The Governor's Task Force On State Employee Health Insurance

Quality & Cost Containment

STATE BOARD OF INSURANCE

1110 SAN JACINTO BLVD. AUSTIN, TEXAS 78786

LYNDON L. OLSON, JR., Chairman
WILLIAM P. DAVES, JR., Member
CAROLE KEETON RYLANDER, Member

TOM BOND, Commissioner
ERNEST A. EMERSON, Fire Marshal
JIM NORMAN, Chief Clerk

September 27, 1984

Honorable Mark White
Governor
State Capitol
Austin, Texas

Dear Governor White:

When you created the Task Force on State Employee Health Insurance Quality and Cost Containment a year ago, you gave us a full agenda and requested a complete report on ways to improve the Uniform Group Insurance Program and trim rising health insurance costs.

This Task Force report offers a comprehensive program and 70 specific recommendations which we believe meet your charge.

Two key recommendations of the Bidding Subcommittee already have been enacted into law by the Legislature in special session. They extended the state's group contract from three to six years and gave the Employee Retirement System greater flexibility to implement needed changes in benefits without having to put the program out to new bid.

The Benefits Subcommittee initiated 18 recommendations, including an education program to help employees make wise decisions on insurance matters; a requirement for second opinions before non-emergency surgery; and increased coverage for use of out-patient surgery facilities.

The Wellness Subcommittee responded to your request for "innovative and challenging" proposals with the "Healthy Texan Discount" plan for the physically fit and nearly 50 other proposals. These include: a policy guide for state agencies in developing restrictions on work-site smoking; a voluntary fitness program of screening, testing, counseling and group exercise; and improvement of nutrition at snack bars and cafeterias in state office buildings.

All of the Subcommittees recommended a single benefit plan in lieu of the present two plan system.

We stand ready as individuals and as a Board to assist you, the Legislature and the Employees Retirement System in taking the steps needed to implement the recommendations of the Task Force.

It is with great pride that we transmit this report to you and commend the Task Force members without whose service, initiative, and hard work this report would not have been possible.

Sincerely,

William P. Daves, Jr., Chairman of the Task Force

Lyndon L. Olson, Jr.

Carole Keeton Rylander

The Governor's Task Force on State Employee Health Insurance
Quality and Cost Containment

TABLE OF CONTENTS

Subcommittee on:

Bidding

GOVERNOR'S TASK FORCE
ON
STATE EMPLOYEE HEALTH INSURANCE QUALITY AND COST CONTAINMENT

SUBCOMMITTEE ON BIDDING

Mr. Lyndon L. Olson, Jr., Chairman
Chairman, State Board of Insurance
Austin, Texas

Mr. Robert W. Blevins, F.L.M.I.
Integrated Insurance Consultants
Dallas, Texas

Mr. Paul D. Glover
Attorney-at-Law
Cage, Hill and Glover
Houston, Texas

The Honorable Gene Green
Texas House of Representatives
Austin, Texas

Mr. John D. Melton
President
Blue Cross/Blue Shield of Texas
Dallas, Texas

The Honorable John Montford
Texas Senate
Austin, Texas

Mr. C. Clifton Robinson, Chairman
National Group Corporation
Waco, Texas

Mr. Gary R. Rogers, President
Texvest Securities Corporation
Austin, Texas

Mr. Robert L. Wormley, President
Anderson-Wormley & Mitchell, Inc.
Austin, Texas

REPORT OF THE SUBCOMMITTEE ON BIDDING
GOVERNOR'S TASK FORCE ON STATE EMPLOYEE HEALTH INSURANCE
QUALITY & COST CONTAINMENT

February 17, 1984

Preface

The Governor's Executive Order (MW-13) dated September 30, 1983 asks the Subcommittee on Bidding to carefully analyze

> . . . all elements which go into the pricing of group health insurance to state government and state employees. Existing and alternative methods for procuring and administering the program should be explored, including the possibility of administering a differentiated program through individual state agencies. A review of the State's bidding process shall be conducted and changes recommended that will encourage additional insurance companies to bid on the state contract.

The Subcommittee was asked to "develop its recommendations by March 1, 1984 or in time to affect the 1984 bidding process." It is the understanding of the Subcommittee that the Employees Retirement System (ERS) has not decided whether to offer the state employee insurance contract for bid in 1984. A new contract was negotiated in 1983. In addition, many of the coverage changes implemented with the new contract did not take effect until January 1, 1984. This may be insufficient time for adequate experience on the effect of these changes to be available to carriers which may be interested in offering a competitive bid on the program.

However, it is felt that some of the information received to date by the Subcommittee on Bidding may be helpful to the Subcommittee on Wellness and the Subcommittee on Benefits as they continue their deliberations.

Background

The Subcommittee on Bidding met three times [November 14, 1983; December 1, 1983; and January 27, 1984] to discuss the state bidding process. At those meetings, the Subcommittee heard from insurance industry representatives familiar with the plan and from ERS experts. Copies of the comments of the insurance carriers are attached to this report for informational purposes.

Recommendations

It is the consensus of the Subcommittee that the following actions by the state would enhance the interest of insurance carriers in the state employee insurance program and may increase the number of competitive bids received by the state:

1. Use Single Benefit Plan

   Multiple benefit plans are difficult to administer. Where such programs exist losses are less predictable. Unless movement between plans is restricted, carriers tend to shy away from such programs. Therefore, a single benefit plan is preferable if it is the intent of the state to continue to attract competitive bids. If multiple plans are retained, very strict administrative rules limiting employees' ability to move from one plan to another should be implemented. Administrative guidelines used by the Texas A&M University System are attached for reference.

2. Retain Uniform Group Plan

   The uniform plan for all state employees and agencies should be retained. Segregating the plan by agency would subvert the concept of group insurance and cause more problems than it would solve. It is possible that segregation of plans would enable smaller carriers to bid on the plan. Some agency plans would probably receive a number of bids while others may not be able to find even one willing carrier.

   In addition, rate structures of smaller plans would be more susceptible to the impact of catastrophic illness since such losses would be spread over a smaller group. There would also be difficulties in the providing smaller agencies with the expertise needed to administer individual insurance plans. If radically different rate structures developed between agencies, the Legislature would face the problem of arriving at a state contribution level that would be fair to all employees.

3. Increase Financial Incentives

   The ERS has done an admirable job in drafting bid specifications to maximize the monetary benefits to the state and its employees. The plan, however, is so weighted in favor of the state and its employees that few carriers are willing to consider underwriting the plan. To increase the number of bidders, the state must either reduce the risk to carriers or increase the carriers' financial incentive to bid on the plan.

The financial incentive could be increased by raising the permissible margin. It is recognized that increasing the financial attractiveness of the plan to carriers may also increase premiums, if all other factors remained unchanged.

The risk to carriers would be removed if the ERS elects to self insure the plan. A number of carriers and other administrators would probably bid on an administrative contract for a self-funded system. The statute permitting self funding requires a reserve and provides that funds needed to meet the reserve can be built into first year premiums. However, the risk for losses in excess of premiums and reserve under a self-funded mechanism would be born by the state. This factor and the potential political pressures inherent in a self-funded plan create concerns not attributable to the private marketplace.

4. Eliminate Requirement For Austin Claims Office

Carriers who testified before the Subcommittee on Bidding indicated one financial disincentive in the current plan is the requirement to maintain an Austin claims office. With modern computer capabilities, this requirement could be optional without impeding quick claim payment or employee service. From a practical standpoint, a carrier would probably still need to maintain a staff of service representatives in or near Austin.

5. Reduce Frequency of Bidding

Carriers may feel more inclined to offer bids on the state program if there were the possibility of retaining the contract for a longer period of time. Current law requires the ERS to bid the contract every three years. A six-year statutory period is suggested with the ERS having the option to re-bid more often. Also, the ERS should be given greater flexibility to renegotiate the contract when coverage changes are mandated by law. Requiring the ERS to re-bid under these circumstances sometimes works to the disadvantage of the state.

Although the Subcommittee on Bidding believes primary jurisdiction for developing recommendations on benefit structures and employee education rests with other Subcommittees, it recognizes that a viable employee insurance program must be designed with an awareness of the current environment and market constrictions in this field and a reasonable approach to benefit design. Major employers in the private sector are finding it necessary to trim benefit packages and introduce cost containment measures to retain affordable coverage. The state undoubtedly faces similar constraints.

Future Subcommittee Deliberations

The Subcommittee believes it has discharged its primary responsibility as outlined in the Governor's Executive Order. However, the Subcommittee stands ready, if requested, to draft appropriate legislation to implement its recommendations; to comment on the effect that recommendations from other subcommittees will have on the bidding process; and to undertake further inquiries or analysis as directed by the Chair of the Task Force.

Submitted By:

Lyndon L. Olson, Jr., Chairman

List of Attachments

1. Letters:

   Letter from James J. McGrath, Assistant Vice President,
   The Equitable Life Assurance Society of the
   United States (dated: December 7, 1983)

   Letter from Dan J. Person, Vice President, Group Insurance,
   The Prudential Insurance Company of America
   (dated: January 24, 1984)

   Letter from Dan M. DeGood, Vice President, Group Insurance,
   Metropolitan Life Insurance Company
   (dated: January 24, 1984)

2. Administrative Specifications for Texas A&M University System

3. Minutes of Subcommittee on Bidding

ATTACHMENT 1

Letters

THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES
Suite 1500, 11 Greenway Plaza Houston, Texas 77046

DEC 9 1983

JAMES J. McGRATH
Assistant Vice President

December 7, 1983

Lyndon L. Olson, Jr.
Chairman,
State Board of Insurance
1110 San Jacinto
Austin, Texas 78786

Dear Mr. Olson:

Tim Williams and I appreciate the invitation you extended to us to attend the meeting which was held by the Governor's Task Force on the State Employees Health Insurance Program. As you requested, I am listing below items which should be taken into consideration in developing future specifications. I believe with these changes in the specifications the insurance industry will show more interest in entering into a business relationship with the State of Texas. The items are as follows:-

1) If you are to continue a two-option plan, it is recommended that the rate structure be as close together as possible so that shifting or risk selection on the part of employees would be minimal. The differential in premiums charged to the employees should be equivilent or as close as possible to the difference in risk for both the high and the low option plan.

Additionally, we would like to include a margin of anywhere from 5 to 6% because of the uncertainties of the current program and its inherent risk.

2) In order to properly underwrite the LTD program, we would like to see Employee Census information on a tape format. The census should include the age, sex, earnings and for the open and closed disability claims, we would like to see the date of disability, the amount of benefit and the duration of the close claim.

3) You should not include a requirement that claims be paid in Austin.

4) It should not be necessary for claim drafts to be issued in the State of Texas.

5) You should make it possible for the insurance company to be reimbursed for cleared claims on a daily basis. There may be funds that may be required up-front in order to handle bank charges and/or anticipated claims. The wording in the specifications should allow the carrier sufficient time and/or funds so as to avoid a cash flow strain. Your current procedure does not allow this. This assumes a minimum premium funding arrangement. If a fully insured conventional program is to be utilized then premium should be paid in advance in the normal manner.

6) If a fully insured conventional approach is required then the margin which is built into the rates should be paid to the insurance carrier. If minimum premium is to be utilized then this margin need not be built into the insured rate, however, under both funding arrangements, the reserves for benefits which are to remain insured such as waiver of premium and incurred and unreported reserves for group life, disabled life reserves for long-term disability and incurred and unreported reserves for health insurance should be submitted to the carrier for accummulation.

If some of these insurance features could be eliminated, then the need for the majority of the reserves could also be eliminated. We would be glad to discuss the details of our recommendations at your convenience.

I believe the above information will allow you to accomplish your objectives. If there is any further information that you might need, please do not hesitate in contacting me.

Very truly yours,

James J. McGrath
Assistant Vice President

JJMcG:tc

CC: David Atkinson
Tim Williams

The Prudential Insurance Company of America
Southwestern Home Office
P. O. Box 2075, Houston, TX 77252
Tel. 713-663-5079

Dan J. Person, CLU
Vice President, Group Insurance

January 24, 1984

JAN 25 1984

Mr. Lyndon L. Olson, Jr., Chairman
State Board of Insurance
1110 San Jacinto
Austin, Texas 78786

Dear Mr. Olson:

In December, we attended the Bidding Subcommittee meeting which sought answers, from the companies attending, as to why insurance carriers would not offer quotations for the State insurance plan. The carriers in attendance each offered ideas and suggestions and in parting, I offered to summarize Prudential's thoughts if you desired us to do so. At the request of Dixie Evatt, the following are our thoughts on changes or alternatives which might encourage companies to quote.

First, please refer to Allen Haight's letters of April 8, 1983, and May 28, 1980, which outline areas of concern in the bidding requests. I will not repeat those concerns, rather, I will attempt to identify those broad areas which should be addressed.

Problems are present in four broad categories, all of which are interrelated. These are 1) Bid Process, 2) Plan Design, 3) Financial, and 4) Claims Administration. Revising one area without addressing the others would not solve the current problem of companies declining to quote, but by listing areas of concern, perhaps some solution can be reached.

1. Bid Process

   The specifications require strict limitations on factors to be used in timing and underwriting, such as:

   A requirement to bid every three years with the clear indication the bid will be awarded to the low bidder (regardless of the quality of work accomplished by the inforce carrier).

Restrictions on the underwriting process which limit the ability to be profitable or to recoup losses, should they occur. These include setting rates too far in advance and limiting margins in concert with a 12-month rate guarantee.

2. Plan Design

The current design encourages potential anti-selection and will not allow proper use of cost containment ideas. This results in higher usage and rates to the employee.

3. Financial

The bid process and plan design create limitations on the financial viability of the plan. If the carrier is to accept the full risk, the carrier should have the responsibility to set rates, retention, margins and the recoup process. When this capability is removed as it is now, the carrier is at a disadvantage to the State and its employees.

4) Claims Administration

The requirement that all claims must be paid in Austin creates significant problems for any carrier assuming the State plan. First, it takes time to create a claims office with properly trained employees. An even greater problem is what to do with those employees at the end of three years when the plan is transferred to a potential low bidder.

In the past, attempts to create forced competition have resulted in just the opposite. The issue is complicated but the overall concept is rather simple. To create the best opportunity for true competition, we recommend the following:

1. In the bid process, establish one health plan, preferably one which embraces sound cost containment concepts. This will create equity among all participants and lead to more consistent underwriting.

2. Remove all restrictions on how carriers are to establish rates. Do not limit margins, trend, etc.

3. Allow claims to be paid in existing offices, both in Austin and other locations out of State, if necessary.

4. Create an attitude of trust with the carrier. Threats of loss of coverage do not create a good work attitude for any carrier, especially if losing the account carries with it a substantial loss of money.

The State plan should be more closely patterned after programs established in private industry. Persistency with one carrier is desirable if the services provided are acceptable. Low rates alone cannot provide the best buy for the State in the long run. The State must treat its insurance carrier as a business partner, not as a vendor.

We certainly don't have all the answers, but we want to cooperate in every way possible to aid you in establishing the best program available for the State plan. Please advise how we can be of service.

Sincerely,

Dan Person

Dan J. Person, CLU
Vice President, Group Insurance

DJP/mp

cc: Ms. Dixie Evatt
Mr. Robert R. Booth, CLU

The Prudential Insurance Company of America
Southwestern Home Office
P.O. Box 2075, Houston, TX 77001

Allen M. Haight, CLU
Vice President, Group Insurance

April 8, 1983

Mr. David H. Atkinson
Director, Group Insurance Division
Employees Retirement System of Texas
18th and Brazos Street
P.O. Box 13207
Austin, Texas 78711

Dear Mr. Atkinson:

The purpose of this letter is to respond to your invitation to bid on the Group Insurance Benefit Plan for Employees and Retirees of the State of Texas. As you no doubt know, we had earlier signaled great interest in this account and I think we had made it known to many that we intended to make a spirited offering. However, after reviewing the requirements in your specifications, we must reluctantly request to be excused from submitting a proposal.

I want you to know that we at The Prudential are disappointed, but we feel that the specifications are slanted so sharply against the insurance carrier that we could not reasonably have a chance to break even over a three-year period (or even six years). Because we view the risk as so adverse, we feel it would not be in the best interests of our policyholders for us to make an offer to insure.

As a good corporate citizen of Texas, we do feel obliged to give you an explanation of the major items resulting in our decision. Perhaps in the future as the program evolves, we could reconsider our position assuming, of course, that many of the objectionable features are removed. The following represents what we find most troublesome:

A. We still find multiple health plans are to be offered to the covered participants. I have made my feelings about this known in the past (my letter dated May 28, 1980) and will not bore you or your Committee with another recitation. But because State contributions do not always increase in exactly the same amount as medical trend and utilization,

we do see anti-selection developing in this account. Historically, reasonably wide swings in enrollments under each of the plans have developed some years and this necessarily complicates our ability to price the overall program properly.

B. An annual election period is still held for all optional benefits. Again, the anti-selection inherent in this type of practice raises the cost of the program to all participants. Further, it makes it most difficult to price prospectively since we cannot accurately predict the employee shifts.

C. The current experience available is of questionable value because of changes in enrollment from year to year. The current experience may not really be reflective of the actual results due to shifts in participation which occurred in 1982.

D. The above situation is complicated each year by the requirement that rerates must be presented in March for implementation in September. This severely limits the amount of claim information we might obtain and from which we would be asked to set our rates. The problem is that due to changes in participation our experience information under the new employee demographics would be sketchy.

Further, we must of necessity build in additional trend and margins when we are forecasting that far in advance. This would not seem to work to the overall advantage of the employees and frankly, there seems to be no good reason to rerate this early except to give the State plenty of time to go to bids if they so choose.

E. The above adverse situations are complicated greatly by the requirement that renewal margins may not exceed 3%. Some may argue that 3% would be satisfactory on an account this size with a single plan and trend factors running closer to inflation. It is our opinion that 3% is woefully inadequate when trend is fluctuating as widely as it has in the last few years and where you have multiple plans with optional

choice built in annually. In our opinion, this tight financing in rates would require extremely high risk charges or extremely high earnings in the first year of the contract so that that surplus could be carried against future years. Again, this would necessitate super high margins on the first year and would seem not to be in the best interests of the participants.

F. A 12-month rate guarantee is required each year. We are not totally adverse to that however, when coupled with the preceding paragraphs, as well as legislated cost shifts against us by the Federal Government, this feature would seem to be suicidal to any insurance company. A 12-month rate guarantee quite naturally carries with it a requirement for higher margins and yet we are restricted via the specifications.

G. The fact that deficit recoup is permitted is gratifying to see, however, the renewal rating procedure would seem to literally preclude any deficit recoup due to adverse selection and extremely low margins.

H. All of the above is further complicated by the requirement that the account must be bid by law every three years. I realize legislation is pending to increase that requirement to every six years, however, the State has demonstrated a history of switching carriers and appears to have done so strictly on a rate basis.

All of the above listed items are major to us by themselves, however, when taken together, the message we receive is one that says the successful bidder will have to take a case with built-in adverse selection, finance it with extremely thin rates, be willing literally, not to recoup any deficits incurred (because the future rating system essentially precludes it) and finally, should be prepared to lose the account should the State obtain a rate advantage from some other competitor. Several years ago, I wrote to you and suggested that unless these unfavorable conditions were removed from the specifications, I suspected that some time in the future competitive bidding would not be a vehicle that could be used by the Employee Retirement System of Texas. I cannot say for certain that "the future" is here but I have strong suspicions that it

may be. As much as The Prudential would like to serve the employees and the taxpayers of the State of Texas, we simply cannot do so without subjecting our owners (policyholders) to a risk we do not think they should take.

While I hesitate to say much more about this subject, I cannot in good conscious close this letter without referring once again to the multiple plan option problem. If you look at all of the objections raised previously in this letter and eliminate objection A. by eliminating multiple plans, I believe you would find that our problems with Paragraphs B., C., D., E., and F. would either disappear or would be greatly minimized. The existence of the multiple plan option is basically the reason Prudential is unable to make a favorable response.

We sincerely appreciate the opportunity to look at the program and we wish you all the best with your competitive bidding process in 1983. If there is any way we can be of any assistance to you in restructuring the program in the future, we would be happy to do so.

Sincerely,

Allen M. Haight, CLU
Vice President, Group Insurance

AMH/mp

The Prudential Insurance Company of America
Southwestern Home Office
P.O. Box 2075, Houston, TX 77001

Allen M. Haight, CLU
Vice President, Group Insurance

May 28, 1980

Mr. Elmer J. Voorhis, Jr.
Commissioner of Insurance
State Board of Insurance
1110 San Jacinto
Austin, Texas 78786

Dear Commissioner:

The purpose of this letter is to again transmit our proposal for the Employee Group Benefit Program covering Employees of the State of Texas. We have bid the plan exactly as requested and we believe we have met all of the requirements of your recent specifications. In order for competitive bidding to work in the best interest of all parties, one of the basic requirements is that there be more than one competitive bid offered. Prudential has been a consistent, spirited competitor and we hope we are this time. We believe our proposal is self-explanatory and, as such, we do not feel a need to comment on it further in this letter.

However, we have some very serious concerns about the future of the competitive bidding process due to some of the requirements made by the specifications. Basically, the account is becoming much more difficult to evaluate and underwrite properly since some of the conditions would seem to put any insurance carrier in a classic "no-win" position. I would like to discuss these issues further in this letter and, although our advice was not solicited, we feel an obligation to bring to your attention specific issues which we feel are causing the State Employee group to move in a direction which will eliminate competitive bidding in the future and increase the cost of the plan to both employees and taxpayers of the State of Texas.

The primary difficulties for any insurance company seem to us to center around two separate issues which present unique problems separately but extreme problems when combined or taken together. Let me address each of them separately:

1. From our standpoint, there is no logical reason for having two employee plans and three dependent plans to choose from. From a purely financial standpoint, this feature tends to increase the cost of the plan via the adverse selection inherent in these kinds of choices. Further, the employee "shift" from one plan to another makes the account almost impossible to evaluate financially with any degree of certainty. A good example is the rather large shift which occurred last year and, should the Prudential be awarded the business on the basis quoted, would likely occur again.

   No one can accurately predict the shift in risk which can occur during the open enrollment period. This underwriting predicament can only be addressed via increased margins to cover the risk of adverse selection which has occurred and which might occur again. The end result is an increase in gross rates thus increasing the cost to the employees. It is our opinion that the ongoing adverse selection available to the participants will eventually make the plan extremely expensive and it may tend to self-destruct. Certainly, a continuation of this feature will eventually price one plan out of existence. One of our other policyholders, a state employee group in the southwestern part of the United States, finally eliminated the dual plan option in September 1979 for this very reason.

   Also, the two plans from which employees may choose are very similar and due to the 100% benefit area at $2,500, we believe they should be valued within 10% of each other. Unfortunately, the experience of each plan produces different results. It is our recommendation that the options available within the State Employee Group Plan be terminated and that all employees become eligible for only one plan of benefits. We believe you will eventually get to this anyway as the differences in plan benefits will continue to shrink as hospital costs escalate. In a few years it won't take long at all for any employee to get into the 100% benefit area due to an average hospital confinement.

I might also add that attempting to peg one of the plans with an employee cost of $40 or less complicates further the multiple plan problem and precludes these two plans from being priced accurately due to the actuarial difference between each plan. For instance, based on our evaluation of the experience emerging under the two plans, there should be a wide difference in rates if both were priced to support each risk independently. This would necessarily assume that no employee shifts from one plan or the other could occur. If no shifts could occur, the high plan would produce rates based on experience approximately 45-50% higher than rates for the low plan. A delicate pricing problem arises when we consider the fact that a good many employees currently in the high plan can shift to a plan which we believe is about 10% inferior in exchange for a premium reduction of 30-35% or so. Obviously, the more people who shift out of the high plan, the higher the rates should be for the lower plan. By assuming the employee shift described in your specifications, we could provide the low plan within the $40 State contribution. However, it seems reasonable to us that the high plan must be priced accurately in case there is no shift or in case it is less than everyone thinks. On the other hand, if it is more (and we think it would be with a 29-30% rate difference), then our low plan rates would still be inadequate. Accordingly, we have increased them further in an effort to account for the adverse selection. This will keep the premiums within 20% of each other and may tend to reduce the employee selection. Conversely, it has a tendency to artificially increase the rates to the employees. From our standpoint, this "catch 22" seems to only work in the adverse interest of the employees of the State of Texas.

In summary, it is our feeling that the only way an insurance company has a chance with multiple plans is to price the high plan accurately and to over-price the lower plans to offset the adverse selection. In an effort to meet your specifications and to keep the number of plan options at a minimum, we would be willing to provide the inforce "low plan for dependents" option to employees within the $40 State contribution.

2. The above adverse selection problem is complicated by the requirement that underwriting deficits incurred under the contract may not be carried forward against a future policy period. In prior years, you permitted deficit carry forwards during the first year of the contract but required that they be eliminated at the end of the second year. While we were never comfortable with that arrangement, the recent change to an annual "stop loss" makes the pricing much more sensitive. Essentially, any insurance company is in a position where it cannot win.

Because of this feature, and the fact that dividends, if any, must be paid, we feel like we must take a much more conservative approach to our rates than we otherwise might. Essentially, since we cannot make very much out of the contract in underwriting gains, we feel obliged to attempt to minimize any losses we may sustain under this arrangement. Accordingly, our rates are higher than they would be in the absence of this provision. This seems to work in the adverse interest of the employees. Further, due to the increased risk and the fact that we cannot recoup deficits, our risk charge must increase. Obviously,this then increases the net cost to the State of Texas, i.e., any dividends earned will be reduced by the additional risk charge before remitted to the State.

It is my recommendation that deficits incurred be allowed to be carried forward to following policy years. This will result in reduced rates as well as reduced risk charges and will not really put the State in a worse position than it otherwise would have been since you will still retain the right to terminate the policy should you desire to do so and an underwriting deficit existed at the time of termination. Essentially, you give up nothing but you do enjoy the lower cost attached to the removal of the no-deficit carry forward provision.

An alternative to removing this provision might be to finance the case on a no-dividend, no-deficit basis. This would be more fair to any insuror since they would be in a total risk position and could either win or lose, depending upon the

experience. In exchange for that, the premium rates could be reduced. I have taken the liberty of quoting on this basis and the financial sheets applying to a no-dividend, no-deficit funding arrangement are attached to this letter for your perusal.

The above thoughts are offered from our perspective and experience in dealing with a large number of large purchasers of employee group benefits. Further, they are offered in the spirit of cooperation with the State of Texas and in the interest of preserving the competitive bidding process which has worked so well in the past but may not work at all in the future.

I would like to make one more suggestion which is, why not ask those who submit a qualified response to your specifications to "try it our way". Any of the carriers who have chosen to respond could update their proposal in a matter of days, recognizing the contemplated changes I would like to suggest. Once the evaluation has been complete, any further modifications of the existing numbers are fairly simple to calculate and I would suggest that by asking for a re-bid among those of us who have responded could carry with it a seven to ten-day deadline and all carriers would be able to respond. What I'm suggesting is that you ask all responding carriers to submit a proposal with the following modifications:

1. Removal of the "no deficit carry forward" provision.

2. Elimination of the multiple plans. Ask each carrier to give you prices for either the current high plan or the current mid-plan or any variation thereof you feel is appropriate.

It is my opinion that such an exercise can't hurt you in any way nor can it cost you anything. It also might lend some credibility to what I have said in that I believe you would get a more aggressive response but if not, you could then stick with your original specifications. We are talking about large amounts of money, a substantial portion of which is employee dollars and it might be worth the extra few days it

would take to consider this alternative. Again, we offer the suggestion in the spirit of what we think is best for the employees of the State of Texas as well as the competitive bidding process. Prudential feels that it is a good corporate citizen and would not be living up to its obligations of public trust if it did not offer these suggestions.

We appreciate the opportunity to submit our proposal. If you feel our suggestions have any merit or you would like to discuss them with us further, please let me know and we will meet at your convenience.

Sincerely,

Allen M. Haight, CLU
Vice President, Group Insurance

AMH/MP

Metropolitan Life Insurance Company
1177 West Loop South, Suite 1180, Houston, TX 77027
(713) 961-9978

Dan M. DeGood
Vice-President
Group Insurance

Metropolitan Insurance Companies

January 24, 1984

JAN 26 1984

Mr. Lyndon L. Olson, Jr., Chairman
Governor's Task Force on State Employees
Health Insurance - Bidding Subcommittee
Governor's Office
Austin, Texas 78711

Dear Chairman Olson

At the conclusion of your Task Force meeting of December 1, 1983, you asked each insurance carrier representative to provide a written summary of their presentation. The following comments will serve to outline the more salient aspects of the presentation I delivered on behalf of Metropolitan Life.

In a letter dated July 28, 1980, Metropolitan Vice President Richard S. Walsh outlined numerous problems and practices of the State plan that served to impede the process of competitive bidding. Since that time the State has made significant changes to the plan which have improved its relative attractiveness in the eyes of an underwriter. Specific to this is: the reduction of plan options, the controls instituted to limit mobility between plans, an increased State subsidy, and a more liberal position concerning deficit carry forward.

While these improvements are significant, they do fail to address the one central issue that would increase the number of insurance carriers willing to bid on the contract. This issue is persistency. It is our belief that persistency can only be achieved when the State accepts the premise that its plan costs will equal claims and retention, as opposed to gross premiums.

Presently, the State is required to bid the plan no less frequently than every three years. Beyond this, the plan can be bid annually if the Trustees determine the incumbent's renewal projections (made 6 months in advance) to be excessive. Clearly, the frequency of bidding under these guidelines needs to be addressed. Mandated bidding every 6 years would be more attractive than the present 3 year legislation. However, a change of this nature will do nothing if the Trustees continue their practice of bidding any renewal deemed excessive.

Two improvements might serve to ease the Trustee's obligation to insureds in this regard. The first would be to decrease the proportionate share of total cost borne by the insureds. The second would be to decrease the time gap between the effective date of renewal increases and the delivery date for pre-renewal cost estimates.

The State's criteria for selecting a carrier needs to be addressed if more bidders are to be attracted. Once the State accepts the premise that its costs will be claims and retentions, then consideration can be given to the carriers' administrative capabilities and retention costs. There are many insurance carriers who have developed sophisticated systems which have the capability of producing significant claim savings. Carrier efficiency and an aggressive cost containment effort could actually lead to lower net costs in the long term. Unfortunately, the State's practice of leaving an underwriter in a loss position has caused many carriers to refrain from bidding, and thus proving this point of real savings.

I summarized my presentation by stating that the State should quit bidding so often, and so often for low rates. I explained that few carriers can afford the expense of preparing a proposal of this magnitude with regularity. No carrier can afford to subsidize the State plan, unless the subsidy is only a cash-flow loss which has a certainty of amortization.

I trust that these comments together with my presentation are useful to the Task Force. Should you require anything further, please let me know.

Sincerely

Dan M. DeGood
Vice President

DMD/ss

ATTACHMENT 2

Administrative Specifications for

Texas A&M University System

THE TEXAS A&M UNIVERSITY SYSTEM
COLLEGE STATION, TEXAS 77843-1262

INSURANCE AND RISK MANAGEMENT OFFICE (409) 845-5435

February 9, 1984

Ms. Dixie Evatt
Assistant Director,
Research and Information Services
State Board of Insurance
1110 San Jacinto
Austin, Texas 78786

Dear Ms. Evatt:

Enclosed is the information which you requested regarding the 31 day enrollment period for group insurance within The Texas A&M University System.

