



Sharing Responsibility for Health Care

State of Tennessee Health Benefits

Presentation for
Memphis Business Group on Health
September 8, 2011

Agenda

- Financial realities of Tennessee's public sector health plans
- Building mutual accountability in benefit design
- Communications challenges
- What's next

Plan Administration

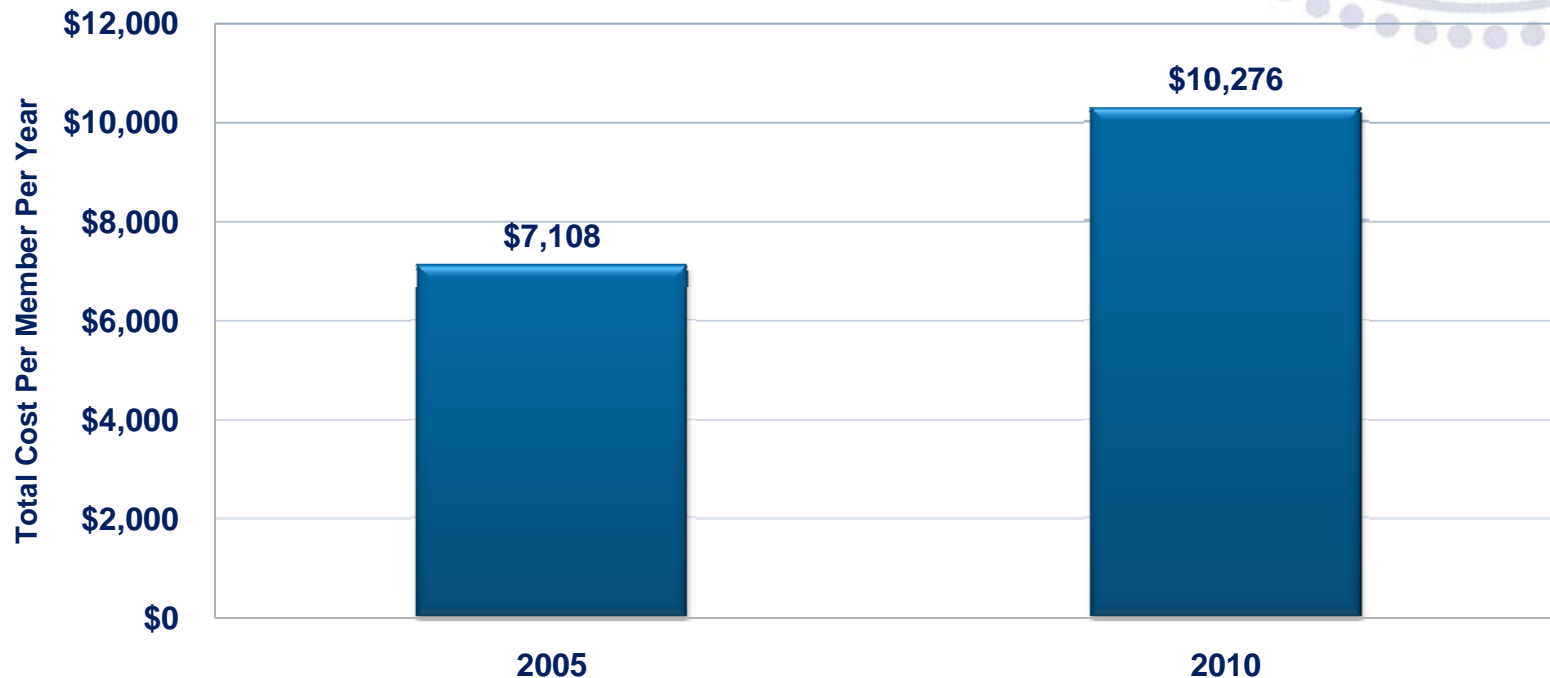
- Administer health insurance benefits for 270,000 public sector employees, retirees and their dependents
- Three financially independent risk pools; each governed by Insurance Committee
- No major benefit changes between 1995 and 2010
- No open enrollment since the 1980's; annual Enrollment Transfer Period allows members to switch between benefit and carrier options

State Share of Premiums

	State Plan	Local Education Plan	Local Government Plan
Active Employees	80%	45%	0%
Retirees under age 65	60%-80%	20%-40%	0%

