ERS
Employees Retirement System of Texas

Senate State Affairs Committee

September 22, 2010

Hearing on Interim Charge #2: Assess the effectiveness of pilot programs designed to encourage the use of clinical integration, payments for good outcomes, use of best practices, focus on wellness and prevention, and bundling of costs for episodes of care, and other health cost savings initiatives.

TEXAS EMPLOYEES GROUP BENEFITS PROGRAM

ERS
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

Senate State Affairs Committee, September 22, 2010

GROUP BENEFITS PROGRAM

UPDATE ON GBP INITIATIVES FROM THE 81ST LEGISLATURE

	Background	Impact on health costs	Impact on State Budget	Impact on Member costs
Alternative Payment and Delivery System Pilot Programs	HB 4586 directed ERS to create medical home and clinical integration pilot projects. After exploring the project with a number of health care systems around the state, all but 3 providers opted out. Those still on track for a January 2011 startup include: Austin Regional Clinic, Kelsey/Seybold Clinic (Houston), and Trinity Clinic/Mother Frances Hospital (Tyler). Detail provided in Appendix A.	Because the pilot program only affects a small population, savings are not expected until after the pilot programs are rolled out statewide.	Because claims cost savings will be minimal, there is no expectation of savings during the FY2012-2013 biennium.	Unknown.
Bariatric Surgery Benefit	SB 2577 required ERS to develop a cost-neutral or cost-positive plan to cover bariatric surgery under the HealthSelect℠ program. An estimated 28.9% of the Texas population is obese.	Reduced health care costs for a person who loses significant weight will occur gradually over 24 months and beyond. The cost of covering bariatric surgery will initially increase health plan costs, with potential savings being generated in the second year after surgery.	In the first year of the biennium, health costs will increase.	Member out-of-pocket costs will be high in the first year, but should decrease as their health improves.
Tobacco Cessation Pilot Program	HB 2559 directed DSHS to coordinate with ERS to create a comprehensive smoking cessation program. DSHS expanded the ACS's Quitline to all state employees, retirees and their families. The pilot project provides free telephone counseling and nicotine replacement therapy through Dec. 31, 2012, paid with federal ARRA funds. HHSC is self-funding a pilot project to offer some coverage of prescription drugs to a limited number of HHSC employees who want to quit smoking. HHSC will reimburse HealthSelect through an inter-agency contract for the plan's cost share of the prescription drugs.	Because the DSHS smoking cessation pilots are new, ERS has no data on how many HealthSelect members are enrolled in the Quitline, or any other smoking cessation programs. DSHS will report on the pilot results. There is very low participation in HealthSelect's free voluntary smoking cessation program, which provides telephone coaching. Of the estimated 59,000 smokers among the adult HealthSelect population, only 68 people have signed up for tobacco cessation coaching.	Neither DSHS' smoking cessation pilot has a financial impact to the GBP Legislative Appropriations Request.	Potential long-term lower health care costs for those who quit smoking.

GROUP BENEFITS PROGRAM

COST SAVING ACTIONS

	Background	Impact on health costs	Impact on State Budget	Impact on Member costs
Contracting: HealthSelect third party administrator (TPA) fee	ERS employs aggressive contract negotiations to save on third-party administrative costs and to ensure access to a comprehensive network with the best provider discounts. In general, 97 cents of every HealthSelect dollar is spent directly on health care claim.	HealthSelect provides access to 90% of all doctors in the state, 92% of all hospitals and more than 4,000 pharmacies. HealthSelect administrative fees are calculated on a "per member per month" (PMPM) basis. In FY2004, the BCBSTX administrative fee was $24.11 PMPM. In FY2010, the administrative fee was $16.89, a decrease of 30%.	Contract savings reduce costs for the state.	Contract savings reduce costs for members.
Contracting: Pharmacy Benefit Manager (PBM)	The HealthSelect PBM contract was originally estimated to save $266 million over four years. In the fall of 2009, a federal ruling on the Average Wholesale Price (AWP) of drugs determined that drug prices had been artificially high since 2000. The court rolled back reimbursement rates for retail pharmacies across the country.	The current estimated savings from the PBM contract are now projected to be $288 million over a four-year time period, a savings of $22 million more than originally estimated. ERS rolled back reimbursement rates after the AWP lawsuit, while many other plans had to maintain current rates until the end of their contract cycle. The AWP lawsuit is projected to generate reimbursement savings of an additional $45 million over 3 years. ERS is also in the process of negotiating additional savings due to the Most Favored Nations clause of the PBM contract, which requires the PBM to give ERS its most favorable contract terms.	Contract savings reduce costs for the state.	Contract savings reduce costs for members.
Contracting: HealthSelect Physicians and Hospitals	Because claims costs represent 97% of the plan's expenditures, provider discounts are important. ERS saved more than $2.6 billion through negotiated provider discounts.	Because of aggressive contracting strategies by ERS and the third-party administrator, physician rates have stayed level or been reduced every year since the ERS contract was signed. Equally aggressive hospital contracting could save more.	Provider discounts save the state money by moderating necessary increases in contributions.	Provider discounts save members money by reducing the need to raise copays and coinsurance.

