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**STATE OF NEW HAMPSHIRE**

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

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**For the Fiscal Year Ended  
June 30, 2011**



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The Department of Administrative Services**

**Linda M. Hodgdon, Commissioner**

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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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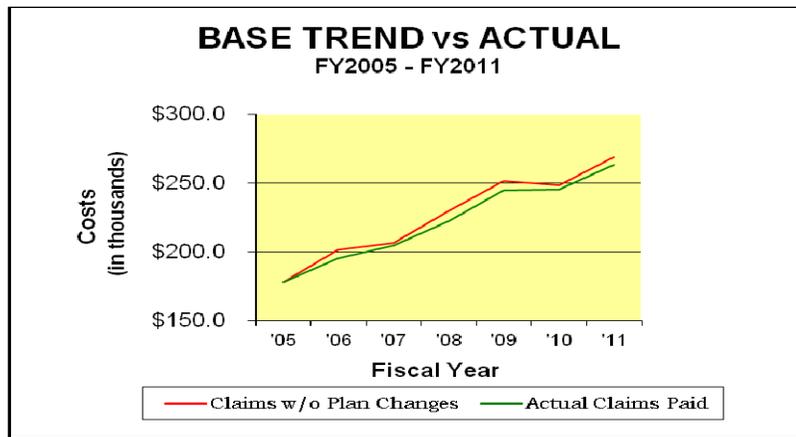
# 1. MANAGEMENT'S DISCUSSION AND ANALYSIS

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, 2011. This information serves to supplement the State of New Hampshire 2011 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

### *Health Benefit Program:*

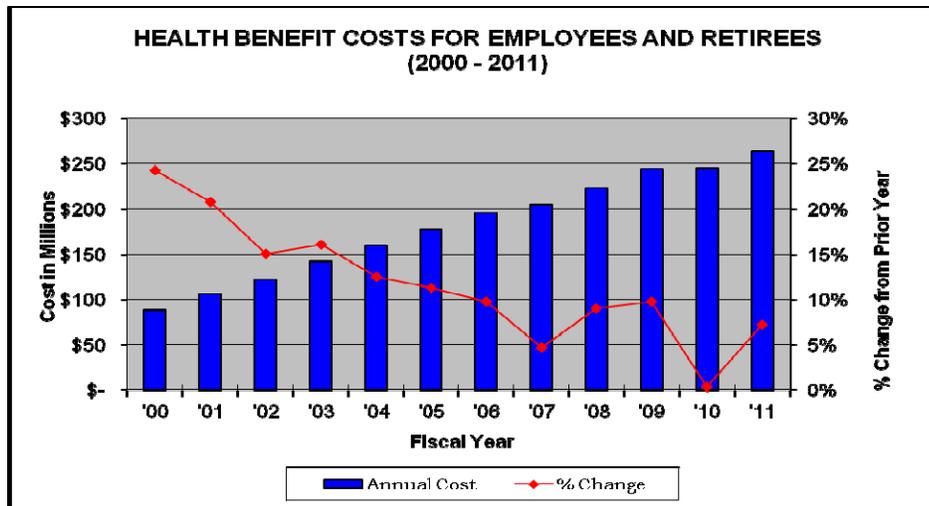
Through its various cost containment initiatives, the Health Program has reduced its *base trend* on average by 2% per year. For the period FY 2005 through FY 2011, the Health Program annual cost increases (including both claims and administration) have been averaging 6.7%. In the absence of these initiatives, trend for the same period would have averaged 8.6% per year. The estimated savings associated with this lowered trend is approximately \$30.5 million (see *TREND*, p. 14).



These savings are a result of aggressive third party administrator (TPA) service procurements, as well as vigorous vendor management. In addition, the Program spends less money by guiding the collective bargaining process through comprehensive financial and modeling support. The Program also reduces costs by continuously implementing cost-effective programs as well as plan design and administrative changes to the benefit. Further savings are achieved through sound fiscal management. Finally, some savings have undoubtedly been realized through the Program's leadership and coordination of the State's employee wellness program.

For FY 2011, the total costs for providing health benefits for all state employees and retirees was \$263.2 million, a 7.3% increase from the prior year. The increase includes the impact of extending dependent coverage to age 26, in January of 2011. This extension resulted in the addition of more than 750 dependents to the Program. Despite cost increases, the Program was able to maintain a surplus, which was largely returned to State agencies through a working rate suspension of \$15.1 million (see Note 7, *Notes to Financial Statements*, p. 13). The surplus represents funds over and above the combined statutorily required reserve for unexpected claims and the Incurred But Not Reported (IBNR) reserve of \$29.4 million.

As of June 30, 2011, the Health Program ended the fiscal year with a \$2.2 million surplus. The year end surplus represents approximately 0.83% of the annual Program expenses.

