

**Texas Health Insurance Pool
Board of Directors Meeting
May 20, 2011**

The meeting of the Board of Directors of the Texas Health Insurance Pool was held Friday, May 20, 2011 at 300 E. 4th St., Rio Room, Austin, Texas.

Notice of the meeting was filed electronically with the Secretary of State's office on Wednesday, May 11, 2011 and published immediately on the *Texas Register* web site (TRD# 2011003294).

Board members present: Gary Cole, Chair; Rick Ott, Vice-Chair; Greg Barbutti, Secretary/Treasurer; Robert Emmick, M.D.; Pati McCandless; Maureen Milligan, Ph.D.; Vicky Paparelli, APRN; Bill Rainey, M.D.; and Marinan Williams. Steven Browning, Pool Executive Director, Denise Haidet, Pool Office Manager, and Betty DeLargy, General Counsel to the Pool, were also in attendance.

Meeting Called to Order

With a quorum of the Board present, Chairman Cole called the meeting to order at 8:31 a.m. Mr. Cole introduced Dr. Maureen Milligan as the newest member of the Board and thanked her for agreeing to serve. He noted that Ms. Milligan is the Deputy Medicaid Director at the Texas Health & Human Services Commission.

I. Approval of Minutes

Dr. Emmick moved to approve the minutes of the January 28, 2011 Board of Directors meeting. The motion was seconded by Dr. Rainey and unanimously approved.

II. Financial Report

Mr. Cole introduced Mr. Don McPhee, of PMB Helin Donovan, who presented the firm's audit report of the Pool's 2010 financial statements. He affirmed that the statutory statements, prepared by Pool management with Board oversight, present fairly, in all material respects, the financial condition of the Pool and comply with generally accepted accounting principles and statutory requirements. He confirmed that the audit provides reasonable assurance that the financial statements are free from material misstatement, error or fraud. Mr. McPhee confirmed that the audit was conducted in accordance with U.S. government auditing standards, and he verified that the Pool, a recipient of federal grant funds during 2010, complied with the requirements of OMB Circular A-133. The audit team encountered no difficulties in dealing with Pool management and did not identify any deficiencies in internal controls. In short, Mr. McPhee stated it was a very clean audit. After further discussion, **Ms. McCandless moved to accept the December 31, 2010 financial audit reports, prepared by PMB Helin Donovan, noting there are no operational changes to be made as a result of the audit. Dr. Emmick seconded the motion and it was unanimously approved.**

Mr. Browning discussed the Pool's Y2010 Annual Statement, filed with the Texas Department of Insurance ("TDI"). He noted that the PMB Helin Donovan financial audit did not identify any issues that would require amendment of the filed Statement. **Ms. Williams moved to ratify the 2010 TDI Annual Statement. The motion was seconded by Mr. Barbutti and unanimously approved.**

Mr. Barbutti moved to approve the Pool's Y2010 audited net loss in the amount of \$97,616,941 as the Y2010 Regular Assessment amount. The motion was seconded by Dr. Emmick and unanimously approved.

Mr. Browning reviewed the Pool's unaudited monthly financial reports for the period of January through March

2011. He reported that nightly sweeps to the JPMorgan government money market fund had been eliminated for both the Depository and Premium Discount Fund accounts because, effective 01/01/2011, non-interest bearing accounts have unlimited FDIC insurance protection. The higher balances now in these two unswept accounts generate compensating balance credits that eliminate all Chase Bank fees, which previously exceeded the amount of interest earned by the sweep accounts.

He reported that the Pool's net loss as of March 31, 2011 was \pm \$7.6 million, compared to a first quarter 2010 loss of \pm \$10.0 million. At Mr. Barbutti's suggestion, the monthly low-income premium subsidy allocations will be reflected as a separate premium revenue line item on the income statement. Mr. Browning explained the accounting method used for the low-income premium subsidy program. He noted that a restricted bank account, the Premium Discount Fund, was set up solely for the collection of the carrier penalties funding the subsidy program. Mr. Browning reported that the annual Directors and Officers Liability policy premium was paid in March. **Mr. Barbutti moved to approve the January, February, and March 2011 Financial Statements. The motion was seconded by Dr. Emmick and unanimously approved.**

Mr. Browning reviewed the TDI First Quarter 2011 Statement filing, which is a reformatted version of the first quarter financials previously approved by the Board. **Dr. Emmick moved to ratify the TDI 1st Quarter 2011 Statement filing. The motion was seconded by Dr. Rainey and unanimously approved.**

The Excess Pool Funds investment report was presented. Mr. Browning noted that the Pool's invested funds were at a seasonal low level, pending receipt of the second assessment installment due June 30th. He reported that he had just received the Milliman updated quarterly cash flow analysis. It still projects adequate operating funds until December 2011, although the Board may later decide to move the assessment deadline to an earlier date in December, instead of the traditional December 31st due date. That payment timing can be reviewed and decided at the fall Board meeting. Ms. Williams asked how the Pool investment policies compare to those used by commercial insurance companies. Mr. Browning explained that he developed the Pool's guidelines based upon those used by other governmental entities, including the guaranty funds, and then applied a somewhat more conservative approach for Pool investments. Mr. Barbutti observed that the Pool is not able to invest in long-term instruments and, unlike many insurance companies, does not have substantial excess reserves.