Dramatic Increase in Per Capita Costs

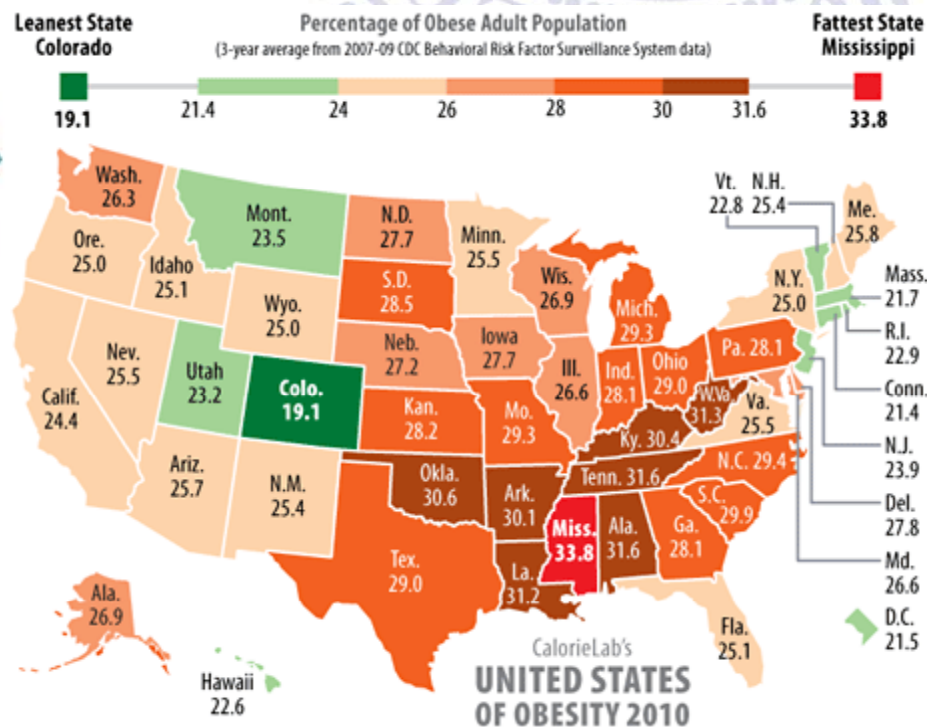
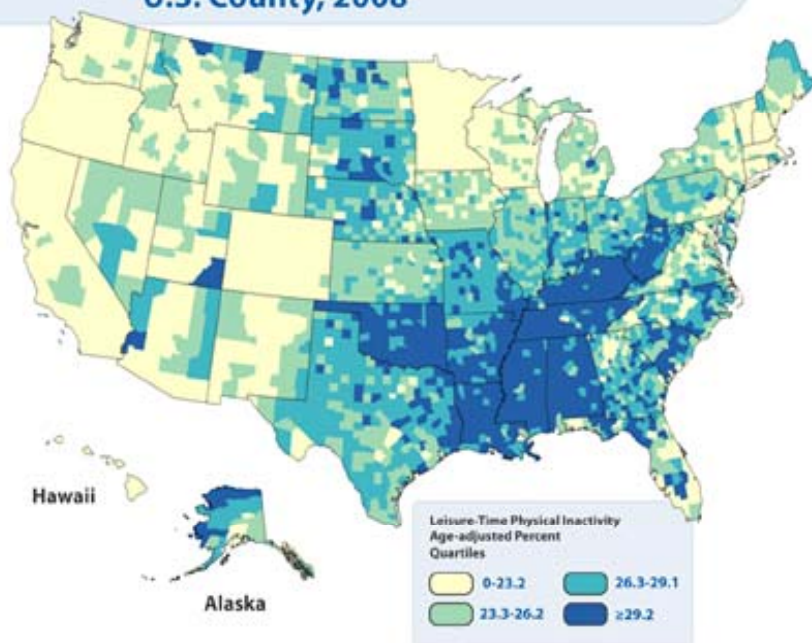
State Plan Spent \$10,276 Per Employee in 2010
(45% Increase from \$7,100 to \$10,300 in 2010)