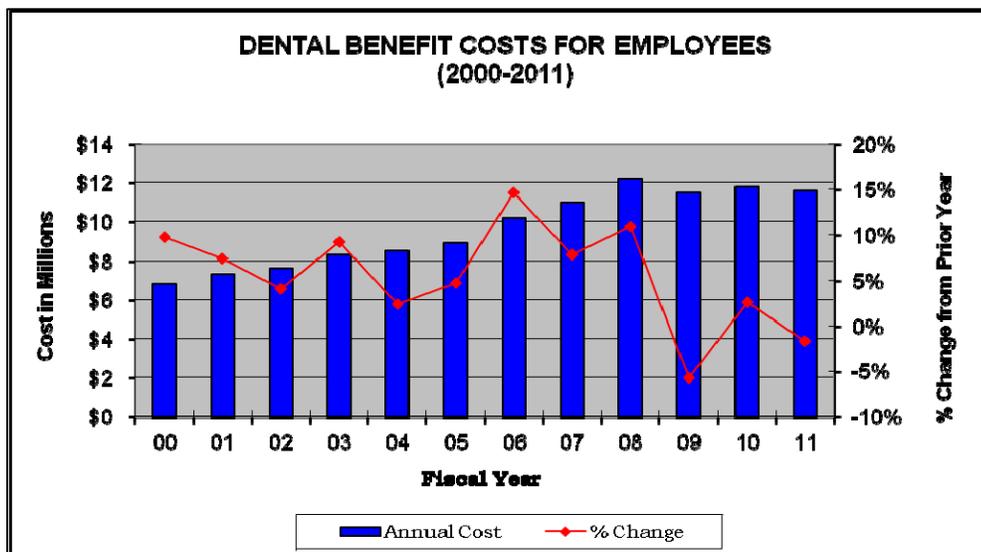


***Dental Benefit Program:***

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 2% per year, while the dental base trend averaged 4.8% per year.

For FY 2011, the total costs of the Dental Program, which covers all state employees, was \$11.6 million. This amount represents a decrease of \$209,000 or -1.8% from FY 2010. The favorable decrease reflects lower administrative fees negotiated by the Program. Like the Health Program, the Dental Program also conducted a working rate suspension during FY 2011 to spend down accumulated surplus in the amount of \$1.5 million.

As of June 30, 2011, the Dental Program ended with a \$22,000 surplus after taking into consideration the statutory and IBNR reserves of \$937,000.



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## FINANCIAL ANALYSIS

### *Fund Balance*

As managers of the Health and Dental Programs, staff work 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. This means the funds in them are non-lapsing at the end of a fiscal year. Therefore, they 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, \$1.579 billion in premium revenue. It paid out \$1.554 billion in expenditures through FYE 2011. During this seven year period, the Health Program was able to waive collection of \$59.5 million in premium, which includes \$15.1 million in FY 2011. This "waived" amount represents funds that were collected from agencies, but not ultimately needed to pay the actual claims. Had the State continued to be fully-insured throughout this period, the nearly \$60million 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. 13). The fund balance for the Health Program as of June 30, 2011 is \$36.1 million, which includes statutory and IBNR reserves of \$15.5 million and \$13.9 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, \$35.5 million in premium revenue, and paid out \$35.3 million in expenditures through FYE 2011. During this three year period, the Dental Program used accumulated surplus to waive collection of \$1.5 million in premium through means of a working rate suspension. The fund balance for the Dental Program as of June 30, 2011 is \$1.1 million, which includes statutory and IBNR reserves of \$596,000 and \$341,000, respectively.

### *Revenue*

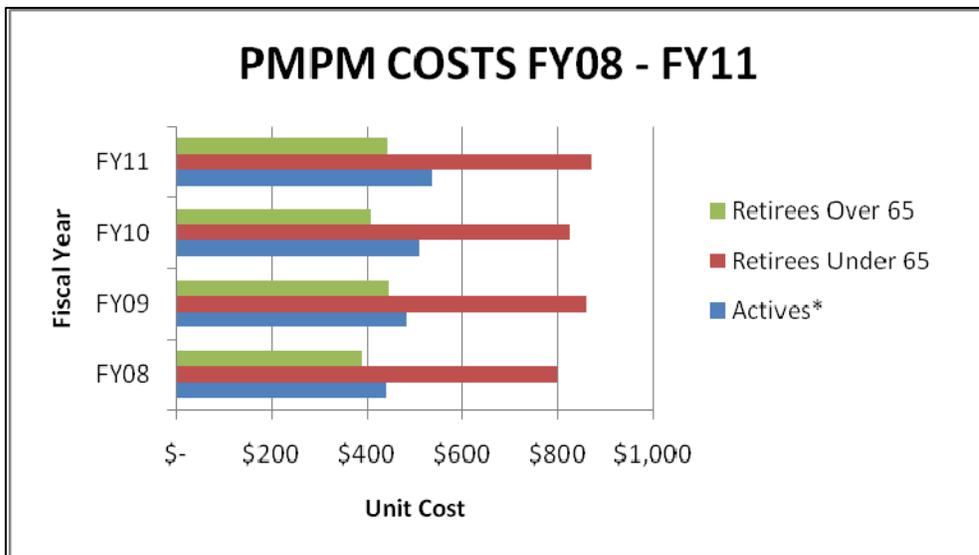
In FY 2011, the Health Program's total premium revenue increased approximately \$8.9 million (3.5%) from FY 2010, to \$261.9 million. The funding sources for the premium comprised 83% state agency contributions, 5.4% NHRS medical subsidy, 4.4% subscriber contributions, with the remainder derived from miscellaneous sources. The bulk of the miscellaneous revenue sources include Medicare Retiree Drug Subsidy Program payments, prescription drug rebates and the Early Retiree Reinsurance Program (ERRP) subsidies (see Note 8, *Notes to Financial Statements*, p. 13). 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 \$15.1 million in accumulated surplus. The funds not collected from state agencies were used to satisfy budget obligations.