If you have any questions or would like further information, please do not hesitate to contact me.

Sincerely yours,

Mary jo Hurley

Mary jo Hurley
Assistant Director,
Insurance and Retirement Programs

enclosures

Employee coverage and dependent medical coverage can be requested on a form furnished to you by the appropriate processing office. This request must be received in your appropriate processing office within 31 days following the date you first become eligible for this insurance. When so received, your insurance will become effective on one of the following:

(a) the date of your eligibility or the date of your request, if later, if your request is received in the appropriate processing office on or before the 10th day of the month in which you become eligible, or

(b) the first day of the month following the date of your eligibility or the date of your request, if later, if your request is received in the appropriate processing office after the 10th day of the month in which you become eligible. HOWEVER, at the option of the employee, a request for coverage that is received in the appropriate processing office after the 10th of the month will become effective on the date the request is received if the employee agrees to pay the appropriate premium for such coverage.

If you do not apply for the insurance within 31 days following the date you first become eligible or if you decline the insurance, and later decide you want insurance, you must furnish evidence of insurability, satisfactory to The Lincoln for each person to be insured. This evidence of insurability will be at your expense. Your insurance will become effective on the date the Office of Insurance and Risk Management receives the approval from Lincoln National Life, provided such approval is received on or before the 10th day of the month. If such approval is received after the 10th day of the month, your insurance will become effective on the first day of the following month.

If you are not actively at work on the Effective Date of your coverage, you are not insured until the next following day on which you are actively at work.

If you are not actively at work on the date the amount of your insurance would otherwise be increased, such increase is not effective until the next following day on which you are actively at work.

If your dependent is confined in a hospital on the date you would otherwise become insured for dependent's insurance (or your insurance would be increased with respect to this dependent) such insurance is not effective until the day following the dependent's final discharge from the hospital. However, a live born baby is eligible whether still hospital confined or not.

GENERAL INFORMATION

Benefits for loss of your life are payable to the beneficiary designated by you. All other benefits are payable to you, unless such benefits have been assigned by law to the Texas Department of Human Resources under the Texas Medical Assistance Program. If you have named more than one beneficiary, and not designated the share for each, the benefits will be paid equally, or to the survivor. If you have named no beneficiary or if you die before The Lincoln makes payment on the disability benefits, payment will be made to your estate or at

Note: This form is required if enrollment is requested after 31 days. It must be approved by Lincoln National Life.

Now Lincoln National Life Insurance Company
~~SOUTHWESTERN LIFE INSURANCE COMPANY~~

Dallas, Texas

DECLARATION IN LIEU OF OR SUPPLEMENT TO MEDICAL EXAMINATION — EMPLOYEE BENEFITS INSURANCE THE TEXAS A & M UNIVERSITY SYSTEM

Please read instructions on reverse side before completing this form

Purpose: ☐ Group Medical Insurance ☐ Yourself ☐ Your Dependents ☐ Optional Group Life Insurance ☐ Long Term Disability ☐ Dependent Life

Date Employed by the Texas A & M University System: _____

Basic Annual Salary: $_____

1.	Names of Proposed Insureds (List A & M Employee First)	Relationship to Employee	Sex	Date of Birth	Height Ft.	Height In.	Weight	Occupation
A.		Employee						
B.								
C.								
D.								
E.								
F.								
G.								
H.								

2. Martial Status of Employee
   ☐ Married ☐ Widowed
   ☐ Single ☐ Divorced

3. Employee's Place of Birth _____ City _____ State

   Residence Address (Please Print)

   _____ Number and Street

   _____ City _____ Zip

   _____ County _____ State

4. Is an application for life or health insurance now pending in any company or association for any of the proposed Insureds? ☐ Yes ☐ No
   (If "Yes", name companies, and amounts applied for.) _____

5. Has any application for issue or reinstatement of life or health insurance covering any of the proposed Insureds ever been declined, postponed or withdrawn? ☐ Yes ☐ No

6. Has any of the proposed Insureds ever applied for and received or been offered a policy of life or health insurance on a plan not applied for or at other than standard rates? ☐ Yes ☐ No

7. Has any of the proposed Insureds within the last three years received a citation for a moving traffic violation? ☐ Yes ☐ No
   If Yes:
   Driver's license number _____
   State of Issue _____

8. Has any of the proposed Insureds ever joined A.A. or been treated for alcoholism or drug addiction? ☐ Yes ☐ No

9. Other than as prescribed by a physician, has any of the proposed Insureds ever used:
   A. Heroin, morphine, or other narcotics? ☐ Yes ☐ No
   B. Barbiturates, sedatives, or tranquilizers? ☐ Yes ☐ No

10. Has any of the proposed Insureds ever used LSD, marijuana, or other similar agents? ☐ Yes ☐ No

11. Has any of the proposed Insureds ever requested or received disability compensation from the United States Government, or from any insurance company, or other source?
    (If "Yes", give reason and amount) ☐ Yes ☐ No

12. Does any of the proposed Insureds have or expect to have any connection with the Armed Forces? ☐ Yes ☐ No

13. Use this space for details of "Yes" answers to Questions 5, 6, 7, 8, 9, 10, and 12.

CHECK CORRECT ANSWER AND GIVE DETAILS: IDENTIFY THE PERSON – DATE – DISEASE – DURATION – TREATMENT – DOCTOR

14. Are all of the proposed Insureds now in good health and free from physical and mental impairments? Yes ☐ ☐ No

15. Was any of the proposed Insureds absent from work or school because of sickness, injury, or health reasons during the last twelve months? Yes ☐ No ☐
    IF YES, how many days? _____.

16. Has any of the proposed Insureds ever been advised to have an operation which was not performed? Yes ☐ No ☐

17. Has any of the proposed Insureds, within the past five years, had any illnesses, consulted any physician, been in a hospital, clinic, or other institution for diagnosis, treatment, or check up? Yes ☐ No ☐

18. Has any of the proposed insureds, within the past five years had x-rays, electrocardiograms, blood tests, or other laboratory tests? Yes ☐ No ☐

19. Is any of the proposed Insureds now under treatment for, or has any of the proposed Insureds ever had, any of the following:
   A. Disease of the brain or nervous system TO INCLUDE neurosis, nervous breakdown, paralysis, tumor, stroke, or epilepsy? Yes ☐ No ☐
   B. Respiratory disease TO INCLUDE tuberculosis, asthma, bronchiectasis, or repeated infections? Yes ☐ No ☐
   C. Heart or circulatory disease TO INCLUDE high blood pressure, chest pain, heart murmurs, or heart attack? Yes ☐ No ☐
   D. Gastrointestinal disease TO INCLUDE peptic ulcer, gall bladder, liver, rectum, colon trouble, or chronic indigestion? Yes ☐ No ☐
   E. Kidney disease TO INCLUDE stones, infections, abnormal urine or prostate trouble? Yes ☐ No ☐
   F. Cancer, tumor, diabetes, rheumatism, anemia, allergy, gland disorder, or chronic infections? Yes ☐ No ☐
   G. Disease or disorder of the bones, skin, ears, eyes, nose, or throat? Yes ☐ No ☐
   H. ANY DISEASE not mentioned above Yes ☐ No ☐

20. A. Does any proposed Insured now have or has any ever had a tumor or disease of breast, uterus or ovaries, or irregular menstruation? Yes ☐ No ☐
   B. Is any proposed Insured now pregnant? Yes ☐ No ☐
   If "Yes," how far advanced?_____

I hereby declare in behalf of myself and of every person who shall have or claim any interest in any insurance issued in consequence hereof, that each of the foregoing statements and answers is full, complete, and true as above recorded. It is expressly understood that the insurance applied for shall not become effective until my application shall have been approved by the Company at its Home Office in Dallas, Texas and I hereby authorize the Company to obtain any information it feels necessary from any physician, surgeon, clinic or hospital. I also agree to submit to an examination if in the opinion of the Company such examination is necessary.

I acknowledge that I have received and read a copy of the notice regarding investigative consumer reports and information which may be obtained from or released to the Medical Information Bureau.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my family or of the health of such persons, to give to Southwestern Life Insurance Company or its reinsurer(s) any such information. A photographic copy of this Authorization shall be as valid as the original.

Date_____

Witness:_____ Signature of Employee:_____

7748D

Detach and give to Proposed Insured.

NOTICE TO PROPOSED INSURED

Pursuant to Public Law 91-508, notice is hereby given that as a part of our normal procedure for processing this application, an investigative consumer report may be obtained whereby information is secured through personal interviews with your friends, neighbors and others with whom you are acquainted. This report, if obtained, typically contains information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of this report. Please address your request to Specialized Markets Underwriting, Southwestern Life Insurance Company, P.O. Box 2699, Dallas, Texas 75221. These reports are obtained in your best interests. They assist us in determining that Southwestern Life's insureds meet certain standards, thus allowing us to continue offering coverage at the lowest possible cost to all who qualify.

MEDICAL INFORMATION BUREAU

One of the prime objectives of Southwestern Life Insurance Company is to provide insurance at low cost. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure that each policyholder contributes his fair share of the cost. In considering this application, information from various sources must, therefore, be considered. These include the results of your physical examination, if requred, and any reports we may receive from doctors and hospitals who have attended you.

(Continued on reverse side)

INSTRUCTIONS

1. Please print or type all information.
2. This form should be completed by the empoyee of The Texas A & M University System.
3. Be sure to include Date of Employment and Salary and to check the appropriate box (or boxes) to indicate the coverage being applied for.
4. When the answer to a question requires an explanation, please refer to family members by alphabetical letter as they are listed in question 1 and be as complete as possible.
5. Your eligible dependents are:
   a. your spouse, and
   b. your unmarried children (including any stepchildren, adopted children or foster children) who rely on you for their principal support and maintenance and who are at least 10 days but less than 19 years of age.
   c. each of your unmarried children (including any stepchildren, adopted or foster children) who rely on you for their principal support and maintenance and who are at least 19 but less than 23 years of age and who are regularly attending an accredited high school or college.
6. Any cost involved for obtaining additional information which may be required by Southwestern must be paid by the person applying for coverage.

FOR INSURANCE COMPANY USE ONLY

GROUP INSURANCE								ORDINARY INSURANCE RECORD					
	LIFE	A. D. & D.	WK. INC.	HOSP.	SURG.	COMP. MED.	MISC.	POLICY NO.	AMOUNT	DIS.	P.B.	D.I. AMOUNT	STATU
EE													
DEP													

GROUP CLAIM RECORD

OTHER CLAIM RECORD

UNDERWRITING ACTION

nformation regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report thereon to he Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange n behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is ubmitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will e disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau nd seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's nformation office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom claim for benefits may be submitted.

The purpose of the Bureau is to protect its members and their policyholders from bearing the expense created by those who would conceal acts relevant to their insurability. Information furnished by the Bureau may alert the insurer to the possible need for further investigation, but nder Bureau rules cannot be used as the basis for evaluating risks. The Bureau is not a repository of medical reports from hospitals and hysicians, and information in the Bureau files does not reveal whether pplications for insurance are accepted, rated or declined.

Southwestern Life Insurance Company

P O Box 2699 / Dallas, Texas 75221

PLEASE PRINT WITH BALL POINT PEN AND PRESS HARD FOR COPIES

THE TEXAS A&M UNIVERSITY SYSTEM PRIMARY GROUP INSURANCE PROGRAM

EMPLOYEE NAME (LAST, FIRST, M.I.)			SOCIAL SECURITY NUMBER
DATE OF BIRTH	DATE OF EMPLOYMENT	PART OF SYSTEM	MARITAL STATUS ☐ SINGLE ☐ SEPARATED ☐ MARRIED ☐ DIVORCED/WIDOWED
MEDICAL COVERAGE ☐ PLAN I ☐ PLAN II	EFFECTIVE DATE OF EMPLOYEE COVERAGE		DEPENDENT COVERAGE ☐ MEDICAL

☐ ADD THE FOLLOWING DEPENDENTS EFFECTIVE _____ (ALL ELIGIBLE DEPS. MUST BE COVERED)

NAME (FIRST, M.I.)	RELATIONSHIP	BIRTHDATE	NAME (FIRST, MI)	RELATIONSHIP	BIRTHDATE

REQUIRED LIFE/AD&D BENEFICIARY

PRIMARY BENEFICIARY (LAST NAME, FIRST NAME, M.I.)	RELATIONSHIP
CONTINGENT BENEFICIARY	RELATIONSHIP

☐ I WAIVE MY OPPORTUNITY TO ELECT MEDICAL COVERAGE AND UNDERSTAND THAT TO BE ELIGIBLE TO PARTICIPATE IN THE FUTURE I MUST FURNISH SATISFACTORY EVIDENCE OF GOOD HEALTH AT MY OWN EXPENSE AT A TIME PRESCRIBED BY THE CARRIER. I UNDERSTAND THAT I WILL BE PROVIDED WITH REQUIRED LIFE COVERAGE AS A CONDITION OF EMPLOYMENT (PREMIUM PAID BY EMPLOYER).

I AUTHORIZE THE TEXAS A&M UNIVERSITY SYSTEM TO DEDUCT FROM MY EARNINGS THE AMOUNT REQUIRED TO COVER MY SHARE OF THE PREMIUM FOR THIS COVERAGE AND I RESERVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME ON WRITTEN NOTICE.

SIGNATURE OF EMPLOYEE _____ DATE _____ SIGNATURE OF WITNESS _____

ATTACHMENT 3

Minutes of the Subcommittee on Bidding

MINUTES
BIDDING SUBCOMMITTEE

GOVERNOR'S TASK FORCE
ON STATE EMPLOYEE'S HEALTH INSURANCE
QUALITY & COST CONTAINMENT

November 14, 1983

Pursuant to the previous call of the Chair, the Bidding Subcommittee of the Governor's Task Force on State Employee's Health Insurance Quality and Cost Containment met at 1:30 p.m., November 14, 1983 at the State Bar of Texas Building, 1414 Colorado, Austin, Texas.

Subcommittee Members Present: Lyndon L. Olson, Jr., Chairman; Paul D. Glover; John D. Melton; C. Clifton Robinson, and Robert L. Wormley.

Subcommittee Members Represented: Robert Blevins represented by Jack Rollier; Rep. Gene Green represented by Betty Barnard; and Gary R. Rodgers represented by Maurice Beckam.

Others Present included Lou Schwartz, State Comptroller's Department; Wanda Mills, Council of University Presidents; Carla Washington, Texas Department of Health; Russell Bridges, Office of the Governor; Margaret L. Benson, Department of Public Safety (GIAC Member); Bill Parr, Legislative Budget Office; Philip Dial, Rudd & Wisdom, Inc.; and Dixie Evatt, Woody Pogue and Evelyn F. Ireland, State Board of Insurance.

A quorum being present, the Subcommittee took the following action:

Heard from Jim Sessions, Assistant Executive Director, Employees Retirement System of Texas, regarding the laws governing state bidding practices and other information about the state bidding process.

Heard from Governor Mark White regarding the charge and work of the Task Force

Discussed points and issues for a final report and a timetable for completion of the Subcommittee's work.

Asked that insurance carriers be invited to attend the next meeting to discuss impediments to bidding on the state contract.

There being no further business, the meeting was adjourned.

Approved:

Lyndon L. Olson, Jr., Chairman

MINUTES
SUBCOMMITTEE ON BIDDING

GOVERNOR'S TASK FORCE
ON STATE EMPLOYEES' HEALTH INSURANCE
QUALITY & COST CONTAINMENT

December 1, 1983

Pursuant to the previous call of the Chair, the Subcommittee on Bidding of the Governor's Task Force on State Employees' Health Insurance Quality and Cost Containment met at 9:00 a.m., December 1, 1983 at the State Board of Insurance Building, 1110 San Jacinto, Austin, Texas.

Subcommittee Members Present: Lyndon L. Olson, Jr., Chairman; Robert Blevins; Paul D. Glover; Representative Gene Green; John D. Melton; Senator John Montford; and C. Clifton Robinson.

Subcommittee Members Represented: Gary R. Rodgers represented by Maurice Beckman.

Others present included Dan DeGood, Metropolitan; Bob English and Bill Brooks, Blue Cross/Blue Shield of Texas; Bettye Barnard, State Representative Gene Green's office; Lou Schwartz, State Comptroller's Department; Luther W. Mills, Texas Employment Commission; Bill Parr, Legislative Budget Office; Dan Person and Bob Booth, Prudential; Tim Williams and James McGrath, Equitable; Jim Sessions and David H. Atkins, Employees Retirement System; Philip S. Dial, Rudd & Wisdom, Inc.; Alfred Gilchrist, Texas Medical Association; Russell Bridges and Elaine Powell, Office of the Governor; and William P. Daves, Jr., Dixie Evatt, and Woody Pogue, State Board of Insurance.

A quorum being present, the Subcommittee took the following action:

Adopted minutes of the November 14, 1983 meeting.

Heard a presentation on bidding in six states with large employee insurance plans.

Heard testimony from four insurance carriers [Metropolitan, represented by Dan DeGood, Vice President; Prudential, represented by Bob Booth, Vice President - Group Underwriting and Dan Person, Vice President - Group Insurance; Equitable, represented by James McGrath, Assistant Vice President and Tim Williams, Group Sales Manager; Blue Cross/Blue Shield of Texas, represented by John Melton, President and Bill Brooks, Division Manager - Actuarial Division].

Agreed to meet again the third week in January 1984.

There being no further business, the meeting was adjourned.

Approved:

Lyndon L. Olson

Lyndon L. Olson, Jr., Chairman

MINUTES
SUBCOMMITTEE ON BIDDING

GOVERNOR'S TASK FORCE
ON STATE EMPLOYEE HEALTH INSURANCE
QUALITY & COST CONTAINMENT

January 27, 1984

Pursuant to the previous call of the Chair, the Subcommittee on Bidding of the Governor's Task Force on State Employee Health Insurance Quality and Cost Containment met at 10:00 a.m., January 27, 1984 at the State Board of Insurance Building, 1110 San Jacinto, Austin, Texas.

Subcommittee Members Present: Lyndon L. Olson, Jr., Chairman; Robert Blevins; Paul D. Glover; John D. Melton; C. Clifton Robinson; Gary R. Rodgers; and Robert L. Wormley.

Subcommittee Members Represented: Senator John Montford represented by Morris Wilkes.

Others present included Tamara Gallman and Lou Schwartz, Comptroller's Department; Homer Scace, Dan Casey and Bill Park, Legislative Budget Board; Bo McCarver, Texas Highway Department; Clayton Garrison and David H. Atkinson, Employees Retirement System; Elaine Powell, Russell Bridges and Shelley Williams, Governor's Office; Dianne Rushing, Coordinating Board; and William P. Daves, Jr., Evelyn Ireland, Dixie Evatt and Woody Pogue, State Board of Insurance.

A quorum being present, the Subcommittee took the following action:

Adopted minutes of the December 1, 1983 meeting.

Discussed recommendations to the full Task Force agreeing to recommend the following actions as ways to increase competitive bidding on the state contract:

1. Use single benefits plan,
2. Retain uniform group plan,
3. Increase financial incentives
4. Eliminate requirement for Austin claims office, and
5. Reduce frequency of bidding

The final text of the report will be developed by the Chair and distributed by mail for approval prior to the February 17, 1984 meeting of the full Task Force.

There being no further business, the meeting was adjourned.

Approved:

Lyndon L. Olson, Jr., Chairman

Subcommittee on:

Benefits

GOVERNOR'S TASK FORCE
ON
STATE EMPLOYEE HEALTH INSURANCE QUALITY AND COST CONTAINMENT

SUBCOMMITTEE ON EMPLOYEE BENEFITS

Carole Keeton Rylander, Chairman
Member, State Board of Insurance
Austin, Texas

The Honorable Bill Coody
Texas House of Representatives
Austin, Texas

The Honorable Chet Edwards
Texas Senate
Austin, Texas

Mr. Claude Hempel, Personnel Director
University of Texas System Administration
Austin, Texas

Mr. John Honea
Director of Insurance and Risk Management
Texas A & M University System
College Station, Texas

Mr. Gary Hughes, Executive Director
Texas Public Employees Association
Austin, Texas

The Honorable Frank Madla
Texas House of Representatives
Austin, Texas

Dr. O. Edwin McClusky
Tyler, Texas

Mr. Eliseo Medina
Organizing Coordinator
Texas State Employees Union
Austin, Texas

The Honorable Ron Mullen, Mayor
City of Austin
Austin, Texas

Janell Robertson
Director of Personnel
Air Control Board
Austin, Texas

Dr. Tom Sanders
Professor of Government
Lamar University
Beaumont, Texas

Mr. Murray Shaw
V.P., Industrial Relations
Tracor, Inc.
Austin, Texas

Mr. Herman L. Wilkins
Director of Personnel
Texas Railroad Commission
Austin, Texas

Ms. Susan Sikes Wills
Southwestern Life Ins. Co.
San Angelo Agency
San Angelo, Texas

FINAL REPORT OF THE EMPLOYEE BENEFITS SUBCOMMITTEE

GOVERNOR'S TASK FORCE ON STATE EMPLOYEE HEALTH INSURANCE QUALITY AND COST CONTAINMENT

Since the appointment of the Governor's Task Force on State Employee Health Insurance Quality and Cost Containment, the Employee Benefits Subcommittee and working groups have met on seven different occasions to consider issues relative to the state employee group insurance plan. During these eight months, the subcommittee debated many recommendations and heard numerous reports from individuals relative to the Group Insurance Program or to the business of health insurance generally.

After much discussion and careful consideration of many factors, the Employee Benefits Subcommittee has adopted a total of sixteen recommendations to forward to the full task force. Some of these recommendations were relatively easy to make while others were extremely difficult. However, all received a great deal of attention to detail and are intended to provide state employees with the most comprehensive health insurance program at a reasonable cost.

While the subcommittee realizes that some of these recommendations are difficult at best and will likely be met with some opposition by employees, it is important to remember that the charge of this subcommittee is two-fold:

(1) to examine benefits available and study ways to assure adequate health care coverage for state employees; and

(2) while reducing the pressure of increased group insurance premiums on the state budget.

Unfortunately, the task of containing health insurance costs cannot be accomplished without making some recommended changes in benefits. However, used in conjunction these recommendations will in many ways enhance the current program and will allow employees the opportunity to become more involved in their own health care decisions.

Because the duties of this subcommittee involved a review of both employee benefits and cost containment, the subcommittee decided to divide into two working groups early this year. The Benefits working group was responsible for analyzing the current benefit package to determine what changes should be recommended, and the Cost Containment working group concentrated on cost saving measures which could be implemented. Both groups held intensive work sessions and developed a total of 28 recommendations for the full subcommittee's consideration.

On April 27, the Benefits Subcommittee met to hear presentations from the two working groups. The results of that meeting and a final meeting on July 16th are included in this report in the form of recommendations for the Task Force's consideration. However, numerous other issues were discussed by the Subcommittee which are not included as recommendations, but are noted in this report.

The State's contributions towards employees' insurance has in the past been limited to provide coverage for the employee only and does not include dependent benefits. Subsequently, employees who elect coverage for their spouse and/or dependents pay for this additional coverage with no state assistance.* Out--of-pocket premiums for dependent coverages are currently as high as $162.16 a month for employees who elect Employee/Family coverage, and that figure will increase to $179.80 a month September 1, 1984. These premium costs are especially difficult for the lower paid employees who often choose the highest plan of coverage because they cannot afford any unexpected medical costs.

The Employee Benefits Subcommittee also concurred with the Bidding Subcommittee's recommendation that legislation be sought to: (1) extend the maximum group insurance contract period from three to six years; and (2) allow ERS to make changes in the types or amounts of coverage without putting the program out to bid. In the Second Called Session of the 68th Texas Legislature, House Bill 35 was passed to make these statutory changes. Therefore, these recommendations are not included as such in the report of the Benefits Subcommittee.

However, in view of these changes, it is strongly recommended that any of the recommendations contained in this report that can be enacted without going to bid be implemented at the earliest possible date. For example, providing that employees are adequately informed of the changes, such provisions as mandatory second opinions and the inclusion of benefits for home health care and skilled nursing care can be enacted almost immediately instead of waiting until the new contract begins September 1985. The Employees Retirement System should be encouraged to review each of the task force recommendations for early enactment.

One other recommendation that received a considerable amount of attention was the possibility of increasing the deductibles and/or co-insurance amounts for the various plans. Again, the subcommittee voted not to make such recommendations in view of the increased deductibles which just went into effect January 1, 1984. The subcommittee felt that adequate time should be allowed to determine the effects of these increases before additional changes were recommended.

* Depending on the type of coverage elected, there are some limited occasions in which the state contribution does provide up to $3.27 payment on dependent coverages per month.

Throughout the many discussions of this group, the primary goal at all times was to improve the insurance plan for the utmost benefit of all employees. While cost containment was an important consideration, our first priority was how to best serve the interests of employees and their families. Though some of these programs will require some sacrifice or occasional inconvenience on the part of the insureds and the insurer, it is our feeling that these recommendations will translate into direct savings for employees and for the state. At the same time, this program will also encourage employees to become better consumers of health care and will require them to take a more active, assertive role in choosing the care that best suits their needs.

DISCUSSION OF RECOMMENDATIONS

1. MULTIPLE VS. SINGLE PLAN

RECOMMENDATION

THE SUBCOMMITTEE RECOMMENDS THAT A SINGLE PLAN OF COVERAGE BE ADOPTED FOR ALL EMPLOYEES UNDER THE UNIFORM GROUP INSURANCE PROGRAM. WHILE WE REALIZE THAT INFLATION ALONE WILL LIKELY SEND PREMIUMS UP IN THE FUTURE, WE ARE CONVINCED THAT A SINGLE PLAN WILL RESULT IN SMALLER INCREASES THAN WOULD BE EXPERIENCED IF THE PROGRAM RETAINS MULTIPLE PLANS. THE SINGLE PLAN CONCEPT SHOULD ALSO ATTRACT MORE COMPETITIVE BIDS WHICH WILL ASSURE THE CONTINUATION OF THE PROGRAM FOR ALL EMPLOYEES AND THEIR FAMILIES.

When the Uniform Group Insurance Program was first implemented, the state's monthly premium contribution was only $15.00 per employee - just enough to purchase a catastrophic protection plan. Because many employees wanted and needed better insurance coverage, the ERS Board of Trustees agreed that employees should be given a choice between a high level comprehensive plan which would require employee contributions and a lower level, basic catastrophic protection plan paid for by the state. The availability of two options has since provided employees some flexibility in purchasing coverage that best suits their needs.

Over the years, however, the availability of multiple plans has resulted in some serious problems which must now be dealt with. Costs have increased to the extent that some employees can no longer afford any coverage for their dependents, and many others are having great difficulty providing coverage. Insurance carriers have been critical of the multiple plan concept due to the inability to predict plan costs and set premiums because of the adverse selection problem associated with migration of group participants between the two plans as is presently permitted.

Further it is realized that if premium rates for each plan were actuarially set to reflect actual losses of each plan, the participation in Plan 1 would be significantly less. Claims experience for the respective plans during the September 1983 - February 1984 period indicated that if the two plans were rated independently, the premium rate increase in September 1984 would have been only 2% for Plan 2 but almost 50% for Plan 1. However, since the plans were not rated separately, both plans received an increase of 24.8%.

Insurers have most recently expressed their concerns by refusing to even bid on the program. In 1983, the state received only one bid; unless something is done to reduce the costs and adverse utilization of the program, there may be no bids the next time around.

In order to reduce the risks associated with the movement between the two plans, beginning September 1983, eligible employees, retirees and dependents were restricted for a two year period from moving from the lower Plan 2 up to Plan 1. Employees can reduce their coverage by transferring from Plan 1 down to Plan 2, but dependents enrolled in Plan 1 are not allowed to reduce coverage for a two year period. Employees enrolled in HMO's are also restricted from Plan 1 for a two year period, but are allowed to transfer into Plan 2.

The purpose of these restrictions is to prevent employees who anticipate increased medical expenses for themselves or dependents from transferring between the two plans in order to maximize the benefits to their own advantage. However, insurers still maintain that although these restrictions improve the problem, it does not alleviate the problem of adverse selection at the time of initial enrollment or at the time the plan is rebid.

In discussing the pros and cons of multiple vs. single plans, the subcommittee realized that varying economic situations applied to employees, affecting their preference for multiple or single plans.

Many employees cannot afford even small out-of-pocket expenses and depend on the comprehensive coverage of Plan 1 to protect themselves from unexpected medical bills. However, as the premiums for Plan 1 coverages continue to increase, more and more employees are unable to afford the protection, even though the rates are lower than they should be due to the rate skewing. The poor claims experience and high risk associated with Plan 1 drives up the price of insurance for all employees, including those who are not receiving the increased benefits of Plan 1.

Another factor that should be considered is the actual level of benefits in relation to the premiums. Because of stop-loss provisions that set a maximum ceiling on the amount of loss any individual or family must bear, in many cases an individual would be better off financially if he/she saved the additional premium costs in Plan 1 and applied that money towards any medical expenses that were not covered by the insurance. This is true even in the case of major illnesses or injuries in which the employee is hospitalized. For example, consider the following cases:

	PLAN 1 EXPENSES		PLAN 2 EXPENSES	
Hospital:	$1,000		$1,000	
Surgeon:	350		350	
Doctor Visits:	25		25	
Lab Tests:	50		50	
Anesthesiologist:	150		150	
	$1,575		$1,575	
Calendar Yr. Ded.	- 150		- 200	
	$1,425		$1,375	
Hospital Deduct.	- 50		- 50	
	$1,375		$1,325	
BCBS Pays: 100% Hospital & 80% of other chgs.	- 1300		80% of Hosp. & other chgs. - 1060	
Balance Paid by Emp.	$75		$265	
	+ 150	ded	+ 200	ded
	$225		$465	

Difference in Employee Out-of-Pocket Costs: $240

As the figures above indicate, the difference in employee out-of-pocket costs between Plan 1 coverage and Plan 2 amounts to $240 in this particular example. The annual difference in premiums, however, amounts to a greater figure as shown below.

PLAN 1 AND PLAN 2 PREMIUM COMPARISONS

	Employee Only	Emp./Spouse	Emp./Child	Emp./Family
PLAN 1	$958.68	$2108.52	$1740.00	$2571.96
PLAN 2	$800.76	$1533.84	$1170.72	$1946.04
ANNUAL DIFFERENCE	$157.92	$574.68	$569.28	$625.92

As these calculations illustrate, protection at the higher level of coverage provided under Plan 1 is not actually the best financial decision in most cases when considering the large differences in annual costs. In order to actually benefit financially from the Plan 1 coverage, most employees would have to experience a severe illness or injury resulting in high medical expenses, the chances of which are unlikely for most families. In the majority of cases, an employee who elects Plan 1 dependent coverages will pay more in premium costs than they will ever spend for out-of-pocket medical expenses under Plan 2.

Insurance carriers who have discussed the problems of multiple plans report anywhere from a 4% to a 10% additional premium margin which is added on to compensate for the availability of multiple plans. As such, all employees are paying for the added benefit availability, but again only those in Plan 1 are actually experiencing the benefits.

