

STATE OF NEW HAMPSHIRE

**SELF-FUNDED
EMPLOYEE AND RETIREE
HEALTH BENEFIT PROGRAM
ANNUAL REPORT**

For the Fiscal Year Ended

June 30, 2012



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The Department of Administrative Services

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This document and related information can be accessed at

<http://admin.state.nh.us/RiskManagement/index.asp>

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1. MANAGEMENT'S DISCUSSION AND ANALYSIS

The following is a discussion and analysis of the financial activities of the Employee and Retiree Health and Dental Benefit Programs for fiscal year ended June 30, 2012. This information serves to supplement the State of New Hampshire 2012 Comprehensive Annual Financial Report (CAFR) and is intended to provide the reader with more in depth knowledge about and background for these Programs.

OVERVIEW AND FINANCIAL HIGHLIGHTS

Medical and Prescription Drug (Health) Benefit Program:

For the five year period of FY 2008 through FY2012, the Health Program annual cost increases (including both claims and administration) averaged 3.7% per year. The low cost increases represent the various cost containment initiatives used to reduce medical and prescription drug based claim trends by an average 3% per year. In the absence of these initiatives, claim trends for the same period would have averaged 7.5% per year. The estimated savings associated with this lowered trend is approximately \$34.4 million over the five-year period (see *TREND*, p. 14).

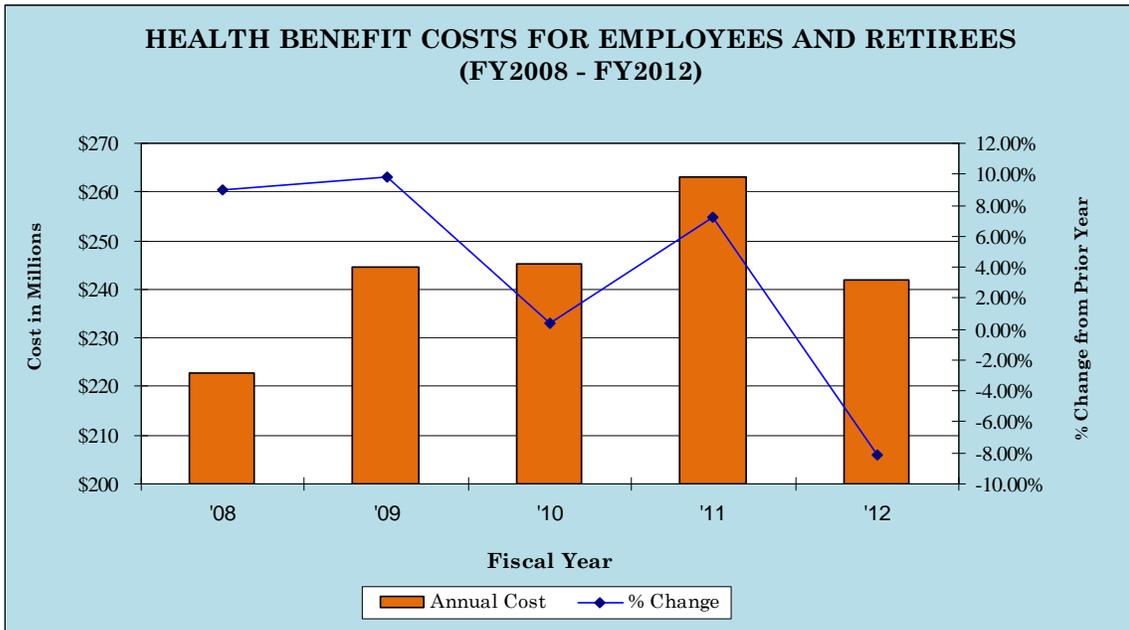
The Health Program continues to achieve these savings through:

- Aggressive third party administrator (TPA) service procurements and vigorous vendor management
- Implementation of cost-effective programs as well as plan design and administrative changes to the benefit
- Participation in the collective bargaining process through comprehensive financial and modeling support
- Overall sound fiscal management

Some savings have undoubtedly been realized through the Program's leadership and coordination of the State's employee wellness program.

For FY2012, the total costs for providing health benefits for all state employees and retirees was \$241.8 million, a 8.2% decrease from the prior year. The decrease includes the drop in enrollment by 6.7%, as a result of a reduction in work-force and the separation of the Community College System of New Hampshire from the State Health Program. On a per member per month (pmpm) basis, FY2012 experienced a 1.6% decrease in pmpm from FY 2011's pmpm of \$540. With the significant decrease in costs, the Program was able to return accumulated surplus to State agencies through a working rate suspension of \$16.7 million (see Note 6, *Notes to Financial Statements*, p.11). The surplus represents funds over and above the combined statutorily required reserve for unexpected claims and the Incurred But Not Reported (IBNR) reserve of \$28.2 million.

As of June 30, 2012, the Health Program ended the fiscal year with a \$628,000 surplus excluding dental surplus. The year end surplus represents approximately 0.26% of the annual Program expenses. This is extraordinarily close considering expenditures of over \$240 million.