	Background	Impact on health costs	Impact on State Budget	Impact on Member costs
Dependent Eligibility Audit	HB 2559 clarified the definition of an eligible dependent in anticipation of the upcoming audit. FY2011 annual enrollment opened an amnesty window, during which members could drop any ineligible dependents from the plan without a penalty. In FY2011, ERS will conduct a 100% dependent eligibility audit to identify and remove ineligible dependents from the insurance plan.	The FY2011 Dependent Eligibility Audit is expected to create a one-time savings through the removal of 3% to 4% of dependents from the plan. A future audit will be scheduled if the current audit reveals an unusually high number of ineligibles.	Because plan costs are tied to enrollment, contributions and claims costs could go down, depending on how many ineligible dependents are removed from the plan.	Qualified members would no longer have to subsidize the cost for ineligible dependents.

GROUP BENEFITS PROGRAM

COST SAVING OPPORTUNITIES

	Background	Impact on health costs	Impact on State Budget	Impact on Member costs
Dependent Premium Surcharge (when they have access to other coverage)	As a group, the most expensive HealthSelect participants are dependent spouses. Eight of the top 10 highest HealthSelect claims are paid on behalf of dependents. 26% of HealthSelect participants report that their dependents have access to other health care coverage, but are enrolled in GBP coverage.	Adding an alternative coverage surcharge would have a positive impact on claims costs if dependents (a) opted out of HealthSelect, and/or (b) made HealthSelect secondary payer	No impact on the state budget as the surcharge would be above and beyond state contribution. Excess revenue from the surcharge would be applied to health claims costs.	Increased cost to members whose dependents have access to other coverage
Therapeutic substitution of generic equivalent	Currently in the PDP, when a physician allows generic substitution on the prescription form, the pharmacist may substitute a generic drug that is the same chemical entity in the same dosage form as the prescribed drug. Therapeutic substitution would automatically replace a physician-prescribed brand-name drug with a chemically different generic drug within the same therapeutic category. A member who chose to fill the brand-name would pay the difference.	The HealthSelect generic dispensing rate (GDR) is 66.8%, compared to a “best-in-class” GDR of 72% for the most successful plans. Each 1% increase in the GDR reduces overall prescription drug costs by more than 2%. For example, a 5% increase would reduce overall prescription drug costs by an estimated $49 million.	By reducing overall plan costs, therapeutic substitution could slow the growth in the state contribution.	Members who switched to generics would lower their costs, while those who chose the brand name drug when a generic was available would have higher costs.