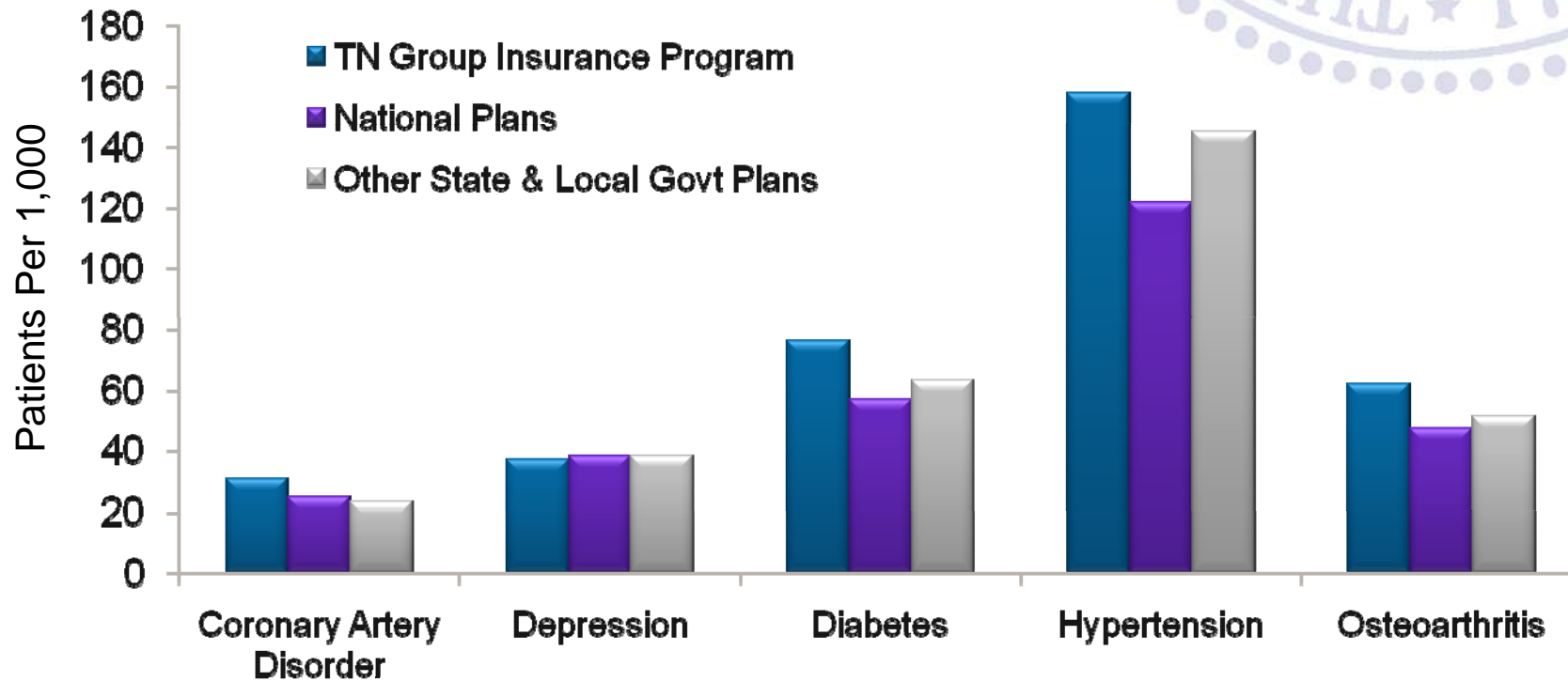
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A Costly Combination