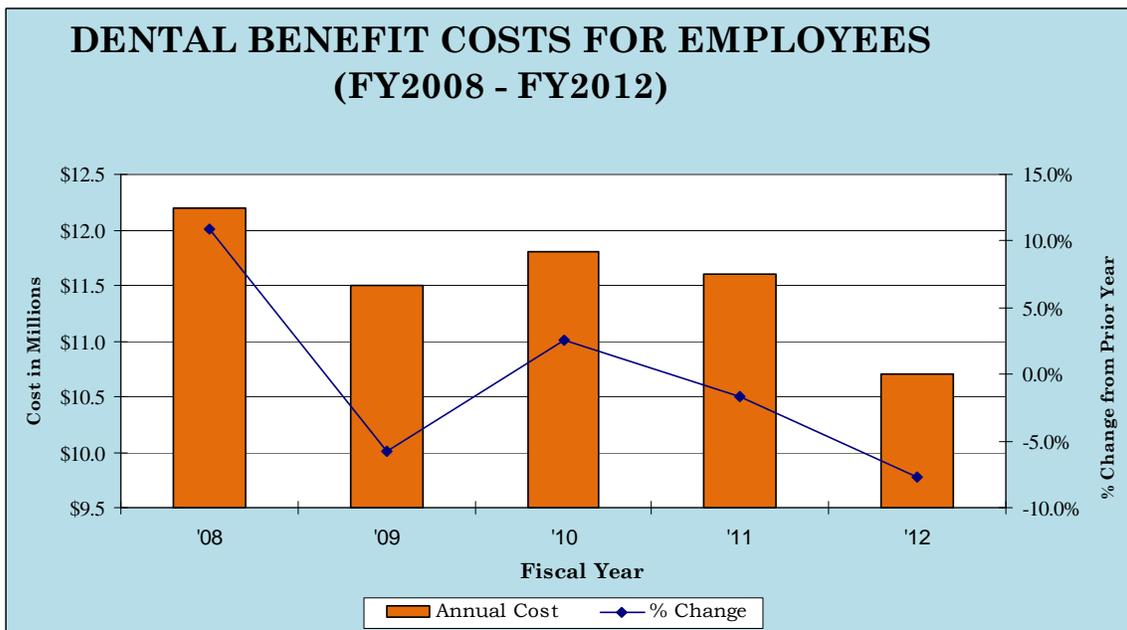


Dental Benefit Program:

The Program costs varied significantly over the years while fully insured. However, since moving the financing of this benefit from a fully insured to a self-funded arrangement in FY 2008, costs increases have become stable and have averaged less than 0% per year, while the dental base trend averaged -1.5% per year.

For FY2012, the total costs of the Dental Program, which covers all state employees, was \$10.7 million. This amount represents a decrease of \$931,000 or -8% from FY 2011. The decrease reflects the drop in enrollment by 10% from FY 2011. Like the Health Program, the Dental Program also conducted a working rate suspension during FY2012 to spend down accumulated surplus in the amount of \$587,000.

As of June 30, 2012, the Dental Program ended with a \$38,000 surplus after taking into consideration the statutory and IBNR reserves of \$837,000.



FINANCIAL ANALYSIS

Fund Balance

As managers of the Health and Dental Programs, staff works diligently to monitor the fund balance and ensure adequate revenue is collected to pay claims and administrative costs. A portion of the fund balance comprises required reserves for unexpected claims as well as for IBNR at year end. All funds above these reserve amounts are considered surplus. The accounts for each of these Programs were created as internal service funds that are non-lapsing and roll-forward each year.

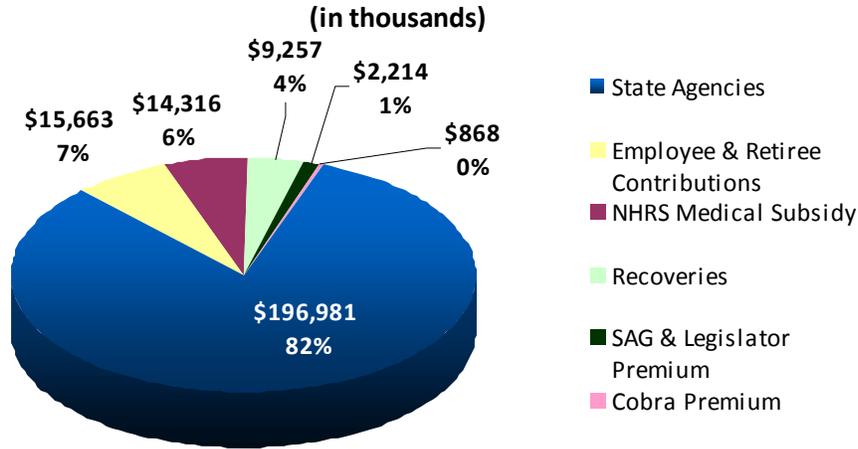
In the Health Program's first full year of self-funding in FY 2005, the initial fund balance was negative \$12.1 million. The negative balance carried forward from FY 2004 was due to the Program paying insurance premiums for a half year (while still fully-insured), along with the start-up costs (i.e. establishing reserves) associated with becoming self-funded in the second half of the year. Since the beginning of FY 2005, the Program has collected, in aggregate, \$1.818 billion in premium revenue. It paid out \$1.796 billion in expenditures through FYE 2012. During this eight year period, the Health Program was able to waive collection of \$76.2 million in premium, which includes \$16.7 million in FY2012. This "waived" amount represents funds that could have been collected from agencies, but that were not ultimately needed to pay the actual claims. Had the State continued to be fully-insured throughout this period, the \$76.2 million would have been paid to (and retained by) an insurer. Instead, the State was able to retain this amount, which accumulated as surplus in the fund. Over the years, it has been periodically "spent" down through means of a rate suspension and returned to the agencies and other payers (see Note 7, *Notes to Financial Statements*, p. 14). The fund balance for the Health Program as of June 30, 2012 is \$33.1 million, which includes statutory and IBNR reserves of \$13.5 million and \$14.6 million, respectively.