III. Executive Director's Report

Mr. Browning presented the updated Board of Directors Summary report, which he reformatted to reflect quarter-over-quarter data for easier trend comparisons. The Pool's application receipt rate was significantly lower in the first quarter of this year, compared to 1Q 2010. Mr. Barbutti asked about loss ratio trends by deductible plan, particularly for the HSA-qualified plan. Mr. Cole requested this information for the next meeting.

Mr. Browning reminded the Board that Alan Kellogg of HealthLinX has conducted the Pool's pharmacy audits for a number of years. Because it is good business practice to periodically rotate auditors, Mr. Browning solicited proposals from several pharmacy auditors; he reported that CGI Federal was the successful bidder and has been engaged for the 2010 pharmacy audit. CGI will soon begin its audit planning with the Medco account team.

Mr. Browning presented the medical claims audit summary report, prepared by Partner-Plus Consulting, Inc. ("PPC"). PPC audited claims processed by BCBSTX on behalf of the Pool for the period covering July 1, 2009 through June 30, 2010. The on-site fieldwork in Richardson was completed last fall, and 365 stratified, random records were selected for review along with the 15 highest cost claim files. In addition to the sample audit, all \pm 600,000 medical claims were electronically screened to identify BCBSTX system edits that might indicate a processing problem. Nan Coleman, PPC's lead auditor, told Mr. Browning that the review could be described as very good, with errors found in only 9 of the 365 sampled claim files. Mr. Browning noted that the electronic screening results would be reviewed during his upcoming visit to Abilene, adding that BCBSTX had already

implemented some system changes in response to various findings produced by the electronic audit. Mr. Browning will provide summary audit results at the fall meeting. The PPC audit found that, for the ±7,200 members who disenrolled during the one-year audit period, BCBSTX had erroneously paid only 12 claims, totaling ±\$1,400.00, after the members' grace periods ended. Ms. Coleman reported that this grace period audit finding was very favorable, as she often finds a much higher frequency of payments made in error for disenrolled members. PPC recommended that BCBSTX provide the Pool with a quarterly overpayment report, to identify claim trends; according to PPC, most carriers prepare these reports. Mr. Browning confirmed that he will discuss this issue with BCBSTX account management.

Dr. Emmick agreed that the audit results looked good. He asked BCBSTX staff for their opinion about the audit findings and to specifically address the negative finding for 14-day claims turnaround time. Mr. Garcia thought the results were favorable and confirmed that the coding issues raised by PPC were quickly addressed and system edits were enhanced. The turnaround time finding was unexpected because BCBSTX has never attempted to manage Pool claims to a certain percentage processed within 14 days, largely because of the importance of properly administering the Pool's preexisting condition exclusion, which can delay processing times.

Mr. Browning reminded the Board that he, Ms. Williams, and Dr. Emmick had been authorized to evaluate and select a disease management program to target the ±5% of Pool enrollees who generate a majority of the Pool's claims. They reviewed several bids and agreed to award the Pool account to MediCor, based in Atlanta, Georgia, which now serves as the third party administrator and case management contractor for the Louisiana and Florida risk pools. He noted that MediCor's program will be customized for the Pool and will target high-cost claimants through telephone contacts by registered nurses. The MediCor contract should be finalized in early June. MediCor will work closely with BCBSTX Case Management to coordinate their separate activities. MediCor will provide regular quarterly Board reports to summarize its activities and resulting savings.

Mr. Browning reviewed the award history for the federal grant program, dating from 2006 to present, along with the Pool's use of those funds. He noted that the Center for Medicare and Medicaid Services contacted him yesterday and verified that the Pool's share of the \$55 million FY11 grant would range from \$7.2 to \$7.5 million.

Mr. Browning reviewed the Timeline calendar, which lists important deadlines through the end of the year. Ms. DeLargy noted that a pending bill would increase the length of time for a notice of a carrier rate increase from 30 to 60 days. It would not legally apply to the Pool, but the Board may choose to adopt the same notice requirement. If passed, the bill would affect rate changes approved starting in 2012.