Leisure-Time Physical Inactivity by U.S. County, 2008

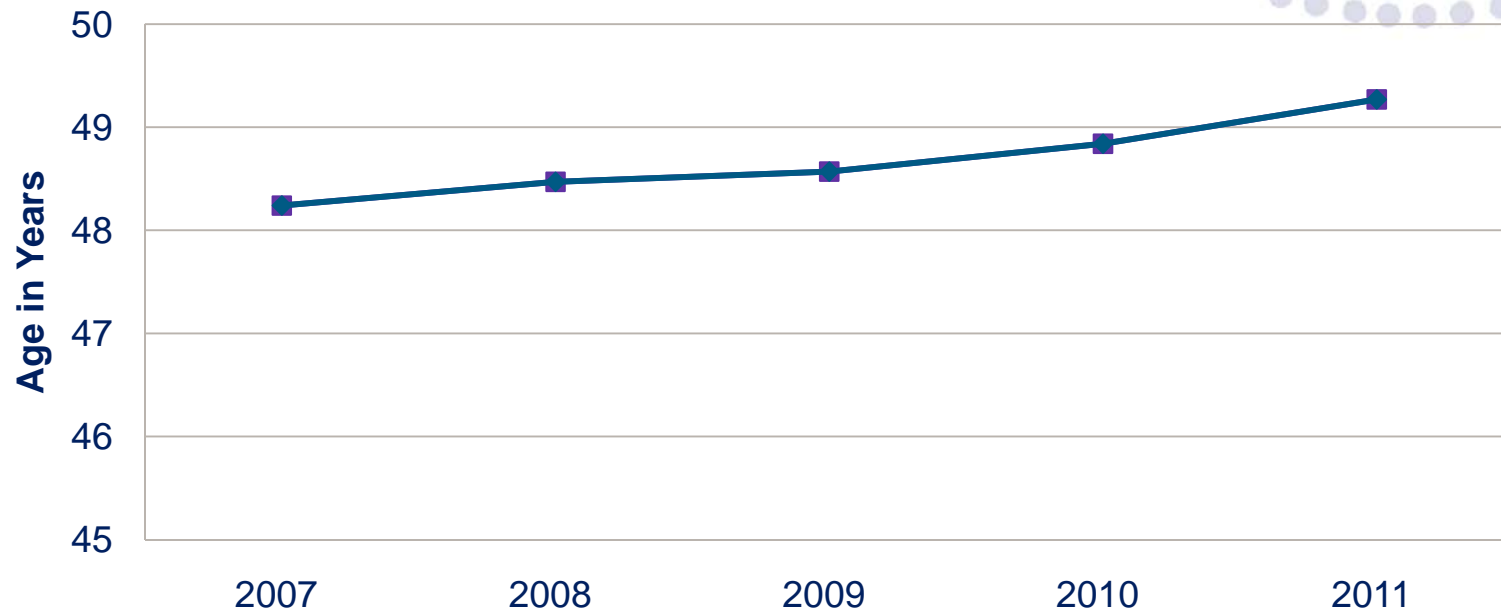


Tennessee's Excess Disease Burden

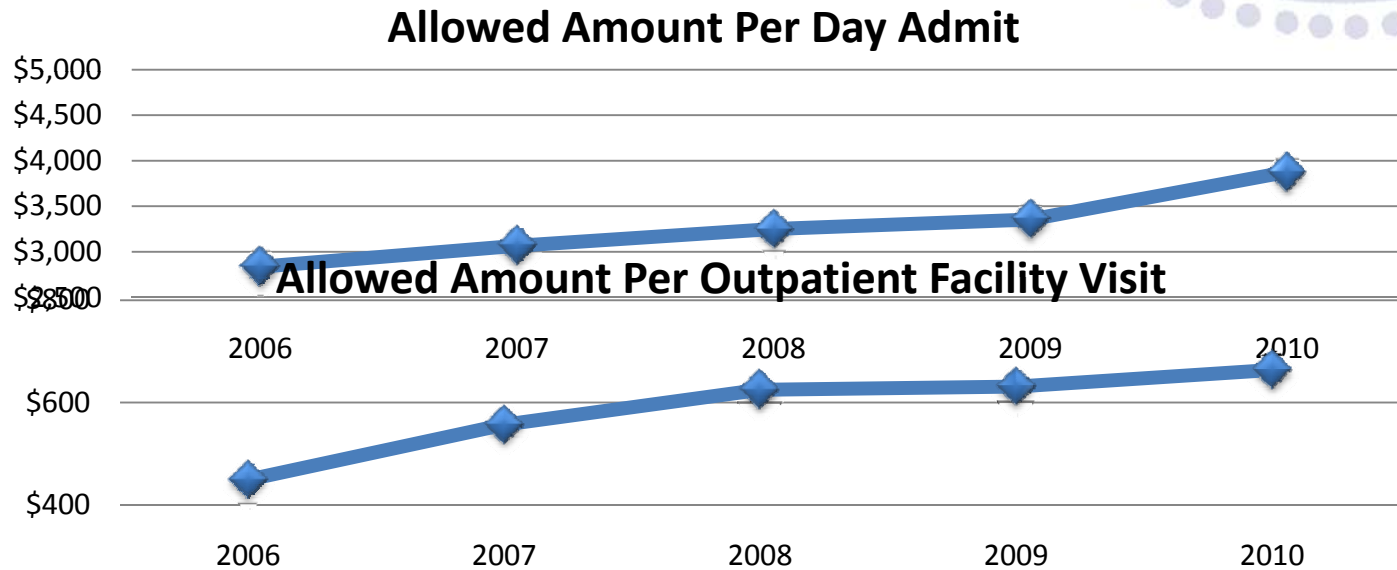


Median Age of Our Adult Members Increasing

Median Age - Active Employees and Spouses 2007-11



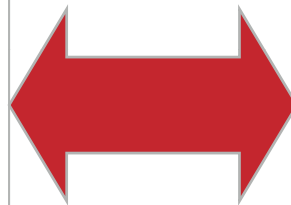
Price per Service Continues to Grow



Change Required to Preserve Benefits

Exploding Health Care Cost Increases

- Heavy disease burden
- High utilization
- Aging population
- Increase in Rx and inpatient per unit price



Finite Resources

- Declining State revenue
- Budget constraints on State contribution
- Stagnant wages

Given the State's financial outlook, continuing cost increases were simply not affordable. We had no choice but to change our approach.