2. FOURTH QUARTER DEDUCTIBLE CARRY-OVER

RECOMMENDATION

THE PROVISION OF ALLOWING CREDIT FOR DEDUCTIBLES SATISFIED IN OCTOBER, NOVEMBER, AND DECEMBER IN THE SUBSEQUENT PLAN YEAR SHOULD BE REMOVED SO THAT DEDUCTIBLES ARE BASED ON CALENDAR YEAR EXPENSES ONLY.

Historically the state employees insurance plan has allowed medical expenses incurred in October, November and December which would apply to deductibles for that plan year to be credited towards deductible requirements applied in the same dollar amount for the following calendar year. For example, if an individual has surgery in November of 1983 and has not yet met the deductible requirements for the 1983 plan year, then all eligible expenses paid by the employee in November and December up to the 1983 deductible requirement will be credited in January 1984 towards the deductible requirements for the 1984 calendar year.

Although inclusion of a carry-over provision used to be a common practice in group policies, most employers have eliminated the allowance in order to reduce costs for both the employee and the employer. Actuaries for the group insurance program have estimated a 1% total premium savings if this provision were eliminated.

3. REIMBURSEMENT FOR ACCIDENTAL INJURIES

RECOMMENDATION

THE 100% ACCIDENTAL INJURY BENEFIT SHOULD BE REMOVED SO THAT ACCIDENT RELATED CLAIMS ARE TREATED THE SAME AS ANY OTHER CONDITION.

In previous years, it has been a relatively common practice for insurance contracts to provide 100% coverage of expenses related to accidental injury. The current group insurance program provides 100% payment up to $300 for treatment related to accidental injuries caused by an external, violent force. However, benefits are not available for non-accidental emergencies, such as appendectomies.

In reviewing this benefit provision, the subcommittee considered the needs of all employees and the consistency of this allowance as it applies to the entire group. Certainly there are a number of employees who are generally in excellent health and never even incur enough medical expenses to meet their annual deductible. For those employees, the 100% accidental injury reimbursement may be the only benefit they use. However, there is also a large number of employees who take good care of themselves in order to stay healthy, but who nonetheless develop a medical condition which requires treatment or surgery. These employees do not receive 100% reimbursement, but must meet deductible and coinsurance requirements in order to receive benefits.

Experience has also indicated that the 100 percent allowance tends to encourage over utilization and perhaps abuse by insureds, simply because there is no out of pocket expense to the employee. Individuals who might otherwise treat themselves for minor cuts and bruises have a greater tendency to seek medical help if 100% payment is provided. It is also difficult for the insurer to determine in some cases whether a claim is truly accidental.

Approximately 24% of all outpatient treatment claims filed are accident related. Actuaries have estimated a one to two percent annual savings in premium cost if the 100% accidental injury provision was removed.

4. HOME HEALTH CARE AND SKILLED NURSING CARE

In order to better meet the personal needs of state employees while also reducing costs, the subcommittee makes the following recommendation:

RECOMMENDATION

INSURANCE COVERAGE SHOULD BE PROVIDED FOR HOME HEALTH CARE MEDICAL SERVICES AND FOR SKILLED NURSING CARE. REIMBURSEMENT FOR HOME CARE PROFESSIONAL FEES SHOULD BE LIMITED TO $50 PER HOME VISIT WITH A MAXIMUM OF 100 VISITS PER YEAR. THERE SHOULD BE NO REQUIREMENT THAT THE INDIVIDUAL BE HOSPITALIZED IN ORDER TO BE ELIGIBLE FOR SUCH SERVICES. HOWEVER, TREATMENT MUST BE RECOMMENDED BY A PHYSICIAN IN ORDER FOR SERVICES TO BE ELIGIBLE FOR REIMBURSEMENT. THE PATIENT'S CONDITION AND CONTINUING NEED FOR CARE MUST BE REVIEWED BY A PHYSICIAN VISIT AT LEAST ONCE A MONTH OR EVERY 10TH HOME VISIT, WHICHEVER COMES FIRST.

The state employees insurance program has recently experienced an extremely high utilization rate in the area of private duty nursing. While many of these patients did actually require full-time, private duty nursing assistance, many could have been better served by other forms of care if coverage was available.

Home health care and skilled nursing care in recognized facilities are among the latest innovations in care for patients who may not require the full time medical attention of a hospital, but do still need periodic nursing care. Home health care coverage pays for medical expenses incurred by insureds who choose to be treated at home instead of a hospital, thereby eliminating the inconvenience and expense of lengthy hospitalization.

It does not provide coverage for homemaker aids, general maintenance or custodial care, but only covers necessary medically related costs. This care is ideal for persons recuperating from an illness or accident who do not need constant medical attention, but could be adequately cared for at home by family members with occasional visits by a nurse.

Those persons who need to be more closely supervised or need regular nursing attention which makes it impractical to go home may be eligible for care at a skilled nursing facility. These facilities provide constant medical care but at a less expensive cost. Many facilities also provide for increased patient freedom in a more informal setting and are more desirable to patients who need long term care.

Under the current program, patients who are receiving custodial care (changing clothes, bathing, cooking, etc.) from private duty nurses are not entitled to benefits for these services. However, if coverage were provided for skilled nursing facilities, these services would be covered as part of the benefits provided at such facilities. Thus, employees who might otherwise remain in a hospital in order to obtain necessary custodial care could receive full benefits and adequate care in a skilled nursing facility - and at a reduced cost to both the patient and the insurer.

5. PRIVATE DUTY NURSING

RECOMMENDATION

PRIVATE DUTY NURSING BENEFITS SHOULD BE LIMITED TO A MAXIMUM ANNUAL CLAIMS PAYMENT OF $8,000 (80% OF $10,000), SUBJECT TO DEDUCTIBLES AND COINSURANCE. THE 20% CO-PAYMENT SHOULD NOT BE CREDITED TOWARDS STOP-LOSS PROVISIONS. A MAXIMUM CONTRACT BENEFIT OF $40,000 (5 YEARS) SHOULD ALSO BE ESTABLISHED. TREATMENT MUST BE RECOMMENDED BY A PHYSICIAN IN ORDER FOR SERVICES TO BE ELIGIBLE FOR REIMBURSEMENT. CUSTODIAL CARE IS NOT AN ELIGIBLE EXPENSE. THE PATIENT'S CONDITION AND CONTINUING NEED FOR CARE MUST BE REVIEWED BY A PHYSICIAN VISIT AT LEAST EVERY EIGHTH SHIFT.

One of the most frequently abused benefits under health insurance programs within recent years is the provision of private duty nursing benefits. The state employees insurance plan is no exception.

Reviews by Blue Cross Blue Shield and the Employees Retirement System have found that, while private duty nursing care is truly medically necessary in many cases, there are a large number of cases where custodial care is being provided under the claim of nursing care. Custodial care is not a health insurance benefit and should not be reimbursed as such.

Because this is an area of great need for those individuals who do need intensive medical care by a private duty nurse, the subcommittee does not recommend that private duty nursing benefits be discontinued. However to keep the cost of benefits at an acceptable level, the subcommittee agrees that maximum benefit limitations are necessary.

6. HOSPICE CARE

RECOMMENDATION

HOSPICE CARE FOR TERMINALLY ILL PATIENTS SHOULD BE CONSIDERED AS AN ELIGIBLE EXPENSE, WITH A MAXIMUM BENEFIT LEVEL NOT TO EXCEED $200 PER DAY FOR UP TO 180 DAYS. CLAIMS MUST BE ACCOMPANIED BY A PHYSICIAN'S STATEMENT THAT THE PATIENT'S ANTICIPATED LIFE EXPECTANCY IS SIX MONTHS OR LESS. ELIGIBLE EXPENSES SHOULD INCLUDE:

- CHARGES FOR HOSPICE FACILITIES, INCLUDING ROOM AND BOARD AND OTHER SERVICES AND SUPPLIES;
- CHARGES FOR NURSING CARE;
- HOME HEALTH CARE SERVICES;
- COUNSELING SERVICES BY LICENSED SOCIAL WORKERS AND LICENSED PASTORAL COUNSELORS.

Hospice programs are designed to provide homelike care involving both medical and emotional support services to terminally ill people. Treatment involves nurses, social workers and clergy who tend patients in independent hospice facilities or in patients' homes. Hospice care includes painkilling medication but does not attempt to prolong the lives of the terminally ill through the use of respirators or cardiopulmonary resuscitation. Such care offers a choice to persons who wish to spend their last days at home with their family instead of in a hospital intensive care unit.

Hospice care is also much less expensive than hospital care. Six months of hospice care at home cost an average of $3,400 in 1982 while the average cost incurred by patients receiving hospital care at various times during those last six months was $15,836. Ninety percent of that $15,836 was attributed to in-patient hospital charges and doctors' fees.

7. OUTPATIENT SURGERY

RECOMMENDATION

OUTPATIENT SURGERY SHOULD BE REIMBURSED AT 100% OF FACILITY COSTS AND 80% FOR ALL OTHER MEDICAL EXPENSES. PROCEDURES WHICH ARE ROUTINELY PERFORMED IN A DOCTOR'S OFFICE ARE NOT CONSIDERED AS OUTPATIENT SURGERY. OUTPATIENT FACILITIES INCLUDE FREE STANDING CLINICS OR MEDICAL CENTERS, HOSPITAL OPERATED OUT-PATIENT FACILITIES, HOSPITALS, AND APPROVED BIRTHING CENTERS. APPROVED BIRTHING CENTERS INCLUDE ONLY THOSE WHICH ARE HOSPITAL-AFFILIATED, OR FREE-STANDING FACILITIES OPERATED BY A LICENSED PHYSICIAN AND CERTIFIED NURSE-MIDWIVES (C.N.M.).

Also referred to as "ambulatory surgery", outpatient surgery allows reimbursement for surgery on a patient admitted to and discharged from a facility on the same day of surgery. Surgery can be performed on an outpatient basis in a hospital, in a hospital operated outpatient facility, or in a freestanding medical center not affiliated with a hospital.

For purposes of increased insurance benefits, "outpatient" procedures include those medical services which historically have been performed in a hospital and does not include medical procedures which are usually done in a doctor's office. Medical authorities have approved numerous surgical procedures which can be safely performed on an outpatient basis, including tonsillectomies, eardrum drainage, adenoidectomies, breast biopsies, dilation and curettage, vasectomy, and hernia repair.

In a recent survey of the largest commercial group health insurance contracts in the country, 96% of the contracts included some form of incentive for ambulatory surgery. However, the most successful programs mandate outpatient surgery for specific procedures.

The current state insurance contract does provide coverage for outpatient surgery on the same basis as inpatient treatment. But due to a lack of education, many employees are not even aware that outpatient facilities are available, and others do not understand the benefits. Once educated, most employees are eager to choose outpatient treatment to avoid a hospital stay and to decrease their own out-of-pocket expenses.

8. SECOND OPINIONS FOR NON-EMERGENCY SURGERY

RECOMMENDATION

SECOND OPINIONS FOR NON-EMERGENCY, ELECTIVE SURGICAL PROCEDURES SHOULD BE REQUIRED OF ALL INSUREDS AS A CONDITION OF RECEIVING FULL INSURANCE BENEFITS. REIMBURSEMENT FOR SECOND OPINIONS SHALL BE 100% OF TOTAL COSTS. THE SECOND CONSULTING PHYSICIAN SHOULD NOT BE FINANCIALLY OR OTHERWISE ASSOCIATED WITH THE FIRST DOCTOR. IF THE INSURED ELECTS TO HAVE THE SURGERY WITHOUT OBTAINING A SECOND MEDICAL OPINION, REIMBURSEMENT WILL BE REDUCED TO ONLY 50% OF ELIGIBLE COSTS.

IF THE FIRST TWO OPINIONS ARE IN CONFLICT AS TO THE NECESSITY OF SURGERY, THE INSURED MUST SEEK A THIRD OPINION, WHICH WILL ALSO BE REIMBURSED AT 100%. IF THE THIRD OPINION IS NOT OBTAINED BEFORE HAVING SURGERY OR IF THE THIRD OPINIONS AGREES THE SURGERY IS UNNECESSARY AND THE INSURED HAS IT DONE ANYWAY, INSURANCE REIMBURSEMENT IS REDUCED TO 50% OF ELIGIBLE COSTS.

Second opinion programs on a voluntary or mandatory basis provide payment for a second doctor's opinion before a patient elects to have non-emergency surgery. Twelve different types of surgery have been recognized by the medical community as warranting second opinions.

While the most effective programs mandate second opinions for certain procedures, most programs, including the current state insurance contract, simply provide 100% reimbursement for the employees who voluntarily obtain the opinion. Voluntary programs experience a much lower utilization rate than mandatory plans.

Many people express a desire and willingness to consult with a second doctor before having elective surgery, but find it difficult to question a physician's judgement by voluntarily requesting a second opinion. But employees who are required to obtain another opinion before having certain procedures performed report that the requirement provides a "way out" in an uncomfortable situation. By explaining to their doctor that they must obtain an additional opinion in order to receive full insurance reimbursement, they are no longer questioning the physician but are simply complying with their insuror.

Employers who require second opinions for non-emergency operations have reported great success in terms of both cost savings and employee satisfaction. Actuaries for the Employees Retirement System have estimated an annual 1% savings on total premium if second opinions were made mandatory for elective, non-emergency surgical procedures. Other actuarial predictions estimate as much as a four to six percent annual savings.

9. WEEKEND HOSPITAL ADMISSIONS AND MONDAY DISCHARGES

RECOMMENDATION

THE SUBCOMMITTEE HAS FOUND WEEKEND HOSPITAL ADMISSIONS FOR NON-EMERGENCY TREATMENT AND MONDAY HOSPITAL DISCHARGES TO BE UNNECESSARY EXPENSES AND RECOMMENDS THAT INSURANCE REIMBURSEMENT BE DENIED ONLY FOR MONDAY DISCHARGES AND FOR FRIDAY AND SATURDAY ADMISSIONS FOR NON-EMERGENCY CARE UNLESS THE PHYSICIAN PROVIDES INFORMATION INDICATING WEEKEND HOSPITALIZATION WAS NECESSARY. ONLY THOSE COSTS INCURRED ON THE SATURDAY AND SUNDAY PRIOR TO MONDAY DISCHARGE, OR ON THE FRIDAY AND SATURDAY ON WHICH THE PATIENT WAS ADMITTED ARE SUBJECT TO THIS RECOMMENDATION. ALL OTHER COSTS INCURRED OUTSIDE THE WEEKEND PERIOD WILL BE TREATED AS THEY USUALLY ARE.

Friday and Saturday non-emergency hospital admissions and Monday hospital discharges have recently been identified as a prime area of benefit abuse. Since operating rooms and laboratories are usually closed for non-emergency cases during the weekend, Friday and Saturday admissions often mean two to three days of unnecessary hospitalization while the patient waits until Monday before treatment begins or surgery is performed. It also indicates that individuals discharged on Monday could have likely been discharged on Friday, since no treatment is usually given on the weekend. Not only is this inconvenient for the insured but is also a needless expense for the patient and the insurer.

(NOTE: Adequate employee education is <u>essential</u> to the success of this recommendation. Employees must be aware that they will not receive payment for weekend admissions <u>before</u> they are admitted and not when they file their claim.)

10. PRE-EXISTING CONDITIONS

RECOMMENDATION

REIMBURSEMENT FOR TREATMENT RELATED TO PRE-EXISTING CONDITIONS FOR NEW ENROLLEES AND THEIR DEPENDENTS SHOULD BE LIMITED TO A MAXIMUM $500 PAYOUT PER INSURED IN THE FIRST 12 MONTHS OF COVERAGE. PRE-EXISTING CONDITIONS INCLUDE ANY MENTAL OR PHYSICAL CONDITION FOR WHICH THE EMPLOYEE/DEPENDENT WAS TREATED OR SEEN BY A PHYSICIAN WITHIN 90 DAYS PRIOR TO THEIR DATE OF ENROLLMENT. AFTER THE FIRST 12 MONTHS OF ENROLLMENT, FULL INSURANCE BENEFITS WILL BE APPLIED REGARDLESS OF PRE-EXISTING CONDITIONS.

The state insurance program has always been extremely generous in its policies on pre-existing conditions for both employees and their dependents. As the contract now reads, employees and their dependents are eligible for full coverage with no restrictions concerning pre-existing conditions if they enroll within the first 31 days of eligibility. After the 31 days have passed, employees and dependents who enroll for insurance are subject to a 90 day waiting period before coverage goes into effect. After insurance is effective, coverage is excluded for twelve months for any condition for which the insured was seen or treated by a physician during the 3 month period immediately before the date coverage is effective.

Under this arrangement, the insurance program has been subject to abuse by individuals who seek state employment for the primary reason of obtaining insurance benefits. Individuals who needed surgery or whose dependents needed treatment have obtained employment with full insurance benefits, only to resign as soon as all medical treatment is complete and insurance is no longer an immediate need. In order to avoid such abuses in the future, a more cost effective policy regarding pre-existing conditions should be implemented.

11. OPEN ENROLLMENT

RECOMMENDATION

ANNUAL OPEN ENROLLMENT PERIODS SHOULD BE ELIMINATED. ANY INCREASE IN BENEFITS, ASSUMING MORE THAN ONE PLAN IS AVAILABLE, SUCH AS TRANSFERS FROM PLAN 2 TO PLAN 1 OR INCREASED LIFE INSURANCE PROTECTION, MUST BE ACCOMPANIED BY EVIDENCE OF INSURABILITY. EMPLOYEES AND DEPENDENTS WHO ARE NOT IN THE INSURANCE PROGRAM WILL RETAIN THE ABILITY TO ENROLL FOR INSURANCE AT ANY TIME DURING THE YEAR BUT WILL BE SUBJECT TO PRE-EXISTING CONDITIONS AND PROOF OF INSURABILITY. IN THE EVENT AN EMPLOYEE WHO IS ENROLLED IN AN HMO IS TRANSFERRED TO A TOWN WHERE HMO COVERAGE IS NOT AVAILABLE, THAT EMPLOYEE AND ANY DEPENDENTS COVERED WILL NOT BE SUBJECT TO PRE-EXISTING CONDITIONS OR EVIDENCE OF INSURABILITY REQUIREMENTS IN ORDER TO JOIN THE GROUP INDEMNITY PLAN.

Prior to September of each year, an "open enrollment" period is held to allow all employees the opportunity to enroll for insurance benefits for the first time, revise existing coverage, or withdraw from the plan. Because open enrollment has encouraged abuse in the past, the Employees Retirement System Board of Trustees approved two significant changes which should reduce some of the problems:

a. Any employee who does not elect to enroll in the High Plan 1 of coverage at the initial date of eligibility or who voluntarily elects to abandon that level of coverage, while remaining eligible to participate in the insurance program, will be denied access to the High Plan 1 of coverage for employee and dependents, until the first day of September, following two full years from such election, unless the contract is rebid.

b. Any employee who does not enroll for coverage within thirty-one days of their initial date of eligibility and who subsequently elects coverage, will have excluded from coverage any condition for which he/she was seen or treated by a physician during the three month period immediately preceding the effective date of coverage, and that exclusion from coverage will continue for the twelve month period immediately following the effective date of coverage.

While these changes are sure to reduce some of the abuses of open enrollment, the policy of allowing any transfer from Plan 2 to Plan 1 without evidence of insurability is not cost-effective and encourages anti-selection. Thus, in order to best serve the interests of employees and the state in reducing plan risks and therefore costs, the subcommittee recommends that a new policy be adopted requiring evidence of insurability for new enrollees, and that open enrollment periods be eliminated.

(NOTE: A limited enrollment period must be held annually to allow employees to move from the indemnity plan to an HMO, from an HMO to the indemnity plan, or from one HMO to another HMO. However, this enrollment will be limited to movement between HMO's and the conventional health plan.)

12. PRE-ADMISSION TESTING

RECOMMENDATION

BASED ON A FULL REVIEW OF THE ISSUES CONCERNING PRE-ADMISSION TESTING, THE SUBCOMMITTEE AGREES THAT THE USE OF PRE-ADMISSION TESTING SHOULD BE ENCOURAGED WHEN SUCH TESTS ARE NECESSARY AND ARE AVAILABLE ON AN OUTPATIENT BASIS. EMPLOYEES SHOULD BE MADE AWARE THAT USE OF PREADMISSION TESTS WILL DECREASE THEIR LENGTH OF HOSPITALIZATION AND WILL THEREBY REDUCE THEIR OWN OUT-OF-POCKET COSTS FOR COINSURANCE EXPENSES.

FURTHERMORE, THE COMMITTEE RECOMMENDS REQUIRING PHYSICIAN JUSTIFICATION FOR IN-PATIENT TESTING OF MORE THAN ONE PRE-OP DAY. IF JUSTIFICATION IS NOT PROVIDED, BENEFITS WILL BE REDUCED TO ONLY 50% OF ELIGIBLE EXPENSES.

With the recent increase in freestanding medical centers and outpatient surgical clinics, a large percentage of necessary medical tests can easily and conveniently be performed on an outpatient basis prior to hospitalization for surgery or treatment. Pre-admission testing eliminates hospitalization time and is usually favored by employees who are given a choice. It is also a very effective way of reducing costs.

Insurers in a recent health insurance survey reported that pre-admission testing reduced hospital medical admissions by an average of 2.3 days per patient, and surgical admissions by 3.8 days. One insurer reported savings of 1.7% of total premium charges in one year.

However, in discussing the effectiveness of pre-admission testing, it was pointed out to the working group that many patients under age 65 do not require pre-admission testing. Insurance programs which provide 100% reimbursement for pre-admission tests may actually encourage unnecessary testing by medical personnel who realize full insurance reimbursement is available.

13. HOSPITAL UTILIZATION REVIEW AND CLAIMS AUDIT REVIEW

RECOMMENDATION

BECAUSE HOSPITAL UTILIZATION AND CLAIMS AUDIT REVIEW PROGRAMS HAVE BEEN SO SUCCESSFUL, THE EMPLOYEES RETIREMENT SYSTEM SHOULD CONDUCT AN IMMEDIATE IN-DEPTH STUDY OF SUCH PROGRAMS TO DETERMINE WHETHER THEY WOULD BE FEASIBLE FOR THE STATE EMPLOYEES GROUP INSURANCE PROGRAM. IF THE STUDY INDICATES THAT EITHER OR BOTH OF THESE PROGRAMS WOULD BE COST EFFECTIVE AND PRACTICAL IN TERMS OF ADMINISTRATION, THEN THEY SHOULD BE IMPLEMENTED AT THE EARLIEST POSSIBLE DATE. ANY ADDITIONAL STAFF THAT MAY BE NECESSARY TO OPERATE THE PROGRAMS SHOULD ALSO BE PROVIDED.

With the ever increasing costs of hospitalization, many employers and insurers have begun an intensive effort to eliminate any identifiable unwarranted expenses. Two of the more successful programs in this direction are claims audit reviews and hospital utilization reviews.

Claims audit reviews involve the use of third party auditing services or in-house claims auditors who review hospital billings to determine whether there are any discrepancies between services reportedly rendered and actually provided. Some insurers contract with auditing firms to review claims while others hire and train their own auditors.

The most successful of these programs utilize trained nurses who review claims over a certain dollar amount to detect any billing errors. Because nurses are familiar with standard treatment and procedures used to treat specific medical conditions, they are better trained to detect any questionable charges for services a patient was supposed to have received. After comparing the patient's actual hospital bill with the hospital's billing records, any discrepancies are submitted to company auditors, who meet with hospital representatives to work out a written agreement on correct billing charges. In a small sampling of audits conducted in 1983 by one auditing service, 1400 bills from 665 different hospitals showed errors of more than $456,000, with an average over-charge to patients of $328.

The Texas A&M University System, which has experienced substantial savings with the use of outside audit firms to audit claims over $5,000, recently started a more economically efficient audit program on claims below $5,000 after determining that approximately 50% of all claims fell below the $5,000 level. Using in-house nurses to review claims less than $5,000, the program realized over $22,000 in savings on the first 33 claims audited in the first month of the program. The TAMU system expects to save in excess of ten times the annual cost of the nurse investigators' salaries. Considering the fact that national survey results indicate 93% of all claims contain some error with an average over-charge of 6-8%, the potential for savings in the state employees group is in excess of nine million dollars annually.

Hospital utilization programs review hospital treatment of insured patients both prior to admission and during the stay in the hospital. The program is designed to prevent inappropriate admissions, inappropriate levels of care, unnecessary days of stay and ancillary services. Many insurers feel that such programs can easily return many times over their cost in reduced hospital expenses.

Most programs operate in basically the same way. All scheduled non-emergency hospital admissions for employees/dependents must be telephoned to the reporting office prior to admission. The scheduled admission data, which includes type of treatment scheduled and other relevant information, is screened against pre-admission criteria to determine need for hospitalization. Admissions which do not meet the criteria are referred to a physician advisor who then contacts the patient's doctor to discuss the case. If the advisor still feels hospitalization is unnecessary, then the insured is informed that benefits will be reduced or will not be paid at all, depending on the contract provisions.

While hospitalized, a continuing review is conducted to determine when discharge is appropriate. The review also includes an analysis of level of care to determine if treatment is medically necessary. If at any time the physician advisor determines that treatment is not necessary or that hospitalization is no longer appropriate, the patient is advised that his/her benefits will be reduced.

While there are many variations of this program, the primary purpose of all hospital utilization reviews is to reduce unnecessary hospital services. Employers have expressed great success with the program in terms of both reduced costs and employee satisfaction. Employees are pleased with the reduction in co-insurance expenses which result from shorter hospital stays and refusal of unnecessary treatment, and are also more secure in knowing that a second physician is reviewing their case to see that care is appropriate.

14. HEALTH MAINTENANCE ORGANIZATIONS

RECOMMENDATION

TO ASSURE EMPLOYEES OF CONTINUING INSURANCE COVERAGE, THE SUBCOMMITTEE RECOMMENDS THAT ALL FUTURE HMO AND GROUP INDEMNITY PLAN CONTRACTS INCLUDE A PROVISION THAT ALLOWS EMPLOYEES TO ELECT COVERAGE WITH THAT GROUP AT ANY TIME DURING THE CONTRACT IF AN HMO WITHIN THAT SERVICE AREA IS DISCONTINUED. ANY PRE-EXISTING CONDITION CLAUSES THAT MIGHT APPLY WOULD BE WAIVED OR REDUCED DEPENDING ON THE TOTAL LENGTH OF TIME THE EMPLOYEE AND DEPENDENTS WERE COVERED.

RECOMMENDATION

THE SUBCOMMITTEE ALSO WISHES TO PROTECT EMPLOYEES FROM CANCELLATION OF COVERAGE BY RECOMMENDING THAT ALL FUTURE HMO CONTRACTS INCLUDE A CLAUSE LIMITING CANCELLATION OF COVERAGE (EXCEPT WHEN AN HMO CLOSES BECAUSE IT IS NOT FINANCIALLY SOLVENT) TO A PERIOD OF 60 DAYS PRIOR TO THE POLICY ANNIVERSARY DATE. THIS WOULD PREVENT HMOS FROM CANCELLING COVERAGES IN THE MIDDLE OF A CONTRACT PERIOD.

Health Maintenance Organizations (HMOs) as we know them today have been in existence since the early 1970's. By definition, an HMO is a formally organized system of health care delivery which accepts the responsibility for providing or otherwise assuring the delivery of an agreed upon set of comprehensive health care services for a voluntarily enrolled group of persons who reside within a specified geographic area. Payment for services is made through a pre-negotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the Plan.

The federal HMO Act of 1973 (P.L. 93-222, "Health Maintenance Organization Act of 1973") established certain guidelines for the regulation of HMOs. The Act provided financial assistance in the form of grants for the development of federally qualified HMOs and specified requirements which must be met to receive federal qualification. For example, federally qualified HMOs must provide "Basic Health Care Services" and must charge a "Community Rate".

As amended in 1976 and 1978, "Basic Health Care Services" include physician services, inpatient and outpatient hospital services, emergency services, short term mental health outpatient care, medical treatment and referral for abuse of alcohol or drugs, diagnostic laboratory and diagnostic and therapeutic radiology, home health services and preventive health services. "Supplemental Health Services", which may be offered either as part of the basic package or as optional services at additional cost, include outpatient prescription drugs, intermediate and long-term care and dental care, vision care, mental health care or rehabilitative services in excess of those required under Basic Health Services.

"Community Rating" means that subscriber payments (premiums) must be based on the total experience of all members of the HMO within the geographic service area. Variations are permitted for differentials in the cost of marketing and administering certain types of groups or for differentials in family size or rate structure.

The HMO Act also requires that employers who (1) contribute toward the cost of a health benefits plan, (2) are covered under Section 6 of the Fair Labor Standards Act of 1938, and (3) employ an average of at lest 25 employees, offer the option of enrolling in one or more qualified HMOs if a federally qualified HMO operating in an area in which at least 25 employees reside formally requests that it be offered. (The State of Texas as an employer meets all three of the above criteria.)

The employer is required to offer one qualified Group Practice Model and one qualified Individual Practice Association Model but may choose to offer additional qualified HMOs. An employer may also offer an HMO which is not federally qualified; however, doing so would not relieve the employer of the responsibility to offer a federally qualified HMO when properly petitioned by a qualified HMO. Federal regulations also specify the employer's responsibilities for contributing towards the cost of the HMOs, providing annual open enrollment periods, and other requirements.

The Texas Health Maintenance Organization Act was enacted with an effective date of December 1, 1975, with extensive amendments effective on June 13, 1979. The State Board of Insurance shares joint regulation of HMOs with the Texas State Board of Health. HMOs are also specifically subject to regulation by the Texas Health Facilities Commission under the Texas Health Planning and Development Act.

In Texas, there are two basic types of HMOs: Group Practice Models and Individual Practice Association Models. In the Group Practice model, the physicians practice together, usually in one or more health centers which are designed and equipped for the provision of complete out-patient care under one roof. The physicians share facilities, records, equipment and personnel and are usually organized into either a professional association or a nonprofit corporation approved by the Texas State Board of Medical Examiners.

In the Individual Practice Association, the HMO arranges for services to be provided by physicians and other health care professionals who practice in their own separate offices. Often each physician continues to see patients who are not members of the HMO.

Enrollment in HMOs by state employees in the group insurance program has shown an increase over the years. Effective September 1, 1984, a total of ten HMOs will be available under the group insurance program to state employees who live within the designated geographic areas.

Enrollment figures for April 1984 are as follows:

	BCBS	%	HMO	%
Employ. Only	41,827	51	10,804	66
Emp./Spouse	8,885	11	626	04
Emp./Children	14,297	18	3,372	21
Emp./Family	16,581	20	1,480	09
Total	81,590	100%	16,282	100%

The Benefits Subcommittee discussed at great length the role of HMOs and the effect participation is having on the group indemnity plan. Of great concern was the high number of young, healthy, single employees (good insurance risks) joining HMOs, thereby reducing the number of good risks in the group indemnity plan. The enrollment figures shown above indicates that, while 66% of the HMO enrollees are in the employee only group, only 51% of the BCBS enrollees participate as such. On the other hand, the employee/family group is represented by 20% of the BCBS population, but only 9% of the HMO members.