Mr. Browning presented the YTD Complaint Log Summary report. As of May 11th the Executive Director's Office had recorded 43 written complaints. Of those, 19 were received from the TDI Consumer Protection division. He stated that four of the 19 TDI complaints were deemed justified, meaning they were the result of a plan administrative error.

The Cancellation Customer Service Survey report was presented and discussed. Mr. Browning noted that the survey was launched in July of 2000. Over the years, the Pool had mailed out ±15,000 surveys to former enrollees, and received 6,018 responses, a 40% response rate. He proposed discontinuation of the survey, which served a useful purpose in the past, but is no longer needed. The great majority of the negative responses concern the Pool's high premium rates and it is labor-intensive to administer the survey. Dr. Emmick noted the survey did show, as predicted in the early years of the Pool, that Pool enrollees have continued to age and greater numbers are cancelling due to Medicare eligibility. There were no objections to discontinuing the survey.

Updated March 31st enrollment figures were presented for the Pre-existing Condition Insurance Plan ("PCIP"), the federal risk pool. Nationwide, only 18,000 individuals have enrolled in the program; of those, 1,300 are in

Texas. Mr. Browning observed that the PCIP outreach programs are still in their early stages. In addition, it is very likely that premium rates will be further reduced in an effort to boost enrollment. Mr. Browning discussed the procedure used by BCBSTX to pend Pool applications received from individuals who appear to be eligible for PCIP. These applicants are contacted by phone to inform them of the availability of PCIP, where they would not face a preexisting condition waiting period. Many of these applicants, however, elect to enroll in the Pool even after being informed of the lower rates and immediate coverage with PCIP. The pended application chart was further discussed.

Ms. DeLargy discussed the status of several pending bills, with possible implications for the Pool. Among others, she briefly summarized HB5, HB273, HB1405, HB1772, HB2102, HB2292, HB2576, HB2723, HB3017, SB1001, and SB1054. Ms. McCandless noted that the Sunset bill for TDI recommends continued operations for the department until 2017. Several amendments were attached to the House-passed version, including an open enrollment period for child-only policies, and a state-based exchange. Ms. DeLargy noted that HB3402 would extend Pool coverage for dependents up to age 26, rather than age 25; this is really not a concern because the Pool now allows uninsurable dependents to remain on the Pool beyond age 25 if they qualify on their own. Ms. DeLargy asked the Medco representatives about the impact of HB438 which, if passed, would require the same coverage for oral chemotherapy medications as for traditional treatment, without specialty copays. Mr. Hammons confirmed that Medco is following the bill and said he would check with Jill Stearns regarding status and impact. It was agreed that this issue would be added to the Pool's annual benefits work group agenda, and Medco will assist with that later review.

Mr. Browning reviewed the report on Pre-Ex Data for New Members, which indicates that 70% of all new enrollees in March and April were HIPAA-eligibles. In the past, less than 50% of enrollees were HIPAA-eligibles. Further, only $\pm 12\%$ of new Pool enrollees are subject to any preexisting condition waiting period; of those, the average limitation period was only 6 months, not a full year.

IV. Board Issues and Administrative Matters

Mr. Browning reviewed the draft Annual Report to the Governor, due by June 1st of each year. He noted that he has condensed the report from its previous ± 20 -page length and added more visuals, with design assistance from Ms. Foran at BCBSTX. He asked the Board to review this draft mock-up report and recommend any changes by the following Wednesday, to allow adequate production time. After further discussion, **Mr. Barbutti moved to adopt the draft 2010 Annual Report to the Governor, and authorize the Executive Director to make any necessary final revisions. The motion was seconded by Ms. McCandless and unanimously approved.**

Mr. Browning presented an updated report for the Pool's low-income premium subsidy program. Since early 2010, the Pool has collected $\pm \$8.2$ million from 65 carriers to fund the program. These funds represent the Pool's share of penalties owed by insurance companies and HMOs to medical providers, primarily hospitals, for clean claims paid late. The Pool's average monthly collection is $\pm \$575,000$, though the amounts vary widely from month to month. The collections currently annualize to $\pm \$7$ million available for subsidies.

More than 3,100 Pool subsidy applications have been received, and $\pm 2,800$ were approved. The average monthly premium subsidy amount for recipients is $\pm \$300$. There are two different subsidy levels, 30% and 50%, based on a household's income as a percentage of the federal poverty level. A majority of approved subsidy participants are receiving a 50% subsidy. Aggregate funding required for the current subsidies is $\pm \$10.0$ million a year, so there is a $\pm \$3.0$ million annual shortfall. This shortfall will be covered by the penalties that were collected throughout Y2010, before the subsidies began January 2011, along with the FY10 and FY11 federal Bonus Grants, authorized by the Board to supplement the subsidy program. This aggregate supplemental reserve should allow the Pool to cover the $\pm \$3.0$ annual shortfall through the end of Y2013.