Simple Math

$$A \times B = C$$

A = Unit cost

B = Number of units

C = Total cost

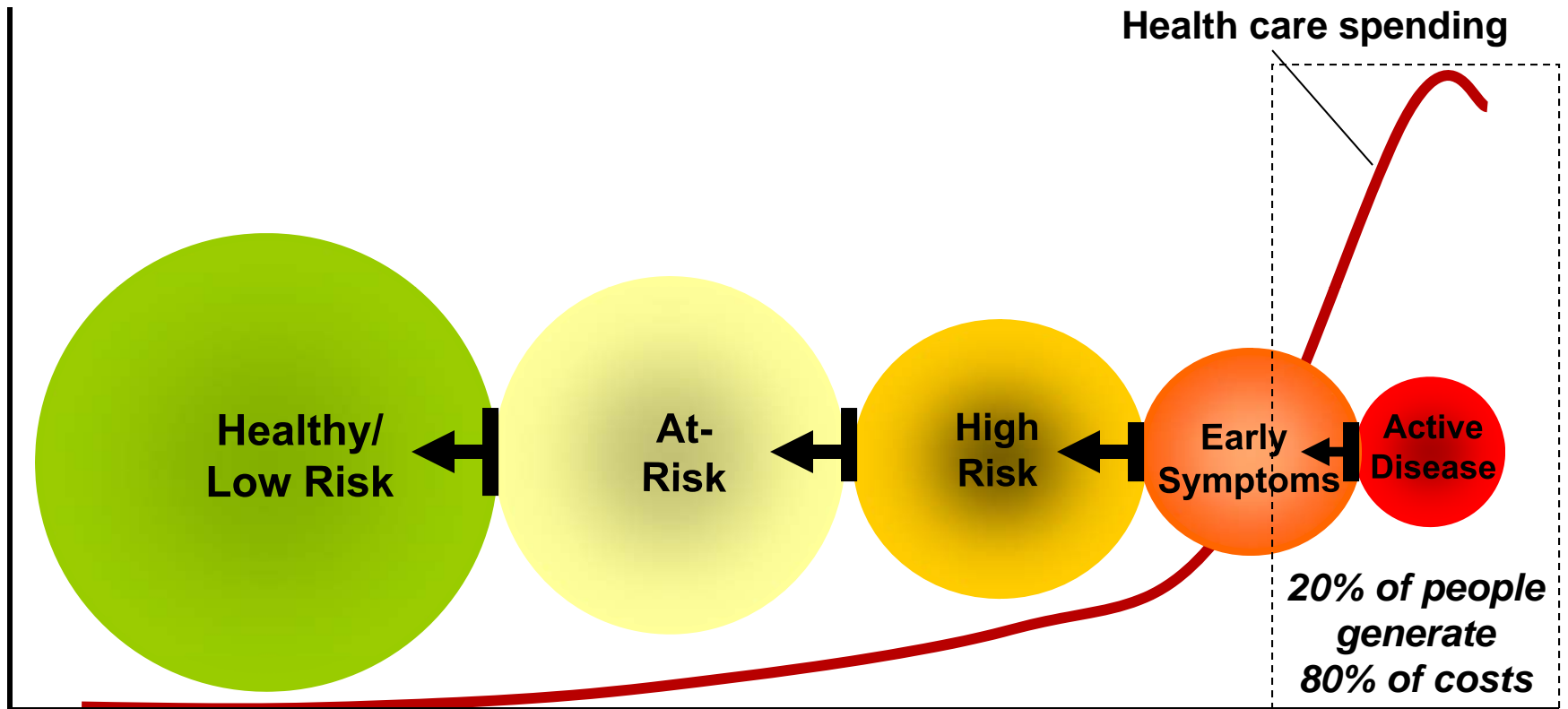
Unit Cost

- Cut benefits and shifted costs to members
 - Higher pharmacy copays for the most expensive brand-name drugs in 2009
 - Elimination of brand name proton pump inhibitors (PPIs)
 - Higher member copays, coinsurance and deductibles in 2011
- Squeezed all possible savings out of our contracting
 - Consolidation of pharmacy purchasing (Caremark, July 1, 2010)
 - New third party administrator contracts with regional pricing with BCBST and Cigna
- Tightened program rules and program integrity
 - Dependent eligibility audit and uniform verification
 - Penalties for members who do not follow subrogation requirements
 - Duplicate claims audit

Number of Units

- Hire younger workers! Turn back the clock!
- Early benefit design efforts to improve member health status and reduce utilization
 - Reduced copays for diabetic drugs and supplies to improve adherence and decrease medical costs
 - Implemented tobacco quit initiative, helping 13,600 members with their quit attempts
 - Consolidated health management services for 2011
 - Expanded wellness program for 2011