	Background	Impact on health costs	Impact on State Budget	Impact on Member costs
Tiered/Restricted Provider Network (medical and/or pharmacy)	HealthSelect provides two levels of benefits for medical providers: in-network and out-of-network. Currently members can fill prescriptions at any retail pharmacy or by mail service. The goal of a tiered network is to reduce costs by steering participants to the most cost-effective providers. A tiered network based on provider quality and efficiency would preserve choice but stratify member out-of-pocket costs. A restricted network would reduce access.	A tiered medical provider network (including physicians, hospitals, free standing facilities and lab and imaging) could provide a potential savings of $30 million annually. Eliminating all but two major chain pharmacies from the pharmacy network could save up to $10.4 million by generating a 2.5% reduction in brand name costs at retail. ERS members indicate they are willing to pay more to preserve choice. A tiered network would provide a balance between choice and cost control.	By reducing overall plan costs, both tiered and restricted networks could slow the growth in the state contribution.	Members could save money by choosing cost-effective providers.
Tiered Retiree/retiree dependent premium contribution based on years of service	In a survey on cost savings ideas for the health plan, most members favored the idea of basing retiree contributions on years of service. For example; the state would contribute 50% for retirees with 10 yrs of service; 75% for 15 yrs; and 100% for 20+ yrs.	No direct impact on claims costs. Potential risk that healthier retirees would drop coverage which could lower revenue (fewer contributions).	Savings would depend on the breadth of the change and the extent of the grandfathering. An additional consideration would be the potential impact on the ERS pension fund.	Direct cost shift from the state to the retiree, but the impact could be minimized if a retiree had alternative coverage options.
Wellness Incentives, Positive and/or Negative	The GBP currently provides voluntary wellness programs at no extra charge. The availability of free wellness benefits has not boosted participation in these programs.	Positive incentives – such as reducing copays or subsidizing prescription drugs for people with chronic conditions – would cost the plan money up front with the assumption of a long term positive impact on health care trend. Disincentives – such as smoker surcharges – could have an Indirect positive impact on costs by creating a financial incentive to quit smoking. Valuing the true impact on claims cost of any wellness incentive is difficult, as savings for many wellness programs come in the form of “avoided costs” rather than reduced charges.	Financial surcharges for smokers or others would be collected above and beyond the state contribution. Excess revenue from the surcharge would be applied to health claims costs. Also, increased enrollment in wellness programs could presumably moderate the growth in the state contribution.	Disease management and smoking cessation programs should help to reduce member costs through improved health and more efficient use of care.

APPENDIX A

An Update on HealthSelect's Alternate Health Care Payment Programs

September 2010

Background:

The 81st Legislature (H.B. 4586, Supplemental Appropriation Bill) authorized ERS to establish pilot programs in the Texas Employees Group Benefits Program (GBP) based on quality of care standards and evidence-based best practices. These programs compensate health care providers under alternative payment systems other than the traditional fee-for-service.

ERS has successfully concluded a pay-for-performance pilot program in Austin and continues to work with a number of groups throughout Texas to further explore innovative ways to improve quality and efficiency.

The following table summarizes ERS' progress toward implementing these systems within HealthSelect of Texas℠:

Provider Group	Program	Location	Status
Austin Pediatric Surgeons	Pay-for-Performance	Austin	Successful 12-month pilot resulted in GBP savings and provider group payments in the amount of $42,250 each. Although the pilot with this provider group was successful, all parties chose not to renew this pilot.
Austin Regional Clinic	Pay-for-Performance and Patient-centered Medical Home	Austin	This project is on target to implement January 2011.
Kelsey/Seybold Clinic	Pay-for-Performance and Patient-centered Medical Home	Houston	This project is on target to implement January 2011.
Trinity Clinic/ Mother Francis Hospital	Clinical Integration and Patient-centered Medical Home	Tyler	Initial meetings have been held. ERS is currently gathering cost data to establish performance targets. This project is on target to implement January 2011.

Texas Medical Home Initiative	Patient-centered Medical Home (multi-payor)	Dallas	This organization is attempting to establish a multi-payor medical home site and is having difficulty in achieving this goal. ERS has had no contact with TMHI since April 2010, but at that time, TMHI was recruiting medical groups and carriers to begin a demonstration project.
Memorial/Hermann Hospital System	Clinical Integration	Houston	Several meetings have been held to discuss clinical and financial targets. The medical group involved in this initiative, MH/MD, discontinued discussions and so ERS put the project on hold.
Covenant Health Partners	Clinical Integration	Lubbock	Covenant has agreed on evidence-based clinical quality targets, cost targets, administrative requirements, the participant study group, and how to measure the results and savings. Implementation of this project has been pending the outcome of a state and federal investigation of Covenant Health Partners. However, after several follow-up calls to Covenant Health Partners with either no response or action, it would appear that CHP is not pursuing this pilot any longer.
Grace Medical Clinic	Patient-centered Medical Home	Lubbock	Conducted initial discussions about a medical home for selected procedures, and the possible cost savings opportunities. This group has indicated that they wish to pursue this pilot and plans to meet with another provider group, Village Clinic in the Dallas area, who is also piloting a medical home.

Program Descriptions:

Pay-for-Performance: Clinical performance and economic benchmarks are set related to delivery of appropriate, quality care producing lower overall health care costs. These can include appropriate usage of outpatient facilities rather than in-patient; reducing duplicative lab work; and performing radiology services at lower cost facilities. A portion of the health plan's savings are shared with providers if both clinical and economical targets are achieved.