A subsidy application form was mailed to all $\pm 27,000$ Pool members a year ago. Next month, the application will again be mailed to all enrollees not currently receiving a premium subsidy. This mailing will offer an

opportunity for assistance to members, who did not qualify in 2010, and new members, who enrolled since last June. Since only new members, who enrolled within the last 12 months, were not able to apply last year, the volume of new applications should be much lower this summer. Funding will continue to be very closely monitored each month to determine how many additional subsidy slots are available. Mr. Browning noted that federal grants for FY12 and FY13 are likely, which would further supplement the program's core funding. Mr. Browning confirmed that current subsidy recipients will have to requalify later this year; those who no longer qualify will lose their subsidies at year-end.

Mr. Browning proposed additional program rules to tighten up the household income definition. As applications were processed last year, it became apparent that some individuals, who qualified for the subsidy based on taxable income, actually had significant income from tax-exempt sources, specifically IRA, interest, and pension/annuity distributions. In addition, some members had net operating loss carryforward deductions, which reduced taxable income, not actual income. Mr. Browning recommended adding back those four categories of deductions to the calculation of household income. He discussed revisions to the application form, including updated federal poverty level limits for Y2011. Mr. Barbutti noted that the funding of the program will need to be addressed during the 2013 session if the federal Affordable Care Act is fully implemented. Mr. Browning agreed that this item should be added to the list of Pool dissolution issues for future Board review and action. At some point, the collection of prompt pay penalty funds will have to be discontinued. He noted that the Board previously decided to form a work group next summer to focus on the various dissolution issues to be addressed. After further discussion, **Ms. Williams moved to approve the updated premium subsidy application form and the additional administrative rules regarding the definition of household income, and moved to authorize the Executive Director to further revise the application form as necessary. Mr. Ott seconded the motion, and it was unanimously approved.**

Mr. Browning discussed a problem that has arisen as a result of one of the early provisions of the Reform Act. Effective September 2010, carriers were no longer permitted to decline applications for children under age 19 for medical reasons. In response, carriers stopped marketing coverage for child-only policies; when a child, with a health condition, is included as a dependent on an application for individual coverage for a family, the premium rate quote provided by some carriers for the child's coverage is very high, in some cases up to eight times the healthy child rate. Although the carriers can no longer reject or rider a child for health reasons, they can still rate up premiums. The refusal of carriers to offer a child-only policy, or to offer coverage only with a very high rate, also impacts the ability of the child to apply for Pool coverage. The child can no longer qualify based on a carrier declination or an agent certification that the child would be declined; not offering any child-only policies does not constitute a declination of coverage for a health reason, as required by the Pool statute. The eligibility criteria of a higher premium rate was removed from the Pool statute many years ago. The only ways a child, with a preexisting health condition, can access the Pool is if the child is HIPAA-eligible, has one of the 54 autoqualifier conditions on the Pool's list, or is a family member of a Pool member or eligible applicant. To partially mitigate this problem, the Pool could expand the conditions list to include some additional common childhood conditions. It was agreed that the benefits work group will recommend additional conditions for the list and recommend whether these conditions should be limited to children or apply to applicants of any age. Mr. Cole appointed Ms. McCandless, Ms. Paparelli, Mr. Barbutti, and himself to the Benefits Review Working Group to analyze and make recommendations for benefit and related modifications to the Board for January 1, 2012 implementation.

At 10:15 a.m. Mr. Cole announced a break. At 10:30 a.m. Mr. Cole brought the meeting back to order.

V. Discussion and Actions on Matters Concerning the Third Party Administrators

A. Report from BCBSTX -- Status of Operations

The following representatives from BlueCross BlueShield of Texas ("BCBSTX") attended the meeting: Terese Foran, Communications Manager; Michael Garcia, Sr. Mgr., State Operations; Keith George, Attorney; Brian

Naiser, Div. V.P., Government Accounts; Marcy Sasser, Sr. Dir., Subscriber Services; and Cyrus Walker, Dir. Account Management, Government Accounts.