Long-term Aim

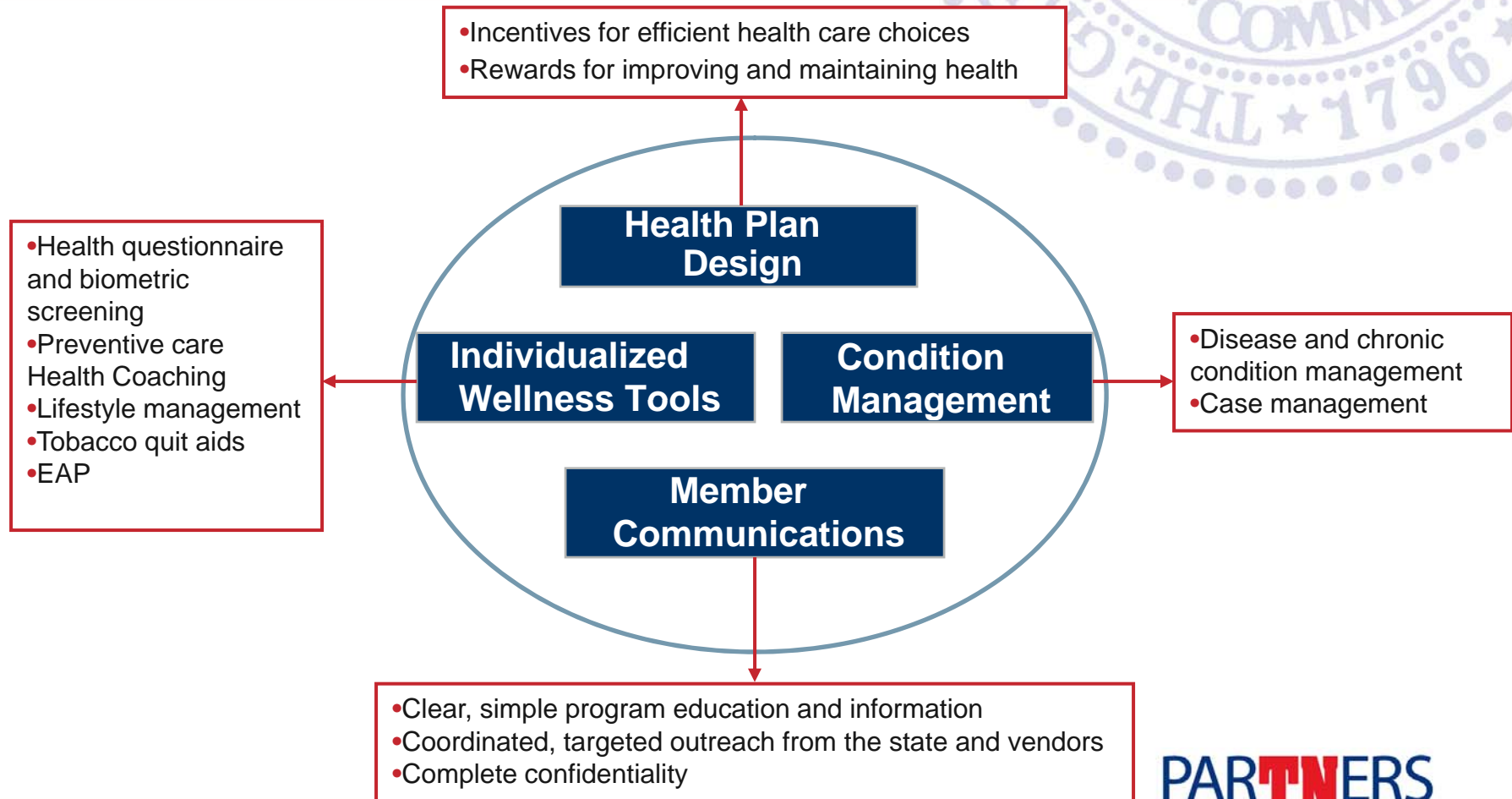


Don't get worse, and over time, help people move to the left.

Plan Design Guiding Principles

- Commitment to comprehensive, affordable and dependable benefits
- Create a partnership to control costs: the State, employees, health care providers, and contractors
- Incentives for taking control of health and health care choices
- Benefit options and choices
- Clear and straightforward differences between choices

Health Management Model



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New Health Plan Design

Standard PPO

- No rewards/incentives for healthy behaviors
- Members pay higher share of costs under this plan versus the Partnership PPO Plan
- Members still have access to the same network and wellness supports as Partnership PPO members

Partnership PPO

- Rewards member commitment to improving or maintaining health
- Member commitment to “Partnership Promise” required

The Partnership Promise

- **Complete a Health Questionnaire** – Members answer questions about current health and behaviors
- **Take a Health Screening** – As part of member's annual physical exam; screening sites also set up throughout the State
- Requirements will step up over time

Communications Challenges

- 270,000 members
- Geographically diverse
- Limited access via email
- Little demographic information available
- All educational levels