In early discussions, the subcommittee was particularly concerned that rate structure inequities may be the reason for the disparities in HMO and BCBS enrollment figures. Rate Plans effective September 1, 1983 through August 31, 1984 are as follows:

BLUE CROSS BLUE SHIELD AND HMO RATES EFFECTIVE
SEPTEMBER 1, 1983 - AUGUST 31, 1984

	BCBS Plan 1	BCBS Plan 2	HMO (average)
Employee Only	$79.89	$66.73	$72.48
Emp./Spouse	175.71	127.82	166.84
Emp./Children	145.00	97.56	138.32
Emp./Family	214.33	162.17	216.55

As the chart indicates, when compared with BCBS Plan 2, HMO rates are consistently higher for all categories. However, a comparison between HMO rates with BCBS Plan 1 reveals that HMO rates are lower for all categories except Employee and Family. Although the difference between the two groups only amounts to an HMO average higher rate of $2.22, it does perhaps indicate one reason why only 9% of the HMO enrollees choose Employee/Family coverage.

However, a number of other factors must be considered when comparing HMO and BCBS enrollees. Since all HMO plans require the individual to use only HMO physicians, individuals with personal physician preferences are not as likely to give up that choice as are young, single, healthy employees who have not yet become well established with a private physician. Since those employees with families most likely already have long-term physician-patient relationships, they are not likely to be good candidates for HMO membership.

It should also be pointed out that effective September 1, 1984, the new HMO rates average out to be more than $20 less than BCBS Plan 1 rates for Employee/Family coverage. New rates are as follows:

BLUE CROSS BLUE SHIELD AND HMO RATES EFFECTIVE
SEPTEMBER 1, 1984 - AUGUST 31, 1985

	BCBS Plan 1	BCBS Plan 2	* HMO (Average)
Employee Only	$99.30	$82.92	$81.92
Emp./Spouse	218.68	159.01	175.35
Emp./Children	180.42	121.33	156.18
Emp./Family	266.80	201.82	243.94

* (Note: Because of a wide disparity in rates among the 10 HMO's approved for operation beginning September 1984, both the lowest rate and the highest rate were dropped for purposes of obtaining a more representative average rate.)

It appears that as HMOs obtain more experience on which to base their rates, the dependent coverage rates are becoming more favorable for state employees. However, the effect of these new rates will not be available until after FY '85 enrollment is complete.

There are also a number of additional factors which should be considered when discussing the HMO rating process. The operation of an HMO requires a large membership to produce a profit. An HMO charges a premium based on the average expected medical costs of the subscriber and dependents, plus a loading factor for its administrative costs and profit margin. This loading is usually a percentage of the premium. Since many of the administrative costs are fixed costs, and only a portion of each premium pays a part of these fixed costs, the HMO must attract a large number of members to completely pay these fixed costs and also realize a profit. Also, the HMO's profit increases by attracting additional members, resulting in additional premiums, and not just through increases in premiums to existing members.

There are a number of other concerns related to the role of HMOs in the group insurance program that warranted this subcommittee's concerns. Of primary importance is the question of what happens to employees covered under an HMO if that HMO ceases to operate due to financial insolvency. Although the chances of this happening are considerably lower than they were ten years ago when HMOs were just becoming popular, some protection should be available to employees if it were to occur again as it has in the past.

15. COORDINATION OF BENEFITS WITH WORKERS' COMPENSATION CLAIMS

RECOMMENDATION

IN ORDER TO IMPROVE COORDINATION EFFORTS BETWEEN THE WORKERS' COMPENSATION PROGRAM AND THE GROUP INSURANCE PROGRAM, THE WORKING GROUP RECOMMENDS THAT THE TWO AGENCIES CONTINUE WORKING TOGETHER TO IDENTIFY SPECIFIC PROBLEMS AND HOW THEY CAN BE REMEDIED. IF LEGISLATION IS REQUIRED IN ORDER TO PREVENT DUPLICATE PAYMENT ABUSE BY CLAIMANTS WHO SEEK BOTH WORKERS' COMPENSATION AND INSURANCE BENEFITS, SUCH LEGISLATION SHOULD BE BROUGHT BEFORE THE TEXAS LEGISLATURE AT THE EARLIEST POSSIBLE DATE.

At the time an insured files a claim under the Uniform Group Insurance Program, he/she is asked to indicate on the claim form if the injury/illness is work related. If the answer is "yes", the claim is denied on the basis that claims which are payable under the state workers' compensation program are not eligible for payment under the state group insurance plan. ERS regulations prohibit the payment of such claims as they are considered to be fraudulent under Article 3.50-2, Sec. 13A(a), Texas Insurance Code. Persons filing fraudulent claims can be expelled from the group insurance program for a period of 5 years.

If the claimant answers "no", then payment is processed. There is no additional screening process to identify work related accidents/illnesses. At this time, there are some unresolved questions concerning the legalities of the exchange of information between the Attorney General's Workers' Compensation division and ERS. However, both agencies should review this problem to determine what action is necessary in order to identify and prevent fraudulent claims.

16. EMPLOYEE EDUCATION

RECOMMENDATION

THE EMPLOYEES RETIREMENT SYSTEM SHOULD HAVE PRIMARY RESPONSIBILITY FOR DESIGNING AN EMPLOYEE EDUCATION SYSTEM. THE PROGRAM SHOULD BE AVAILABLE TO ALL STATE EMPLOYEES AND SHOULD BE REVISED REGULARLY AS BENEFITS CHANGE OR AS NEW INFORMATION IS AVAILABLE. THE EDUCATION SHOULD BE AN ON-GOING PROJECT TO KEEP EMPLOYEES AS INFORMED AS POSSIBLE ON HOW TO EFFECTIVELY USE THEIR INSURANCE.

ADEQUATE FUNDS SHOULD BE MADE AVAILABLE TO ERS TO CARRY OUT THE RESPONSIBILITIES OF IMPLEMENTING THE EDUCATIONAL PROGRAM, INCLUDING FUNDING FOR ADDITIONAL STAFF, NECESSARY AUDIO/VISUAL EQUIPMENT, AND FUNDS FOR CONTRACTING PROJECTS WHICH NEED PROFESSIONAL ASSISTANCE (SUCH AS SLIDE SHOW PRESENTATIONS OR FILMS).

IN ORDER TO MAXIMIZE THE BENEFITS OF THE EDUCATIONAL PROGRAM, AN INTENSIVE CAMPAIGN EFFORT SHOULD BE MADE TO PRESENT THE MATERIALS TO AS MANY EMPLOYEES AS POSSIBLE. IN-HOUSE PROGRAMS SHOULD BE SCHEDULED AT STATE AGENCIES IN AUSTIN WITH 25 OR MORE EMPLOYEES, AND PRESENTATIONS SHOULD BE STAGGERED SO AS TO ALLOW ALL EMPLOYEES AN OPPORTUNITY TO ATTEND. AGENCIES WITH LESS THAN 25 EMPLOYEES CAN REQUEST THAT AN IN-HOUSE PRESENTATION BE MADE IF THEY DESIRE, OR THEY MAY WANT TO ALLOW THEIR EMPLOYEES TO ATTEND A PRESENTATION AT ANOTHER AGENCY OR AT ERS FACILITIES. HOWEVER, ALL EMPLOYEES SHOULD BE GIVEN THE OPPORTUNITY TO ATTEND THE EDUCATIONAL PROGRAM.

TO ALLOW THOSE EMPLOYEES LOCATED OUTSIDE OF AUSTIN THE CHANCE TO PARTICIPATE, ERS SHOULD ARRANGE FOR PRESENTATIONS IN AT LEAST THE MAJOR STATE EMPLOYMENT CENTERS OUTSIDE AUSTIN. THIS SHOULD INCLUDE THOSE TOWNS WITH 50 OR MORE STATE EMPLOYEES. STAGGERED PROGRAMS SHOULD BE SCHEDULED AS NECESSARY TO ALLOW ALL EMPLOYEES THE OPPORTUNITY TO PARTICIPATE.

TO ASSURE THE COOPERATION OF STATE AGENCY DIRECTORS, IT IS FURTHER SUGGESTED THAT THE GOVERNOR ISSUE AN EXECUTIVE ORDER OR PERHAPS A PERSONAL LETTER TO ALL AGENCY DIRECTORS EXPLAINING THE IMPORTANCE OF THE PROGRAM AND ASKING FOR THEIR COOPERATION IN ENCOURAGING EMPLOYEE PARTICIPATION.

Many of the recommendations suggested in this report will be successful only if an adequate employee education program is implemented. Employees who do not understand the importance of cost containment cannot be expected to use their insurance benefits wisely, or to make cost conscious decisions about their medical care generally.

Numerous studies have been conducted to determine employees' reactions to certain cost containment measures which are perceived by employees as a reduction in benefits (such as increased deductibles, mandatory second opinion programs, and reduced payment for weekend hospital admissions). The results of these studies indicate that communication is a key factor in employee acceptance, and that companies who take time to explain to employees how to use their new benefits report that employees are much more receptive to the changes and less likely to oppose or complain about benefit reductions. Employers with in-depth communication programs have even reported such results as higher productivity, decreased absenteeism, and increased employee morale.

With regard to the specific recommendations of this report, effective communication is particularly important to prevent insureds from obtaining medical care they believed was covered, only to find out that a second opinion was required. The features of this particular recommendation and others are not intended to impose a financial burden on employees but are designed to contain costs and make insureds more involved with their health care by eliminating unnecessary treatment. These goals will not be met if details of the plan are not adequately explained.

17. RESOURCE COST ALLOCATION REIMBURSEMENT

RECOMMENDATION

THE EMPLOYEES RETIREMENT SYSTEM SHOULD STUDY AND FOLLOW CLOSELY THE DEVELOPMENT OF RESOURCE COST ALLOCATION AS AN ALTERNATIVE METHOD OF ESTABLISHING REIMBURSEMENT LEVELS. IF THIS STUDY INDICATES POTENTIAL FOR SIGNIFICANT COST SAVINGS, ITS IMPLEMENTATION SHOULD BE STRONGLY CONSIDERED.

Health insurance was developed for protection against the high cost of in-hospital services. This ultimately led to disproportionate coverage for technological and surgical procedures. Further, most new procedures have a period of development in which resource costs are high. The absence of traditional marketplace forces in medicine and plan design have often resulted in prices going up rather than down with widespread acceptance of the procedure and a drop in resource costs. These historical distortions have been locked into the usual, customary, and reasonable (UCR) system and other charge-based reimbursement formulas. The result has been the creation of powerful incentives that reward physicians, through higher reimbursement, for the performance of technological and procedural services more than those received for personal or "cognitive" services.

A 1979 study at Harvard University School of Public Health identified four major resource costs in medical services: 1) time spent by the physician in performing a procedure or visit; 2) complexity of the service rendered; 3) the physicians' investment in professional training; 4) overhead expenses. This and other studies sponsored by the Health Care Financing Administration demonstrate a three-fold discrepancy between reimbursement for technological and procedural services, when compared with "cognitive" services.

If reimbursement schedules were based on resource costs, allowances for some services (patient consultations) would increase, while allowances for other services (technological procedures) would decrease, and many others would remain unchanged. This approach would provide incentives that are the opposite of those imbedded in the current system. Several studies have concluded that a reimbursement system based on resource costs would reduce overall health care expenditures.

A resource costs approach has been implemented in Massachusetts for its Medicaid and Workmen's Compensation Programs. Medical associations, including American Society of Internal Medicine, American Academy of Family Practice and American Academy of Pediatrics are working to promote this emphasis on cognitive services. The American Medical Association and nine state medical associations (including Texas have adopted resolutions favoring it.

The Senate has directed the Institute of Medicine to report in 1985 on the impact of resource cost reimbursement systems on Medicare reimbursement and expenditures.

18. PRESCRIPTION DRUG PLANS

RECOMMENDATION

IN ORDER TO PROVIDE STATE EMPLOYEES WITH THE MOST COMPREHENSIVE, UP-TO-DATE INSURANCE BENEFITS AVAILABLE, IT IS RECOMMENDED THAT A PRESCRIPTION DRUG PLAN BE IMPLEMENTED FOR ALL GROUP INDEMNITY PLAN PARTICIPANTS AT THE EARLIEST POSSIBLE DATE.

One of the benefits included in the group insurance indemnity plan is the coverage of prescription drugs. Coverage is included under the "Other Medical Expense" portion of the group plan and benefits are paid subject to any deductible and copayment.

Under the present system, the insured is reimbursed for any eligible expenses at the time the claim is filed. Usually this means the insured purchases the medication and then is reimbursed at a later date. However, as the cost of medications has increased over the years, an unexpected illness requiring an outlay of cash for physician visits and prescription drugs puts many state employees at a financial disadvantage. Claims in excess of one hundred dollars are not uncommon for even relatively minor illnesses and injuries. While some doctors will still file insurance claims for their clients instead of demanding payment at the time service is rendered, most do not. And when you consider the cost of drugs in addition to the physician's fee, these unexpected expenses can wipe out a family's remaining monthly income until the employee is paid again or until a claim check is received from the insurer.

To deal with this problem, and for numerous other reasons, prescription drug plans have been implemented by thousands of employers in recent years, including many insurance companies who include the benefit in their own employees' plan. The program is relatively easy to implement and administer, and reduces paperwork for both the insured and the insurer.

While there are a number of prescription drug programs available to choose from, all operate along the same lines. When the employee or covered dependent receives a prescription from his/her physician, the member presents his/her plastic I.D. card to one of the many participating member pharmacies. The prescription is filled, the member pays only the deductible (anywhere from $1 to $3 as determined by the employer) and receives the prescription with a minimal cash outlay. The pharmacist is then responsible for filing the claim, eliminating the need for employees to file individual claim forms each time a prescription is filled.

Employers who have a prescription drug program report great success and high employee satisfaction. The benefits are highly visible and are available to employees immediately without having to meet an annual deductible. And for the many state employees and dependents who never use their insurance benefits because they stay healthy and therefore do not meet the annual deductible, this may be the only benefit they receive.

For the employer, prescription drug plans not only are credited with improving employee satisfaction, but also assures that high drug costs will not keep employees from receiving medication they need to make them well and get them back to work as quickly as possible. Also, because claim processing work is reduced with the elimination of employee claim forms for drugs, claim processing errors are greatly reduced. Most prescription drug programs also include utilization review programs to detect both inadvertent and intentional misuse, further reducing potential losses.

Subcommittee on:

Wellness

GOVERNOR'S TASK FORCE
ON
STATE EMPLOYEE HEALTH INSURANCE QUALITY AND COST CONTAINMENT

SUBCOMMITTEE ON WELLNESS

Mr. William P. Daves, Jr., Chairman
Member, State Board of Insurance
Austin, Texas

Ms. Carolyn Hinckley Boyle
Community Wellness Coordinator
Brackenridge Hospital
Austin, Texas

Mr. Robby Collins
Administrator of Employee Relations
Dallas Independent School District
Dallas, Texas

James H. "Red" Duke, Jr., M.D., Department of Surgery
The University of Texas Health Science Center
Houston, Texas

Ms. Ethel B. Fleming, Assistant Director of Nursing
The University of Texas,
M.D. Anderson Hospital Cancer Center
Houston, Texas

Karl L. Shaner, Dr.P.H.
Vice President for Research and Development
Texas Hospital Association
Austin, Texas

Mr. Robert C. Sneed, Attorney-at-Law
Sneed, Vine, Wilkerson, Selman & Perry
Austin, Texas

Charles L. Sterling, Ph.D.
Executive Director
The Aerobics Center
Dallas, Texas

ACKNOWLEDGEMENTS

Subcommittee on Wellness

The Subcommittee would like to acknowledge the fine work and contributions of the following people:

Teresa Amos, R.D., David Atkinson, Terry Baylor, Ph.D., Tom Davis, Homer DeGlandon, Audrey Denman, M.S., R.D., Dixie Evatt, Juli Fellows, Ph.D., Fred Ford, Greg Gregory, Michael Horwitz, Ph.D., Harry Hubbard, Terrell Hunter, Evelyn Ireland, Ann King, Carolyn Klein, M.S., R.D., Rob LaRue, Judith Latimer, Dianne Longely, Patricia Otis, Tom Phillips, Elaine Powell, Nancy Robinett-Weiss, M.S., R.D., Tamra Shea-Oatman, Charles Spinn, Elon Whitlock, Shelley Williams, Herb Wilson, and Morris Winn

INTRODUCTION

The Wellness Subcommittee was charged with:

> ". . . considering innovative methods of health care cost containment, including long-range wellness planning and programs, alternate health care delivery mechanisms, physical fitness and programs and education on the nature and use of the health care plan and providers."(1)

Towards these goals, the Subcommittee has spent a great deal of time examining the myriad issues surrounding wellness and its implications on the Uniform Group Insurance Program.

Since its inception, the Subcommittee met eight times and adopted its final recommendations on July 27, 1984.

Five advisory groups were appointed to make indepth studies and recommendations in five important areas:

- Employee Incentives
- Smoking Policies for State Agencies
- Pre-Employment Physicals and Screenings
- Food at State Agencies
- Needs Assessments

The Subcommittee has been privileged to call on the expertise of many experts in the areas of wellness, employee benefits, and personnel management, among others. These individuals made invaluable contributions toward the recommendations contained in this report.

In forwarding this report to the full Task Force, the Subcommittee would like to provide a brief explanation of the wellness concept and its potential impact on the Uniform Group Insurance Program.

In the literature, programs to achieve high levels of health are referred to interchangeably as wellness and health promotion programs. The World Health Organization defines health as "a state of complete physical, mental and social well being and not merely the absence of disease and infirmity."(2)

Health promotion is defined by the American Hospital Association as:

> The process of fostering awareness, influencing attitudes and identifying alternatives so that individuals can make informed choices and change their behavior in order to achieve an optimum level of physical and mental health and improve their physical and social environment.(3)

The word wellness has been developed to denote programs used to promote health.

Wellness and health promotion have been gaining increased attention and acceptance over the past few years because employers and health care professionals are beginning to understand the costs that are attributable to lifestyle-related illnesses, such as cardiovascular disease, cancer, strokes, and injuries. Health care professionals estimate that lifestyle-related illnesses account for 60 to 70 percent of current health insurance claims costs.(4,5)

The Subcommittee recognizes that lifestyle illnesses may account for even more than 70 percent of all current claims costs and suggests that all people have the power within themselves to change any part of their lifestyle.

The strategy for promoting wellness is to reduce the incidence of preventable illness and injuries by providing motivation and access to appropriate programs. A total wellness strategy examines a wide range of employee behavior from wearing seat belts to selecting a nutritious meal. Smoking cessation, stress management, weight control, blood pressure monitoring, exercise classes, nutrition counseling, and employee assistance programs for employees with personal problems are some of the activities contained in a wellness program.

Injury prevention should also be a component in wellness programs. Several recommendations regarding injury prevention are contained in the "Safety" section of this report. Throughout this report the word "injuries" has been used in place of "accidents" because the Subcommittee believes all accidents are preventable and that every on-the-job injury can be prevented. Preventing every injury should be one goal of a wellness program.

In some instances, no specific program is recommended for certain major health care problems because the Subcommittee has found that resources exist in the community to address these needs. The lack of specific state programs for these problems should in no way diminish the critical need to provide referral to existing resources. For instance, alcoholism and other chemical dependencies are cited in this report as one of the most critical health care problems in our nation today (see "Employee Assistance Programs"). Employee education, information, and referral through an employee assistance program were found to be the best method for state enhancement of recovery of these illnesses.

The Subcommittee has attempted to make recommendations that will complement the fine work of the Bidding and Benefits Subcommittees. The Subcommittee has taken notice of the recommendation of both the Bidding and Benefits Subcommittees to adopt a single plan of coverage for all employees under the Uniform Group Insurance Program rather than perpetuating the multiple plans system. Because a single plan of coverage is an essential cost containment measure, the Wellness Subcommittee strongly endorses the single plan concept and urges that it be implemented.

The Subcommittee realizes that many agencies will not have the financial resources necessary to implement each recommendation contained in this report. However, there are many low cost, practical alternatives to these programs through the creative use of existing resources within the community and the agencies themselves. For example, home safety education, maternal health education for preventing expensive premature births, and nutrition education may be effectively communicated through agency newsletters and pamphlets provided by local and state organizations which advocate education and prevention in these and other fields.

The recommendations in this report are intended to create a comprehensive network of programs designed to benefit all state employees individually and as a group and are not intended to single out any particular group or behavior. It is essential that each recommendation be read in conjunction with the other recommendations in order to realize the full impact of the entire report and the positive effect it will have on the Uniform Group Insurance Program.

Employees are the state's most important asset, and deserve the best care possible through fitness and wellness programs that will reduce health care costs and absenteeism, increase productivity, and improve attitudes and morale.

This report contains an Executive Summary which briefly describes each recommendation. Following the Executive Summary is a section that lists each recommendation and provides additional background information and discussion.

The report contains 48 recommendations which have been grouped into 11 major categories.

On September 17, 1984, the Task Force adopted the Wellness Subcommittee report by resolution. The resolution also provided for the creation of an Implementation Committee charged with addressing the steps necessary to implement the financial incentive at the earliest possible date. The Implementation Committee will consist of a member of the Employees Retirement System, State Board of Insurance, and the Texas Department of Health. The final report of the Implementation Committee is to be submitted to the Employees Retirement System in time to be considered before the next bidding cycle. A copy of the resolution is contained in Exhibit 8 in the Appendix.

EXECUTIVE SUMMARY
Final Recommendations of the Wellness Subcommittee

The Subcommittee makes the following recommendations to the Governor's Task Force on State Employee Health Insurance Quality and Cost Containment:

I. Smoking

A. It is recommended that each state agency adopt a smoking policy to restrict smoking in its buildings. The following is a model for use in developing such a policy:

MODEL SMOKING POLICY FOR STATE AGENCIES

SECTION 1: PREFACE

The purpose of this section is to provide employees with an understanding of the (Name of Agency) policy on smoking. The policy is designed to foster the health and safety for all employees conducting agency business. It is not intended to totally prohibit smoking on agency premises but does restrict it in certain areas and in certain circumstances.

Smoking poses a significant risk to the health of the smoker. According to the U.S. Surgeon General, smoking causes more premature deaths and disabilities than any other known agent. Smoke can damage sensitive technical equipment and can be a safety hazard. In sufficient concentrations, side-stream smoke is annoying to many nonsmokers and may be harmful in the work environment. It is harmful to individuals with heart and respiratory diseases or allergies related to tobacco smoke.(6)

Smoking is a complex behavioral problem which has some properties of both a psychological and physiological addiction. Many individuals require assistance and support to eliminate smoking from their lives. It is not a problem which can be solved completely by prohibition or restriction.

The agency encourages and supports the efforts of smokers who desire to quit smoking. Employees who do smoke are encouraged to attend smoking cessation seminars and classes. Educational materials on smoking will be available at the agency as well as information on resources for smoking cessation.

This policy is provided to assist (Name of Agency) employees in finding a reasonable accommodation between those who do not smoke and those who do, and demonstrates the agency's desire to improve the health of all employees. Employees are encouraged to display courtesy and respect for the preferences of co-workers to have a work area in which they feel comfortable, relaxed, productive, and healthy.

SECTION 2: POLICY

a. Smoking is not permitted in auditoriums, hearing rooms, conference rooms, meeting rooms, snack bars, cafeterias, coffee shops, elevators, restrooms, or copy rooms. These areas should be designated by "no smoking" signs.

   If, at any time, smoking is allowed in the above areas, smoking and non-smoking seating must be designated. When smoking is not permitted in meetings, regular breaks should be scheduled.

b. Insofar as possible, Division and Section managers should develop work space in such a way as to accommodate both smokers and non-smokers. Requests for smoke-free work areas will take precedence over what may be considered the division's most attractive or convenient physical arrangement. Of necessity, however, the work flow, safety, and accessibility needs of a division should receive consideration in arrangement plans.

c. Individuals who do smoke are requested to be considerate of those employees who do not smoke. Where necessary, individual air filtering devices should be furnished to eliminate potential problems for non-smokers.

d. "Thank you for not smoking" signs will be available upon request.

e. A copy of the agency's smoking policy must be prominently displayed within the agency.

f. To improve their own health and well-being, employees who smoke are strongly encourage to attend smoking cessation classes.

B. It is recommended that each agency offer smoking cessation classes, as authorized under the State Employees Health Fitness and Education Act of 1983, to employees who want to stop or reduce smoking.

C. It is recommended that each state agency participate in the "Great American Smoke-Out" sponsored each November by the American Cancer Society.

II. Nutrition and Weight Control

A. Food for State Employees

1. General Standards of Food Offerings

It is recommended that the food offered at state snack bars be planned to help employees meet the "Dietary Guidelines for Americans" set by the U.S. Department of Health and Human Services and the U.S. Department of Agriculture.

2. Snack Bar Customer Survey

It is recommended that a survey about food service be conducted of a 10 percent sample of state employees in four state agencies having on-site snack bars operated by the Texas Commission for the Blind. The Interagency Nutrition and Wellness Panel should conduct the survey. It is recommended that this survey be conducted at two state agencies in the Capitol Complex, one state school, and one large agency outside the Capitol Complex. A sample questionnaire is attached (see Exhibit 1 in the Appendix).

3. Dietitian

It is recommended that the Governor recommend that a licensed or registered dietitian be appointed/hired to assist the Commission for the Blind on a consulting basis to work with managers to ensure that the food offerings are meeting recommended guidelines for good nutrition.

4. Eating Environment

It is recommended that the Governor seek private sector consultation for the Commission for the Blind food service managers, possibly from groups such as the Texas Restaurant Association, Texas Dietetic Association, food service design and marketing consultants, or state university programs in restaurant and food service management or nutrition. The State Purchasing and General Services Commission also should assist the outside consultants in redesigning, repainting, and improving the appearance so that the snack bars are comparable in appearance to commercial snack bars in the private sector.

5. Cleanliness

It is recommended that the Commission for the Blind expand its training on sanitary practices, and that ongoing monitoring of the facilities be expanded.

6. Orientation and Training

It is recommended that a centralized orientation and training program for sighted workers in state snack bars be provided. It should emphasize cleanliness, nutritional goals, and ways the staff can best assist the visually impaired managers.

7. Group Purchasing

Because each snack bar may not have a large enough volume by itself for purchasing healthier foods, it is recommended that a group purchasing system be set up for whole grain breads and buns, salt-free snacks, low fat ice cream products, etc. Through volume purchasing, the managers can offer a variety but keep their prices lower. One area that appears uniformly lacking is in healthy breakfast grain products. It is recommended that the snack bar managers jointly contract with a local bakery to prepare special whole grain fruit muffins or other nutritious breakfast products that could be offered at all sites.

8. Snack Bar Specialization

It is recommended that snack bars reduce their number of offerings (rather than trying to be full service restaurants) and focus on improving the quality of those offerings. With an emphasis on quality instead of quantity, it should expand the number of customers of the facilities. It also is recommended that each snack bar manager be encouraged to develop a few specialties that are very well prepared -- and hopefully, that snack bar would become well known for excellence in these specialties. Examples of items for specialization might include Mexican food, Chinese food, Italian food, quiche, pocket sandwiches, vegetarian plates, breakfast tacos, and baked goods.

9. Consumer Advisory Council

It is recommended that every agency with a food service facility develop a Consumer Advisory Council that meets quarterly. A suggestion box would be placed in each snack bar, and the suggestions would go to the Consumer Advisory Council. The Council will make recommendations to the snack bar managers. The Council should coordinate its activities with the Interagency Nutrition and Wellness Panel.

10. Incentives/Recognition

It is recommended that an incentive/recognition program be established that recognizes snack bar managers for doing an excellent job in their current location and for their commitment to promoting wellness. An award program could be established by the Commission for the Blind in categories such as:

a. Cookoff/Bakeoff -- This would be an annual competition where a snack bar staff would prepare one of their best specialties served in the snack bar. There would be several categories, such as breakfast, snack items, lunch entrees, etc., and prizes would be awarded. Winning recipes would be shared with all managers.

b. Nutrition Awareness -- It is recommended that agency snack bars be used as a site for distributing information on good nutrition, and that an award category be established for promoting nutrition awareness. The activities could be jointly sponsored by the state agency and the snack bar manager. An application for the award would be jointly submitted by the agency and the snack bar manager, and the application would detail the activities for the year that promoted good nutrition.

c. Best Snack Bar -- The application for this award would be submitted by the state agency served by the snack bar. The Consumer Advisory Council would detail improvements made in the food offerings, the environment, and statements of customer satisfaction. It is hoped that this would become a coveted award.

B. It is recommended that each state agency offer nutrition and weight reduction classes and activities under the State Employees Health Fitness and Education Act of 1983.

C. It is recommended that each agency provide weight scales and height/weight charts for use by employees in monitoring their weight. Written materials on how to lose weight should also be provided by the agency.

III. Physical Fitness

A. It is recommended that, in existing state facilities which have physical fitness facilities, agency employees be permitted and encouraged to use patient/client exercise facilities when such facilities are available and not in use (e.g. MHMR facilities). Employee use of the facilities should be restricted to before and after the employee's working hours.

B. It is recommended that each new state office building be designed to include a room for physical fitness and exercise classes and shower facilities. The room should be equipped with carpet and folding chairs in order to accommodate a variety of activities including exercise classes and wellness lectures.

Any major remodeling of existing state buildings should include plans for physical fitness and shower facilities. Provisions for physical fitness rooms are optional for state-leased office space.

C. It is recommended that an inter- or intra- agency "Olympics" competition be sponsored annually for state employees and spouses.

D. It is recommended that state agencies should conduct fitness activities authorized under the State Employees Health Fitness and Education Act of 1983.

E. It is recommended that the Attorney General's Office develop a uniform liability release form to be filled-out by state employees prior to participation in any state agency sponsored physical fitness or exercise programs.

IV. Employee Assistance Programs (EAPs)

1. It is recommended that each state agency should establish and maintain an employee assistance program for employees whose job performance may be adversely affected by mental, emotional, marital, legal, alcohol/drug, financial, or other problems.

2. It is recommended that each state agency should provide education programs for increased awareness and prevention of substance abuse. Furthermore, each agency should provide stress management classes as authorized under the State Employees Health Fitness and Education Act of 1983.

3. It is recommended that state agencies with inadequate funding for EAPs provide written information and other materials on local resources for alcoholism and drug dependency treatment programs, including Alcoholics Anonymous, Al-Anon, Alateen, treatment centers, and counseling.

V. Pilot Wellness Program

A. It is recommended that the state seek funding through grants or private sector donations to fund an intensive pilot program promoting employee wellness. A sample pilot program is contained in Exhibit 3 in the Appendix.

B. It is recommended that donations or grants of approximately $155,000 be sought initially to cover the expenses of the first year pilot program. At the end of that period, a study should be done of the results of the pilot and the feasibility of expanding it to other agencies. The study should be designed to measure the pilot's impact on the participants' physiological and psychological well being, as well as the impact on health care costs, sick leave, absenteeism and on-the-job injuries.