Mr. Naiser provided several corporate updates. He noted that BCBSTX just received the Association's "Best of Blues" award in the "Customer Experience" category, their fifth Best of Blues award, and more than any other Blues plan has received since the award program's inception in 2008. BCBSTX recently opened a federal government relations office in Washington, D.C. to increase visibility at the federal level. Pending TDI approval, BCBSTX will offer a child-only policy, called Blue Pathways, effective August 1, 2011. This plan would be available to children ages 1 to 19, with a \$2,500 deductible, 75% coinsurance, 100% coverage for preventive services, \$15 generic drug copays, and a \$3,000 out-of-pocket maximum. Unfortunately, this new plan will not resolve all of the issues regarding child access to coverage, as discussed previously, as it will not be offered to children under age one, and the premium rates, based on medical underwriting, could be expensive. Mr. Naiser said he will ask a BCBSTX underwriter to assist Mr. Browning in identifying medical conditions common to children, for possible inclusion on the Pool's list of autoqualifying medical conditions.

Ms. Walker reviewed follow-up items from the last meeting: 1) 78% of the Pool members who called the BCBSTX 24/7 nurse line were repeat callers; 2) the provider network growth previously reported at 4% occurred in the Austin, Houston and Dallas urban areas; and 3) the growth in the BCBSTX behavioral health network is across all license areas. Ms. Williams asked the account team to coordinate BCBSTX nurse line and case management efforts with the Pool's new disease management vendor.

Ms. Walker provided 1Q 2011 account highlights. She confirmed that the premium rate increase notice packets were timely mailed for the May 1st rate increase. Total medical benefits paid by the Pool was 3.7% lower than 1Q 2010, as members continue to shift to higher deductible plans. Network provider discounts increased slightly to 59.4%; in-network claims penetration increased to 98.1%, compared to 97.9% the prior year. Patient cost share increased by 5.9%, as would be expected with the shift to the higher deductible plans. The number of claimants with \$50,000 or more in medical benefit costs over a rolling 12 month period increased to 3.2% of all claimants. BCBSTX network discounts, coordination of benefits, and other cost savings programs increased total Pool savings during the quarter by 2.8%, to \$176 million.

Coordination of benefits savings increased significantly because more Medicare members have diseases for which Medicare pays primary, such as end-stage renal disease. Subrogation recoveries were up 450% for the quarter due to two large cases that settled. The new mandatory case management provision is working well, with no enrollees refusing case management. The Blue Choice network provider count increased by 4.6%.

Mr. Garcia reported a drop in application activity, though net enrollment has remained the same. The application approval rate was 81.5%. The pend procedure for applicants eligible for the federal pool resulted in 96 Pool applicants deciding to pursue coverage with the federal risk pool. Deductible plan selection and member demographic trends were discussed. Ms. Walker added that internal deductible migration analysis indicates a growing trend over the past two years where new enrollees start out at a lower deductible plan, incur expensive services, and then move to a higher deductible with lower premiums. Mr. Garcia reported that Pool telephone inquiries involving a customer service advocate are down by 4%, due to the increased use by members and providers of automated resources. The new automated systems provide answers to straightforward questions, while the advocates generally handle the more complex inquiries, as reflected in the drop in the first contact closure rate.

Mr. Garcia noted that the number of medical claims processed in the first quarter was 9% lower than in 1Q 2010. The high cost tracking reports were reviewed. Mr. Garcia reviewed the 2010 and 2011 performance standards charts. Mr. Browning confirmed that penalties were assessed for the 5 standards in 2010 that fell below minimum standards. Thus far this year, no penalties have been assessed.

Mr. Cole asked if the BCBSTX Bridges to Excellence program had been extended to cardiac conditions, as

planned. Ms. Walker confirmed that this program was implemented in January; she offered to provide the benefits work group with examples of benefit design incentives developed by other plans to steer patients to physicians with the Bridges to Excellence designation. Dr. Emmick observed that physicians are interested in this program because it is well designed, independent of insurance companies, and they actually receive the promised higher reimbursements. Ms. Walker explained that Bridges to Excellence is a third-party designation; BCBSTX was the first Texas carrier to reimburse certified providers at higher rates. Both Bridges to Excellence and NCQA have verified that these accredited physicians provide cost-effective services that generate claim savings. Further, BCBSTX periodically reviews claims data for Bridges to Excellence providers to validate those savings and thereby justify the higher contract reimbursement rates paid these providers.

B. Report from Medco -- Status of Operations

The following representatives from Medco Health Solutions attended the meeting: Ajay Dalal, Dir. Clinical Services; Patrick Fiduccia, Manager Financial Analytics; Bryan Hammons, Dir. Clinical Services; David Runyan, Account Manager; and Ken Wagg, Account Manager.