In its first full-year of self-funding in FY 2009, the Dental Program had a starting fund balance of \$137,000. Since then, the Program has collected, in aggregate, \$46.2 million in premium revenue, and paid out \$46 million in expenditures through FYE 2012. During this four year period, the Dental Program used accumulated surplus to waive collection of \$2.1 million in premium through means of a working rate suspension. The fund balance for the Dental Program as of June 30, 2012 is \$1 million, which includes statutory and IBNR reserves of \$537,000 and \$300,000, respectively.

Revenue

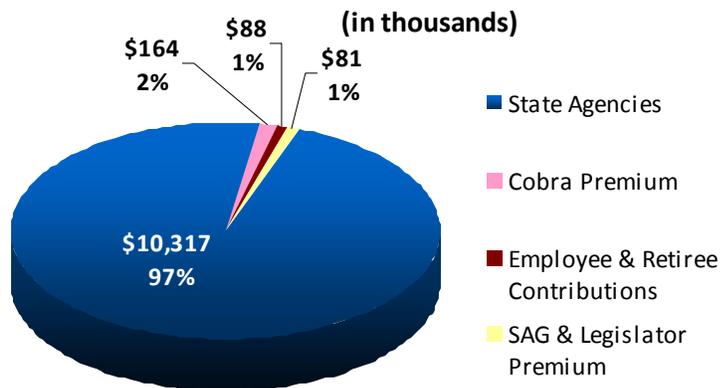
In FY2012, the Health Program's total premium revenue decreased approximately \$22.6 million (8.6%) from FY 2011, to \$239.3 million. The funding sources for the premium comprised 82% state agency contributions, 6% NHRS medical subsidy, 7.8% subscriber premium and contributions, with the remainder derived from miscellaneous sources. The bulk of the miscellaneous revenue sources include Medicare Retiree Drug Subsidy Program payments and prescription drug rebates. As mentioned above in the ***Fund Balance*** section, total premium collected was reduced as a result of the working rate suspension, which allowed the Program to spend down \$16.7 million in accumulated surplus. The funds not collected from state agencies were used to help satisfy a \$50 million budget reduction that was collectively bargained for in the FY2012 – FY2013 contract.

FY 2012 HEALTH REVENUE SOURCES



The Dental Program collected \$10.7 million of premium revenue in FY2012, which amounted to a \$200,000 (-1.8%) decrease from FY 2011. All but 3% of the premium collected was from state agency contributions. Like the Health Program, the Dental Program premium collected was also reduced to spend down \$587,000 in excess surplus. Again, the dental premium was reduced through a working rate suspension and approximately \$587,000 was not collected from state agencies. The funds were used to help satisfy a collectively bargained \$50 million budget reduction.

FY 2012 DENTAL REVENUE SOURCES

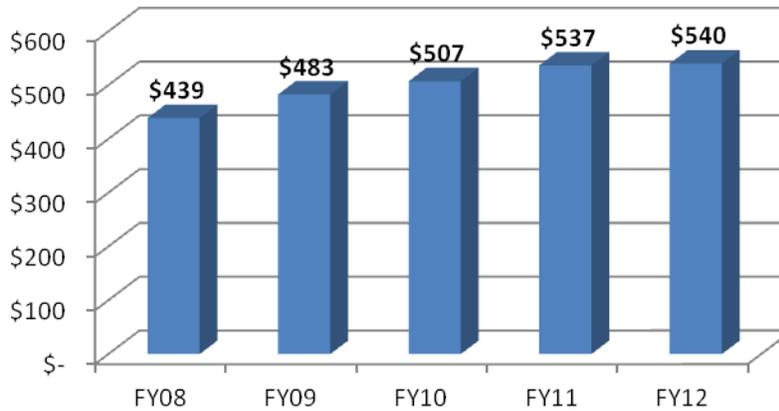


Expenditures

In FY2012, total Health Program expenditures decreased \$21.5 million (8.2%), to \$241.8. As expected, medical claims comprised the largest share of this expense at \$173.3 million (71.7%), while prescription drug claims equaled \$57.9 million (24%). The remaining expenses were administrative costs associated with operating the Program and constitute 4.4% of the total expenditures.