Advisory Committee

- Made up of 18 agency benefits coordinators (ABCs)
- Help administer the health insurance plans
- Became our “eyes and ears” in the field
- Monthly calls to test market materials and share FAQs

Launching the Communications

- Set the stage for benefit changes
- Make an initial call to action
- Introduce the program branding
- Multiple resources:
 - Newsletters
 - Email
 - Website
 - Enrollment kit
 - Call center
 - Field training



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Newsletters

MARCH 2010

PARTNERS FOR HEALTH NEWSLETTER

FOR ALL STATE GROUP INSURANCE PROGRAM MEMBERS

WELCOME to the first issue of PartNers for Health. This is the first in a series of newsletters about upcoming changes to your benefits. Keep these newsletters with your other PartNers for Health communications for future reference.

CHANGE IS COMING

We want to provide our members with comprehensive, affordable and dependable health care, but it's becoming harder and harder for us to afford our current benefits programs. Our health care claims have jumped from less than \$600 million to almost \$1.3 billion in just eight years. Unless we act now, we'll be facing a much more difficult situation in the near future that could threaten our ability to provide coverage for members and their families. Most of the changes that we're making will become effective in 2011. However, a change in pharmacy coverage will come this summer.

One Pharmacy Benefits Manager for All Plans

Starting July 1, 2010, CVS Caremark will become the pharmacy benefits manager for all plan members, regardless of whether you are in the PPO, POS or HMO. We chose CVS Caremark through a competitive bid process. They offered us the highest-quality plan at the lowest cost to the State.

CVS Caremark is one of the largest pharmacy benefits managers in the country and the number one provider of prescriptions. They fill or manage more than one billion prescriptions a year. Their network of more than 1,600 pharmacies in Tennessee (61,000 nationwide) includes many major chains and independents as well as CVS pharmacies. Changes in the pharmacy you use now is part of the network. If you fill your prescriptions by mail, CVS Caremark offers a choice. You can order online, by phone or by mail.



Attention Retirees!

If you are a retiree younger than age 65, this change may affect you, too! CVS Caremark will also administer your prescription drug coverage starting July 1, 2010. You will receive your new pharmacy benefits ID card in the mail in early June.

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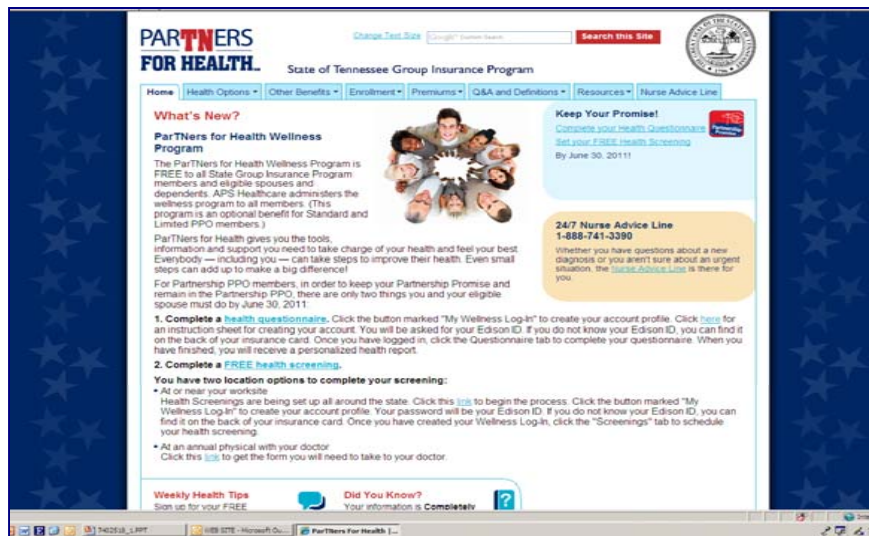
Together, we are committed to:

- helping you get the appropriate prescription
- supporting your overall health and well-being
- providing you with a convenient way to fill prescriptions.

- Printed to reach diverse audience
- Educational resource for ABCs
- Established template
 - Basic education
 - Description of options
 - FAQs