The Dental Program collected \$10.9 million of premium revenue in FY 2011, which amounted to a \$1.5 million (-11.8%) decrease from FY 2010. The reduction was largely a result of lower working rates charged because the Program had better financial terms with its vendor. 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 \$1.5 million in excess surplus. Again, premium not collected from state agencies was used to satisfy budget obligations.

***Expenditures***

In FY 2011, total Health Program expenditures increased \$17.8 million (7.3%), to \$263.2m. As expected, medical claims comprised the largest share of this expense at \$182.8 million (69.5%), while prescription drug claims equaled \$69.5 million (26.4%). The remaining expenses were administrative costs associated with operating the Program and constitute 4.1% of the total expenditures.

The following graph shows the total costs on a per member per month (PMPM) basis by total members, broken out by Active employees and both Retirees under the age 65 and those over the age of 65, for the period of FY 2008 through FY 2011.



*\*Includes Trooper Plan*

The Dental Program expenditures decreased \$208,000 (-1.8%) to \$11.6 million in FY 2011. Since retirees do not participate in the 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 \$497,000 and represent 4.3% of the total dental expenditures.

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## ECONOMIC CONDITIONS AND OUTLOOK

If current trends averaging 6.7% per year continue, Program expenditures will exceed \$300 million by FY 2014. These amounts are generally viewed as unsustainable.

Although the Programs have proven the financial advantage of self-funding, the State must address the challenge of health care and cost increases that exceed the savings derived from management and plan changes. In particular, the Health 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 Affordable Care Act (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 \$50 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 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.

Similar goals are reflected in the Pillar Project of Governor Lynch's NH Citizens Health Initiative. These are:

- Aligning payments, goals and incentives across systems of care
- Promoting individual healthy lifestyle choices as well as the role of public health in the health care system
- Emphasizing the use of care coordination and health information technology to help prevent and manage chronic illness

These topics and priorities can be studied more thoroughly at [www.citizenshealthinitiative.org](http://www.citizenshealthinitiative.org). To accomplish these ambitious goals, the Program must remain informed and engaged with industry trends and developments, while educating its members and other stakeholders about the importance of these fundamental and necessary changes to health care. These efforts were underway in FY 2011 and will continue in FY 2012 and beyond.

## 2. PROGRAM FINANCES AND FISCAL INFORMATION

### COMBINING SCHEDULE OF BALANCE SHEET ACCOUNTS (Unaudited)

FOR THE FISCAL YEAR ENDED JUNE 30, 2011

(expressed in thousands)

	Health			Total	Dental	Total
	Active	Retirees	Troopers			
<b>ASSETS</b>						
<b>Current Assets:</b>						
Cash and Cash Equivalents	\$ 20,097	\$ 7,665	\$ 5,402	\$ 33,164	\$ 1,038	\$ 34,202
Accounts Receivable	942	1,959	11	2,912	42	2,954
Total Assets	\$ 21,039	\$ 9,624	\$ 5,413	\$ 36,076	\$ 1,080	\$ 37,156
<b>LIABILITIES</b>						
<b>Current Liabilities:</b>						
Accounts Payable	\$ 84	\$ 43	\$ 2	\$ 129	\$ 41	\$ 170
Claims Payable	2,612	1,684	43	4,339	80	4,419
Incurred But Not Reported (IBNR)	9,099	4,476	310	13,885	341	14,226
Total Liabilities	\$11,795	\$ 6,203	\$ 355	\$ 18,353	\$ 462	\$ 18,815
<b>FUND BALANCES</b>						
Reserved per RSA21-I:30-b	9,091	3,835	2,621	15,547	596	16,143
Unreserved, Undesignated Surplus/(Deficit)	153	(414)	2,437	2,176	22	2,198
Total Fund Balances	21,039	9,624	5,413	36,076	1,080	37,156

At the beginning of FY 2011, the combined Fund balance of the Health and Dental Programs was approximately \$38.6 million, including required reserves. During the fiscal year, the Programs conducted two working rate suspensions in the total of \$16.7 million, which lapsed \$7.7 million to the General Fund. Following the working rate suspensions, the Programs together had a surplus, after reserves of \$2.2 million at the end of FY 2011. This surplus represents funds above IBNR and the statutory unexpected claims reserve. 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, 2011 (expressed in thousands)**