The following graphs show the total costs on a pmpm basis by total members, broken out by Active employees and both Retirees under age 65 and those over the age of 65, for the period of FY 2008 through FY2012.

ACTIVE PMPM



**Includes Trooper Plan*

RETIREE PMPM



The Dental Program expenditures decreased \$931,000 (-8%) to \$10.7 million in FY2012. Since retirees do not participate in the self-funded dental plan, these costs represent only claims associated with Active employees and special agencies, which participate in the plan pursuant to statute. Administrative costs were \$443,000 and represent 4.1% of the total dental expenditures. Retirees have the option to buy into a fully insured dental plan and they pay a monthly fully insured group rate premium and therefore the program does not pay the claims.

ECONOMIC CONDITIONS AND OUTLOOK

Although the Programs have proven the financial advantage of self-funding, the State must continue to address the challenges of health care cost increases to ensure programs are sustainable. In particular, the Health Program must monitor and assess the effects of the Affordable Care Act (ACA), which in FY2012 included implementing various administrative requirements related to enhanced appeals procedures and conducting a review of plan design to ensure compliance with new requirements related to preventive health coverage. For FY2013, the Health Program will begin preparing other administrative and fiscal obligations such as, issuance of Summary of Benefits and Coverage, W-2 reporting requirements, and budgeting costs related to comparative effectiveness research fees and transitional reinsurance fees. In addition, the Program must be cognizant of the looming excise tax in 2018 that will be levied on both insured and self-funded employer-sponsored health plans which exceed coverage thresholds established by the ACA. The 40% excise tax will be assessed on the balance of the value of coverage exceeding the thresholds for health plans to the employer. *With the current trajectory, the Health Program expects the impact of the excise tax in 2018 to exceed \$14 million a year.* To reduce this future tax liability, the Program must act now to lower its overall costs, but within the constraints of the ACA. This may include increasing co-pays, coinsurance and/or deductibles.

So as to maintain high quality health and dental coverage that is affordable for the long-term, the Program must leverage its purchasing power to drive change in the larger health care system. Shifting costs to employees or retirees will not significantly bend the overall *cost curve*. Lowering total health care expenditures must involve real change on the part of health care providers and consumers alike.

The goal of the Program is to continue to effectively manage its fiscal and operational responsibilities while encouraging such change. Through its procurements processes, the Program seeks new reimbursement models that align providers' cost and quality incentives with those of the State. For example, hospital systems and physicians payments should reflect their ability to coordinate care, eliminate unnecessary diagnostics, and emphasize prevention. In addition, the Program will continue to encourage the use of cost-effective providers through its offering of the Compass Smart Shopper program, which rewards employees and retirees to obtain certain services at lower cost facilities. Finally, the Program must continually promote cost awareness and individual health management at the worksite and through the wellness and other services of its benefit administrators.

2. PROGRAM FINANCES AND FISCAL INFORMATION

COMBINING SCHEDULE OF BALANCE SHEET ACCOUNTS (Unaudited)

FOR THE FISCAL YEAR ENDED JUNE 30, 2012

(expressed in thousands)

	Health			Dental	Total	
	Active	Retirees	Troopers			
<u>ASSETS</u>						
Current Assets:						
Cash and Cash Equivalents	\$ 16,526	\$ 10,436	\$ 4,177	\$ 31,139	\$ 965	\$ 32,104
Accounts Receivable	469	1,447	5	1,921	53	1,974
Total Assets	\$ 16,995	\$ 11,883	\$ 4,182	\$ 33,060	\$ 1,018	\$ 34,078
<u>LIABILITIES</u>						
Current Liabilities:						
Accounts Payable	\$ 453	\$ 360	\$ 13	\$ 826	\$ 36	\$ 862
Claims Payable	2,708	663	56	3,427	107	3,534
Incurred But Not Reported	8,579	4,658	312	13,549	300	13,849
Total Liabilities	\$ 11,740	\$ 5,681	\$ 381	\$ 17,802	\$ 443	\$ 18,245
<u>FUND BALANCES</u>						
Reserved per RSA21-I:30-b	8,470	3,806	2,354	14,630	537	15,167
Unreserved, Undesignated	(3,215)	2,396	1,447	628	38	666
Total Fund Balances	\$ 16,995	\$ 11,883	\$ 4,182	\$ 33,060	\$ 1,018	\$ 34,078

At the beginning of FY2012, the combined Fund balance of the Health and Dental Programs was approximately \$37.2 million, including required reserves. During the fiscal year, the Programs conducted a working rate suspension in the total of \$17.4 million, which lapsed \$6 million to the General Fund. Following the working rate suspension, the health and dental programs together had a surplus, after reserves, of \$666,000 at the end of FY2012. This surplus represents funds above IBNR and the statutory unexpected claims reserve. It is important to note that working rates are set on a calendar year basis and generally generate surpluses in the first six months, which are used up in the last six months due to the effect of medical inflation.