Patient-Centered Medical Home: Enhanced access and care that is coordinated among physicians and across facilities, including health information exchange, extended office hours and open scheduling. Enhanced services are paid for by the health plan through per participant/per member payments. If clinical quality and cost performance targets are met, the health plan shares savings with participating practices.

Clinical Integration: A physician network that is focused on improved patient outcomes, improved safety and reduced costs through ongoing evaluation and modification of practice patterns. If administrative, clinical quality and economic performance targets are met, the health plan's savings are shared with physicians.

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APPENDIX B

Senate State Affairs Committee, September 22, 2010

Potential cost impact of selected federal health reform (PPACA) provisions on the Texas State Employees Group Benefits Program

Provision	Notes	Potential GBP Cost Impact
Limits Waiting periods. Coverage waiting periods cannot exceed 90 days.	GBP coverage starts the first day of the month after the 90 day wait.	Increased cost 9/1/14
Imposes Plan Sponsor Fees. Charges plan sponsors a $2 fee per covered life in 2012 and a $1 fee per covered life in 2013. From 2014 to 2019, the fee is based on the percentage increase in health care costs.	The GBP covers 530,000 lives.	Increased cost 9/1/14
Eliminates Lifetime Limits on Insurance Coverage. Insurance companies cannot impose lifetime dollar limits on essential benefits, like hospital stays.	The GBP has a $1 million lifetime limit on out-of-network coverage. No limits apply to other coverage.	Increased cost 9/1/11
Covers dependents up to age 26. The federal law requires plans to cover all children, regardless of marital status. It may allow previously excluded children back into the plan.	GBP covers all unmarried children up to age 25. There are 5,500 children age 25 who could rejoin the GBP.	Increased cost 9/1/11
Limits flexible spending account contributions. TexFlex contributions will be limited to $2,500 a year starting January 1, 2013.	Current annual limit is $5,000; 15% of TexFlex participants contribute more than $2,500	State's FICA tax will increase 1/1/13
Imposes a Cadillac Plan Excise Tax. Imposes an excise tax on "Cadillac Plans," defined as employer-sponsored health plans with aggregate values exceeding $10,200 for individual coverage and $27,500 for family coverage, an amount that will be adjusted for inflation in the future.	GBP does not currently meet the threshold for a "Cadillac Plan."	Neutral, may increase future costs. 9/1/18
Provides Free Preventive Care. All new plans must cover certain preventive services (ex. mammograms and colonoscopies) without charging deductibles, co-pays or coinsurance	The requirement to provide free preventive care has a potential cost impact to the plan of $46 per person. This does not include prescription drugs or nonprescription medications.	Increased cost 9/1/11
Closes the Medicare Part D "donut hole." Mandates prescription drug discounts for Medicare beneficiaries who reach the coverage gap, and gradually phases down the Medicare drug coinsurance rate to close the gap by 2020.	Unless there are structural changes to the Retiree Drug Subsidy program, closing the donut hole would not impact ERS.	Neutral
Creates an Early Retiree Reinsurance Program. Allows ERS to apply for reimbursement of claims for retirees older than age 55 who are not qualified for Medicare. Reimbursement is for 80% of the cost of claims between $15,000 and $90,000.	The GBP application to apply for reimbursement was approved. $5 billion of federal funds are available nationwide. The potential positive impact on the GBP would be $60 million, if the GBP is reimbursed for eligible expenses.	Potential revenue for FY11 and FY12
Limits on increased member cost sharing. PPACA could limit the plan's options for increasing member costs in the future.	For example, if a member's health care contribution exceeds a certain percent of their household income, they could opt out of the GBP and get coverage from the exchange. In that case, the plan could be assessed penalties.	Potential increased cost 9/1/2014

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APPENDIX C

Summary of FY2012-2013 Legislative Appropriations Request

ERS serves as a fiduciary for the programs we administer for the State of Texas. We request funding necessary to make them actuarially sound and meet our mission to provide quality benefits at a reasonable cost.

Retirement Request

ERS and the Legislature addressed pension sustainability last session, including increasing state and employee contributions. The base request assumes those contribution rates will continue. The base request covers the normal cost of benefits but is not enough to pay off outstanding liabilities. As a result, the trust's funded ratio will decline and the State's unfunded liabilities will grow. The exceptional item request is the most economical way for the State to address the outstanding liabilities since it would leverage investment earnings over the long term and pay down the unfunded balance.