	Health				Dental	Total
	Active	Retirees	Troopers	Total		
<b><u>OPERATING REVENUES</u></b>						
<i>State Contributions:</i>						
Active Employees	\$ 169,476	\$ -	\$ 4,331	\$ 173,807	\$10,548	\$184,355
Retired Judges & Constitutional Officers	-	515	-	515	-	515
Retired Employees	-	43,487	-	43,487	-	43,487
<i>Non-State Contributions:</i>						
Employee/Retiree Premium Share	8,722	2,795	29	11,546	9	11,555
Other Employers <sup>1</sup>	1,259	-	-	1,259	75	1,334
COBRA Participants	667	-	-	667	137	804
Legislator Participants	697	172	-	869	113	982
Retirement Subsidies & Deductions <sup>2</sup>	-	14,250	-	14,250	-	14,250
Part D Subsidy	-	4,591	-	4,591	-	4,591
Recoveries <sup>3</sup>	6,000	4,773	118	10,891	-	10,891
<b>Total Contributions</b>	<b>186,821</b>	<b>70,583</b>	<b>4,478</b>	<b>261,882</b>	<b>10,882</b>	<b>272,764</b>
<b><u>OPERATING EXPENSES</u></b>						
Medical Payments	139,388	39,776	2,809	181,973	11,127	193,100
Pharmaceuticals	37,068	32,042	432	69,542	-	69,542
Ancillary Benefits	789	-	40	829	-	829
<b>Total Health Care Expenses</b>	<b>177,245</b>	<b>71,818</b>	<b>3,281</b>	<b>252,344</b>	<b>11,127</b>	<b>263,471</b>
Administrative Expenses <sup>4</sup>	6,038	4,298	171	10,507	497	11,004
Enrollment	266	120	9	395	-	395
<b>Total Operating Expenses</b>	<b>183,549</b>	<b>76,236</b>	<b>3,461</b>	<b>263,246</b>	<b>11,624</b>	<b>274,870</b>
Operating Income (Loss)	3,272	(5,653)	1,017	(1,364)	(742)	(2,106)
Change in Net Assets	3,272	(5,653)	1,017	(1,364)	(742)	(2,106)
GAAP Adjustment	371	298	(38)	631	55	686
Fund Balance - July 1	17,396	14,979	4,434	36,809	1,767	38,576
<b>Fund Balance - June 30</b>	<b>\$ 21,039</b>	<b>\$ 9,624</b>	<b>\$ 5,413</b>	<b>\$ 36,076</b>	<b>\$ 1,080</b>	<b>\$ 37,156</b>

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

<sup>2</sup>Retirement Subsidies and Deductions is the medical subsidy amount received from the NH Retirement System.

<sup>3</sup>Recoveries comprise Rx rebates, ERRP proceeds and recoverables associated with claim adjudications.

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

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## NOTES TO FINANCIAL STATEMENTS

### ***1. Program Background***

In October 2003, the Employee Benefit Risk Management Fund (the “Fund”) was established by the Department 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 premium, and subsequently claim expenses upon the transition to self-funded status in December 2007. To administer these self-funded Programs, the Department contracts with TPAs, 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. *Specials*, 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, *Specials* 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 collecting of premium from *Specials*.

For FY 2011, the total cumulative fund balance was \$37.2 million, which represents a \$1.4 million decrease from prior fiscal year. After subtracting the required reserves, and conducting a \$16.7 million rate suspension, a surplus remained equal to \$2.2 million.

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

For FY 2011 the format of the Combining Schedule of Revenues, Expenditures and Changes in Fund Balance Accounts is similar to the format of the State of New Hampshire Comprehensive Annual Financial Report (“CAFR”) for the Fiscal Year Ended June 30, 2011. One additional line was added to the Risk Management Unit schedule to account for a GAAP Adjustment to the Fund Balance at July 1, 2010 and report on an accrual basis in FY 2011. Historically The Department has reported the Schedule of Revenue, Expenditures and Changes in Fund Balance on a cash basis, and thus are presented in this format in prior fiscal years’ financial statements (see *APPENDIX*, p. 19).

The “Administrative Expense” line includes Salary & Benefits for FY11. Historically, this item has been reported as a separate line (see Note 3.A. for more all items included in “Administrative Expenses”).

### 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 FY 2011 administrative expenses for the Health Program.

	Actives	Troopers	Retirees	TOTAL
Medical	4,155,966	114,697	3,615,206	7,885,869
Pharmacy	298,856	6,304	272,188	577,348
HRA	129,024	0	0	129,024
Consulting	224,151	7,907	91,764	323,822
Salary & Benefits	605,242	20,843	238,793	864,878
Vaccinations	612,364	21,141	75,907	709,412
Miscellaneous*	13,089	451	4,556	18,096
<b>TOTAL</b>	<b>\$6,038,692</b>	<b>\$171,343</b>	<b>\$4,298,414</b>	<b>\$10,508,449</b>

\*Miscellaneous expenses include mailers, 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 enrollment expense charged by the vendor is a fixed monthly amount, which is allocated on a per capita basis to each benefit plan. For FY 2011, the State paid \$394,035 to its enrollment administrator.