COMBINING SCHEDULE OF REVENUES, EXPENDITURES AND CHANGES
 IN FUND BALANCE ACCOUNTS (Unaudited)
 FOR THE FISCAL YEAR ENDED JUNE 30, 2012 (expressed in thousands)

	Health				Dental	Total
	Active	Retirees	Troopers	Total		
<u>OPERATING REVENUES</u>						
State Contributions:						
Active Employees	\$ 145,109	\$ -	\$ 1,814	\$146,923	\$ 10,317	\$ 157,240
Retired Judges & Constitutional Officers	-	595		595	-	595
Retired Employees	-	49,463		49,463	-	49,463
Non-State Contributions:						
Employee/Retiree Premium Share	10,690	4,795	178	15,663	88	15,751
Other Employers ¹	1,389	-	18	1,407	-	1,407
COBRA Participants	868	-	-	868	164	1,032
Legislator Participants	586	221	-	807	81	888
Retirement Subsidies & Deductions ²	-	14,316	-	14,316	-	14,316
Part D Subsidy	-	3,719	-	3,719	-	3,719
Recoveries ³	2,312	3,190	36	5,538	-	5,538
Total Contributions	160,954	76,299	2,046	239,299	10,650	249,949
<u>OPERATING EXPENSES</u>						
Medical Payments	129,471	40,458	2,675	172,604	10,250	182,854
Pharmaceuticals	28,956	28,541	411	57,908	-	57,908
Dental Insurance Premiums	-	-	-	-	-	-
Ancillary Benefits	667	-	38	705	-	705
Total Health Care Expenses	159,094	68,999	3,124	231,217	10,250	241,467
Administrative Expenses ⁴	5,774	4,488	178	10,440	443	10,883
Enrollment ⁵	72	32	3	107	-	107
Total Operating Expenses	164,940	73,519	3,305	241,764	10,693	252,457
Operating Income (Loss)	(3,986)	2,780	(1,259)	(2,465)	(43)	(2,508)
Change in Net Assets	(3,986)	2,780	(1,259)	(2,465)	(43)	(2,508)
GAAP Adjustment	(57)	(522)	28	(551)	(19)	(570)
Net Assets - July 1	21,038	9,625	5,413	36,076	1,080	37,156
Net Assets - June 30	\$ 16,995	\$ 11,883	\$ 4,182	\$ 33,060	\$ 1,018	\$ 34,078

¹Other Employers include non-governmental and quasi-governmental employers, such as Pease Development Authority, State Employees' Association, etc.

²Retirement Subsidies and Deductions is the medical subsidy amount received from the NH Retirement System.

³Recoveries comprise Rx rebates and recoverables associated with claim adjudications.

⁴See Note 3.A. Notes to Financial Statements (p. 11), for a full description and breakout of Administrative Expenses by plan.

⁵See Note 3.B. Notes to Financial Statements (p 12).

NOTES TO FINANCIAL STATEMENTS

1. Program Background

In October 2003, the Employee Benefit Risk Management Fund (the “Fund”) was established by the Department of Administrative Services (DAS) to account for the financial activity of the Health and Dental Programs. Upon establishment of the Fund, the fully insured Health Program became self-funded. All expenses were paid directly from the Fund for medical and pharmacy services provided to eligible employees, retirees, and their dependents; administrative costs, including enrollment services, as well as ancillary benefits such as health club membership, exercise equipment and health education classes. The Fund was also used to pay dental premiums, and subsequently claim expenses upon the transition to self-funded status in December 2007. To administer these self-funded programs, DAS contracts with third party administrators which receive, accumulate and process the claims for the various healthcare services, and are thereafter reimbursed.

Fund revenues for the Health Program include agency contributions for their active employees and retirees as well as retired judges and constitutional officers. The statutory medical subsidy of the NHRS and the federal Medicare Part D subsidy also contribute revenue to the Fund. *Statutorily Authorized Groups (SAGs)*, which are certain non-governmental and quasi-governmental employers, such as the State Employees’ Association (“SEA”), and the Pease Development Authority (“PDA”), respectively, also participate in the Program and contribute to the Fund, as do legislators. Rebates from prescription drugs are paid on a quarterly basis into the Fund, and are allocated to their respective benefit plan. Finally, former employees who are eligible to participate under the federal Consolidated Omnibus Budget Reconciliation Act (“COBRA”) contribute monthly payments as revenue to the Fund.

Revenue for the Dental Program includes agency, COBRA, SAGs and legislator contributions.

The State budgets for these Programs using actuarial “premium” rates that are developed and inputted into the State’s budget system every biennium. This method allows for the budget-writers to project benefit costs by using the rates with current and anticipated enrollment. The Programs’ rates are then charged to agency benefits accounts on the bi-weekly pay schedules at a contribution rate (i.e. based on the plan working rates) intended to cover all of the costs associated with the active benefit plans. The budget for retiree health plans are funded through monthly expense entries charged to agencies and through invoicing and collection of premium from those SAGs and legislators enrolled in the retiree plan.