Mr. Hammons introduced Mr. Ajay Dalal, who has been with Medco for 5 years, and who will replace him as the Pool's Clinical Services Director. Mr. Hammons announced he has taken another position within the company involving Medicare Part D claims. Mr. Hammons said that he has thoroughly enjoyed working on the Pool account the past 5 years, and with such a professional and efficient Board of Directors.

Mr. Fiduccia presented the Medco 1Q 2011 reports. The non-sedating antihistamine preferred drug step-therapy rule was implemented January 1, 2011, and savings have already been recognized. Mr. Dalal confirmed that this category, once in the top tier of utilization, has diminished due to the numerous over-the-counter ("OTC") product introductions. Clarinex is the remaining branded prescription, but he suspects it will become available as OTC before it converts to generic. In 1Q 2011, Pool spend was only \$50,000 for Clarinex and the Allegra products. The remaining preferred generic product is Xyzal, which is still a covered prescription drug. Mr. Fiduccia reported that a few health plans cover OTC drugs with a reduced copay, but other plans no longer cover the antihistamine category at all because of the OTC availability. OTC coverage through the drug benefit is difficult to administer, as the member must have a prescription for the OTC product in order to receive the copay benefit. Mr. Fiduccia reported that effective May 1st the Pool successfully enrolled in the GeCCO genotype trial (Genotype-Guided Comparison of Clopidogrel and Prasugrel Outcomes Study), which is designed to determine whether outcomes achieved with Plavix are comparable to those from the new, more expensive blood thinner, Effient. Preliminary results from Pool participants should be available soon.

Mr. Fiduccia reported that Medco launched the RapidRx program to help high-volume physicians become more comfortable dealing with Medco's mail service, formulary, and numerous clinical intervention programs. What began as a small pilot has rapidly grown to include more than 16,000 prescriber offices. In addition, Medco has added an application download for Verizon smart phones, which allows access to three tools: 1) MyRx Choices, through which members can view the price of medications and preferred alternatives; 2) the Medicine Cabinet program, which lists the member's current prescribed medications; and 3) the member's prescription ID card for use at the pharmacy. The application will be available for Apple and AT&T customers very soon. Future developments will include a GPS application to allow the member to determine a pharmacy's network status while at the pharmacy, and prescription label scanning to start the refill process.

Mr. Fiduccia discussed the Medco Health Store. A total of 391 Pool members are now registered to use the Store, but only 30 have actually submitted orders. One valuable feature within the Store is the Drug Interaction Checker, which issues alerts at check-out if products in the cart adversely interact with the member's prescription drugs. Mr. Browning asked if the Health Store is promoted in the Pool member welcome packets mailed by Medco. Mr. Runyan said it has not been, but he will provide Mr. Browning with those materials for review.

Mr. Fiduccia presented the Pool's 1Q 2011 financial data. The Pool's drug costs, net of estimated rebates, administrative fees, and Medco copay waivers, totaled \pm \$23.5 million, a 12.5% increase over 1Q 2010 results. Price inflation was the primary driver of non-specialty drug trend over the past 12 months, partially due to cost increases for Lipitor, ahead of its loss of patent protection later this year. Utilization of specialty drugs increased 12.8% over the past 12 months, with significant increases in the use by members of rheumatoid arthritis, multiple sclerosis, and cancer drugs. In addition, the cost of MS drugs has experienced high price inflation.

Mr. Fiduccia reported that 22,376 enrollees filled a prescription during the quarter; this is 83.5% of all members enrolled during that time period. The Pool's generic dispensing rate--the ratio of generic scripts to all scripts filled--continues its upward path, ending the quarter at 65.1%; this rate will only improve as additional patents expire. The Pool's generic dispensing rate is the best among Medco's risk pool accounts. Mr. Barbutti asked if there is a way to determine the Pool's optimal generic dispensing rate. Mr. Fiduccia said Medco has analyzed maximum potential switch rates for accounts in the past and he agreed to look at this for the Pool and report back. Medco continues to fund the copay waiver program for new generic scripts filled through the mail service; during the quarter, 502 Pool enrollees received a copay waiver for \pm 1,100 scripts. The Pool mail order program penetration rate continues to improve, now up to 36.2% of all days of therapy; Medco's average book of business mail penetration rate is 34.1%. The Pool also has a very high generic substitution rate, with members selecting generic equivalents to their branded counterparts 99.2% of the time.