#### C. Total of Administrative and Other Expenses

For FY 2011, the Health Program total amount paid for administrative and other expenses was \$10.9 million, or approximately 4.1% of the total Program expenses. Based on the total FY 2011 Program enrollment, this amount represents an administrative per enrollee per month (PEPM) fee of \$41.19, which is an increase of 0.8% from FY 2010. Approximately 71% of the PEPM fee is associated with the medical administration fee of \$29.32 PEPM, which is below the average industry norm of \$29.69 for self-funded programs.<sup>1</sup>

#### 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 decreased 17.6% from FY10 to FY11, from \$4.25 to \$3.50. The total FY 2011 dental administrative expenses decreased by 31% from \$720,000 in FY2010 to \$497,000. This reduction is attributable to the decrease in the fee per Subscriber and the decrease in State employee enrollment.

<sup>1</sup>Based on a 2010 Segal Company study of 2,000 self-funded health programs.

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#### **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.

Beginning in July 2007, employees began contributing toward the cost of health coverage. The 2007-2009 SEA collective bargaining agreement required employees to contribute \$25 per pay period. In January 2009, this amount increased to \$30 per pay period.

Under the Troopers’ CBA, new hires after September 1, 2005 are required to contribute only on multi-person plans. The contribution is 10% of the difference between an employee-only coverage plan and the multi-person plan.

Effective July 1, 2009, retirees in the Under Age 65 plan are required to pay a premium contribution in the amount of \$65 per month for each retiree, and \$65 per month for each covered spouse under age 65.

For FY 2011 the total amount of employee and retiree contributions received for the Program was \$11.5 million. Since there were no changes to the contribution amounts required by employees or retirees in FY 2011, this amount was consistent with the total FY 2010 contributions received. The contributions for FY 2011 were collected as follows:

	<b>FY 2011</b>
Actives	\$ 8,721,639
Retirees	2,794,646
Troopers	28,904
	<hr/>
	\$11,545,189
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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 FY 2011, the estimated annual claim and administrative costs reserve for the Health Program increased by 22% to \$15.5 million, from \$12.7 million in FY 2010. The increase was largely due to a manual adjustment at fiscal year end of the Trooper plan reserve in anticipation of the Department’s decision to rate this group separately effective CY 2012. Since this group lacks credible size, the recommendation of the Department’s actuarial consultants was to increase its statutory reserve from 5% to 70% of estimated annual claims and administrative costs.

In FY 2011, the Department also made a policy decision to extend the statutory reserve law to the Dental Program, which established a \$596,000 reserve.

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Lastly, the IBNR liability for the Programs combined, as calculated by the Department's actuarial consultant, was \$14.2 million and represented an increase of \$435,000, or 3.2%, from FY 2010. Together, the Fund continually met those reserve requirements, and the cash surplus in excess of these statutorily required reserve amounts was \$2.2 million as of June 30, 2011.

### ***6. Working Rate Suspension***

As directed by Commissioner Linda Hodgdon, the Department 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 include state agencies, retirees, legislators and *Specials*; and sometimes employees. By waiving the collection of premium from state agency budgets, the unused funds get utilized by the State to satisfy budget requirements.

From the Health Programs first year of self-funding through FY 2011, \$59.5 million (total Funds) in suspensions have been conducted. For FY 2011, the Program was required to generate \$4.5 million in General Fund lapses which was fulfilled with a \$15.1 million rate suspension that provided approximately \$7.4 million in General Funds.

In addition, the Dental Program conducted a \$1.5 million. rate suspension during the year which yielded approximately \$454,000 in General Funds.

### ***7. Early Retiree Reinsurance Program***

Under ACA, the Early Retiree Reinsurance Program (ERRP) was created to provide a subsidy to employer health plans that offer coverage to non-Medicare eligible retirees under the age of sixty-five. The ERRP subsidy was federally funded with \$5 billion and reimburses eighty percent (80%) of claim costs that fall between its \$15,000 and \$90,000 thresholds for eligible health plans.

In FY 2011, the Health Program received \$3.2 million.

### ***8. Subsequent Events***

For FY 2012, the Program will be implementing employee and retiree medical and prescription drug plan design changes negotiated through collective bargaining and approved by the Fiscal Committee, respectively. These changes will affect claims experience and provide favorable cost savings. Changes include increased premium contributions by employees, increased medical and prescription drug co-pays, and more aggressive management of the prescription drug plan including mandatory generic prescriptions and quantity limits. Overall, the plan changes are expected to save approximately \$37.5 million over the biennium.

Starting July 1, 2011, non-Medicare eligible retirees enrolled in the Health Program will have their monthly premium contribution change from a flat fee of \$65 per retiree and \$65 per spouse, to a percentage of premium. The percentage has been set at 12.5% of the total monthly premium per retiree, and spouse and represents an increase from the flat fee contributions. In addition, those retirees who lack or do not have sufficient pension to have the contribution deducted will be invoiced directly by the Department.