Base request: maintains the current 6.95% state contribution and assumes no growth in payroll.

Exceptional items:

- Additional state contribution of 2.39% of payroll needed to meet the actuarial sound contribution rate as defined by statute.
- Law Enforcement and Custodial Officers Supplemental Retirement Fund (LECOS): Additional state contribution of 0.49% of payroll needed to meet the actuarially sound state contribution.

Insurance Request

Although the base request is calculated on the funding ERS received last session, it is not enough to cover current benefit costs or expected medical cost increases. It also does not replace the supplemental funding from the contingency reserve fund that the plan relied on during the past biennium. The plan already shifted $143 million in costs to members in FY 2011 to address an existing funding gap.

Base request of $2.5 billion is prescribed by the Legislative Budget Board and is below FY 2011 spending levels. Funding at this level would not be enough to maintain the existing plan benefits or structure.

Exceptional Items:

- $575.6 million is needed to maintain existing benefits and cover increased health care costs as a result of health care reform ($46.2 million) and medical inflation ($417.7 million) and to replace the funding that has been provided by spending down the contingency reserve fund ($111.6 million).
- $311.2 million is needed for a 60-day contingency reserve fund as required by Texas Insurance Code, Sec 1551.21.

This LAR request is based on data available on August 30, 2010. These figures will change as valuation updates occur throughout the year.

Employees Retirement System of Texas

Fiscal Year 12-13 Base Request (08/31/10)

Assuming Current Levels With LBB Adjustments as Base for All Programs

APPENDIX C

Goal/Objective/STRATEGY:	Estimated 2010	Budgeted 2011	Requested 2012	Requested 2013	Requested 2012-13 Biennium
1 To Administer Comprehensive and Actuarially Sound Retirement Programs					
1 Ensure Actuarially Sound Retirement Programs					
1 ERS - RETIREMENT @ 6.95%	396,828,631	408,042,003	407,055,299	407,055,303	814,110,602
2 LECOS RETIREMENT PROGRAM @ 1.59%	23,781,999	23,914,782	23,848,390	23,848,391	47,696,781
3 JRS - PLAN 2 @ 16.83%	11,380,232	11,351,883	11,366,057	11,366,058	22,732,115
4 JRS - PLAN 1	27,300,248	27,189,972	27,245,110	27,245,110	54,490,220
5 PUBLIC SAFETY BENEFITS	5,923,207	6,173,207	6,048,207	6,048,207	12,096,414
6 RETIREE DEATH BENEFITS	8,088,040	8,088,040	8,088,040	8,088,040	16,176,080
TOTAL, GOAL 1	**$473,302,357**	**$484,759,887**	**$483,651,103**	**$483,651,109**	**$967,302,212**
2 Provide Employees & Retirees with Quality Health Program					
1 Manage GBP for State & Higher Education Employees					
1 GBP - GENERAL STATE EMPLOYEES	1,189,280,616	1,274,281,049	1,250,491,206	1,250,491,209	2,500,982,415
TOTAL, GOAL 2	**$1,189,280,616**	**$1,274,281,049**	**$1,250,491,206**	**$1,250,491,209**	**$2,500,982,415**
TOTAL, AGENCY BASE STRATEGY REQUEST	**$1,662,582,973**	**$1,759,040,936**	**$1,734,142,309**	**$1,734,142,318**	**$3,468,284,627**

Fiscal Year 2012-13 Exceptional Items (08/31/10)

Assuming Current Levels With LBB Adjustments as Base for All Programs

			Requested 2012		Requested 2013		2012-13 Biennium	
#	Strategy	Exceptional Item	GR and GR Dedicated	All Funds	GR and GR Dedicated	All Funds	GR and GR Dedicated	All Funds
1	1-1-1	ERS Retirement Actuarially Sound Level, Increase of 2.39%	89,142,848	141,160,489	89,142,848	141,160,489	178,285,696	282,320,978
2	1-1-2	LECOS Actuarially Sound Level, Increase of 0.49%	6,769,075	7,436,355	6,769,075	7,436,355	13,538,150	14,872,710
3	2-1-1	GBP Cost Increases, Contingency Fund Spend Down Replacement, and Health Care Reform Increases	137,286,858	222,322,830	218,139,566	353,255,995	355,426,424	575,578,825
4	2-1-1	GBP Needed to Fund 60 Day Reserve Fund	91,987,431	148,964,776	100,163,023	162,204,358	192,150,454	311,169,134
		TOTAL, AGENCY EXCEPTIONAL ITEMS	**$325,186,212**	**$519,884,450**	**$414,214,512**	**$664,057,197**	**$739,400,724**	**$1,183,941,647**