Mr. Fiduccia reviewed the timeline of major branded drugs coming off patent through 2013. Three high utilization drugs, Lipitor, Levaquin, and Zyprexa, lose protection later this year, which will contribute to generic conversion savings. But even more savings will be realized beginning the latter half of 2012, when the largest wave of expirations will occur, including Plavix, Actos, and Singulair. Savings to the Pool will be automatic because enrollees must pay the cost difference if they choose to continue using a brand drug after a generic equivalent becomes available. The eventual level of savings will depend on several factors, including the number of generic manufacturers that enter the market for each drug after the six-month single-source generic exclusivity period that follows patent expiration. In an effort to encourage enrollees to convert to generic Lipitor and not to a different brand drug like Crestor, Medco will launch a special \$25 copay waiver program through mail service later this year. Ms. Milligan asked if Medco can estimate the Pool's drug cost savings from these scheduled expirations. Mr. Fiduccia responded that Medco is now developing a model to attempt to develop meaningful estimates; when available, he will use this tool to estimate the range of possible savings.

Mr. Fiduccia reported that the Pool's enrollees covered 25.5% of the cost of their drugs during 1Q 2011. This share will decline over the year as deductibles are satisfied, to the 18% range by year-end. Further, 84% of Pool enrollees are classified as chronic or complex condition patients, and they generated 99% of the Pool's drug costs in 1Q 2011. Mr. Dalal presented Medco's new HealthStage Segmentation program, which provides tailored, customized communications to four categories of patients receiving maintenance medications.

Although many Pool members successfully communicate on line with Medco, the company is working to register the 59% of enrollees who are not registered with medco.com. Once registered, Medco can provide clinical interventions through the web site and via email alerts to close more gaps in care. Many patients have low drug adherence rates or do not take their medications properly. Medco can counsel these enrollees and offer options to correct these gaps. Closing these gaps in care will reduce costs, estimated to average \$724 per gap based on Medco's experience and Pool clinical data. Ms. Milligan asked if the Pool's medical and pharmacy data are linked; they are not able to offer a single sign-on to enrollees, but the BCBSTX and Medco account teams agreed to work to enhance the member's ability to cross back and forth between their platforms.

Mr. Dalal discussed the list of the Pool's top 25 medications by cost during 1Q 2011. The rheumatoid arthritis drugs continue to drive costs, with 49 members added to therapy. Multiple sclerosis drugs represent the other significant cost category. Mr. Dalal agreed to start marking the drugs on this list that are going off patent. Medco's specialty therapy and coverage management programs reduced Pool specialty drug costs by \$1,035,443

during the quarter. Coverage management rules include prior authorizations, step-therapy and quantity restrictions; therapy management reviews occur when mail order specialty pharmacists consult with physicians to determine proper dosage rates. All Medco clinical management programs combined, including RationalMed and utilization review, reduced Pool costs by \$5.7 million during 1Q 2011, a 45% savings increase compared to 1Q 2010. Concurrent drug utilization review savings reflect edits that occur at the point of sale, including denials for: 1) refills too soon; 2) severe drug-drug interactions; and 3) duplicate therapies.

Mr. Fiduccia reported that all of the Pool's contract performance guarantees were met in 2010.

C. Report from HealthLinX--Pharmacy Audit and Action Items Update

Mr. Browning reported that Mr. Kellogg was unable to attend the meeting due to mechanical problems with his flight. In his absence, Mr. Browning briefly presented some of Mr. Kellogg's comments. Mr. Kellogg plotted drug costs for five risk pools across a 27-month period ending March 31st. The Texas Pool's costs ranked in the middle of the group. The Pool benefitted from Medco network pharmacy reimbursement rates that were reset in 2010. Mr. Browning agreed to ask Mr. Kellogg to provide a color version of this chart going forward so that it is easier to read. Mr. Kellogg also reported that his audit of the drug claims processed by Medco in 2009 should be finalized within a few weeks; the results will be reported at the next meeting.

Mr. Browning presented an update for the pharmacy benefit manager request for proposal ("RFP") process, including the timeline of important dates and the list of the 13 companies that submitted a proposal. Mr. Kellogg conducted extensive analysis of these bids and provided a detailed evaluation summary to the PBM RFP working group, composed of Mr. Barbutti, Mr. Cole, and Dr. Emmick. The work group members conferred with Mr. Kellogg, Mr. Browning, and Ms. DeLargy several times and thoroughly reviewed the terms of each bidder's proposal. The group reached consensus to narrow the field from 13 to 4 finalists: CatalystRx, CVS Caremark, Medco, and Prime Therapeutics. Mr. Browning said the working group had hoped to make a selection recommendation to the Board at this meeting, but the bids were so competitive that further study was required. The Pool statute requires the Board to make a selection by June 30th of the year preceding contract implementation, so a special-purpose Board meeting later next month would be required. Mr. Browning noted that the working group will submit final questions to the finalists and proceed to a recommendation decision.