## 3. PLAN INFORMATION

### TREND

The following chart displays the impact of the Health Program's efforts to manage costs over time<sup>2</sup>. These efforts comprise the procurement and negotiation of favorable contract terms as well as plan design changes negotiated through the collective bargaining process, or 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 trend associated with the various plans, on an aggregate basis, is set forth below:

Medical/RX Combined	Total Health Plans		
	% Change in	Base Trend	"Trend Savings"
FY 2005 to 2006	6.5%	10.1%	3.6%
FY 2006 to 2007	5.9%	6.7%	0.8%
FY 2007 to 2008	7.2%	11.0%	3.8%
FY 2008 to 2009	8.0%	11.0%	3.0%
FY 2009 to 2010	3.2%	4.5%	1.2%
FY 2010 to 2011	6.3%	8.3%	2.0%
7-Year Average	6.2%	8.6%	<b>2.4%</b>

1. Medical and Rx experience based on the Program's claims and enrollment from July 1, 2004 to June 30, 2011.
2. Rx experience and trends reflect claim cost only and do not reflect prescription drug rebates or the Medicare Part D subsidy.
3. Base Trend is an actuarial derived estimate representing the year to year trend increase for the Program, absent of plan design changes. The base trend above reflects trend increases absent the following:
  - a. September 1, 2005 Active HMO and POS medical and prescription drug benefit design changes.
  - b. September 1, 2005 improved prescription drug financial terms resulting from the move from CIGNA to LGC/Medco.
  - c. July 1, 2007 improved prescription drug financial terms resulting from the move from LGC/Medco to LGC/Caremark.
  - d. January 1, 2008 greater medical network discounts resulting from the move from CIGNA to Anthem.
  - e. January 1, 2009 SEA active HMO medical plan benefit design changes.
  - f. January 1, 2010 improved prescription drug financial terms resulting from LGC/Caremark one-year extension.
  - g. October 1, 2010 prescription drug benefit design changes.
  - h. December 1, 2010 improved prescription drug financial terms.
  - i. June 1, 2011 improved prescription drug financial terms.
4. "Trend Savings" represents this difference between the Program's actual change in claims cost and the estimated change the Program would have experienced in the absence of the benefit design changes, medical network discount variances, and PBM financial term variances.

The Program's seven-year average trend savings was 2.4% on medical and prescription drug claims, and represents millions in avoided costs during this period. The savings are derived from plan design changes and procurements results. 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 \$30.5 million over seven years.

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

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## ENROLLMENT

During FY 2011, total members in the Health Program increased by 0.84% from the prior fiscal year. The change was mostly attributable to the Active plans, whereas The Retiree and Trooper plans member counts remained relatively unchanged since FY 2010.

As of June 30, 2011, the Program enrollment by groups was as follows:

	Health				Dental
	Actives	Retirees	Troopers	Total	
Employee	11,101	9,858	301	21,260	11,577
Dependents	16,985	1,069	653	18,707	17,783
Total	28,086	10,927	954	39,967	29,360

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

## 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 and its wellness workgroup. The Health Benefits Committee and its wellness workgroup develops and implements comprehensive wellness programs that continually support and assist state employees, retirees and their dependents in achieving greater health and wellness.

Most state employees spend the majority of their waking hours at their place of employment making the worksite an excellent setting to promote and provide wellness. State worksites provide a unique opportunity to reach a large number of employees and to reinforce and promote healthy behaviors. A healthy motivated state workforce is extremely important and can impact the cost of the Health Program. Nationally, employers recognize the benefits of workforce health promotion and are instituting wellness programming to reduce health care costs and improve employee health and morale (Centers for Disease Control).

In 2010, the Program's medical benefit administrator, Anthem prepared and presented a Client Advisory Services Executive Summary for the State of New Hampshire. This Summary included Clinical Observations and Recommendations to reduce health care costs from the five conditions managed by the administrator's Condition Care Disease Management Program. The medical administrator stated that 54.5% of total paid claims for CY 2010 are potentially lifestyle related and to minimize these costs, members should avoid tobacco products, maintain a healthy diet, strive to get to a healthy weight, exercise at least a ½ hour each day, increase intake of fruits and vegetables, limit red meat intake, and moderate alcohol consumption.

The estimated cost of unhealthy behaviors is drawing attention from employers and acting as a catalyst for investment in employee wellness programs. According to the U.S. Centers for Disease Control and Prevention, medical expenses for obese employees are estimated to be 42 percent higher than for a

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person with a healthy weight. An American Productivity Audit found that tobacco use was a leading cause of worker lost production time — more than alcohol abuse or family emergencies.

Workforce health promotion (WHP) programs have evolved from fitness programs, to health promotion programs, to comprehensive wellness programs. In the past, the focus was on physical fitness. Today, the focus has broadened to include topics such as nutrition, mental health, and chronic disease prevention, as well as the workplace environment, policies, productivity, and others. A healthy workforce leads to fewer medical and lost time claims, less absenteeism and greater productivity.