VI. Health Needs Assessment

A. It is recommended that a health status/needs assessment be conducted at an early date of a sample or all state agency employees. The purposes of the assessment are:

1. to gauge the current health status and health risk factors of state employees and retirees in order to guide the implementation of risk reduction programs, and

2. to serve as baseline data for future assessments in order to evaluate changes in health status and health risks.

The assessment should be conducted by the Center for Health Promotion Research and Development at the University of Texas Health Science Center at Houston. The results of the assessment should be submitted to the Public Health Promotion Division of the Texas Department of Health.

B. It is recommended that the insurance carrier for the Uniform Group Insurance Program be required to provide claims experience data, by disease category, on an agency-by-agency basis to the Employee Retirement System for distribution to agencies and others to develop state wellness programs. These reports should not identify any individual employee and should be used only for epidemiological purposes to identify health risk factors, claims costs, and other conditions that could potentially be reduced by specific prevention, risk reduction, or cost containment programs. The reports will not be used to experience rate or otherwise justify separate rates for each agency.

VII. Health Screenings

A. It is recommended that state agencies offer their employees health risk screening questionnaires on a voluntary basis and that the results be confidential. These can serve as an excellent educational and motivational tool.

B. It is recommended that certain state agencies be selected to conduct pilot programs for the following voluntary tests:

1. blood pressure screenings
2. glaucoma screening
3. hemocult
4. urine analysis
5. blood glucose screening for diabetes
6. breast cancer self-examinations
7. testicular self-examinations
8. height/weight measurements

If these tests are used, the results may be provided to the employee's physician for interpretation and consultation.

C. It is recommended that the "General Program Guidelines Relating to the State Employees Health Fitness and Education Act of 1983" be amended to remove the current restrictions on invasive health screenings and appraisals in order to permit blood testing on a voluntary basis.

VIII. Maternal Health Education

In order to promote good health care practices among pregnant employees, and thereby reduce the likelihood of premature births or other complications of pregnancy, it is recommended that state agencies (individually or collectively) offer classes and literature on special health issues related to pregnancy. Subjects covered could include the importance of good nutrition, the elimination of alcohol intake and smoking, and other medical concerns related to pregnancy. This information could be offered as a component of ongoing health promotion classes, as special classes, through use of the agency's newsletter and bulletin boards, or by distributing educational literature.

IX. Safety

A. It is recommended that each state agency with more than 200 employees be required to make an annual report to the Governor on the record of its injury prevention program. In addition, the Workers' Compensation Division of the Attorney General's Office should make an annual report to the Governor giving the injury rates for each agency, the types of injuries, and the cost to the state for those injuries using Bureau of Labor Statistics methods. The reports should contain information from the most recent year and the previous five years. The chief executive officer of agencies with substandard programs and/or injury experience will be required to submit a plan to the Governor of corrective actions on those areas.

B. It is recommended that the state employee classification system be expanded to include a new classification entitled "Safety Coordinator." This job classification would be used for state agencies, injury prevention coordinators, and injury prevention representatives in the Attorney General's Workers' Compensation Division.

C. It is recommended that the Governor, in cooperation with the Attorney General's Workers' Compensation Division, issue an Executive Order requiring state agencies with more than 200 employees to develop an appropriate, written injury prevention program.

D. It is recommended that the Workers' Compensation Division of the Attorney General's Office and the Governor's Office co-sponsor a statewide occupational safety and injury prevention conference for state agency executives and agency safety coordinators.

E. It is recommended that program evaluations be conducted by the use of the "Workers' Compensation Handbook for State Agencies" and the Occupational Safety and Health Evaluation System that is in use and is available from the Attorney General's Workers' Compensation Division. Incident and disabling injury rates are to be computed by use of Bureau of Labor Statistics methods. Comparisons to national rates and trends will be made if such information is available.

F. It is recommended that each state agency adopt a uniform seat belt policy as a part of their personnel policy requiring state employees driving on state business to fasten their seat belts in a state owned vehicle or in a non-state owned vehicle (i.e. their personal vehicle). All state vehicles should have a notice posted in the vehicle reminding the driver to observe the seat belt policy.

G. It is recommended that state agencies with positions requiring regular performance of physically demanding tasks establish screening criteria for assignment to such positions so as to minimize injuries and resulting workers compensation claims. For example, potential employees who will be required to regularly lift and carry heavy loads (e.g. 50 pounds or more) may be screened to establish their capacity to safely and efficiently lift and carry a "test" object that is similar to the loads they will be required to handle on the job.

H. It is recommended that each state agency provide home and recreational safety education programs and/or safety literature to employees and families. This information could be offered through the use of the agency's newsletter and bulletin boards or by distributing educational literature.

X. Sick Leave

A. Pilot projects should be established in various state agencies to study innovative sick leave and annual leave policies for the purpose of providing incentives for employees to stay well and reduce the use of sick leave. Because of the unique sick leave situation and critical staffing needs in hospitals, one pilot project should be conducted in a hospital. If legislative authority is necessary to implement such programs, then legislation should be introduced during the 69th Session of the Texas Legislature.

B. Sick leave accounting in all state agencies should be segregated to report sick leave attributable to an employee's illness and sick leave attributable to his or her spouse, and dependents' illnesses.

XI. Financial and Other Incentives

A. Financial Incentives

It is recommended that all state employees be given a discount or reduction in their life and health insurance premiums provided employees and insured spouses meet certain annual tests and qualifications. Furthermore, it is recommended that the Employee Retirement System work in conjunction with the State Board of Insurance and the Texas Department of Health, using the best actuarial data and methodology available, to determine the amount of initial discount or reduction in premium and develop a detailed implemention program to be instituted at the next bidding date.

Annual tests and qualifications:

1. Total abstinence from the use of all tobacco products within the past year (includes cigarettes, pipes, cigars, snuff, and chewing tobacco);

2. Weight not to exceed the upper limit of the 1983 Metropolitan height/weight tables or, if the employee chooses, evidence from a physician, Registered Nurse, Licensed Vocational Nurse, or other licensed health professional approved by the Texas Department of Health that the employee or dependent is not obese as measured by hydrostatic weighing, skinfold caliper assessment, or body mass index calculation;(7)

   Protocols for hydrostatic weighing and skin fold caliper assessment tolerances will be developed by the Texas Department of Health.

3. Blood pressure normal (140 over 90) or below including blood pressure controlled by medication.

All tests are to be conducted on a voluntary basis on or off premises and are to be certified by the employee and insured spouse.

Weight and blood pressure tests may be conducted and certified either by the employee's/insured spouse's physician, Registered Nurse, Licensed Vocational Nurse, or other health professional approved by the Texas Department of Health, or, in the event the agency sponsors weight and blood pressure

tests, by the individuals administering such on-site agency tests. The application for the discount will be reviewed and certified by the employee's supervisor and the agency's chief executive officer. A sample application form containing employee, spouse and agency certifications is contained in the Appendix (see Exhibit 6).

The financial incentives final plan should contain provision for waiving of enforcement of the blood pressure requirements when: (i) such condition has been and is continuing to be medically treated; (ii) the treating practitioner certifies that such condition is continuing and incurable; and (iii) such facts supporting waiver have been found by a review board established by the Employee Retirement System to be true.

Prior to implementation of financial incentives, determination shall be obtained: (i) from the Office of Federal Contract Compliance that such incentives do not violate the Rehabilitation Act of 1973 (or other applicable Federal statutes), and (ii) from the Texas Human Rights Commission that such incentives do not violate applicable human rights laws of the State of Texas.

The Subcommittee recognizes that the Legislature sets the level of the state's contribution for the Uniform Group Insurance Program. For the purposes of the financial incentive recommendation, it is recommended that the future contribution level be the average amount of the premiums for the "preferred" rated group and the "regular" rated group.

B. Other Incentives

It is recommended that the Governor sponsor a recognition/ award program for individual employees and entire state agencies for achievement of high levels of wellness. Awards could include letters from the Governor, certificates of merit, pins, and/or pictures of winners.

C. It is recommended that a "Legislative Health Fair Day" be held at the Capitol for legislators and state employees.

D. It is recommended that state employees be given the option of converting a certain percentage of their unused sick leave each year to "well days" or receive cash payments for a certain amount of unused sick leave. This conversion or payment should occur at a designated time each year or periodically upon the accumulation of a minimum number of sick leave hours.

E. It is recommended that a portion of participants' costs for behavior change interventions (for example smoking cessation classes and weight control classes) be reimbursed to employees who attend all class sessions and who achieve a certain level of behavior change, such as abstinence from smoking for 3 to 6 months or losing a certain number of pounds.

F. It is recommended that individual state agencies use a variety of awards/incentives for employees who either make significant changes in their health behaviors or who achieve certain levels of health/wellness.

G. It is recommended that serious efforts be made to include non-Austin based state employees in recognition and incentive programs as much as possible.

RECOMMENDATIONS AND DISCUSSION

RECOMMENDATIONS AND DISCUSSION

I. Smoking

INTRODUCTION

Since the first Surgeon General's report on the dangers of smoking in 1964, the public has grown increasingly concerned with the effects of smoking on non-smokers and smokers alike. And according to the most recent Surgeon General's report, smoking continues to cause more premature deaths and disabilities than any other know agent. Yet smoking related illnesses are considered to be the most preventable.

Public concern over smoking has resulted in the passage of anti-smoking ordinances in public buildings, implementation of non-smoking policies in private industry, and city and state "clean air" laws.

Numerous studies show that smoking is the leading cause of heart disease and cancer. Because persons who smoke have much higher health risk factors, smokers have higher health care utilization.

Non-smokers, when exposed to smoke are also at risk from sidestream smoke caused by involuntary smoking.

The degree of risk from involuntary smoking is not known completely however, enough evidence currently exists to justify warnings from the Surgeon General and the American Medical Association on the health hazards of involuntary smoking on the non-smoker.(8)

An American Lung Association pamphlet summarizes the harmful substances in sidestream smoke. It says:

> Sidestream smoke--the smoke from the burning end -- has higher concentrations of noxious compounds than the mainstream smoke inhaled by the smoker. Some studies show there is twice as much tar and nicotine in sidestream smoke compared to mainstream. And three times as much of a compound called 3-4 benzpyrene, which is suspected as a cancer-causing agent. Five times as much carbon monoxide, which robs the blood of oxygen. And 50 times as much ammonia.
>
> There is also evidence that there is even more cadmium in sidestream smoke than in mainstream. Cadmium is now under investigation as one of the compounds in cigarette smoke that damages the air sacs of the lungs and causes emphysema.(9)

The hazards of involuntary smoking on non-smokers are detailed in a 1983 report from the American Medical Association's Council on Scientific Affairs. (10)

The report cites numerous studies in which researchers have identified certain health hazards of involuntary smoking on three groups: sensitive or special populations, healthy adults, and the fetus.

Sensitive populations include persons with cardiovascular and chronic pulmonary disease, infants and young children, and persons with asthma and allergies. Studies on these groups show that involuntary smoking exacerbates the symptoms of persons who have cardiovascular disease, chronic pulmonary disease, asthma and allergies. Infants and young children of smokers have been found to have a higher incidence of childhood respiratory illness including common colds, influenza, bronchitis, and pneumonia. Maternal smoking has been correlated with sudden infant death syndrome.(11)

Studies on healthy adults exposed to sidestream smoke have shown that healthy adults suffer numerous irritation effects (eye irritation, nasal symptoms, headache, cough, sore throat, nausea, and dizziness). Non-smoking women married to a smoker, and children whose parents smoke are more likely to develop small-airways disease which impairs the lungs. Exposure to sidestream smoke is estimated to increase the risk of lung cancer in non-smokers by one-third.(12)

Studies on the health hazards of smoking and sidestream smoke on the fetus show that mothers who smoke give birth to babies who weigh less than babies born to non-smoking mothers. Birth weight is an indicator of prenatal development and mortality rates. One study showed that children of mothers who smoke have ". . . measurable deficiencies in long-term growth and development, in terms of physical, intellectual, emotional and behavioral indices." Researchers have also found evidence that sidestream smoke increases the health hazards of the fetus.(13)

The purpose of recommending a smoking policy for state agencies is to provide a more healthy environment for all state workers and to improve the health and welfare of all employees. In addition, the policy supports the efforts of all smokers to reduce or stop smoking. All state agencies should provide employees who smoke with information on smoking cessation and should sponsor on-site smoking cessation classes.

Because smoking has an adverse effect on employee health, which results in increased health care costs, a reduction in smoking is expected to have a favorable impact on the Uniform Group Insurance Program by decreasing the morbidity and mortality attributable to smokers.

A recent study indicated that middle-aged men who are heavy smokers will each cause an average of $59,000 in extra medical bills and lost work during their lifetimes. Assuming that 30% of the middle aged males (ages 35 - 44) in the Uniform Group Insurance Program smoke (there were approximately 15,000 males ages 35-44 in Plans I and II in December 1982), and assuming that all these 4,500 males stopped smoking, the state could realize an ultimate savings of over $265 million.(14)

The Subcommittee believes very strongly that the State of Texas should adopt a uniform policy on smoking. Active support from the Governor, state agency executives, and elected officials is a key to achieving this goal.

The model smoking policy which is recommended is a hybrid policy using smoking policies developed by the Texas Department of Health, the State Treasurer's Office, and the National Conference on Smoking Or Health.

The Subcommittee believes the model policy is appropriate for most state agencies that have no current smoking policy in place. However, agencies with existing policies may want to revise their policies to incorporate additional smoking restrictions.

In addition to recommending the smoking policy, the Subcommittee has included two additional recommendations which will lend additional support in accomplishing the goals of the smoking policy.

The Subcommittee considered whether to recommend that state agency snack bars discontinue the sale of tobacco products. However, an opinion survey of snack bar managers indicated a negative reaction to such a recommendation. Therefore, the proposed recommendation was withdrawn.

RECOMMENDATIONS

A. It is recommended that each state agency adopt a smoking policy to restrict smoking in its buildings. The following is a model for use in developing such a policy:

MODEL SMOKING POLICY FOR STATE AGENCIES

SECTION 1: PREFACE

The purpose of this section is to provide employees with an understanding of the (Name of Agency) policy on smoking. The policy is designed to foster the health and safety for all employees conducting agency business. It is not intended to totally prohibit smoking on agency premises but does restrict it in certain areas and in certain circumstances.

Smoking poses a significant risk to the health of the smoker. According to the U.S. Surgeon General, smoking causes more premature deaths and disabilities than any other known agent.(15) Smoke can damage sensitive technical equipment and can be a safety hazard. In sufficient concentrations, side-stream smoke is annoying to many nonsmokers and may be harmful in the work environment. It is harmful to individuals with heart and respiratory diseases or allergies related to tobacco smoke.

Smoking is a complex behavioral problem which has some properties of both a psychological and physiological addiction. Many individuals require assistance and support to eliminate smoking from their lives. It is not a problem which can be solved completely by prohibition or restriction.

The agency encourages and supports the efforts of smokers who desire to quit smoking. Employees who do smoke are encouraged to attend smoking cessation seminars and classes. Educational materials on smoking will be available at the agency as well as information on resources for smoking cessation.

This policy is provided to assist (Name of Agency) employees in finding a reasonable accommodation between those who do not smoke and those who do, and demonstrates the agency's desire to improve the health of all employees. Employees are encouraged to display courtesy and respect for the preferences of co-workers to have a work area in which they feel comfortable, relaxed, productive, and healthy.

SECTION 2: POLICY

a. Smoking is not permitted in auditoriums, hearing rooms, conference rooms, meeting rooms, snack bars, cafeterias, coffee shops, elevators, restrooms, or copy rooms. These areas should be designated by "no smoking" signs.

   If, at any time, smoking is allowed in the above areas, smoking and non-smoking seating must be designated. When smoking is not permitted in meetings, regular breaks should be scheduled.

b. Insofar as possible, Division and Section managers should develop work space in such a way as to accommodate both smokers and non-smokers. Requests for smoke-free work areas will take precedence over what may be considered the division's most attractive or convenient physical arrangement. Of necessity, however, the work flow, safety, and accessibility needs of a division should receive proper consideration in arrangement plans.

c. Individuals who do smoke are requested to be considerate of those employees who do not smoke. Where necessary, individual air filters should be furnished to eliminate a potential problem for non-smokers.

d. "Thank you for not smoking" signs will be available upon request.

e. A copy of the agency's smoking policy must be prominently displayed within the agency.

f. To improve their own health and well-being, employees who smoke are strongly encourage to attend smoking cessation classes.

Discussion: It is recommended that the model policy be implemented by each state agency. However, the special characteristics of some agencies may require changes in the policy to accommodate certain needs. The following outline will identify some of the steps to take in implementing the policy:

1. Major Activities

   - Thorough review of policy changes
   - Endorsement by agency CEO and top management and supervisors
   - Presentation of policy to employees and addition to personnel manual. Plan educational/promotional campaign to educate employees.
   - Provide information on smoking cessation to encourage smokers to quit. Provide on-site seminars.

2. Activity Schedule

   Top management should form a task force to plan each phase and activity of the plan to insure an orderly transition to the new smoking policy.

3. Resources Needed

   - Employee task force
   - Posters and flyers for the education phase. Many promotional items are available from the American Heart Association, American Lung Association, American Cancer Society, and others.

- Funding for smoking cessation seminars and classes. The employee should pay all or part of the cost.

- "No Smoking" signs for designated non-smoking areas

4. Responsibilities

   The agency CEO or administrator should be responsible for adopting the smoking policy.

   The personnel and training offices should be responsible for tailoring the policy to agency needs.

   The employee task force with support from personnel and the CEO, would be responsible for promoting the plan and developing and distributing educational material, and for advising the CEO on the availability of smoking cessation seminars.

B. It is recommended that each agency offer smoking cessation classes, as authorized under the State Employees Health Fitness and Education Act of 1983, to employees who want to stop or reduce smoking.

   Discussion: Smoking cessation classes are available through many individuals and public and private organizations. The cost of the programs and effectiveness will vary. The Sub-committee believes that smoking cessation classes are a critical component in the model smoking policy because abstinence from smoking will have positive long term benefits to the agency as well as the individual employee.

C. It is recommended that each state agency participate in the "Great American Smoke-Out" sponsored each November by the American Cancer Society.

   Discussion: The "Great American Smoke-Out" has become an effective program in increasing the public's awareness of the dangers of smoking and provides excellent incentives and recognition for persons who want to stop smoking. Actively supporting this program is another way the state can demonstrate support for its smoking policy.

II. Nutrition and Weight Control

INTRODUCTION

Poor dietary habits have been linked to high blood pressure, heart disease, diabetes, cancer, bone disease, respiratory disease and birth defects, among others. The dollar cost alone of poor nutrition in the United States is estimated to be $30 billion annually.

Increasingly, dietitians and other nutrition experts say that obesity is the nation's number one nutrition problem and that as many as 80 percent of the population are overweight to some degree.

According to an article in the Journal of Occupational Medicine (November 1982), actuarial and epidemiologic studies relating body build, weight and mortality have demonstrated that the greater the weight (for a given height) the greater the chance of death. The influence of obesity is largely mediated through increases in blood pressure, higher total cholesterol, and blood glucose levels.(16)

Obesity, i.e. greater than 20% of ideal body weight, affects 25% to 45% of Americans over 30 years of age. Of workers, 13.6% of males and 21.1% of females are estimated to be overweight (defined as 20% or more over desired weight).(17)

With these things in mind, the Subcommittee has developed 12 recommendations aimed at improving state employees' health through increasing the awareness and availability of better nutrition and encouraging weight reduction programs. A healthier work force, through better nutrition, will lead to cost savings through increased productivity, decreased absenteeism, and lower health care costs.

RECOMMENDATIONS

A. Food for State Employees

Because of the physical location of many state agencies, the primary food service facility available to state employees is the snack bar provided in the agency building. In some cases, this may be the only available source for food and beverages at breakfast, morning break, lunch, and afternoon break. Because state employees have the potential of eating a majority of their meals and snacks at the work place, the quality of the food available at the state agency can have a big impact on an employee's nutritional status.

The Subcommittee asked a panel of four Registered Dietitians to tour selected state snack bars and visit with their managers, and to make recommendations on the food offerings and operation of the facilities. These 10 recommendations are contained under the "Food for State Employees" section.

It is believed that these recommendations can be implemented with assistance from a number of individuals and groups, including:

- Texas Commission for the Blind
- Texas Department of Health, Director of Nutrition Services
- State agency heads and their appointed Consumer Advisory Council (see recommendation 9)
- State Purchasing and General Services Commission
- Private sector groups who can assist with a study of management and environment
- Private sector bakeries and other sources of quality food.
- Interagency Nutrition and Wellness Panel

1. General Standards of Food Offerings

It is recommended that the food offered at state snack bars be planned to help employees meet the "Dietary Guidelines for Americans" set by the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. These guidelines include:

- Eat a variety of foods
- Maintain ideal weight
- Avoid too much fat, saturated fat, and cholesterol
- Eat foods with adequate starch and fiber
- Avoid too much sugar
- Avoid too much sodium.

To meet these guidelines, state snack bars could include the following types of offerings:

Fresh fruits

Fresh vegetables (possibly raw as accompaniments to sandwiches)

Salads (with dressings separate)

Low calorie salad dressings

Whole grain breads, buns, and crackers

Whole grain cereals

Juices with no added sugar

Low fat or skim milk

Salt alternatives or substitutes

Low fat yogurt

Nuts and seeds, preferably salt-free

Freshly prepared soups low in sodium

Slices of low fat cheese

Popcorn (preferably without butter and salt)

Beans as side orders to sandwiches instead of chips

Frozen juice bars, frozen yogurt bars, low calorie ice cream-type treats

Granola bars

Sugar-free mints and gum

Decaffeinated coffee and herbal iced and hot tea also are recommended.

To meet the guidelines, snack bars should limit their offerings of:

Fried foods

Sauces and gravies on meats and vegetables

High fat sandwich meats, such as bologna, hot dogs, salami, sausage, bacon

White bread and crackers

Snacks high in fat and salt, like chips

High fat donuts, croissants, honey buns, etc.

High sugar/low fiber cereal selections

High fat ice cream products.

2. Snack Bar Customer Survey

It is recommended that a survey about food service be conducted of a 10 percent sample of state employees in four state agencies having on-site snack bars operated by the Texas Commission for the Blind. The Interagency Nutrition and Wellness Panel should conduct the survey. It is recommended that this survey be conducted at two state agencies in the Capitol Complex, one state school, and one large agency outside the Capitol Complex. A sample questionnaire is attached (see Exhibit 1 in the Appendix).

Discussion: The Interagency Nutrition and Wellness Panel is conducting a similar survey on vending machines at MHMR, Texas Department of Corrections, and the Texas Youth Council. The Panel may be the appropriate group to conduct the survey. The tabulated results would be given to the Director of Nutrition Services at the Texas Department of Health, who would make recommendations to the Commission for the Blind and the Governor based on the results of the survey. The Director of Nutrition Services also would visit with the managers of the four snack bars to determine what roadblocks would be encountered in meeting the requests of the customers. Results of the survey would be shared with the managers of all state snack bars and the Health & Human Services Coordinating Council.

3. Dietitian

It is recommended that the Governor recommend that a licensed or registered dietitian be appointed/hired to assist the Commission for the Blind on a consulting basis to work with managers to ensure that the food offerings are meeting recommended guidelines for good nutrition.

Discussion: Several of the snack bar managers interviewed said they had limited knowledge about nutrition and would like some assistance. The Licensed or Registered Dietitian would:

- Conduct training for new managers about nutrition
- Write a section of the "Business Enterprises Program Manual" on nutrition
- Make field visits to Commission snack bars and provide on-the-job training and recommendations on menus.

4. Eating Environment

It is recommended that the Governor seek private sector consultation for the Commission for the Blind food service managers, possibly from groups such as the Texas Restaurant Association, Texas Dietetic Association, food service design and marketing consultants, or state university programs in restaurant and food service management or nutrition. The State Purchasing and General Services Commission also should assist the outside consultants in redesigning, repainting, and improving the appearance so that the snack bars are comparable in appearance to commercial snack bars in the private sector.

Discussion: Most of the snack bars visited in the study did not have a pleasant eating environment. Some of the problem areas were: crowded conditions, poor layout and traffic flow for customers, fragmented organization of food items, awkward seating, poor lighting, unattractive decor.

5. Cleanliness

It is recommended that the Commission for the Blind expand its training on sanitary practices, and that ongoing monitoring of the facilities be expanded.

Discussion: A number of complaints were heard from customers regarding sanitary practices in the state snack bars, including food preparers smoking in the preparation area and handling money and then handling food.

6. Orientation and Training

It is recommended that a centralized orientation and training program for sighted workers in state snack bars be provided. It should emphasize cleanliness, nutritional goals, and ways the staff can best assist the visually impaired managers.

Discussion: A comprehensive training program is offered for the visually impaired managers of the snack bars, but no ongoing training is provided for snack bar workers.

7. Group Purchasing

Because each snack bar may not have a large enough volume by itself for purchasing healthier foods, it is recommended that a group purchasing system be set up for whole grain breads and buns, salt-free snacks, low fat ice cream products, etc. Through volume purchasing, the managers can offer a variety but keep their prices lower.

One area that is uniformly lacking is in healthy breakfast grain products. It is recommended that the snack bar managers jointly contract with a local bakery to prepare special whole grain fruit muffins or other nutritious breakfast products that could be offered at all sites.

Discussion: A bulk food purchasing plan for state institutions is being developed by the Interagency Nutrition and Wellness Panel and the State Purchasing Commission. The plan will provide bulk purchasing and distribution to single vendors through MHMR. The Interagency Nutrition and Wellness Panel should be contacted to determine whether a similar plan could be developed for snack bar purchasing.

8. Snack Bar Specialization

It is recommended that snack bars reduce their number of offerings (rather than trying to be full service restaurants) and focus on improving the quality of those offerings. With an emphasis on quality instead of quantity, it should expand the number of customers of the facilities. It also is recommended that each snack bar manager be encouraged to develop a few specialties that are very well prepared -- and hopefully, that snack bar would become well known for excellence in these specialties. Examples of items for specialization might include Mexican food, Chinese food, Italian food, quiche, pocket sandwiches, vegetarian plates, breakfast tacos, and baked goods.

9. Consumer Advisory Council

It is recommended that every agency with a food service facility develop a Consumer Advisory Council that meets quarterly. A suggestion box would be placed in each snack bar, and the suggestions would go to the Consumer Advisory Council. The Council should coordinate its activities with the Interagency Nutrition and Wellness Panel.

Discussion: The Council will make recommendations to the snack bar manager on the quality of food, the environment, and staff recommendations for new items. The Consumer Advisory Council would be appointed by the head of the agency. The Commission for the Blind or the Interagency Nutrition and Wellness Panel would provide written guidelines to the Council about its advisory role and scope.

10. Incentives/Recognition

It is recommended that an incentive/recognition program be established that recognizes snack bar managers for doing an excellent job in their current location and for their commitment to promoting wellness. An award program could be established by the Commission for the Blind in categories such as:

a. Cookoff/Bakeoff -- This would be an annual competition where a snack bar staff would prepare one of their best specialties served in the snack bar. There would be several categories, such as breakfast, snack items, lunch entrees, etc., and prizes would be awarded. Winning recipes would be shared with all managers.

b. Nutrition Awareness -- It is recommended that agency snack bars be used as a site for distributing information on good nutrition, and that an award category be established for promoting nutrition awareness. The activities could be jointly sponsored by the state agency and the snack bar manager. An application for the award would be jointly submitted by the agency and the snack bar manager, and the application would detail the activities for the year that promoted good nutrition.

c. Best Snack Bar -- The application for this award would be submitted by the state agency served by the snack bar. The Consumer Advisory Council would detail improvements made in the food offerings, the environment, and statements of customer satisfaction. It is hoped that this would become a coveted award.

B. It is recommended that each state agency offer nutrition and weight reduction classes and activities under the State Employees Health Fitness and Education Act of 1983.

Discussion: Nutrition and weight reduction classes and activities are a standard component in any balanced wellness program. These programs complement employee exercise programs, smoking cessation, and other health promotion activities.

There are many nutrition and weight reduction resources available through the private and public sectors. Many are inexpensive and easy to implement.

C. It is recommended that each agency provide weight scales and height/weight charts for use by employees in monitoring their weight. Written materials on how to lose weight should also be provided by the agency.

Discussion: Weight scales and educational materials provided at the work site will increase employee awareness of the need to maintain their proper weight and will reinforce the need to eat proper foods. The cost of providing weight scales and supporting information should be low. The long term effect on employee health will far outweigh the initial costs.

III. Physical Fitness

INTRODUCTION

In recent years, regular physical exercise has gained wide acceptance as one component of a healthy lifestyle. Because of the relationship to good job performance, many exercise authorities and health professionals have recommended that physical fitness programs be offered in the occupational setting. Studies have shown that physical fitness programs can produce improvements in cardiorespiratory fitness and cardiovascular health and can promote long-term commitment to exercise.

Physical fitness programs have been shown to improve employee performance, reduce absenteeism, improve employee job satisfaction, significantly reduce stress, and reduce employee turnover, and reduce job related injuries.

While few scientific studies are available, there is growing evidence that physical fitness programs can contain or reduce health care costs. According to a recent article in the Personnel Administrator, the National Institute of Health has developed information which estimates that the average white-collar company would save about $466,000 in annual medical costs for each group of 1,000 employees by promoting good health and helping reduce disease factors in employees.(18)

Based on this emerging evidence, the Subcommittee has made five recommendations to encourage physical fitness programs for state employees, with particular emphasis on work site programs.

The Subcommittee acknowledges the fine work of the Governor's Commission on Physical Fitness and the Governor's office in developing the "General Program Guidelines" for use in implementing the State Employees Health Fitness and Education Act of 1983 and encourages all state agencies to take advantage of the physical fitness activities authorized in the "Guidelines".

RECOMMENDATIONS

A. It is recommended that, in existing state facilities which have physical fitness facilities, agency employees be permitted and encouraged to use patient/client exercise facilities when such facilities are available and not in use (e.g. MHMR facilities). Employee use of the facilities should be restricted to before and after the employee's working hours.

B. It is recommended that each new state office building be designed to include a room for physical fitness and exercise classes and shower facilities. The room should be equipped with carpet and folding chairs in order to accommodate a variety of activities including exercise classes and wellness lectures. Any major remodeling of existing state buildings should include plans for physical fitness and shower facilities. Provisions for physical fitness rooms are optional for state-leased office space.

Discussion: A key ingredient in successful physical fitness activities is the proximity of the activity to the employees. On site facilities will provide employees easy access to ongoing fitness classes and lectures and should enhance greater employee participation.

It is not intended that a physical fitness room be large and elaborately equipped. The room should be multi-purpose and large enough to accommodate exercise classes for 20 to 25 participants. Carpet is recommended in order to reduce the possibility of injury. When not reserved for exercise classes, the room should be accessible for health promotion educational programs and relaxation activities.

C. It is recommended that an inter- or intra- agency "Olympics" competition be sponsored annually for state employees and spouses.

Discussion: This event could be scheduled during a midweek state holiday. Events which appealed to the not-so-fit, as well as the very fit, should be offered. Noncompetitive events such as New Games and health demonstrations could be included.

NOTE: New Games are noncompetitive, nonaggressive physical activities designed for groups of people (young and old) to enhance team spirit and cooperation.(19)

D. It is recommended that state agencies should conduct fitness activities authorized under the State Employees Health Fitness and Education Act of 1983.