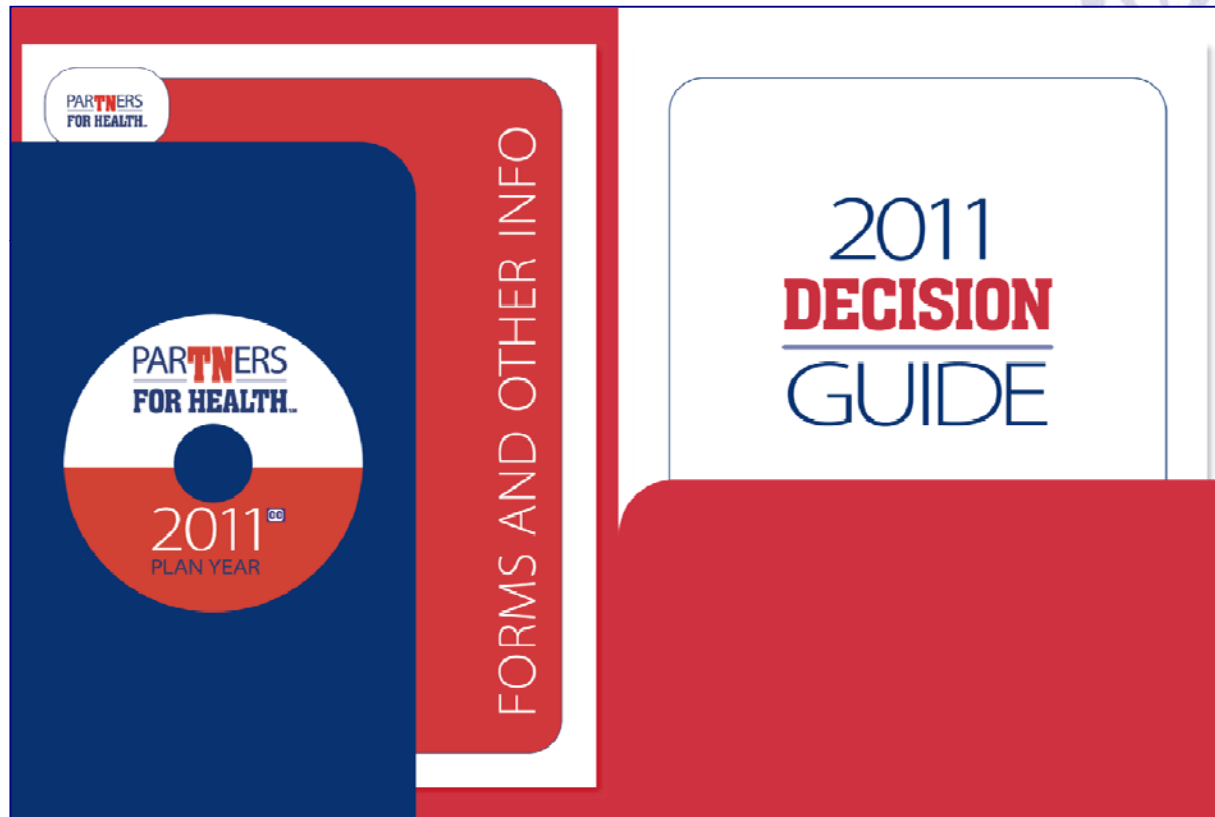
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www.partnersforhealthtn.gov



- Key content areas included health options, other benefits, premiums, enrollment, FAQs, definitions and resources
- Rate look-up tool provided individualized premium information
- Kept current with daily updates, new FAQs

Enrollment Kit



- Pocket folder
- Decision Guide
- DVD
- Customized Forms and Other Info

ParTNers for Health Call Center

- Available to members 24/7 through October 15, 2010
- Services provided by a subcontractor
- Dedicated call center professionals
- Trained on new benefit

Field Training

- Agency benefits coordinator training was critical
- Ongoing communication with ABCs throughout plan design and communication development phases
- In-person group training sessions conducted August 2010

Results

- More engaged members, ABCs and Insurance Committees
- Vast majority made an active decision
- 78% chose the Partnership PPO
- Partnership members slow to complete the promise
- Higher illness burden for adults in the Standard PPO
- Hitting financial targets; too early for clinical results

Finding cost savings in redesigning plans

The new plans:

- Give beneficiaries greater financial stake in their health and health care purchasing decisions
- Leverage the state's purchasing power and vendor core competencies to drive costs down
- Build data-driven cost containment and health management practices into the plan design
- Increase the accountability of contractors, providers and members

What's New for 2012?

- New benefit design changes
 - Chronic disease maintenance tier for pharmacy
 - Co-pay cap on physician visits
 - Reduced co-pay for convenient care clinic visit
- Partnership Promise for 2012
 - Must keep contact information up to date!
 - Adult members must participate in health coaching if identified by Wellness contractor

Number of Units – more to do

- Help current members from getting worse
- Prevent “claim-less time bombs”
- Provide more information to members
- Incorporate more efficient delivery system models

Next Challenges and Opportunities

- Ongoing plan accountability
 - Increase member accountability for taking steps to reduce health risk and take charge of their own health
 - Improve carrier and provider accountability to adhere to best practices
- Continued improvements to ensure best value in purchasing and benefit design
- Health insurance exchange and PPACA