### ***WELLNESS PROGRAM IMPROVEMENT AND DISEASE PREVENTION***

For employees in the Active HMO and POS health plans, the Program encourages completion of a Health Assessment Tool (HAT), which determines a personal health score. The HAT provided by the Program's medical administrator is a health literacy tool specializing in applying health and behavioral science to new media and technology. It offers resources and health coaching designed to help improve member's health and well-being. As an incentive to taking the HAT, individuals receive \$200 through a Health Reimbursement Arrangement (HRA) for use toward health plan medical and prescription drug copayments, deductibles and POS "co-insurance".

For CY 2010, 6,068 employees, or 52% of the eligible population, took the HAT, an increase of 0.5% from CY 2009.

Employees in the HMO health plan are eligible to receive reimbursement for up to \$200 per subscriber per calendar year for the purchase of one piece of home exercise equipment that provides a cardiovascular/muscular total body workout. State HMO members are also eligible for up to \$450 in gym/fitness facility reimbursement per subscriber contract per calendar year. An employee can seek reimbursement for only one of these programs, in any given year.

In FY 2011, the Program paid a combined \$829,000 in incentives for its employees in these programs, which is a 6.7% decrease in utilization from FY 2011.

In an effort to help members quit tobacco, the Program supports many resources and benefits to improve the chances at succeeding. Reducing the number of members who use tobacco saves money and lives and paying for such resources is the single most cost-effective health benefit that can be provided to members. The Program offers coverage for tobacco cessation medications that are FDA approved and reimburses members up to \$150 for participating in a tobacco cessation counseling program offered by an approved facility through the Community Health Education Reimbursement Program. In CY 2011, 1,002 Program members made a quit attempt with an estimated 217 succeeding.

In FY 2011, Program staff and partners continued to provide leadership and resources for agency wellness coordinators through four quarterly trainings covering over twenty-four wellness topics. These trainings aided agency wellness coordinator efforts to serve as their agency's liaison to the wellness program. The role of the agency wellness coordinator is to assist in educating all state employees on healthy lifestyles and wellness models. The success of the Program's effort in wellness and health improvement has led to the following recognition over the past year:

- Named as a Significant Achievement in the *June 2011 Program Performance and Audit Report* released by the NH Office of Legislative Office Budget Assistant
- National Diabetes Education Program *August Partner Spotlight*
- New Hampshire Business Review *Worksite Wellness: Best Practices from N.H.'s Largest employer*

## 4. FY2011 Key Program Accomplishments

Activity	Summary
<b>Retiree medical and prescription drug plan changes</b>	Sought to balance need for benefit savings and additional premium contribution with concerns for affordability and access to care. Retiree plan design changes resulted in 10% cost reduction for State over the biennium.
<b>Early Retiree Reinsurance Program</b>	State received \$3.2 million in federal subsidy in FY 11 due to successful participation in this temporary program.
<b>Active medical and prescription drug plan changes through collective</b>	Provided financial projections and modeling to bargaining process, along with technical advice on numerous proposals. Negotiated changes resulted in savings of 6% over current plan.
<b>Actuarial Valuation of Other Postemployment Benefits (OPEB)</b>	Managed the preparation and release of the third valuation of the state plan liability that was produced by The Segal Company. The report, <i>as of December 31, 2010</i> , can be viewed at <a href="http://admin.state.nh.us">http://admin.state.nh.us</a> .
<b>Administrative service procurements</b>	Completed procurement for pharmacy benefit manager that resulted in contract terms projected to save 9.7% over prior financial terms. A further reduction in the administration fee through an amendment of the contract in April, 2011 generated an additional \$800,000 savings per year for the remaining contract period.
<b>Compass Smart Shopper Program</b>	Incentive program for utilizing cost-effective health care providers was installed in July 2010 and continuously enhanced throughout FY 2011 with additional services, promotion and education. Program raises awareness among state employees of the high cost of health care by rewarding use of lower cost provider of various medical procedures.

## 5. FY2012 Program Goals

Activity	Summary
<b>HIPAA Compliance</b>	Attain full compliance of privacy and security rules throughout all Program operations.
<b>Administration of life insurance benefit</b>	Complete implementation of life insurance benefit management program, including vendor procurements and contract management, plan design, and compliance and financial oversight.
<b>Patient Protection and Affordable Care Act</b>	Monitor policy and legal developments and maintain compliance with applicable rules, including Form W-2 disclosures, benefits explanations, appeals procedures and coverage requirements.
<b>Evaluate and implement cost-effective options for Medicare Part D coverage for retirees</b>	In FY 2012, the Program expects to implement a new prescription drug program for Medicare-eligible retirees that will maintain coverage level, yet generate significant savings for the State beyond those currently obtained through the Retiree Drug Subsidy Program, which approximate \$4 million per year.