VI. Public Comment

Mr. Cole requested public comment. He noted that Ms. Debbie de la Riva and Mr. Daniel Bond had requested an opportunity to address the Board. Mr. Bond stated that he is enrolled in the Pool and appears on the Pool's high-cost claimant tracking report. He is a severe hemophiliac and wanted the Board to know how grateful he is to have Pool coverage. He thanked the Board members for their efforts on his behalf and to the community as a whole. He briefly discussed his medical history and emphasized the importance of having ready access to factor to avoid debilitating joint bleeds. He noted that he has received his factor from Hemophilia Health Services, Medco's factor specialty company, for many years and has never had any problems with delayed shipments of factor medication. They have done a wonderful job. He did, however, encourage the Board to consider allowing hemophilia treatment centers ("HTCs") to also provide factor to patients. As an experienced factor user, he is able to do his own home infusions, but he thinks that HTCs represent the best way for families new to the therapy to obtain their factor and get the associated training and support they need. Mr. Browning confirmed that the Pool has an exclusive delivery arrangement with Medco/Accredo for clotting factor, but that the benefits work group could revisit that arrangement this summer. Ms. McCandless agreed that the Pool should explore what special services are offered by HTCs. Mr. Browning observed that Medco/Accredo also provides home-based training and support to the Pool's ±15 factor patients. He said that he will obtain more information about those services. Ms. DeLargy stated that Medco will deliver the factor to the HTCs, but the issue may be whether the HTCs are willing to accept delivery. Mr. Cole wondered if the Pool's factor patients are fully aware of Medco's ability to deliver factor to their HTC of choice; with such a small patient base, awareness of this option should be easily accomplished. After further discussion, agreement was reached to study this issue

further and for the work group to make any recommended program changes to the Board. Mr. Cole thanked Mr. Bond for his input and the information he provided to the Board.

Ms. de la Riva said that she has attended past Pool Board meetings and appreciated the opportunity to address the Board today. She became involved with hemophilia advocacy after her son was born with the condition 16 years ago. Ms. de la Riva distributed a letter to the Board outlining her concerns. She thanked the Board and Pool staff for creating an outstanding program and added that the Pool is recognized nationally as a well run program. The Pool serves as a very important safety net for the hemophilia community in Texas. She attended the meeting today to encourage the Board to consider opening the Pool's factor benefit to hemophilia treatment centers, to allow HTC's to provide factor to Pool patients. She confirmed that patients can access HTC support services without obtaining their factor at the HTC, but because government funding for HTC's has diminished, it is vital to their long-term viability to be able to sell factor as well. Ms. De la Riva emphasized that she is not professionally affiliated with any HTC. In her view, sole-source provider arrangements discourage competition, which can adversely affect patient care. Although Medco/Accredo provides excellent services, the community has a fear that services could diminish if another sole-source factor provider were engaged. She also believes that sole-source providers cannot always timely meet the needs of patients in rural or remote locations.

Ms. de la Riva explained that HTC's buy their factor through a special program called PHS pricing, which saves her family \$0.10 per unit compared to home health care providers. The Pool should take advantage of this pricing discount. She agreed to provide Mr. Browning with contacts at the HTC's who could provide pricing data to the Pool. Ms. DeLargy noted that the Pool elected to use the Medco single-source arrangement because of discounted pricing from Medco, to not only save the Pool money, but extend the lifetime maximum benefits for these patients. Mr. Browning agreed, but confirmed that it was time to perform an updated financial analysis for this benefit.

Ms. McCandless suggested that the new PBM contract could contain a provision to allow the Pool to utilize HTC's if they match or come close to the pricing offered by the PBM. Mr. Barbutti asked for more information about the HTC's. Ms. de la Riva stated that there are two HTC's in Texas; they have several satellite offices around the state. She clarified that she is not advocating for the HTC's to become sole-source providers for the Pool, but to simply open the benefit to the HTC's as well. Mr. Browning confirmed that he will compare the services provided by the HTC's and Medco, and the updated factor pricing they offer. Mr. Barbutti observed that the Board has always been reluctant to limit access to any service or drug. He thanked Ms. de la Riva for bringing this issue to the Board's attention for further review. Mr. Cole thanked Ms. de la Riva for her input.

VII. Executive Session

Mr. Cole announced that the Board did not need to go into Executive Session.

VIII. Adjournment

Mr. Cole announced that in March Mr. Browning received the *Shirley Hutzler Excellence in Legislation* award from the Texas Association of Health Underwriters, in recognition of his service to the state's health agents.

Ms. McCandless moved to adjourn the meeting. The motion was seconded by Dr. Rainey and unanimously approved. There being no further business, Mr. Cole adjourned the meeting at 12:40 p.m.