For FY2012, the total cumulative fund balance was \$34.1 million, which represents a \$3.1 million decrease from prior fiscal year. After subtracting the required reserves, and conducting a \$17.4 million rate suspension, a surplus remained equal to \$666,000.

2. Schedule of Revenue, Expenditures and Changes in Fund Balance

For FY2012, the format of the Combining Schedule of Revenues, Expenditures and Changes in Fund Balance Accounts remains similar to the format of the State of New Hampshire Comprehensive Annual Financial Report (“CAFR”) for the Fiscal Year Ended June 30, 2012. The schedule continues to report on an accrual basis and the GAAP Adjustment line FY2012 is inserted to report accruals that lower the beginning fund balance.

3. Administrative and Other Expenses

A. Administrative Expenses

The administrative expenses for the health plans largely comprise medical and pharmacy administration charges from those Program vendors. The medical administration charge is based on the number of subscribers, while the pharmacy administration charges are based on a fee per claim processed. The remainder of the administrative expenses are associated with the health

reimbursement arrangement (HRA), consulting and miscellaneous expenses. Except for the medical, pharmacy and HRA administration costs, all other costs are allocated to each of the plans on a per capita basis. Below is a breakout of FY2012 administrative expenses for the Health Program.

	Actives	Troopers	Retirees	TOTAL
Medical	3,854,455	116,996	3,710,959	7,682,410
Pharmacy	246,883	5,367	287,490	539,739
HRA	129,851	665	-	130,516
Consulting	274,485	10,294	120,178	404,957
Salary & Benefits	638,454	22,275	257,600	918,329
Vaccinations	605,381	21,832	86,259	713,472
Miscellaneous*	24,144	855	25,928	50,927
TOTAL	\$5,773,653	\$178,284	\$4,488,412	\$10,440,349

**Miscellaneous expenses include mailers, HIPAA materials, and fees paid to the UNH Institute for Health Policy and Practice for the work of the NH Purchaser's Group on Health*

B. Enrollment

The contract with the State's enrollment administrator ended in September 2012. For FY2012, the State paid \$65,673 to its enrollment administrator. The enrollment expense charged by the vendor was a fixed monthly amount, which was allocated on a per capita basis to each benefit plan. For the remainder of FY2012 the State self-administered enrollment activity.

C. Total of Administrative and Other Expenses

For FY2012, the Health Program total amount paid for administrative and other expenses was \$10.5 million, or approximately 4.4% of the total Program expenses. Based on the total FY2012 Program enrollment, this amount represents an administrative per subscriber per month (PSPM) fee of \$42.86, which is an increase of 4.1% from FY2011.

D. Dental Program Administrative Expenses

The administrative expense for dental is a monthly fee per Subscriber based on the number of State subscribers at the end of each month. The fee remained at \$3.50 during FY2012. The total FY2012 dental administrative expenses decreased by 11% from \$497,000 in FY2011, to \$443,000. This reduction is mostly attributable the decrease in State employee enrollment.

4. Contributions

For the Health Program, employee contributions vary depending on the group under which the employee is categorized. Active and Trooper employees have negotiated distinct contributions under their respective collective bargaining agreements ("CBA"). Retiree contributions comprise payments made by the NHRS that are attributable to the cost of dependent coverage for those retirees electing such coverage. In addition, non-Medicare eligible retirees and their spouses pay a monthly contribution.

ACTIVES

The active employee population consists of three unions including the New Hampshire Troopers Association (NHTA), the State Employee Association (SEA) and the New England Police Benevolent Association (NEPBA). Members of each union are covered by the same health benefit plan with the same plan design and same monthly working rates. The FY2012-2013 SEA collective bargaining agreement requires employees to contribute a tiered amount each pay period based on the plan effective with the pay period beginning September 1, 2011. Employees must contribute \$20 per pay period for an employee only plan, \$40 per pay period for a two-person plan, and \$60 per pay period for a family plan. The NEPBA collective bargaining agreement for the same period requires NEPBA employees to contribute \$30 per pay period for an employee only plan, \$42 per pay period for a two-person plan, and \$52 per pay period for a family plan. Historically NEPBA and SEA paid identical premium contributions.

TROOPERS

Under the Troopers' CBA for 2011-2013, all employees are required to pay \$30 per pay period effective with the pay period beginning September 1, 2011. Historically, new hires after September 1, 2005 were required to contribute only on multi-person plans. The contribution was 10% of the difference between an employee-only coverage plan and the multi-person plan.

RETIREEES

For FY2012, retirees' premium contribution for the Under Age 65 plan changed from \$65 per month for each retiree, and \$65 per month for each covered spouse to 12.5% of the monthly health premium for the individual retiree plan and 12.5% of the monthly health premium for a retiree plus spouse plan.

Below is a chart to clearly show the health benefit contributions for each group of members.