Discussion: The guidelines implementing the Act contain information regarding the use and modification of available facilities for health fitness programs.

E. It is recommended that the Attorney General's Office develop a uniform liability release form to be filled-out by state employees prior to participation in any state agency sponsored physical fitness or exercise programs.

Discussion: Some state agencies have expressed concern about their liability in offering fitness activities at state facilities. It is recommended that the Attorney General's office assist in clarifying the legal issues and providing any necessary release forms.

IV. Employee Assistance Programs (EAPs)

INTRODUCTION

Over the last few years, Employee Assistance Programs have gained national attention from employers as statistics have indicated the success of such programs. Many employers have implemented EAPs in an effort to offset lost production costs, while others are simply interested in helping troubled employees. But whatever the reason, the programs have been extremely effective by all accounts.

Though the logistics may vary from company to company, EAPs are designed to provide confidential screening and referral or counseling services to employees and their families who suffer from any type of personal problems, including alcohol and drug abuse, emotional and mental problems, marital problems, and financial or legal problems. Companies may use a single consultant agency which makes necessary referrals, while others contract with a number of specialists such as professional counselors, psychologists, psychiatric social workers, doctors, and attorneys who aid employees directly instead of making referrals.

Until recently, most employers had no official policy to use in dealing with troubled employees. However, research reveals that up to 15 percent of the national work force is affected by personal problems that adversely affect work performance. As such, employers pay a high price for troubled workers.

Total cost estimates for business losses attributable to employee personal problems were $51 billion in 1981 and the figures are rising annually.

Alcoholism, which is considered by many to be this nation's number one health problem, leaves business and industry with an annual $20 billion expense in lost production, with health services related to drinking adding up to another $12 billion a year.

In 1981, the economic cost of alcohol abuse and alcoholism in Texas was $4.5 billion and represented 2.9 percent of total personal income for the state.

Of this, $668 million went to health care, $1.1 billion was for mortality, $2.4 billion was for lost productivity, and $105 million went to the criminal justice system.

To combat these enormous losses, many employers have turned to Employee Assistance Programs for help. As of 1979, approximately 10 million workers were covered by EAPs, including 1.6 million federal government employees and 1.5 million state government employees. And while the programs are generally inexpensive and are a highly visible employee benefit, they also have produced high savings for employers. For example:

1. The U.S. Postal Service estimates an annual cost savings of $2,221,362.(20)

2. Potomac Electric Power Company in Washington, D.C., realized a 2-to-1 return on its investment in its Employee Advisory Service - $74,000 savings in reduced extended sick days, lost time accident days, and visits to the medical department with an investment of $36,000.(21)

3. American Telephone and Telegraph Company reports savings of $448,000 from decreased on and off-the-job accidents, absenteeism and disability payments.(22)

4. New York Transit reports a savings of $2,000,000 for its program covering 43,000 employees.(23)

Since September of 1981, employees of the Texas State Board of Insurance have been participating in an Employee Assistance Program. As a result of the Board's interest in the National Association of Insurance Commissioners' (NAIC) study of chemical dependency and insurance, the Board agreed in September 1981 to sponsor employee assistance seminars for all SBI employees. The seminars were voluntary and were attended by nearly 300 employees. Employee and supervisory discussions indicated a high interest in a more comprehensive employee assistance program dealing with marital, financial, chemical dependency, and legal problems.

In January 1981, the SBI was invited to participate in a three month EAP pilot program funded by the Texas Commission on Alcoholism. The program, which was entitled the Creative Assistance Program (CAP) was designed to demonstrate the cost benefits, personnel management enhancement, and humanitarian desirability of employee assistance. Through the program, managers were trained to be aware of how employees' job performances are often hampered by personal crises outside the office.

The availability of the CAP provides those employees a source of help which, in turn, improves their job performance and the performance of other employees who may be affected by a troubled employee. It also allows supervisors time to concentrate on other matters instead of dealing with employees' personal problems, for which they are not generally trained to handle.

During the course of the pilot program, 28 SBI employees (approximately 4% of the total employee population) utilized the program. In individual and group sessions with managers, the general consensus was that the program improved employee morale, and that there was a great potential for additional improvements if the program was continued. An employee survey also indicated wide support for the program and its continuance.

Subsequently, after resolving certain legal issues concerning implementation of a permanent program, on August 20, 1982, the SBI entered into a permanent contract with Creative Assistance, Inc. of Austin. The contract was effective through April 1984, at which time a new contract was entered into between the SBI and the Employee Assistance Center of Texas (EACT). The program provides training for the supervisory staff of the SBI, focusing on procedures for dealing with troubled employees. If the employee does decide to seek the assistance of EACT, evaluation and referral services are provided to the employee. If appropriate, EACT refers the client to the treatment resource best suited to the employee's need, including but not limited to financial and legal advisors, physicians, psychologists, public and private agencies, hospitals, treatment facilities and Alcoholics Anonymous. EACT does provide appropriate follow-up and reporting to the SBI subject to restrictions and regulations relating to client confidentiality and privacy.

During the full term of the Creative Assistance Program's contract period, a total of 90 employees sought assistance. Eighty-eight of these 90 employees utilized referral services of the program. In addition, the program held 15 training sessions for supervisors and employees and conducted numerous promotional activities at the SBI to promote employees' awareness of the program. The cost of the SBI program is approximately $1.25 per employee per month; a total of $650 per month.

Studies have shown that individuals suffering from personal problems are much more likely to be in poor health, and therefore poor insurance risks. Although chemical dependency is the greatest contributor to health problems of troubled employees and their families, other personal conflicts create tension and stress among employees and increase their susceptibility to illness, disease, and injury. Thus, it should be pointed out that in addition to the other, more obvious benefits of an employee assistance program, reduced insurance costs are also a significant factor to consider when looking at financial benefits. Employees who have access to an employee assistance program are more likely to seek professional assistance, thereby reducing the incidence of serious medical conditions related to tension and worry. This lower insurance utilization rate translates directly into insurance savings for both the employees and the state.

RECOMMENDATIONS

1. It is recommended that each state agency should establish and maintain an employee assistance program for employees whose job performance may be adversely affected by mental, emotional, marital, legal, alcohol/drug, financial or other problems.

2. It is recommended that each state agency should provide education programs for increased awareness and prevention of alcoholism and other substance abuse. Furthermore, each agency should provide stress management classes as authorized under the State Employees Health Fitness and Education Act of 1983.

   (Note: The Texas House of Representatives Committee on Labor and Employment Relations is currently considering employee assistance programs to help with substance abuse problems. The committee will determine if legislative action can help foster the use of EAPs by all employers in Texas. The committee believes that EAPs can help save costs of training and recruiting employees, and of fighting lawsuits or grievance actions brought by terminated employees, in addition to savings as a result of reduced insurance premiums, absenteeism, and lost productivity.)

3. It is recommended that state agencies with inadequate funding for EAPs provide written information and other materials on local resources for alcoholism and drug dependency treatment programs, including Alcoholics Anonymous, Al-Anon, Alateen, treatment centers, and counseling.

   Discussion: Even though EAPs are relatively inexpensive, some state agencies may not have funds available for such programs. However, many organizations in the alcoholism and drug dependency treatment field have printed materials which could serve as excellent resources for employees needing help for themselves or family members. For example, the Texas Commission on Alcoholism (TCA) has a variety of films, brochures, and other literature on many aspects of alcoholism. A literature catalog is also available. In addition, TCA's Employee Assistance Division will also provide technical assistance to agencies interested in these programs.

   TCA's regional alcoholism authorities, which are located throughout the state, compile regional resource directories on the various services available in the region. The TCA printed material is available at cost, and films can be borrowed.

V. Pilot Wellness Program

INTRODUCTION

The Subcommittee is convinced that healthy employees and those programs that promote their health can help reduce the trend toward increasing health insurance costs, absenteeism, and decreased productivity.

Benjamin Disraeli understood the vital importance of wellness when he said, "The health of the people is really the foundation upon which all their happiness and all their powers as a state depend."

Many employers in the public and private sectors have taken Disraeli seriously and are actively pursuing health promotion programs for their employees. It is hoped that the State of Texas will do the same.

A study by the Health Research Institute reported that 1,500 major employers reduced their health care costs from $1,115 to $806 per person through an employee wellness program.(24)

In 1972, NASA utilized a self administered questionnaire as part of a 12 month physical fitness program to verify changes in health attitudes. The relationship between improved work performance and attitudes was quite strong. Not only did participants report that they could work harder mentally and physically, but they also reported increased positive feelings about health status, greater endurance, increased energy, reduced weight, and decreased stress and tension.(25)

In 1982, the Institute for Aerobics Research delivered a comprehensive fitness/wellness and stress management program to approximately 5,000 Dallas Independent School District employees and their spouses. At the completion of the pilot project, Superintendent Linus Wright stated, "it has proven to be one of the most positive and successful programs that I have seen in 34 years of my involvement in education." The "Personalized Aerobics Lifestyle System" (PALS), utilized by the Institute in the DISD project, produced positive results in terms of individual teacher health, lifestyle, fitness status, and ability to manage stress. An extension of these results was a positive effect on absenteeism. The average absenteeism rate for participants was 5.86 days per year compared to 8.36 days per year for non-participants, a reduction of approximately 30%. This same trend was maintained the following year, with district wide implementation of the wellness program, and resulted in a $452,000 savings for the school district through reduced substitute teacher salaries alone.(26)

Blue Cross of Indiana credits its health promotion program with keeping its increase in health care spending for employees down to 8 percent over three years, compared with a 60 percent increase over two years for a control group. The firm's absenteeism dropped 50-75 percent because of the health promotion plan. In terms of dollars saved, Blue Cross of Indiana estimates it saved over $1 million from 1980 to 1982.(27)

Recognizing the positive impact healthy employees can have on an employer's health insurance claim costs, the Benefit Trust Life Insurance Company (BTL) recently began offering a group medical plan premium refund for employers who sponsor health promotion programs. The new refund program, which became effective within the past few months, applies only to groups that are manual rated---experience rated groups, such as the Texas Uniform Group Insurance Plan, are not eligible for the refund. The premium refund will be 3 percent of the annual medical plan premium or 25 percent of the cost of the employer's wellness program, whichever is less. The refund is given each year the program and group insurance contract remain in force.

Wellness activities which are eligible under the BTL premium refund policy include smoking cessation clinics, hypertension or multiphasic screening programs, organized exercise or physical fitness classes, stress management seminars, and others.

According to BTL, "wellness is a positive way for an employer to work toward cost containment, one that workers will respond to."

A recent article in Compensation Review stated that basic medical research has shown that the majority of illness in the United States predictably results from people's own health habits.(28) Many illnesses do not occur at random, striking helpless victims, but are known to be controllable and preventable. On the average, according to the article, these illnesses account for 60 percent of current claims costs. The Texas Medical Association estimates that about two-thirds of all major illness and premature deaths are linked to lifestyle habits. The following chart, developed by Gary T. McIlroy, M.D., president and founder of Meidinger Health Risk Management, Inc., shows the relationship between various lifestyles, illnesses, and costs resulting from the lifestyles.(29)

Lifestyles	Illnesses	Costs
Smoking	Cardiovascular disease	Workers' compensation payments
Lack of exercise	Stroke	Long-term and short-term disability payments
Obesity	Alcoholism	Medical claims
Alcohol abuse	Chronic pulmonary disease	Hospital claims
Stress		Absenteeism
		Replacement costs

By reducing the incidence of preventable illnesses, wellness programs, with proper claims data, can have a significant impact on health insurance costs.

For example, the Uniform Group Insurance Program's claim costs for the twelve month period 9/1/82 through 8/31/83 was approximately $100 million (about 16 percent of those claims were incurred prior to the 9/1/82 fiscal year, but were actually paid during the 9/1/82 - 8/31/83 period). If it is true that 60 percent of the claims were from preventable lifestyle illnesses, the cost of such illnesses was approximately $60 million.

RECOMMENDATIONS

A. It is recommended that the state seek funding through grants or private sector donations to fund an intensive pilot program promoting employee wellness.

   The pilot program would be offered to approximately 300 employees at two selected state agencies, and would include these components:

   1. Medical screening and health/fitness assessment
   2. Distribution of personalized lifestyle manuals
   3. Individual counseling/goal setting sessions
   4. Education/Instruction
   5. Group exercise classes
   6. Review and feedback of results
   7. Program assessment
   8. Ongoing evaluation

   A sample pilot program has been developed and is contained in Exhibit 3 in the Appendix.

B. It is recommended that donations or grants of approximately $155,000 be sought initially to cover the expenses of the first year pilot program. At the end of that period, a study should be done of the results of the pilot and the feasibility of expanding it to other agencies. The study should be designed to measure the pilot's impact on the participants' physiological and psychological well being, as well as the impact on health care costs, sick leave, absenteeism, and on-the-job injuries.

VI. Health Needs Assessment

INTRODUCTION

Health risk management is one of the most comprehensive approaches to controlling health care costs. It is a method of systematically examining, managing, planning, and evaluating wellness programs and their impact on health care liabilities. In addition, it assists in proper allocation of resources toward reducing the highest risk factors in a given population.

A first step in developing a health risk management program is the development of baseline data on the current health status of an employee population to identify the potential for certain prevalent health risk factors such as cardiovascular disease, cancer, strokes, diabetes, and injuries. Baseline data, with periodic updates, permits the early recognition of trends in disease development.

Gathering baseline data from employees can be easily accomplished by using a simple, confidential questionnaire. Once analyzed, data from the questionnaire can be used to measure existing risk factors, as well as employee interest in various wellness programs.

Currently, such baseline data are not available on state employees. The Subcommittee believes a health status/needs assessment questionnaire for state employees should be administered as soon as possible.

RECOMMENDATIONS

A. It is recommended that a health status/needs assessment be conducted at an early date of a sample or all state agencies. The purposes of the assessment are:

   1. to gauge the current health status and health risk factors of state employees and retirees in order to guide the implementation of risk reduction programs, and

   2. to serve as baseline data for future assessments in order to evaluate changes in health status and health risks.

   The assessment should be conducted by the Center for Health Promotion Research and Development at the University of Texas Health Science Center at Houston. The results of the assessment should be submitted to the Public Health Promotion Division of the Texas Department of Health.

Discussion: In order to achieve a high percentage of responses, the data collection effort should be conducted in a manner to assure employee confidentiality, while permitting identification of locality and agency. The questionnaire should be brief and should elicit information relating to the major health risk factors such as smoking, physical fitness, nutrition, alcohol, and stress. A sample "Health Risk Assessment Survey" is contained in Exhibit 2 in the Appendix.

Subsequent surveys should be administered and evaluated every one or two years to update the database and adjust the emphasis of wellness activities where needed.

B. It is recommended that the insurance carrier for the Uniform Group Insurance Program be required to provide claims experience data, by disease category, on an agency-by-agency basis to the Employee Retirement System for distribution to agencies and others to develop state wellness programs. These reports should not identify any individual employee and should be used only for epidemiological purposes to identify health risk factors, claims costs, and other conditions that could potentially be reduced by specific prevention, risk reduction, or cost containment programs. The reports will not be used to experience rate or otherwise justify separate rates for each agency.

Discussion: The Dallas Independent School District (DISD), in cooperation with an insurance carrier, is in the process of developing a series of periodic reports analyzing claims experience data for the District's self insured plan. This program may provide a model for the state to use in designing a system to analyze claims data. Following is a summary of the DISD system:

Six reports will be generated and will provide a wide range of claims detail. The reports include:

1. A summary of total benefits paid under the policy. Information provided includes:

    - hospital and nonhospital claims for all claimants, for employees and for dependents only
    - types of services, according to internal limits of the plan's design
    - total charges considered compared to allowable charges
    - total payments authorized
    - deductible and coinsurance features
    - coordination of benefits

2. Hospital utilization by providers to compare hospital usage trends. Information provided includes:

   - identification of provider
   - inpatient and outpatient admissions
   - average length of each hospitalization
   - average charge for each admission
   - total room and board charge
   - total miscellaneous charge
   - providers are identified by name, tax I.D. number, and zip code
   - includes comparison to length of stay norms

   NOTE: Each charge can be compared to the average charge for any particular condition treated by the specific provider named and to regional norms to enable the identification of excessive charges.

3. Hospital utilization by age to compare costs by age groups for each type of illness or accident reported during specified time periods. Information provided includes:

   - conditions or diagnosis
   - total room and board and miscellaneous charges
   - average charge per admission
   - average length of stay
   - relationship to national norms

   NOTE: This report enables the evaluation of trends in a specific hospital and the utilization according to age.

4. Day of admission/discharge by hospital to compare admission and discharge practices of different hospitals. Information provided includes:

   - each hospital used
   - day of admission
   - day of discharge

- number of admissions
- percentage of admissions according to the day of the week
- average length of stay
- average total charges

5. Procedure cost analysis provides an examination of medical fee trends and enables the identification of those physicians and clinics whose charges and medical practices may exceed accepted norms. Information provided includes:

   - procedure code and description
   - frequency of procedures performed
   - place of treatment
   - total charges per procedure
   - total average amounts saved resulting from claims adjudication reductions

   NOTE: The report also summarizes total procedures performed by all physicians and will offer comparison to geographic norms.

6. Alphabetical claims listing to provide claims history for group members, handling inquiries, and tracking claims experience for each covered individual. Information provided includes claims listed by:

   - insured person's last name
   - relationship
   - claim number
   - draft number and amount and to whom the claim was paid

VII. Health Screenings

INTRODUCTION

Screenings for health risk factors are an important component in any wellness program, second only to actual modification of employee behavior through smoking cessation, nutrition, exercise, weight control, stress management, and other activities.

The Subcommittee believes that health screenings for state employees will have immediate and long-term implications on the Uniform Group Insurance Program.

Immediate gains include identification of actual disease pathology in individuals who are unaware of their conditions, such as cancer, extreme hypertension, and diabetes. Identifying the presence of these conditions can lead to immediate treatment and follow-up, thus eliminating further complications and additional costly medical expenses.

Additionally, individuals who are in reasonably good health, but who are on the borderline for developing serious illness and diseases, have a better opportunity to be identified in time to prevent the onset of a life-threatening condition.

Although no direct evidence is available, it is likely that the long-term benefit of health screenings will be seen in lower health insurance costs for older employees and retirees. According to a recent article in Business and Health, ". . . alterations in lifestyles during the young adult and middle years directly reduce future risks for debilitating and life threatening conditions such as lung cancer and cardiovascular disease. In the best of all worlds, they carry over into retirement to provide continued health protection throughout life."(30) Cardiovascular diseases are considered to be the most prevalent and costly kinds of illnesses in the retirement years.

Health risk screening may be accomplished through questionnaires containing items which indicate the relative risk for individuals for certain diseases or conditions and through the use of physiological screening tests that are simple to administer, relatively inexpensive, and have high predictive capacity.

The use of health risk screening can sensitize individuals to the degree of risk they have for particular diseases or conditions and guide them toward the risk reduction actions or programs that are most appropriate for them. Health risk screening can identify those individuals who could achieve the maximum benefits from participation in the wellness programs to be offered and, thus, be the most efficient use of the limited resources available.

The November 1983 Personnel Journal reported a recent study indicating that informing individuals of their own high risk factors (through health screening tools) motivates many of them to change their habits and reduce their risks. The study, conducted by the National Institutes of Health, showed that a group of men who were informed that they were at high risk of heart disease reduced their risk significantly.(31)

Another important application of the health screening questionnaire is to produce a "management report" which compiles and analyzes all the individual questionnaires. The report provides aggregate statistical descriptions of the current health risks of specific employee populations and projections on the type and incidence of illness over a certain period (for example, 10 years). The report can also identify the distribution of risk-producing behaviors within the group.(32)

One employer who used the management report found that 357 of its 2,000 employees had a 25% (or greater than average) risk of having a heart attack. Of these high risk individuals, 62% were heavy smokers (greater than average) and 51% had high blood pressure (less than average). Armed with these kinds of reports, an employer can develop or change a wellness program to target activities where they are most needed.(33)

The Subcommittee has made the following recommendations in the interest of developing data to be used by the state, individual agencies, and employees to increase employee awareness of lifestyle illnesses, identify and treat such illness, and plan wellness program that will address the most costly health risk factors.

RECOMMENDATIONS

A. It is recommended that state agencies offer their employees health risk screening questionnaires on a voluntary basis and that the results be confidential. These can serve as an excellent educational and motivational tool.

   Discussion: Health risk screening questionnaires have become a very popular component in wellness programs sponsored by public and private organizations. Many screening questionnaires have been developed and are inexpensive to administer. In the Austin area alone, there are numerous organizations that offer health risk screenings, including the University of Texas Adult Cardiovascular Fitness Program, Brackenridge Hospital, YMCA, and The Hills Medical/Sports Complex.

In one such program, a computerized health risk appraisal is used to give the employee an estimate of his or her risk of dying within the next ten years and lists specific behavior modification needed to reduce that risk (such as smoking cessation, weight loss, blood pressure control, and wearing seat belts). The package includes administering and scoring the computerized appraisal and returning it to the employee with general feedback on the appraisal results. On-site blood pressure screening is used to increase the validity of the assessment. Individuals with hypertension are referred to their physician. The cost is $12 per person. A sample questionnaire and computer analysis are located in Exhibit 4 in the Appendix.

B. It is recommended that certain state agencies be selected to conduct pilot programs for the following voluntary tests:

1. blood pressure screenings
2. glaucoma screening
3. hemocult
4. urine analysis
5. blood glucose screening for diabetes
6. breast cancer self-examinations
7. testicular self-examinations
8. height/weight measurements

If these tests are used, the result may be provided to the employee's physician for interpretation and consultation.

Discussion: The purpose for conducting a pilot project for these screenings is to determine the cost effectiveness in early detection of various kinds of cancer, glaucoma, hypertension and diabetes. If these screenings prove to be cost effective, they should be made available to all state employees. Early detection and treatment of these diseases could significantly reduce costs to the Uniform Group Insurance Program.

C. It is recommended that the "General Program Guidelines Relating to the State Employees Health Fitness and Education Act of 1983" be amended to remove the current restrictions on invasive health screening and appraisals in order to permit blood testing on a voluntary basis.

Discussion: The current State Employee Health Fitness Guidelines restrict the use of invasive procedures, such as blood testing and proctoscopic examinations. Some of these invasive procedures are considered to be among the most cost-effective mechanisms for screening and early detection. Such screening should obviously be voluntary and should be performed by qualified professionals.

Removing these restrictions would permit individual agencies to select the screening procedures which would be the most effective and efficient for their employees and which would result in the best assessment of health risks to guide their program priorities.

VIII. Maternal Health Education

INTRODUCTION

In considering the health needs of state employees, it is especially important to make special note of the health concerns of pregnant women. Doctors agree that proper medical care is vital to both the mother's and baby's health, and education programs are an excellent way of providing information to expectant mothers.

Due to the physical demands of pregnancy, there are numerous precautions that all pregnant women should take to protect the unborn child. For example, recent studies have shown that alcohol and smoking can cause permanent damage to the fetus, and it is suggested that women eliminate any alcohol intake and smoking during pregnancy. Though most doctors will make this information available to their patients, there are occasions when the woman is not aware of these and other facts. Because physician visits are often brief and do not provide much opportunity for extensive counseling, outside educational programs are particularly useful in educating women on such things as proper nutrition, exercise, good health habits, and post-natal care.

It is also a well-documented fact that good health care during pregnancy reduces the incidence of premature births. Although the survival rate of premature babies is excellent due to recent advances in medical technology, the necessary medical care is very expensive. It is not unusual for a premature baby to require hospitalization of up to 8 weeks and sometimes longer and often the stay includes lengthy intensive care treatment. One Austin Hospital estimates that the average cost for treating babies in the neonatal intensive care unit is $1,456 per day.

Since the state insurance plan provides coverage for babies from the moment of birth, the cost of treating premature infants directly affects the cost of insurance for all employees. And these costs can continue for years if the prematurity results in any permanent damage to the child.

RECOMMENDATION

In order to promote good health care practices among pregnant employees, and thereby reduce the likelihood of premature births or other complications of pregnancy, it is recommended that state agencies (individually or collectively) offer classes and literature on special health issues related to pregnancy. Subjects covered could include the importance of good nutrition, the elimination of alcohol intake and smoking, and other medical concerns related to pregnancy. This information could be offered as a component of ongoing health promotion classes, as special classes, through use of the agency's newsletter and bulletin boards, or by distributing educational literature.

IX. Safety

INTRODUCTION

Injury prevention and work site safety are implicit in any program to promote employee health and welfare. Today injuries are the fourth leading cause of death in the nation, behind heart disease, cancer, and stroke. Injuries have a great impact on the cost of medical care as well as the state's workers' compensation program.

In 1975 the Workers' Compensation Act for Texas state employees became effective and established the State of Texas as a self insurer with all funding appropriated by the Texas Legislature.

The Workers' Compensation Division was created within the Attorney General's Office to administer the Workers' Compensation Act. The primary responsibility of the division is to administer the Act in a fair and equitable manner, respecting the rights of the injured employee and protecting the legitimate interests of the State of Texas.

In 1983, the State of Texas paid $9,824,500 to state workers injured on the job. This is a 100 percent increase over the claims paid in 1978. The number of claims reported have decreased from 6,636 in 1978 to 6,207 in 1983.(34)

The State of Texas is currently paying out approximately $1 million per month for workers' compensation. Approximately two-thirds of that amount is for injuries in prior years. A total of 97 percent of on-the-job injuries to state workers are minor injuries. But the major injuries are very costly.

The greatest number of injuries are "trips and falls" which are preventable in any kind of job. Studies indicate that office workers suffer more falls than factory workers, and that falls cause the most serious injuries. In one survey, falls were responsible for 55 percent of all days lost because of office injuries.(35) It is estimated that the state could save millions of dollars by reducing trip and fall injuries alone.

Although the state workers' compensation program has experienced a decrease in the number of claims, increasing hospital and medical costs, as well as the statutory weekly benefit amounts (which have tripled in 10 years) have contributed to the increasing claim costs. Since hospital/medical costs and the level of statutory benefits cannot be controlled by the Workers' Compensation Division, reducing the incidence and severity of covered injuries has been cited as the most effective way to reduce workers' compensation costs and improve employee health and morale.

According to the Group Insurance Division of the Employees Retirement System, some state employees file health insurance claims for work-related injuries covered under the state workers' compensation program. This can result in double reimbursement and is prohibited by the Retirement System. Although the impact of this abuse is not known, it is certain to be a burden on health insurance costs.

Because the Subcommittee is concerned over the impact of injuries on the state health insurance program and the overall wellness of state employees, it is recommending programs to increase awareness and place emphasis on injury prevention and job safety.

With regard to the recommendations concerning the state workers' compensation program, the Subcommittee feels that increasing the awareness of state agency executives on the costs of their workers' compensation claims will produce needed changes to reduce the number of claims.

RECOMMENDATIONS

A. It is recommended that each state agency with more than 200 employees be required to make an annual report to the Governor on the record of its injury prevention program. In addition, the Workers' Compensation Division of the Attorney General's Office should make an annual report to the Governor giving the injury rates for each agency, the types of injuries, and the cost to the state for those injuries using Bureau of Labor Statistics methods. The reports should contain information from the most recent year and the previous five years. The chief executive officer of agencies with substandard programs and/or injury experience will be required to submit a plan to the Governor of corrective actions on those areas.

   Discussion: These reports will be used by the Governor's office to identify agencies which need improved injury prevention programs.

B. It is recommended that the state employee classification system be expanded to include a new classification entitled "Safety Coordinator." This job classification would be used for state agencies, injury prevention coordinators, and injury prevention representatives in the Attorney General's Workers' Compensation Division.

   Discussion: The new classification should detail the type of educational background the persons need, skills required, and the appropriate level of the individual within an agency's organizational structure. It is desirable that the safety coordinator be directly responsible to a top administrative officer. An agency's need for safety coordinators may vary according to the agency's size and nature of its services.

C. It is recommended that the Governor, in cooperation with the Attorney General's Workers' Compensation Division, issue an Executive Order requiring state agencies with more than 200 employees to develop an appropriate, written injury prevention program.

Discussion: Injury prevention programs should be developed in cooperation with the Attorney General's Workers' Compensation Division.

D. It is recommended that the Workers' Compensation Division of the Attorney General's Office and the Governor's Office cosponsor a statewide occupational safety and injury prevention conference for state agency executives and agency safety coordinators.

Discussion: The conference should focus on the role agency executives can have in reducing workers' compensation claims and should provide practical inservice training designed specifically for agency safety coordinators. This conference could be held in conjunction with the Annual Workers' Compensation Seminars by expanding the current format and agenda.

E. It is recommended that program evaluations be conducted by the use of the "Workers' Compensation Handbook for State Agencies" and the Occupational Safety and Health Evaluation System that is in use and is available from the Attorney General's Workers' Compensation Division. Incident and disabling injury rates are to be computed by use of Bureau of Labor Statistics methods. Comparisons to national rates and trends will be made if such information is available.

Discussion: Program evaluations have already been developed by the Attorney General's Workers' Compensation Division and should be conducted on all agencies as soon as possible.

F. It is recommended that each state agency adopt a uniform seat belt policy as a part of their personnel policy requiring state employees driving on state business to fasten their seat belts in a state owned vehicle or in a non-state owned vehicle (i.e. their personal vehicle). All state vehicles should have a notice posted in the vehicle reminding the driver to observe the seat belt policy.

Discussion: Mandatory seat belt policies are a common ingredient in major business and industry safety programs. The national concern over wearing seat belts was highlighted recently by the enactment of a mandatory seat belt policy in New York state. The new law is expected to have a "snowball" effect in other states. It is estimated that the new law will save about 400 lives, 70,000 injuries, and $240 million annually in New York State.

In addition, the Department of Transportation recently issued final rules requiring passive restraints (automatic seat belts or air bags) for all new cars by September 1, 1989, unless two-thirds of the U.S. population is covered by mandatory seat belt usage laws by April 1, 1989. During the Second Called Session of the 68th Texas Legislature, a bill was passed requiring mandatory use of child safety seats or restraints in automobiles. The bill requires safety seats or seat belts for children under age 4. The measure becomes effective October 31, 1984.

G. It is recommended that state agencies with positions requiring regular performance of physically demanding tasks establish screening criteria for assignment to such positions so as to minimize injuries and resulting workers' compensation claims. For example, potential employees who will be required to regularly lift and carry heavy loads (e.g. 50 pounds or more) may be screened to establish their capacity to safely and efficiently lift and carry a "test" object that is similar to the loads they will be required to handle on the job.

H. It is recommended that each state agency provide home and recreational safety education programs and/or safety literature to employees and families. This information could be offered through the use of the agency's newsletter and bulletin boards or by distributing educational literature.

Discussion: Many injuries, which may eventually result in health care claims and expensive emergency room expenses, occur at home. Educating employees and families on home and recreational safety may lead to fewer home injuries and healthier employees and families. Home safety education can be handled through cost effective media such as agency newsletters and bulletin boards, as well as distribution of home safety literature available through various medical and safety organizations.