Agency code: **327** Agency name: **Employees Retirement System**

ITEM	ITEM NAME	Est 2010	Bud 2011	BL 2012	BL 2013	Excp 2012	Excp 2013	Total Request 2012	Total Request 2013
1	Expand Coverage to Dep up to Age 26	$0	$0	$0	$0	$7,693,000	$8,389,000	$7,693,000	$8,389,000
2	100% Preventive Care	$0	$0	$0	$0	$14,269,000	$15,508,000	$14,269,000	$15,508,000
3	Eliminate Lifetime Maximum	$0	$142,000	$71,000	$71,000	$87,000	$101,000	$158,000	$172,000
4	PCORTF Fee	$0	$0	$0	$0	$0	$309,000	$0	$309,000
	Total, Cost Related to Health Care Reform	**$0**	**$142,000**	**$71,000**	**$71,000**	**$22,049,000**	**$24,307,000**	**$22,120,000**	**$24,378,000**
	METHOD OF FINANCING								
	GENERAL REVENUE FUNDS	$0	$82,544	$41,273	$41,273	$12,817,083	$14,129,660	$12,858,356	$14,170,933
	GR DEDICATED	$0	$5,155	$2,577	$2,577	$800,379	$882,344	$802,956	$884,921
	SUBTOTAL, GR & GR - DEDICATED FUNDS	**$0**	**$87,699**	**$43,850**	**$43,850**	**$13,617,462**	**$15,012,004**	**$13,661,312**	**$15,055,854**
	FEDERAL FUNDS	$0	$27,988	$13,994	$13,994	$4,345,858	$4,790,910	$4,359,852	$4,804,904
	OTHER FUNDS	$0	$26,313	$13,156	$13,156	$4,085,680	$4,504,086	$4,098,836	$4,517,242
	TOTAL	**$0**	**$142,000**	**$71,000**	**$71,000**	**$22,049,000**	**$24,307,000**	**$22,120,000**	**$24,378,000**
	FULL-TIME-EQUIVALENT POSITIONS(FTE):	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

ERS
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

APPENDIX D

Senate State Affairs Committee, September 22, 2010

GROUP BENEFITS PROGRAM
SUMMARY OF IMPLEMENTED LEGISLATION, 81ST LEGISLATURE

Bill Number	Author/Sponsor	Summary
SB 39	Zaffirini/Zerwas	Requires coverage of routine expenses associated with clinical trials for the prevention, detection or treatment of life-threatening disease or conditions by health plans.
SB 704	Nelson/Kolkhorst	State agencies executing PBM contracts after 9/1/2009 may not include provisions that exclude the agency from disclosing cost information. An agency must also disclose amounts charged by and pricing information related to PBM services (unless excluded by a contract executed prior to September 1, 2009) to another state agency requesting the information. Requires that multiple-month supply of maintenance drugs covered under the GBP may be filled at retail pharmacies at the same out-of-pocket cost and same reimbursement rate as mail-order (removes the retail maintenance fee.) Also requires PBM to provide ERS with annual report on actual acquisition costs and rebates. Permits ERS to include audit provisions in PBM contracts.
SB 872	Lucio/Menendez	Permits eligible survivors of law enforcement officers, custodial officers, fire fighters, or other public servants covered in the Group Benefits Program to continue their health insurance if the officer is killed in the line of duty. Survivors will receive a state contribution for health insurance as if they are active state employees.
SB 2577	Jackson/Zerwas	Requires ERS to develop a cost-neutral or cost-positive plan to cover bariatric surgery under the HealthSelect program.
HB 2256	Hancock/Jackson	Provides a procedure for mandatory mediation of out-of-network claims for certain facility-based physicians.
HB 2559	Truitt/Duncan	Clarified the definition of dependent within the Group Benefits Program, in anticipation of the upcoming dependent eligibility audit. Allowed DSHS and ERS to create a state employee pilot program consistent with federal guidelines for chronic disease prevention and wellness initiatives, to be funded with Federal stimulus money received by DSHS
HB 4586	Pitts/Ogden	Authorizes ERS to establish a pilot program to test alternate payment systems under the GBP in FY2011 – See SB10