	Actives (per pay period)		Troopers (per pay period)	Retirees Under Age 65 (monthly)
	SEA	NEPBA		
Employee Only	\$ 20.00	\$ 30.00	\$ 30.00	12.5% of monthly premium
Two Person Plan	\$ 40.00	\$ 42.00	\$ 30.00	12.5% of monthly premium
Family Plan	\$ 60.00	\$ 52.00	\$ 30.00	12.5% of monthly premium

For FY2012 the overall total amount of employee and retiree contributions received for the Program increased by 35.7% from the prior year to \$15.7 million. The contributions for FY2012 were collected as follows:

FY2012	
Actives	\$ 10,689,971
Retirees	\$ 4,794,542
Troopers	\$ 178,372
	<u>\$ 15,662,885</u>

There are no employee contributions assigned to the Dental Program for full-time employees.

5. Claims Reserve

Per RSA 21-I:30-b, the Program must maintain two claim reserves. Under the law, one reserve must be maintained equal to the sum of at *least* five percent (5%) of estimated annual claims and administrative costs of the health plan, and the second must equal an amount to pay the actuarially determined incurred but not reported (“IBNR”) liability.

For FY2012, the estimated annual claim and administrative costs reserve for the Health Program decreased by 6% to \$14.6 million, from \$15.5 million in FY 2011. The decrease was due to lower than expected expenses during FY2012. The Dental Program also experienced a drop in the reserve amount from \$596,000 to \$537,000.

Lastly, the IBNR liability for the Programs combined, as calculated by the Department’s actuarial consultant, was \$13.8 million and represented an decrease of \$377,000, or 2.7%, from FY 2011. Together, the Fund continually met those reserve requirements, and the cash surplus in excess of these statutorily required reserve amounts was \$666,000 as of June 30, 2012.

6. Working Rate Suspension

As directed by the Commissioner of the Department of Administrative Services, the Program conducts Working Rate Suspensions (WRS) from time to time to reduce accumulated fund surplus in the Health and Dental Programs. The WRS operates by suspending the collection of working rates (i.e. premium) for a predetermined amount of time, based on the desired amount of surplus to be reduced. Participants in the WRS included state agencies, retirees, legislators and SAGs. By waiving the collection of premium from state agency budgets, the unused funds are utilized by the State to satisfy budget requirements.

From the Health Programs first year of self-funding through FY2012, \$76.2 million (total Funds) in suspensions have been conducted. As part of a planned \$50 million budget reduction for FY2012 and 2013, the Program conducted a rate suspension which resulted in approximately \$5.8 million in General Fund lapses during FY2012.

In addition, the Dental Program conducted a \$628,000 rate suspension during the year which yielded approximately \$241,000 in General Funds.

7. Subsequent Events

As part of phase 2 implementation of the Enterprise Resource Planning (ERP) system, the State will launch the Human Resource and Payroll modules. Upon launching these modules will allow to the State to fully self-administer eligibility and enrollment. The first phase of implementation of the State’s ERP system included accounting and budgeting functions.

3. PLAN INFORMATION

TREND

The following chart displays the impact of the Health Program’s efforts to manage costs over time. These efforts comprise the procurement and negotiation of favorable contract terms as well as plan design changes negotiated through the collective bargaining process, or approved by the legislative fiscal committee for retirees. In order for a self-funded benefit program to realize savings, it must dedicate staff and technical resources to these kinds of activities.

The following trend analysis represents only medical and prescription drug claims and does not include the Health Program’s dental or administrative expenses.

The trend associated with the various plans, on an aggregate basis, is set forth below:

Medical/RX Combined	Total Health Plans Combined		
	% Change in	Base Trend	"Trend Savings"
FY 2007 to 2008	7.2%	11.1%	3.8%
FY 2008 to 2009	8.0%	11.1%	3.1%
FY 2009 to 2010	3.2%	4.4%	1.2%
FY 2010 to 2011	6.3%	8.3%	2.1%
FY 2011 to 2012	-2.2%	2.7%	5.0%
5-Year Average	4.5%	7.5%	3.0%

Source: Segal Trend Analysis (FY2007-FY2012)

The Program's five-year average trend savings was 3.0% on medical and prescription drug claims, and represents millions in avoided costs during this period. The Base Trend is the State's actual trend and it reflects estimated adjustments for benefit design changes, medical network discount variances, and Pharmacy Benefit Manager (PBM) financial term variances. The "Trend Savings" represents the difference between the State's actual change in claims costs and the estimated change the State would have experienced in the absence of the benefit design changes, medical network discount variances, and PBM financial term variances. Plan design and contract changes generate savings for the year in which they occurred. When the savings are estimated by re-setting the base for future experience, the generated claims cost establishes a base and the subsequent year is measured off the adjusted claims base. Under this approach, the Program has saved the State \$34.4 million over five years.