X. Sick Leave

INTRODUCTION

The question of "Sick Leave vs Well Pay" has received increasing attention lately as more employers are looking at ways of reducing costs related to lost productivity. With the acknowledgement that absenteeism is costly to any business, sick leave policies have become an important issue in the attempt to deal with absenteeism.

Under the 1983 Appropriations Act enacted by the Texas Legislature, provisions for sick leave accrual and usage for state employees are as follows:

a. An employee begins earning sick leave on the first day of employment at the rate of eight (8) hours for each month or fraction of a month employed. Any unused sick leave is carried over to the next month.

b. Sick leave may be taken when sickness, injury, or pregnancy and confinement prevent the employee from performing his/her duty, or when a member of his/her immediate family is ill. Immediate family includes those individuals related by kinship, adoption, or marriage who are living in the same household or are totally dependent upon the employee for personal care or services on a continuing basis.

   If sick leave is taken for a period of more than 3 working days, a written statement showing the cause or nature of the illness must be submitted to the administrative head of the employing agency.

   Sick leave records are maintained on each employee by the agency he/she is employed with. Since Texas does not have a central personnel authority, all leave records are kept within the individual agencies making it impossible to obtain any conclusive data on sick leave usage by employees. However, a survey of 10 state employers in November 1983 provides sick leave utilization figures for fiscal year 1983:

Average Sick Leave Taken
FY 1983
Sample from Ten State Agencies

Department	# of Employees	Total Sick Leave Hours Taken	Average # of Sick Leave Hours Taken per Emp. Hours - Days
D.H.R.	12,342	833,174	67.5 - 8.44
Parks & Wildlife	2,552	108,460	42.5 - 5.31
Coordinating Board	160	11,459.75	71.6 - 8.95
T.E.A.	902	60,807	67.4 - 8.43
State Auditor	185	11,492.25	62.1 - 7.76
T.E.C.	3,178	243,902.5	76.7 - 9.59
MHMR (20 Facilities)	17,714	1,247,576	70.4 - 8.8
Rehabilitation	1,744	118,592	68.0 - 8.5
Water Resources	867	56,763	65.5 - 8.19
Highway	14,678	770,440	52.5 - 6.56
Dept. of Corrections	6,390	334,969.75	52.4 - 6.55
TOTAL	60,712	3,797,636.25	62.55 - 7.82

SOURCE: Survey of Agencies named - November 1983
State Auditor's Office

A number of variations have been enacted which use the well-pay concept as the basis of the program. In a recent survey among state and local governments concerning their sick leave practices, 77% of the 94 respondents indicate that they provide for some form of compensation to employees for unused sick leave credit.(36) The predominant provisions are to convert unused sick leave to retirement credit or to cash, as follows:

1. Convert sick leave to retirement credit 48%

2. Convert sick leave to cash 39%

3. Convert sick leave to vacation 13%

A number of other incentive programs are also in practice among employers. The types of incentives offered include monetary rewards for good attendance, additional vacation "bonus" days, and salary increases. Monetary awards are often given in the form of a year end bonus check for perfect or outstanding attendance. (Some employers award this bonus at the time an employee's performance is evaluated rather than year end). Vacation bonus days are awarded on the basis of how many "sick days" the employee used, with those using no sick days receiving up to 40 hours additional vacation time annually.

The State Agency Coordinating Council, formerly the State Agency Management Effectiveness Council, has been studying sick leave options as a means to recognize and reward sick leave accrual. The Subcommittee supports these efforts and encourages the Committee to adopt recommendations which will reward employees who stay well.

In calculating sick leave utilization, most companies agree that it is also important to consider the reason for sick leave utilization in order to effectively address the problem. Thus all sick leave reporting figures ideally should be collected indicating whether the employee used sick leave because he/she was sick, or because a dependent was ill. These figures are especially important if incentives are directed towards rewarding employees who stay well, and include some allowances for employees who must stay home with children with "routine" childhood illnesses. Some reward programs provide a limited number of credit days for employees with children, but require that the child's illness be verified by a physician's statement in order for the credits to be used. In this way employees with children feel the program does not put them at a disadvantage.

RECOMMENDATIONS

A. It is recommended that pilot projects should be established in various state agencies to study innovative sick leave and annual leave policies for the purpose of providing incentives for employees to stay well and reduce the use of sick leave. Because of the unique sick leave situation and critical staffing needs in hospitals, one pilot project should be conducted in a hospital. If legislative authority is necessary to implement such programs, then legislation should be introduced during the 69th Session of the Texas Legislature.

B. It is recommended that sick leave accounting in all state agencies should be segregated to report sick leave attributable to an employee's illness and sick leave attributable to his or her spouse, and dependents' illnesses.

XI. Financial and Other Incentives

INTRODUCTION

The Subcommittee believes that the state's employees are its most important asset and that the cost of improving the health and welfare of the employee will be offset many times through reduced medical costs, lower absenteeism, lower turnover, higher morale, and higher productivity.

After examining many successful wellness programs, the Subcommittee has made seven recommendations for the purpose of motivating employees to continue or initiate wellness activities which result in healthy lifestyles. Changing lifestyles to reduce the risk of heart disease, cancer, stroke, and injuries, is a long range proposition and requires a sustained effort by employees and management. Therefore, it is critical that employees receive various kinds of long and short-range incentives to reward them for their efforts toward improving their health.

The incentives which have been recommended range from financial rewards to recognition for achieving certain fitness levels and behavior changes. Many of these rewards are inexpensive and will have a positive impact on sustained employee participation, which will in turn have a major impact on containing costs in the Uniform Group Insurance Program.

After much thought and discussion, the Subcommittee agreed that the strongest incentive for motivating employees to improve their health would be offering a discount or reduction in premiums for both health insurance and life insurance to employees and insured spouses who achieve certain wellness criteria. In this way, healthy employees can be encouraged to stay in the insured plan rather than switch to HMOs as health premiums rise.

The Subcommittee acknowledges that this is a departure from the current health insurance system and would require changes in the administration of the current state health insurance plan. Because developing and implementing the discount raises many important questions and issues, the Subcommittee recommends that the Employee Retirement System work in conjunction with the State Board of Insurance and the Texas Department of Health, using the best actuarial data available, to determine the amount of initial discount or reduction in premium and develop a program so that future rates or discounts can be based on experience (see Exhibit 7 for actuarial report).

The Subcommittee has taken notice of the recommendation of both the Bidding and Benefits Subcommittees to adopt a single plan of coverage for all employees under the Uniform Group Insurance Program rather than perpetuating the multiple plans system. Because a single plan of coverage is an essential cost containment measure, the Wellness Subcommittee strongly endorses the single plan of coverage concept and urges that it be implemented.

RECOMMENDATIONS

A. Financial Incentives

It is recommended that all state employees be given a discount or reduction in their life and health insurance premiums provided employees and insured spouses meet certain annual tests and qualifications. Furthermore, it is recommended that the Employee Retirement System work in conjunction with the State Board of Insurance and the Texas Department of Health, using the best actuarial data and methodology available, to determine the amount of initial discount or reduction in premium and develop a detailed implementation program to be instituted at the next bidding date.

Annual tests and qualifications:

1. Total abstinence from the use of all tobacco products within the past year (includes cigarettes, pipes, cigars, snuff, and chewing tobacco);

2. Weight not to exceed the upper limit of the 1983 Metropolitan height/weight tables or, if the employee chooses, evidence from a physician, Registered Nurse, Licensed Vocational Nurse, or other licensed health professional approved by the Texas Department of Health that the employee or insured spouse is not obese as measured by hydrostatic weighing, skinfold caliper assessment, or body mass index calculation;(37)

   Protocols for hydrostatic weighing and skin fold caliper assessment tolerances will be developed by the Texas Department of Health.

3. Blood pressure normal (140 over 90) or below, including blood pressure controlled by medication.

All tests are to be conducted on a voluntary basis on or off premises and are to be certified by the employee and insured spouse.

Weight and blood pressure tests may be conducted and certified either by the employee's/insured spouse's physician, Registered Nurse, Licensed Vocational Nurse, or other health professional approved by the Texas Department of Health or, in the event the agency sponsors weight and blood pressure tests, by the individuals administering such on-site agency tests. The application for the discount will be reviewed and certified by the employee's supervisor and the agency's chief executive officer. A sample application form containing employee, spouse and agency certifications is contained in the Appendix (see Exhibit 6).

The financial incentives final plan should contain provision for waiving of enforcement of the blood pressure requirements when: (i) such condition has been and is continuing to be medically treated; (ii) the treating practitioner certifies that such condition is continuing and incurable; and (iii) such facts supporting waiver have been found by a review board established by the Employee Retirement System to be true.

Prior to implementation of financial incentives, determination shall be obtained: (i) from the Office of Federal Contract Compliance that such incentives do not violate the Rehabilitation Act of 1973 (or other applicable Federal statutes), and (ii) from the Texas Human Rights Commission that such incentives do not violate applicable human rights law of the State of Texas.

The Subcommittee recognizes that the Legislature sets the level of the state's contribution for the Uniform Group Insurance Program. For the purposes of the financial incentive recommendation, it is recommended that the future contribution level be the average amount of the premiums for the "preferred" rated group and the "regular" rated group.

Discussion: Since inception of the first Blue Cross/Blue Shield plan in Texas, the group health insurance mechanism has contributed to spiraling health care costs by raising individual's expectations of payment for any hospital/medical service and procedure. The Subcommittee believes that the health care financing mechanism must now be restructured if possible to focus attention on the medical costs of unhealthy lifestyles.

It is time to re-think traditional group insurance concepts in order to find ways to motivate and reward the growing numbers of persons who have chosen healthy lifestyles.

Secretary of Health and Human Services (HHS), Margaret Heckler, touched on this theme in a recent presentation on health promotion when she announced that one of the major health promotion objectives of the HHS is, "That by 1990, most major health and life insurers offer differential insurance premiums to smokers and non-smokers."(38)

The Subcommittee believes that employees who apply for the discount should be given the flexibility of having the tests conducted by their own physician (or nurse) or through agency sponsored tests. The protocol for the on-site testing should be developed by the Texas Department of Health. Because applicants for the discount may need to have their blood pressure tested more than once requiring a series of days, the qualification period should be long enough to accommodate multiple tests.

In some instances, the 1983 Metropolitan height/weight tables will be inadequate for certain individuals. Therefore, additional tests have been recommended to enable individuals to qualify based on body fat measurements. Hydrostatic weighing and skin fold caliper assessment are methods to measure body fat. In qualifying for the discount, the Texas Department of Health will establish protocols for testing individuals with unique health situations, such as pregnancy.

B. Other Incentives

It is recommended that the Governor sponsor a recognition/ award program for individual employees and entire state agencies for achievement of high levels of wellness. Awards could include letters from the Governor, certificates of merit, pins, and/or pictures of winners.

Discussion: Recognition could be given for both significant improvements as well as attainment of some specific levels of wellness. Awards could be made for a variety of wellness achievements such as weight loss, smoking cessation, or physical fitness.

The Governor's Commission on Physical Fitness' "Task Force on State and Local Government" could be a resource in the development of such an award program.

C. It is recommended that a "Legislative Health Fair Day" be held at the Capitol for legislators and state employees.

Discussion: Such an event could increase awareness among legislators of the importance of health/fitness issues as well as provide learning opportunities and health fitness screenings (e.g. blood pressure screenings) for state employees in the capitol area. State employees outside the Capitol area should be provided with material to coordinate similar events concurrent with the Austin activities.

In March 1984, the State of Florida sponsored "Living Well in Florida Month" to encourage all Floridians to become involved in healthier living. One of the activities held during the month included a "health testing fair" in the state capitol in which cabinet members, legislators, and state employees were invited to take a free health screening test. The program was coordinated by the Florida Governor's Council on Physical Fitness and Sports and was considered to be very effective in promoting healthy lifestyles for state employees.

D. It is recommended that state employees be given the option of converting a certain percentage of their unused sick leave each year to "well days" or receive cash payments for a certain amount of unused sick leave. This conversion or payment should occur at a designated time each year or periodically upon the accumulation of a minimum number of sick leave hours. (See also recommendation A on page 130 under "Sick Leave").

Discussion: The present system reinforces the use of sick leave, regardless of need. Converting sick leave to a form of personal leave or cash would reward employees who stay well and could be used to encourage employees to participate in health promotion activities.

The State Agency Coordinating Committee, formerly the State Agency Management Effectiveness Council has been studying sick leave options as a means to recognize and reward sick leave accrual. The Subcommittee supports these efforts and encourages the Committee to adopt recommendations which will reward employees who stay well.

E. It is recommended that a portion of participants' costs for behavior change modifications (for example, smoking cessation classes and weight control classes) be reimbursed to employees who attend all class sessions and who achieve a certain level of behavior change, such as abstinence from smoking for 3 to 6 months or losing a certain number of pounds.

Discussion: For example, employees who paid a $25 fee to attend a weight loss clinic, attended all sessions, and lost a certain percentage of weight could receive a full or partial reimbursement of the $25 fee. Available resources for such reimbursement may vary for each state agency; therefore, each agency should be responsible for establishing its reimbursement rates.

Recognizable areas of behavior change, for which standards could be established, include abstinence from smoking, weight loss, improvement in resting and working heart rates, blood pressure, flexibility, and strength.

The Texas Department of Health and the Governor's Commission on Physical Fitness should be asked to develop behavior change standards to guide agencies in establishing reimbursement policies.

F. It is recommended that individual state agencies use a variety of awards/incentives for employees who either make significant changes in their health behaviors or who achieve certain levels of health/wellness.

Discussion: Incentives and awards such as employee pictures displayed in the building and special recognition in agency newsletters could be included and could be done at a minimal cost. In addition, employees could be given special parking places for being the agency's "healthy employee of the month." T-shirts and bumper stickers could also be used as effective motivators and incentives.

G. It is recommended that serious efforts be made to include non-Austin based state employees in recognition and incentive programs as much as possible.

Discussion: Certain of the recommendations in this section, such as health insurance discounts and sick leave conversion, would be available to employees regardless of their location around the state. However, special efforts should be made to provide local events and activities throughout the state whenever possible to provide a uniform recognition/incentive program.

BIBLIOGRAPHY

1. Executive Order No. MW-13, September 30, 1983: "Establishing the Governor's Task Force on State Employee Health Insurance Quality Cost Containment."

2. Iwao M. Moriyama, "Problems in the Measurement of Health Status," Indicators of Social Change - Concepts and Measurements; Sheldon & Moore (Eds.). (New York:Russell Sage Foundation, 1968), p. 585.

3. Charles A. Berry, M.D., M.P.H., An Approach to Good Health for Employees and Reduced Health Care Costs for Industry, (Health Insurance Institute, Washington, D.C., 1981) p. 9.

4. Gary T. McIlroy, M.D., "Health Care Cost Containment in the 1980's," Compensation Review, Fourth Quarter 1983 (Periodicals Division of the American Management Association), p. 31.

5. "Health Tips," Texas Medical Association, Austin, Texas, April 1984.

6. "Smoking Called No. 1 Personal Health Risk," Houston Post, May 24, 1984, p. A1.

7. Emma Seifrit Weigley, Ph.D., R.D., "Average? Ideal? Desirable? A Brief Overview of Height-Weight Tables in the United States," Journal of American Dietetic Association, Vol. 84, No. 4, April 1984, pp. 417-423.

8. Report of the Council on Scientific Affairs to the American Medical Association's House of Delegates, Report No.: D(I-83) presented by Ray W. Gifford, Jr., M.D., Chairman of the Council on Scientific Affairs, 1983.

9. "Second-Hand Smoke-Take a Look at the Facts," published by the American Lung Association, 1982.

10. Ibid, Report of the Council on Scientific Affairs to the American Medical Association.

11. Ibid.

12. Ibid.

13. Ibid.

14. "Heavy Smoker Costs Estimated at $59,000," San Antonio Express, March 27, 1984, p. 12-A. The article reports on a study on smoking released March 26, 1984 by Policy Analysis, Inc., Brookline, Mass.

15. Ibid, Smoking, Houston Post.

16. "They are What They Eat," Employee Services Management, Vol. 27, No. 1, February 1984.

17. Jonathan E. Fielding, M.D., M.P.H., "Effectiveness of Employee Health Improvement Programs," Journal of Occupational Medicine, Vol. 24, No. 11, November 1982, p. 912.

18. John J. Hoffman, Jr. and Charles J. Hobson, "Physical Fitness and Employee Effectiveness," Personnel Administrator, April 1984, p. 108.

19. Andrew Fluegelman (Ed.), The New Games Book (Double Day and Company; Headlands Press; New York, New York, 1976.)

20. Ibid, Berry, An Approach to Good Health for Employees, p. 28.

21. Ibid.

22. Ibid.

23. Ibid.

24. "Health Forecast," March-April 1983, Vol. 3, No. 2.

25. Durbeck, D. C., F. Heinzelman, J. Schacter, W. L. Haske, G. H. Payne, R. Y. Moxley, M. Nemiroff, D. D. Limoncelli, L. A. Arnold, and S. M. Fox. "NASA vs. Public Health Service Health Evaluation and Enhancement Program," The American Journal of Cardiology, Vol. 30, November 20, 1972.

26. "Employee Wellness Program Proposal for the State of Texas," prepared by the Institute for Aerobics Research, Dallas, Texas, 1984. This report was submitted to the Wellness Subcommittee of the Governor's Task Force on State Employee Health Insurance Quality and Cost Containment.

27. "Health Promotion Plan Significantly Cuts Health Expenses," Washington Insurance Newsletter, September 7, 1983, p. 3.

28. Gary T. McIlroy, M.D., "Health Care Cost Containment in the 1980's," Compensation Review, Fourth Quarter 1983, p. 31.

29. Ibid, p. 30.

30. Pauline K. Robinson, "Facing Up to Health Care Costs of Retirees," Business and Health, June 1984, p. 24.

31. James E. Bernstein, M.D., "Handling Health Cost by Reducing Health Risks," Personnel Journal, November 1983, pp. 882-887.

32. Ibid.

33. Ibid.

34. Information provided by the Workers' Compensation Division of the Texas Attorney General's Office, Austin, Texas.

35. "Firms Focus on Office Worker Injuries," Business Insurance, September 13, 1983. p. 54.

36. Thomas L. Jacobs, "IPMA Forum," IPMA News, June 1982, p. 12.

37. Ibid, "Average? Ideal? Desirable? A Brief Overview of Height-Weight Tables in the United States."

38. Presentation by Margaret Heckler, Secretary of Health and Human Services to the Health Insurance Association of America's video teleconference on work site health promotion, March 13, 1984.

APPENDIX

EXHIBIT 1

Food Service Survey

Ideas for Survey -- Employees

Demographics

1. In What Building of the Capitol Complex do you work?

   _____ _____ _____
   _____ _____ _____

2. When do you usually take your lunch break?
   11-12 ___ 12-1 ___ 1-2 ___ after 2 ___ Rarely ___

3. What time do you take a morning break?
   9 ___ 9:30 ___ 10 ___ 11 ___

4. Where do you obtain foods/beverages for a morning break? (See list in #7 below). _____

5. What time do you take an afternoon break?
   2 ___ 2:30 ___ 3 ___ 3:30 ___ 4 ___

6. Where do you obtain foods for an afternoon break? (See list in #7 below) _____

7. In an average week how many times do you eat from the following:

_____	vending machine	____	bring from home
_____	area restaurant/cafeteria	____	other
_____	snack bar in your building	____	other
_____	snack bar in another building		

8. Do you usually eat breakfast on workdays? Yes ____ No ____

9. If yes, where do you eat breakfast?
   home ___ snack bar ___ area restaurant ___ other ___

10. If you bring your own lunch, are any of the following available for your use:
    microwave___ preparation area___ refrigerator___ separate dining area (not office)___

11. Where do you usually eat lunch?

____	in my car	____	outside on grounds
____	in meetings	____	at desk
____	snack bar table	____	other _____
____	area restaurant		_____

12. Where do you consume snacks? (see list in #11 above).

13. What are the hours of your workday? From _____a.m. until _____p.m.

State Agency Snack Bar

1. Do you sometimes eat breakfast at the state agency snack bar? Yes___ No___

2. Do you sometimes eat lunch at the state agency snack bar? Yes___ No___

3. If you currently take advantage of the lunch specials would you agree, disagree, or have no opinion about the following statements?

Specials are:	Agree	Disagree	No Opinion
appropriate serving size	____	____	____
tasty, seasoned well	____	____	____
greasy	____	____	____
too heavy on sauces/gravy	____	____	____
too light on sauces/gravy	____	____	____
too salty	____	____	____
not salty enough	____	____	____
salted to your taste	____	____	____

Other comments on snack bar food:

4. Specials you'd like to see offered include: _____

_____

_____

Ideas for snack bar alternative list

Item/description

1. fruit cup
   fresh fruit salad
2. yogurt/fruit bowl
   fresh fruit/plain yogurt
3. soup/salad
   a cup of homemade soup and fresh garden veg salad
4. sandwich on whole grain (chicken, tuna, partially skim milk cheese, turkey) served with veg. sticks
5. pocket sandwich
   vegetables and melted cheese
6. raw vegetables with cottage cheese plate
7. spuds
   potato stuffed with small amount of butter, yogurt, cheese, chives
8. pinto beans with cornbread or vegetarian casserole
9. quiche
10. chef salads
11. peanut butter sandwich

Breakfast

1. High fiber cereals: bran flakes, raisin bran, grapenuts, grapenuts with raisins
2. fruit/yogurt
3. whole grain/raisin toast or English muffins
4. bran muffins
5. smoothies
6. peanut butter on toast

Snack Racks

If the following items were removed from racks, would you miss them?

	Yes	No
candy bars	___	___
fried pies	___	___
chips	___	___
cheetos	___	___
pork rinds	___	___
donuts	___	___
honeybuns	___	___
other candy	___	___
mints/gum	___	___

If the following items were added to the racks would you buy them?

	Yes	No
frozen yogurt	___	___
frozen fruit bars	___	___
frozen juice bars	___	___
low calorie dressings	___	___
unsalted nuts/seeds	___	___
herbal teas or de-caffeinated teas	___	___
unsalted/unbuttered popcorn	___	___
part skim milk cheese/ whole grain crackers	___	___

EXHIBIT 2

Health Risk Assessment

HEALTH RISK ASSESSMENT SURVEY

Please check the appropriate box or give information for each item.

Age: _____ years Sex: ☐ Male ☐ Female Weight: _____ lbs.

Height: ____ feet ____ inches Marital Status: _____

Do you exercise regularly (at least 3 times a week)? ☐ Yes ☐ No

If YES, please check the type(s) of exercise you participate in:

☐ Walk ☐ Jog ☐ Swim ☐ Bicycle ☐ Other _____

Do you smoke? ☐ No ☐ Yes -- If YES, please check the following:

☐ Cigarettes -- ☐ 1 pack/day ☐ 2 packs/day ☐ 3 packs/day

☐ Cigars ☐ Pipe

Do you drink? ☐ No ☐ Yes -- If YES, please check the following:

☐ Beer -- ☐ Occasionally ☐ 1 or 2/day ☐ More than 2/day

☐ Wine -- ☐ Occasionally ☐ 1 or 2/day ☐ More than 2/day

☐ Liqour -- ☐ Occasionally ☐ 1 or 2/day ☐ More than 2/day

Would you be interested in participating in any of the following type programs?	Yes	No	Maybe
Weight control and nutrition	☐	☐	☐
Stress management	☐	☐	☐
Smoking cessation	☐	☐	☐
Reducing alcohol consumption	☐	☐	☐
Aerobic exercise	☐	☐	☐

Do you have any suggestions for improving the health status of state employees or for reducing the cost of health insurance?

_____

_____

_____

THANK YOU FOR PARTICIPATING IN THIS SURVEY

EXHIBIT 3

Wellness Program

EMPLOYEE WELLNESS PROGRAM

PROPOSAL FOR THE

STATE OF TEXAS

INSTITUTE FOR AEROBICS RESEARCH

12330 PRESTON ROAD

DALLAS, TEXAS 75230

ABSTRACT

Title of Study: State of Texas Employee Wellness Program

Submitted by: The Institute for Aerobics Research

Address: 12330 Preston Road, Dallas, TX 75230 Phone: (214) 239-7223

Project Director: Kenneth Cooper, M.D. Title: President and Founder

Contact Person: Charles L. Sterling, Ed.D. Title: Chief Executive Officer

Duration: Three Years

PROGRAM GOALS

The goal of the proposed project is to install a voluntary wellness program for the State of Texas employees.

STATEMENT OF NEED

The need for a wellness program for employees grows from the national concern regarding the loss of human resources to degenerative diseases. A review of recent demographic data regarding the extent and costs associated with degenerative diseases in the United States indicates that a disturbing significant portion of the nation's productivity is being lost. Many cost conscious employees have shifted from a passive to an active role by attacking the constant rise in health care and benefit expenses through an aggressive health/fitness program. There is a growing acceptance that it is an administrative responsibility to define and deliver programs to improve employee fitness and wellness and to reduce absenteeism and health care costs for the organization. When organized and delivered in a systematic fashion by trained fitness leaders, a validated wellness program, such as the model developed by the Institute for Aerobics Research (IAR), can demonstrate significant improvements in both the physiological and psychological status of employees.

PROGRAM DELIVERY

The IAR Wellness Program contains eight essential components--medical screening and health/fitness assessment, the Personalized Aerobics Lifestyle System (PALS) Manual, Individual Counseling/Goal Setting, Education, Group Exercise, Review and Feedback, Program Assessments, and Recognition/Motivation. The organization and delivery of the components is critical to the success of the program.

The proposed program will be implemented in two phases over three years. Phase one, a pilot program serving 300 participants in two cities, will provide for extensive efforts toward development, validation, and evaluation of the project. Phase two, a statewide implementation, expands the wellness program to all geographic areas of the state, serving approximately 25,000 in year two and 50,000 in year three. Local wellness leaders will assume primary responsibility for delivery of services during the statewide implementation phase. IAR staff will provide on-going training and technical assistance to assure the quality and integrity of the program. Other unique features of the program delivery model include a Wellness Advisory/ Evaluation Committee to oversee the implementation of the program, disseminate information and results, and make recommendations regarding future directions, and a State of Texas Wellness Newsletter disseminated quarterly to all participants. Evaluation of the program will include both management by objective and outcome based evaluation techniques.

EXPECTED BENEFITS/RESULTS

For the employee, benefits expected to result from the implementation of a wellness program would include reduced absenteeism and health care costs, improved employee morale, and increased productivity. Participants in the wellness program can expect to improve elements of their lifestyle, as well as physiological and psychological characteristics, i.e., body weight, blood pressure, aerobic capacity, cholesterol levels, self-esteem, nutrition practices, etc. Improvements in lifestyle habits can serve as a foundation for lifelong wellness and happiness.

TABLE OF CONTENTS

PROGRAM NARRATIVE

BUDGET

PROGRAM NARRATIVE

PROGRAM GOALS AND EXPECTED BENEFITS

The goal of the proposed project is to install a voluntary Wellness Program for the State of Texas employees. From an administrative viewpoint, maintaining the functional ability of employees is of utmost importance in an organization. It is well known that a physically fit, energetic employee who possesses a positive self-concept can make a greater contribution to the organization. For the employer, benefits expected to result from the implementation of a wellness program would include:

- Reduced absenteeism
- Greater productivity
- Improved employee morale /job attitudes
- Reduced health care costs

Participants in the Wellness Program can expect to improve elements of their lifestyle, as well as physical fitness levels as follows:

- Improvements in Lifestyle
  - Reduce/stop smoking
  - Reduce alcohol consumption
  - Modify overeating habits
  - Adhere to a regular exercise program
- Improvements in Physical Fitness
  - Achieve proper weight and reduce body fat
  - Improve muscular strength and flexibility
  - Increase aerobic capacity
  - Reduce cholesterol and triglyceride levels
  - Reduce blood pressure

Improvements in lifestyle habits can serve as a foundation for lifelong wellness, including:

- Greater awareness of nutrition and health concepts
- Increased ability to manage stress
- Improved morale, confidence and self-esteem
- Improved awareness for conditions of disease

STATEMENT OF NEED

The need for a wellness program for employees grows from the national concern regarding the loss of human resources to degenerative diseases. A review of recent demographic data regarding the extent and costs associated with degenerative disease in the United States indicates that a disturbingly significant portion of the nation's productivity is being lost. In 1972, a governmental commission estimated that a total of $32 billion annually was associated with direct and indirect costs for heart disease. By 1976, the annual cost associated with heart disease had increased 36% to approximately $50 billion.[1] Today, heart disease is clearly the leading cause of death and disability in the United States, affecting 52% of the adult population.[2] One and a half million individuals suffer and die from hypertension and stroke yearly and over one-half million die from kidney failure and coronary artery disease.[3]

Many cost conscious employers have shifted from a passive to an active role by attacking the constant rise in health care and benefit expenses through an aggressive health/fitness program. Success stories from organizations that have reduced absenteeism and health care costs and improved employee health abound. A study by the Health Research Institute reported that 1,500 major employers reduced their health care costs from $1,115 to $806 per person through an employee wellness program.[4] In 1972 NASA, in association with the U.S. Public Health Evaluation and Enhancement Program, utilized a self administered questionnaire as part of a 12 month physical fitness program, to verify changes in health attitudes. The relationship between improved

work performance and attitudes was quite strong. Not only did participants report that they could work harder mentally and physically, but they also reported increased positive feelings about health status, greater endurance, increased energy, reduced weight and decreased stress and tension. These positive changes in mental fitness were in addition to significant improvements in physical fitness as measured through pre and post testing, i.e. treadmill test, skinfold measures, and blood pressure.[5]

In 1982, the Institute for Aerobics Research delivered a comprehensive fitness/wellness and stress management program to approximately 5,000 Dallas Independent School District employees and their spouses. At the completion of the pilot project, Superintendent Linus Wright stated, "it has proven to be one of the most positive and successful programs that I have seen in 34 years of my involvement in education." The "Personalized Aerobics Lifestyle System" (PALS), utilized by the Institute in the DISD project, produced positive results in terms of individual teacher health, lifestyle, fitness status and ability to manage stress. An extension of these results was a positive affect on absenteeism. The average absenteeism rate for participants was 5.86 days per year compared to 8.36 days per year for non-participants, a reduction of approximately 30%. This same trend was maintained the following year, with district wide implementation of the wellness program thus resulting in a $452,000.00 savings for the school district through reduced substitute teachers salaries alone. Further, the absenteeism data suggest that "time on task" was increased because the teachers spent more time in the classroom. It is well

documented, and no surprise, that no other variable in classrooms relates more significantly to increased student achievement than "time on task."

There is a growing acceptance that it is an administrative responsibility to define and deliver programs to improve employee fitness and wellness and to reduce absenteeism and health care costs for the organization. When organized and delivered in a systematic fashion by trained fitness leaders, validated wellness programs, such as PALS, can demonstrate significant improvements in both physiological and psychological status of employees.

COMPONENTS OF AN EFFECTIVE WELLNESS PROGRAM

Based on its past experience in leading and assisting business, industry and other agencies in implementing effective wellness programs, the Institute for Aerobics Research has defined a model containing eight major components. The organization and delivery of the program components as outlined below are critical for overall program success.

