Consumer-Directed Health Care Is Hot. But Is It a Danger to the Medical Insurance System?” *CFO Magazine*, August 2003, p. 55.
- Lindsay R. Resnick, “Consumer-Driven Health Plans Pose New Set of Challenges,” *National Underwriter*, January 2002, p. 20.
- Katherine H. Capps and Sandy Mau, “Yet Another Silver Bullet for Health Care,” *Business and Health Care*, July 1, 2003, <http://bnh.pdr.net/be_core/b/index.jsp>, April 13, 2004.

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