## 6. APPENDIX : PRIOR YEAR FINANCIALS (cash-basis)

### SCHEDULE OF REVENUE, EXPENDITURES AND CHANGES IN FUND BALANCE ACCOUNTS FOR ACTIVE HEALTH PLAN (Unaudited) FOR FISCAL YEARS ENDED JUNE 30, 2008 THROUGH JUNE 30, 2010 (Expressed in thousands)

	FY2010	FY2009	FY2008
<b><u>OPERATING REVENUES</u></b>			
State Contributions:			
Active Employees	\$168,270	\$153,200	\$141,649
Other Employers	1,252	1,118	1,054
Non-State Contributions:			
COBRA Participants	821	491	615
Legislator Participants	694	622	559
Recoveries	3,359	1,957	3,363
Total Contributions for Health Benefits	174,397	157,388	147,240
<b><u>OPERATING EXPENSES</u></b>			
Health Care Expenses			
Medical Payments	133,223	126,379	117,835
Pharmaceuticals	35,024	33,523	29,909
Ancillary Benefits	856	790	589
Total Health Care Expenses	169,103	160,692	148,333
Administrative Expenses	5,403	5,383	4,812
Salary & Benefits	364	281	-
Enrollment	216	183	222
Total Operating Expenses	175,086	166,539	153,367
Operating Income (Loss) <sup>1</sup>	(689)	(9,151)	(6,127)
Investment Income	-	665	1,205
Change in Net Assets	(688)	(8,486)	(4,922)
Net Assets - July 1	18,078	26,564	31,486
Net Assets – June 30	\$17,390	\$ 18,078	\$ 26,564

<sup>1</sup>The Operating Losses for FY2008 through FY2010 are attributable to working rate suspensions which reduced the revenue collected.

**SCHEDULE OF REVENUE, EXPENDITURES AND CHANGES  
IN FUND BALANCE ACCOUNTS FOR RETIREE HEALTH PLAN (Unaudited)  
FOR FISCAL YEARS ENDED JUNE 30, 2008 THROUGH JUNE 30, 2010  
(Expressed in thousands)**

	FY2010	FY2009	FY2008
<b><u>OPERATING REVENUES</u></b>			
State Contributions:			
Retired Judges & Constitutional Officers	\$ 554	\$ 571	\$ 435
Retired Employees	52,458	50,916	41,077
Non-State Contributions:			
Legislator Participants	161	144	126
Retirement Subsidies & Deductions	14,442	15,023	15,545
Recoveries	7,119	1,575	2,095
Total Contributions for Health Benefits	74,734	68,229	59,278
<b><u>OPERATING EXPENSES</u></b>			
Health Care Expenses			
Medical Payments	37,683	37,923	35,576
Pharmaceuticals	30,084	31,080	27,243
Ancillary Benefits	-	-	-
Total Health Care Expenses	67,767	69,003	62,819
Administrative Expenses	4,142	3,482	3,703
Salary & Benefits	291	222	-
Enrollment	173	144	164
Total Operating Expenses	72,373	72,851	66,686
Operating Income (Loss) <sup>1</sup>	2,361	(4,622)	(7,408)
Investment Income	-	465	662
Change in Net Assets	2,361	(4,157)	(6,746)
Net Assets - July 1	12,618	16,775	23,520
Net Assets - June 30	\$ 14,979	\$ 12,618	\$ 16,774

<sup>1</sup> The Operating Losses for FY2008 and FY2009 are attributable to working rate suspensions which reduced the revenue collected.

**SCHEDULE OF REVENUE, EXPENDITURES AND CHANGES  
IN FUND BALANCE ACCOUNTS FOR TROOPER HEALTH PLAN (Unaudited)  
FOR FISCAL YEARS ENDED JUNE 30, 2008 THROUGH JUNE 30, 2010  
(Expressed in thousands)**

	<u>FY2010</u>	<u>FY2009</u>	<u>FY2008</u>
<b><u>OPERATING REVENUES</u></b>			
State Contributions:			
Active Employees	\$ 3,775	\$ 3,421	\$ 3,452
Non-State Contributions:			
Other Employers	-	17	-
Recoveries	62	45	77
Total Contributions for Health Benefits	<u>3,837</u>	<u>3,483</u>	<u>3,529</u>
<b><u>OPERATING EXPENSES</u></b>			
Health Care Expenses			
Medical Payments	2,471	2,292	2,296
Pharmaceuticals	347	277	294
Ancillary Benefits	33	52	14
Total Health Care Expenses	<u>2,851</u>	<u>2,621</u>	<u>2,604</u>
Administrative Expenses	122	123	104
Salary & Benefits	8	6	-
Enrollment	5	4	5
Total Operating Expenses	<u>2,986</u>	<u>2,754</u>	<u>2,713</u>
Operating Income (Loss)	852	729	816
Investment Income	-	37	117
Change in Net Assets	852	766	932
Net Assets – July 1	<u>3,582</u>	<u>2,816</u>	<u>1,884</u>
Net Assets – June 30	<u>\$ 4,434</u>	<u>\$ 3,582</u>	<u>\$ 2,816</u>

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## 7. HEALTH BENEFIT STAFF

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