ENROLLMENT

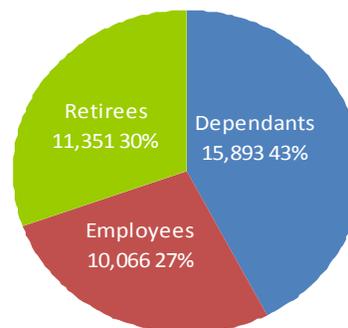
During FY2012, total members in the Health Program decreased by 6.7% from the prior fiscal year. The change was mostly attributable to the Active plans which decreased by 10.6%, while the Retiree plan member counts increased approximately 3.9% from FY 2011.

As of June 30, 2012, the Program enrollment by groups was as follows:

	Health				Dental*
	Actives	Retirees	Troopers	Total	
Employee	9,785	10,364	281	20,430	10,332
Dependents	15,275	987	618	16,880	16,199
Total	25,060	11,351	899	37,310	26,531

*Note: Retirees are not included in the Dental Program. See p.7

Fiscal Year 2012 Health Enrollment



WELLNESS

In 2006, Governor John Lynch signed Executive Order 2006-07, *An Order Relative to State Employee Wellness*. This Order directed all executive departments and agencies to support the efforts and goals of the Health Benefits Committee (HBC) and its workgroup. The HBC Workgroup develops and implements comprehensive wellness programs that continually support and assist state employees, retirees and their dependents in achieving greater health and wellness. Faced with high health care costs, the State is turning to worksite health programs to help employees adopt healthier lifestyles and lower their risk of developing costly chronic diseases while improving worker productivity.

Nationally, worksite wellness has become a large focus in reducing employee health costs. In October 2011, the Centers for Disease Control and Prevention (CDC) began the National Healthy Worksite Program (NHWP). The NHWP is designed to assist employers in implementing health protection and promotion strategies that will lead to specific, measurable health outcomes to reduce chronic disease rates. For most employers, chronic diseases—such as heart disease, stroke, cancer, obesity, arthritis and diabetes—are among the most prevalent, costly, and preventable of all health problems. The NHWP seeks to promote good health through prevention, reduce chronic illness and disability, and improve productivity outcomes that contribute to employers' competitiveness.

In FY2012, the HBC Workgroup and partners continued to provide support and resources to agencies by developing a Wellness Program Plan. The purpose of this plan is to assist in identifying gaps, prioritizing high-impact strategies, and assess health promotion and disease prevention programming. By developing a plan, the HBC Workgroup targeted changes in the worksite environment, communication practices, policy and cultural change to help employees and family members adopt healthier lifestyles and, in the process, lower their risk of developing costly chronic diseases.

The HBC Workgroup began FY2012 by reviewing needs assessment data, which can be considered the market research phase for a wellness program plan and is critical for a program that reflects member needs and health care cost drivers. Because the majority of illness and health care utilization results from key health indicators, the HBC Workgroup developed three committees to address eight strategic goals identified through the needs assessment:

1. Implementing an Annual Employee Health Education Program
2. Diabetes Management
3. Tobacco Cessation
4. Healthy Body Weight
5. Stress Management
6. Evaluation Plan
7. Leadership Health Promotion
8. Preventive Health Utilization

In collaboration with state agency wellness coordinators, State Health Benefit Program Vendors, and the Department of Health and Human Services, the HBC Workgroup designed and implemented health promotion interventions aimed at individual risk reduction coupled with environmental supports. Many of these interventions were recommended by the CDC NHWP. Although evaluating these interventions is ongoing, the

following highlights demonstrate improving the health of employees and lowering their risk of developing costly chronic disease:

- Developed an Annual Employee Health Education Program comprised of three learning modules focusing on health and wellness, medical self-care and health benefit programming. The Program's learning modules provide valuable information to help employees make educated health-related decisions.
- Partnered with the NH Department of Health and Human Services (DHHS) and the National Diabetes Education Program to raise awareness about the importance of setting goals and making a plan to prevent type 2 diabetes and diabetes-related complications. The HBC Workgroup worked with Commissioner Nicholas Toumpas and communicated to fellow agency leaders and wellness coordinators about resources available through worksite workshops and other educational materials to help employees and family members make a plan to prevent diabetes and its complications.
- Promoted health plan coverage and programs educating employees about the health benefits of tobacco cessation and resources to quit.
- Developed and launched a voluntary award program that recognizes agencies for developing and implementing exceptional employee wellness programming and communication. Agencies are awarded recognition based on national and regional wellness standards that demonstrate effectiveness, economic efficiency, and feasibility of interventions to promote community health and prevent disease.
- Provided training to wellness coordinators and managers on identifying and reducing workplace stress-related issues.
- Created an evaluation plan using multiple key evaluation indicators including participation in health improvement programming, improvements in health behaviors, preventive health utilization, physical environment and cultural support.
- Ten agency leaders participated in at least six wellness programs throughout the year including onsite wellness screenings, employee health education, Governor's 90 Mile Challenge, and championed health topics such as diabetes prevention, colorectal cancer screening, health assessment completion, and cardiovascular health.
- 54% of employees completed a Health Risk Assessment that identified risk factors, provided individualized feedback, and linked the employee with at least one intervention to promote health and/or prevent disease.

4. HEALTH BENEFIT STAFF

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