1. Medical Screening and Health/Fitness Assessment-- includes complete blood analysis, resting and exercising ECG and blood pressures, assessment of body weight and percentage of body fat, strength and flexibility tests, cardiovascular endurance (treadmill stress test) and a medical/health history questionaire.
2. Personalized Aerobic Lifestyle System (PALS) Manual-- contains personalized profiles for health risk, coronary risk, psychological perception and physical fitness. Guidelines for exercising and a dietary analysis with recommendations for nutrition/eating practices are also included in each PALS manual.
3. Individual Counseling/Goal Setting Sessions-- addresses the profiles and analysis provided in the PALS manual. A review of past fitness and nutrition performance are the basis for setting realistic goals for improvement in health status.
4. Education/Instruction-- five modules presented weekly in 30-45 minute sessions on the following topics:
   - Wellness-presents concepts and components of a Wellness Lifestyle

- Coronary Risk-presents determination and reduction of risk factors
- Exercise-presents type, intensity and duration of exercise for fitness
- Nutrition-presents balanced and sound dietary practices
- Stress Management-presents daily stress levels and management techniques

5. Group Exercise Classes-- provided twice weekly over the duration of the project. Class size is typically 30-40 persons and meetings are scheduled before or after work hours. Aerobic acitivities are included and each participant is trained to individually monitor his/her own heart rate.
6. Review and Feedback of Results-- provided to adjust nutrition and exercise goals and guidelines as necessary. Participants complete a weekly fitness report card for motivation and to encourage adherance to the program.
7. Progress Assessments-- conducted at designated intervals over the duration of the program. Participants are reassessed on the variables measured at the initial assessment. The treadmill stress test is administered every two years. An assessment of Aerobic power (12 minute walk/run) will be administered in place of the treadmill test in "even" years.
8. Motivation-- a variety of motivational sources are used with the program to contribute to program interest, enthusiasm and adherence. These include the following:

- Behavior Contracting
- Weekly Report Card Use
- Aerobic Point System
- T-shirts
- Evening Seminars for Family

PROGRAM DELIVERY

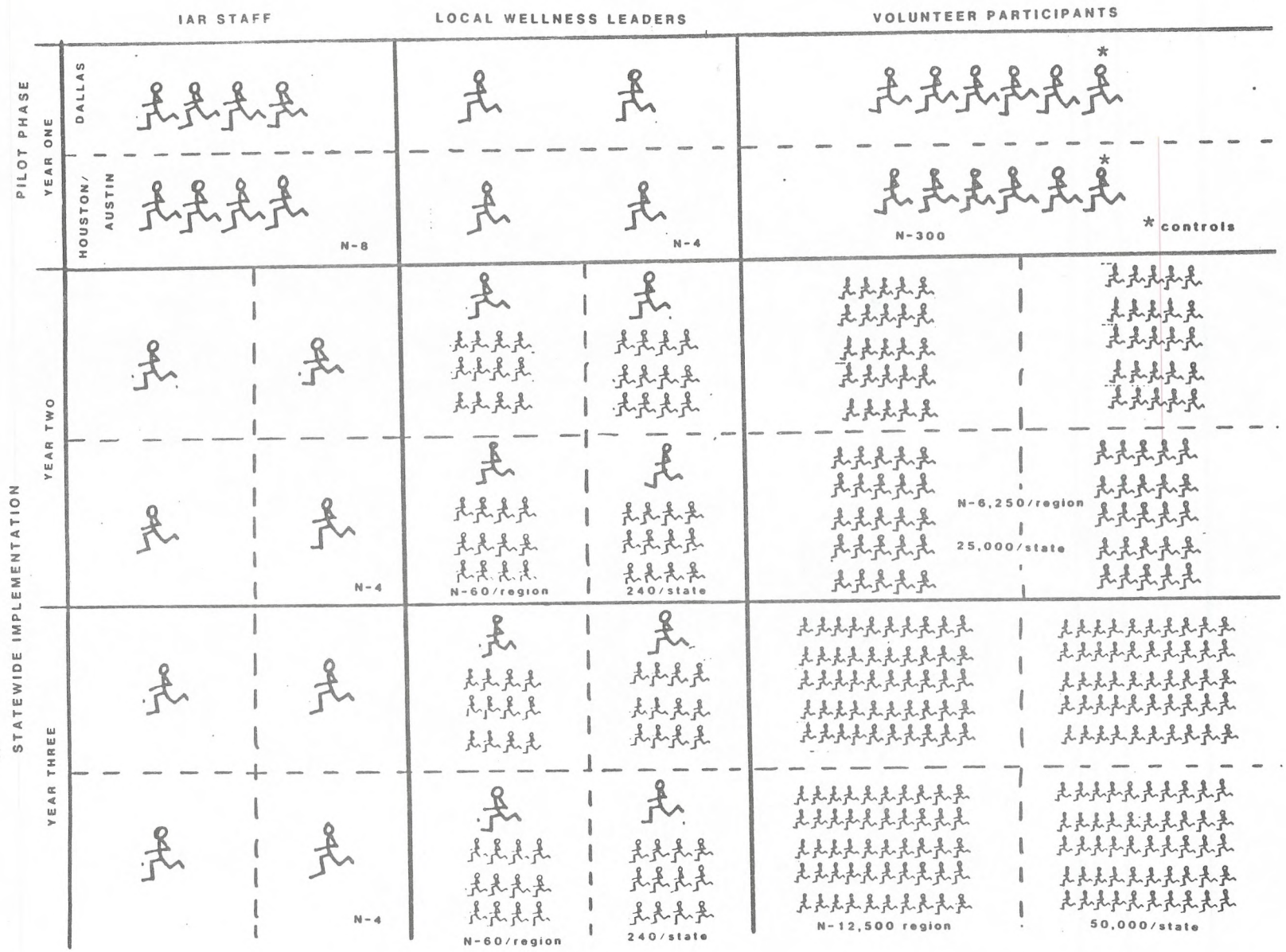
The proposed program will be implemented in two phases over three years. Phase one, the pilot program, provides for extensive efforts toward development, validation and evaluation of the project. A sample of 300 participants will be selected for the pilot study, to be offered in two cities. The methodology for program delivery provides for a high level of involvement of IAR personnel during year one.

Phase two, statewide implementation, expands the wellness program to all geographic areas of the state, serving approximately 25,000 in year two and 50,000 in year three. Local wellness leaders will assume primary responsibility for delivery of services during the statewide implementation. IAR staff will provide ongoing training and technical assistance to assure the quality and integrity of the program.

It is the intent of IAR that following the pilot year and two years of expanded implementation statewide, that the State of Texas Wellness Program will be operating in an exemplary manner. The proposed Wellness Program follows the model which has been successfully implemented by IAR for the Dallas I.S.D. (1981-82 pilot year, 1982-83 and 1983-84), the Richardson I.S.D. (1983-84) and with City of Dallas Employees (1984).

Following is a display illustrating the multiplier effect of the model over three years. Also provided are discussions of unique features of each of the three years of implementation. Detailed outlines of activities, timelines, and responsibilities for each year are provided following each discussion.

STATE OF TEXAS WELLNESS PROGRAM



YEAR ONE

PILOT PHASE

- A Wellness Advisory/Evaluation Committee will be formed to oversee the implementation of the program, disseminate information and results and make recommendations based on the pilot project's evaluation regarding the statewide implementation of the project. A committee of eight members is recommended to serve terms of two years.

- Pilot program activity sites will be chosen in the Dallas and Houston or Austin areas, based on availability of space and convenience to the program participants. Two sites per city are recommended.

- IAR staff will assume primary responsibility for delivery of service to participants during the pilot phase. Four State of Texas employees will be trained as Wellness Leaders to assist the Institute staff in testing, counseling, and delivering services to the 300 volunteer participants. Wellness leaders will continue to conduct the exercise classes when the education and assessment components have been completed.

- All health/physical assessments will be conducted during regular work hours. The individual counseling/goal setting component will be offered at the work site. All other educational and exercise sessions will be conducted before/after regular work hours.

- The pilot phase will include extensive evaluation activities related to both project implementation and impact. An experimental design utilizing a control group of 50, 25 per city, will compare participants (N=250) to non-participants on selected physiological and psychological variables. The State of Texas will be encouraged to collect data to answer questions about the project's effect on absenteeism and health care costs.

- The pilot phase will conclude with an end-of-project meeting to present the evaluation results to the Advisory/Evaluation Committee. The plan for statewide implementation will be refined based on the evaluation findings and the committee's recommendations.

PILOT PHASE

YEAR ONE

ACTIVITIES	TIMELINE	RESPONSIBILITY IAR	RESPONSIBILITY STATE	EXPLANATIONS
• Secure contractual agreement	Week #1	**	**	
• Contact key individuals to obtain nominations for membership on Advisory/ Evaluation Committee	Week #1		**	
• Contact nominees regarding willingness to serve on committee	Week #1		**	IAR furnishes sample letter of invitation
• Develop sample support materials to use in promoting/recruiting participants for the program	Weeks #1 & 2	**	**	Printing/distribution by State of Texas
• Determine sites for pilot program	Week #2	**	**	
• Conduct visits to sites to view space and determine facility needs	Week #2	**	**	
• Order/purchase equipment for testing and delivery of program	Week #2	**		
• Develop/duplicate all materials to be utilized in program delivery	Week #3	**	**	Printing completed by State personnel
• Select 8 members for Advisory/Evaluation Committee who are representative of the following categories: - State geographic regions - Agencies - Job classifications - Demographic categories	Week #3		**	

** Indicates primary responsibility

PILOT PHASE

YEAR ONE

ACTIVITIES	TIMELINE	RESPONSIBILITY IAR	RESPONSIBILITY STATE	EXPLANATIONS
• Conduct orientation meeting with committee to present overview of Wellness Program	Week #4	**	**	1 day meeting at IAR
• Identify 4 Wellness Leaders to assist IAR personnel in testing, counseling and delivery. Wellness Leaders will serve as assistant trainers during Statewide implementation phases	Week #5		**	IAR furnishes guidelines for selection
• Designate an employee liason to serve as public relations/communications contact person to be responsible for: - local news releases - flyers/brochures - inter-agency newsletter	Week #5		**	One per city = 2
• Designate an employee Wellness Manager to facilitate internal communications and program flow as follows: - recruitments - registration/orientation - schedule appointments - locate facilities/space for program delivery	Week #5		**	One per site = 4
• Conduct training for Wellness Leaders	Weeks #8 & 9	**		12 days at IAR
• Conduct registration/orientation with all potential participants	Week #9	**	**	Liasons and managers assi
• Select 50 controls (25 per city) to be stratified and representative of the state employee profile	Week #10	**		

** Indicates primary

PILOT PHASE
YEAR ONE

ACTIVITIES	TIMELINE	RESPONSIBILITY IAR	RESPONSIBILITY STATE	EXPLANATIONS
• Select a sample of 250 (125 per city) to be stratified and representative of the state employee profile	Week #10	**		
• Begin delivery of program components spouse and participant orientation	Week #11	**		Wellness Leaders assist IAR staff Participants receive registration packet
• Enter all participants (N=300) in the Wellness database using SS# for identification purposes	Week #12	**		Computer generated participant lists
• Initial assessments on physiological and psychological variables: -treadmill performance -low back and posterior thigh flexibility -upper and lower body muscular strength -height, weight and percent body fat -blood pressure -blood chemistry -total well-being assessment -job satisfaction	Weeks #13-16			First week, blood drawn Weeks 2-3, medical screening and fitness assessments
• Counseling and goal setting	Weeks #19-21	**		
• Education and exercise	Weeks #22-30	**		
• Continue group exercise classes	Weeks #30 and ongoing		**	Wellness Leaders conduct classes ** Indicates primary responsibility

PILOT PHASE

YEAR ONE

ACTIVITIES	TIMELINE	RESPONSIBILITY		EXPLANATIONS
		IAR	STATE	
• Progress Testing (repeats initial physiological and psychological assessments)	Weeks #31-32	**		
• Collect and analyze data on the following variables: -Employee participation/adherence -Absenteeism -Health care costs	Weeks 12-30		**	IAR provides assistance
• Monitor implementation of all activities using process evaluation techniques	ongoing	**	**	
• Awards/Recognition Ceremony	Week #35	**	**	Optional
• File progress reports with Advisory/ Evaluation Committee members	Weeks #14, 22 and 32	**		
• File comprehensive final report	Week #42	**		
• Conduct end-of-project meeting with Advisory/Evaluation Committee to review report, make recommendations and refine plan for statewide implementation	Week #42	**	**	1½ day meeting (site to be determined)
				** Indicates primary responsibility

YEAR TWO

STATEWIDE IMPLEMENTATION

- Information regarding the statewide implementation of the Wellness Program will be communicated through posters, flyers, newsletters, department meetings and the employee communication network. Local wellness liaisons and managers will facilitate registration and scheduling.

- Two hundred forty local wellness leaders will be recruited to serve approximately 25,000 participants. The four State of Texas employees who were trained as leaders for the pilot phase will assist IAR staff in the twelve day training workshops. Training activities will be conducted on a regional basis.

- Four IAR staff, one per geographic region, will serve as contact person for the Wellness Program to conduct training and provide assistance to insure the integrity of the program.

- The State of Texas will contract with local agencies to conduct medical screening and assessments. IAR will provide assistance in locating services, which will include a treadmill stress test for all first year participants.

- Each participant will receive a complete PALS manual and one Adult FITNESSGRAM. The FITNESSGRAM is a computerized fitness profile with guidelines for improving performance levels.

- A State of Texas Wellness Newsletter will be developed and disseminated quarterly to all participants. IAR staff will provide health related articles for the newsletter.

- Mid-year and final evaluation reports will be furnished to the Advisory/Evaluation Committee.

STATEWIDE IMPLEMENTATION

YEAR TWO

ACTIVITIES	TIMELINE	RESPONSIBILITY		EXPLANATIONS
		IAR	STATE	
• Advise committee members of their responsibilities during implementation years.			**	
• Recruit participants on a statewide basis. Set minimum number of participants for offering program by site.			**	Total participants = 25,000
• Reproduce materials for delivery of services.			**	
• Define sites within cities/regions.			**	
• Determine space and equipment needs.			**	
• Select Wellness Leaders			**	Approximately 1/100 participants. Some variation will occur by site.
• Expand the communications network as follows: - Wellness Liasons (1 per site) - Wellness Managers (1 per site) - Regional Wellness Managers (4)			**	
• Conduct training for Wellness Leaders at 4 regional locations. Four Leaders from pilot phase will serve as Assistant Instructors.		**		Two 12 day training workshops per region = 8
• Conduct search and contract with local agencies for medical screening, initial and progress assessments			**	IAR assists in search

STATEWIDE IMPLEMENTATION

YEAR TWO

ACTIVITIES	TIMELINE	RESPONSIBILITY IAR	RESPONSIBILITY STATE	EXPLANATIONS
• Register participants and conduct orientation			**	
• Implement program components on ongoing basis.			**	Replicates pilot program Includes one adult FITNESSGRAM per participar
• Produce a statewide Wellness Newsletter on quarterly basis			**	IAR furnishes health promotion articles
• Conduct on-site visits to selected locations to assure program validity and integrity	ongoing	**		
• Provide ongoing technical assistance for quality control.	ongoing	**		Telecommunications and correspondence
• Analyze program data for evaluation purposes		**	**	
• Produce mid-year and final evaluation reports		**	**	Copies provided to Advisory/Evaluation Committee members

YEAR THREE

STATEWIDE IMPLEMENTATION

- The role of the committee will be primarily to assist in dissemination of information about the Wellness Program and to give advise regarding future directions. Four member positions should be rotated on a yearly basis, beginning this year.

- Because of attrition, some wellness leaders will need to be replaced. Training for new leaders, as well as training to upgrade the skills of the experienced leaders will be an important part of this phase. In the second year of statewide implementation the 240 wellness leaders will serve approximately 50,000 participants. IAR contact persons will continue to conduct training and provide assistance as needed.

- Second year participants will receive two adult FITNESSGRAMS during this phase. For this group, the 12 minute walk/run will replace the treadmill stress test as a measure of cardiovascular endurance. First year participants will receive the program components as outlined previously. As second year participants move into year three their PALS manuals will be replaced and upgraded with new guidelines.

- The statewide wellness newsletters and mid-year and final evaluation reports will continue to be produced.

STATEWIDE IMPLEMENTATION

YEAR THREE

ACTIVITIES	TIMELINE	RESPONSIBILITY		EXPLANATIONS
		IAR	STATE	
• Rotate membership of Advisory/Evaluation Committee. Select 4 new members			**	
• Recruit new participants on a statewide basis. Determine number of second year participants			**	Add 25,000 participants
• Reproduce materials for delivery of services			**	
• Determine space and equipment needs. Add sites as needed			**	
• Recruit new Wellness Leaders			**	Approximately 1/200 participants
• Conduct training/retraining for Wellness Leaders		**		One 12 day training session for new leaders Eight 5 day sessions to upgrade skills of experienced leaders
• Contract with local agencies for medical screening and initial and progress assessments			**	Aerobic power assessment (12 minute walk/run) replaces treadmill stress test for 25,000 second year participants
• Register participants and conduct orientation			**	
				** Indicates primary responsibility

STATEWIDE IMPLEMENTATION

YEAR THREE

ACTIVITIES	TIMELINE	RESPONSIBILITY		EXPLANATIONS
		IAR	STATE	
• Implement program components on ongoing basis			**	
• Conduct on-site visits to selected locations and provide technical assistance upon request		**		
• Collect data for evaluation/individual feedback purposes - First year participants receive PALS manual and one adult FITNESSGRAM - Second year participants receive two adult FITNESSGRAMS		**	**	State assures quality of data
• Produce a statewide Wellness newsletter on a quarterly basis			**	
• Analyze data and produce mid-year and final evaluation reports		**	**	Copies provided to Advisory/Evaluation Committee Members ** Indicates primary responsibility

PROGRAM EVALUATION

Evaluation of the pilot Wellness Program will include both management by objective and outcome based evaluation techniques. Management objectives critical to the implementation of the Wellness Program will be carefully monitored by both IAR and State of Texas personnel. Elements to be evaluated include communication and dissemination, adherence, and attendance, scheduling of space and facilities and delivery of program components. An evaluation of this type will help to ensure that all tasks are carried out efficiently, project timelines are met and the budget is followed. Problems which might occur during the pilot phase will be corrected before statewide implementation is undertaken.

Also during the pilot phase health/physical fitness assessments will be analyzed using a repeated measures design to determine if significant improvements are made by the participant group (N=250) compared to the control group (n=50). The Institute for Aerobics Research will conduct and analyze data related to the following outcome variables:

Physiological Variables

- Cardiovascular fitness determined by treadmill performance
- Low back and posterior thigh flexibility
- Upper and lower body muscular strength
- Height, weight and percentage of body fat
- Blood pressure
- Blood chemistry

Psychological Variables

- Total Well-being
- Freedom from worry
- Energy level
- Satisfaction
- Cheerful attitude
- Relaxed attitude
- Emotional control
- Stress management
- Job satisfaction

The Institute for Aerobics Research will also provide assistance to the State of Texas personnel in collecting and analyzing data related to:

- Employee participation
- Absenteeism
- Health care cost

During the pilot phase, three interim progress reports will be furnished to the Wellness Advisory/Evaluation Committee. At the conclusion of the pilot project, a comprehensive evaluation report will be presented to the committee during a one and one-half day meeting. The purpose of the final session is not only to disseminate the findings of the study to persons who had interest in the program, but to solicit their recommendations in planning for statewide implementation of the program in future years.

Evaluation of the Wellness Program during subsequent years of implementation will utilize a quasi-experimental design (no control

group). Data will be collected on the same physiological and psychological variables as outlined in the pilot phase, with one exception. After the first year of participation, individuals will receive a treadmill stress test every other year. Another assessment of aerobic power, the 12 minute walk/run, will be substituted on "even" years. During statewide implementation, assessments will be for the purpose of providing feedback to the individual regarding their progress, as well as for evaluating the impact of the program on a longitudinal basis. The adult FITNESSGRAM, a report card providing individual profiles on four fitness variables along with guidelines for making improvements, will be introduced during the statewide implementation phase.

REFERENCES

1. Dreitner, Robert. "Employee Physical Fitness: Protecting an Investment in Human Resources." Personnel Journal, July 1984.

2. Miller, David K. and Allen T. Ear. Fitness: A Lifetime Commitment. Burgess Publishing Co., Minneapolis, Minnesota, 1979.

3. American Heart Association. Publication of Hypertension, 1983.

4. Health Forecast, March-April 1983, Vo.. 3, No. 2.

5. Durbeck, D. C., F. Heinzelman, J. Schacter, W. L. Haske, G. H. Payne, R. Y. Moxley, M. Nemiroff, D. D. Limoncelli, L. A. Arnold, and S. M. Fox. "NASA V. S. Public Health Service Health Evaluation and Enhancement Program," The American Journal of Cardiology, Vol. 30, November 20, 1972.

BUDGET

PILOT PHASE

PROJECTED LINE ITEM BUDGET

A) Personnel:

1) Research and Training Associate (2)

Assessments, Counseling and Delivery....80 days @ $238.00/day = $19040.00

2) Research and Training Associate (4)

Assessments .....25 days @ $476.00/day = $11900.00

3) Research and Training Associate (2)

Counseling .....15 days @ $238.00/day = $ 3570.00

4) Physician (2)

.....25 days @ $600.00/day = $15000.00

5. Medical Technician

.....30 hrs. @ $ 10.00/hr. = $ 300.00

6. Clerical (1/3)

.....27 days @ $ 59.50/day = $ 1606.50

Personnel Total: $51416.50

B) Indirect Charges:

Social security, insurance, worker's compensation, retirement, mortgage, utilities.....$38562.00

Indirect Charges Total: $38562.00

C) Expendable Items:

1) Audiovisual Software (slides and overheads)

.....2 sets @ $112.00 = $ 224.00

2) Cassette Tapes

..... 10 @ $ 6.00 = $ 60.00

3) ECG Paper

.....12 cs. @ $ 75.00 = $ 900.00

4) Electrodes

..... 9 cs. @ $175.00 = $ 1575.00

5) Miscellaneous

..... $ 300.00

Expendable Items Total: $ 3059.00

D) Participant Materials and Supplies

1. Personalized Aerobics Lifestyle Manuals (computer generated based on individual data)..... 300 @ $ 95.00 = $28500.00

2. Aerobics Way (book)

..... 300 @ $ 3.00 ea. = $ 900.00

3. T-Shirts

..... 300 @ $ 5.00 ea. = $ 1500.00

4. Motivational Items (trophies and awards)

..... 300 @ $ 2.00 ea. = $ 600.00

5. Exercise Mats

..... 300 @ $ 16.00 ea. = $ 4800.00

6. Blood Analysis (300 - 1 analysis)

..... 300 @ $ 10.00 = $ 3000.00

Participant Materials and Supplies Total: $39300.00

E) Data Processing Time and Service

1) Program Evaluation Report

..... $ 2000.00

Data Processing Time and Service Total: $ 2000.00

F) Equipment

		Quantity	Lease Per Unit	Total
1)	Treadmill (Pacer #R-3D)	2	$ 1640.00	$ 3280.00
2)	ECG & Oscilloscope	2	$ 4800.00	$ 9600.00
3)	Defibrillator	2	$ 680.00	$ 1360.00
4)	Sphygmomanometer	2	$ 88.00	$ 176.00
5)	Stethescope	2	$ 14.00	$ 28.00
6)	Large Blood Pressure Cuff	2	$ 22.00	$ 44.00
7)	Emergency Crash Cart	2	$ 160.00	$ 320.00
8)	Cassette Player	2	$ 40.00	$ 80.00
9)	Clinic Cot	2	$ 116.50	$ 233.00
10)	Flexibility Box	2	$ 12.00	$ 24.00
11)	Anthropometric Tape	2	$ 4.00	$ 8.00
12)	Mats - Sit Ups and Flexibility	4	$ 12.00	$ 48.00
13)	Stationary Scales	2	$ 160.00	$ 320.00
14)	Skinfold Calipers (Lange)	2	$ 74.50	$ 149.00
15)	Stopwatch	4	$ 14.00	$ 56.00
16)	Room Partitions	10	$ 80.00	$ 800.00
17)	Bench Press	2	$ 987.00	$ 1974.00
18)	Leg Press	2	$ 1205.00	$ 2410.00

Equipment Total: $20910.00

Grand Total:

..... $155247.50

Recommended Funding Options

Participants Fee	$ 175.00
State Of Texas Fee (per participant)	$ 342.49
Total Cost per participant	$ 517.49

PROJECTED PROPOSAL BUDGET OVERVIEW

LINE ITEMS	YEAR ONE PILOT PHASE	YEAR TWO STATEWIDE IMPLEMENTATION	YEAR THREE STATEWIDE IMPLEMENTATION
	See Itemized Budget Pages 26-29		
1. Institute for Aerobics Research Services			
1.1 Program Development [plus travel expenses (delivery plan, design, scheduling and technical assistance)]		1.1 22,500.00	1.1 22,500.00
1.2 Training (workshops for training 240 wellness leaders)		1.2 136,000.00 8-12 day training sessions	1.2 83,178.00 1-12 day training session 8-5 day training sessions
1.3 Personnel (four IAR staff for on/off site monitoring plus travel expenses)		1.3 120,000.00	1.3 120,000.00
1.4 Indirect Charges (social security, insurance, workman's compensation)		1.4 90,000.00	1.4 90,000.00
1.5 Evaluation		1.5 21,000.00	1.5 42,000.00
1.6 Materials (PALS manual and Adult FITNESSGRAM		1.6 1,537,000.00	1.6 1,862,500.00
1.7 Program Delivery Materials (transparencies, educational plans, S.O.P. manual, audio exercise tapes, focus feedback and evaluation forms)		1.7 46,875.00	1.7 46,875.00
1.8 Equipment (cassette players for exercise classes)		1.8 15,000.00	1.8 1,000.00
1.9 Blood Analysis (one per participant)		1.9 250,000.00	1.9 500,000.00
		subtotal: 2,238,375.00	subtotal: 2,768,053.00
2. Contracted Medical Screening and Fitness Assessments			
2.1 Stress Test and Fitness Assessments (projected cost of $300.00 each)		2.1 7,500,000.00	2.1 7,500,000.00
2.2 Progress Assessments (projected cost of $75.00 each)		2.2 1,875,000.00	2.2 5,625,000.00
		subtotal: 9,375,000.00	subtotal: 13,125,000.00
		total: 11,613,375.00	total: 15,893,053.00
3. Recommended Funding Options (excluding state personnel costs)			
3.1 participant fee	3.1 175.00	3.1 175.00	3.1 175.00
3.2 State of Texas fee	3.2 342.49	3.2 289.53	3.2 142.66
3.3 Total Cost per participant	3.3 517.49	3.3 464.53	3.3 317.66

EXHIBIT 4

Computerized Health Questionnaire and Analysis

SPECIAL CODES	LINE 1
0 1	1-6

LAST NAME	FIRST NAME	M I	
			7-26

SOCIAL SECURITY NUMBER	
	27-35

PLEASE ENTER YOUR ANSWERS IN THE EMPTY BOXES (use numbers only)

1. SEX [1] Male [2] Female — 36

2. RACE/ORIGIN [1] White (non-Hispanic origin) [2] Black (non-Hispanic origin) [3] Hispanic [4] Asian or Pacific Islander [5] American Indian or Alaskan Native [6] Not sure — 37

3. AGE (At Last Birthday) Years Old — 38-39

4. HEIGHT (Without Shoes) Example: 5 foot, 7½ inches = [5] ' [0][8] '' (No Fractions) — 40-42

5. WEIGHT (Without Shoes) Pounds — 43-45

6. TOBACCO [1] Smoker [2] Ex-Smoker [3] Never Smoked — 46

(Smokers and Ex-smokers) Enter average number smoked per Day in the last five years (ex-smokers Should use the last five years before quitting.)

Cigarettes Per Day	47-48
Pipes/Cigars Per Day (Smoke Inhaled)	49-50
Pipes/Cigars Per Day (Smoke Not Inhaled)	51-52

(Ex-smokers only) Enter Number of Years Stopped Smoking (Note: Enter 1 for less than one year) — 53-54

7. ALCOHOL [1] Drinker [2] Ex-Drinker (Stopped) [3] Non-Drinker (or drinks less than one drink per week) — 55

If you drink alcohol, enter the average number of drinks per week:

Bottles of beer per week	56-57
Glasses of wine per week	58-59
Mixed drinks or shots of liquor per week	60-61

8. DRUGS/MEDICATION How often do you use drugs or medication which affect your mood or help you to relax? [1] Almost every day [2] Sometimes [3] Rarely or Never — 62

9. MILES Per Year as a driver of a motor vehicle and/or passenger of an automobile (10,000 = average) Thousands of miles — [0][0][0] 63-67

10. SEAT BELT USE (percent of time used) Example: about half the time = [5][0] — % 68-70

11. PHYSICAL ACTIVITY LEVEL — 71

[1] Level 1 - little or no physical activity

[2] Level 2 - occasional physical activity

[3] Level 3 - regular physical activity at least 3 times per week

NOTE Physical activity including work and leisure activities that require sustained physical exertion such as walking briskly, running, lifting and carrying.

12. Did either of your parents die of a heart attack before age 60? [1] Yes, One of them [2] Yes, Both of them [3] No [4] Not sure — 72

13. Did your mother, father, sister or brother have diabetes? [1] Yes [2] No [3] Not sure — 73

14. Do YOU have diabetes? [1] Yes, not controlled [2] Yes, controlled [3] No [4] Not sure — 74

(Continued on Other Side

15. Rectal problems (other than piles or hemorrhoids).
Have you had. Rectal Growth? [1] Yes [2] No [3] Not Sure — 75
Rectal Bleeding? [1] Yes [2] No [3] Not sure — 76
Annual Rectal Exam? [1] Yes [2] No [3] Not sure — 77

16. Has your physician ever said you have Chronic Bronchitis or Emphysema? [1] Yes [2] No [3] Not Sure — 78

LINE 2

17. Blood Pressure (If known — otherwide leave blank) Systolic (High Number) — 1-3
Diastolic (Low Number) — 4-6

18. Fasting Cholesterol Level (If known — otherwise leave blank) MG/DL — 7-9

19. Considering your age, how would you describe your overall physical health?
[1] Excellent [2] Good [3] Fair [4] Poor — 10

20. In general how satisfied are you with your life?
[1] Mostly Satisfied [2] Partly Satisfied [3] Mostly Disappointed [4] Not Sure — 11

21. In general how strong are your social ties with your family and friends?
[1] Very strong [2] About Average [3] Weaker than average [4] Not Sure — 12

22. How many hours of sleep do you usually get a night?
[1] 6 hours or less [2] 7 hours [3] 8 hours [4] 9 hours or more — 13

23. Have you suffered a serious personal loss or misfortune in the Past Year? (For example, a job loss, disability, divorce, separation, jail term, or the death of a close person)
[1] Yes, one serious loss [2] Yes, Two or More serious losses [3] No — 14

24. How often in the Past Year did you witness or become involved in a violent or potentially violent argument?
[1] 4 or more times [2] 2 or 3 times [3] Once or never [4] Not sure — 15

25. How many of the following things do you usually do?
- Hitch-hike or pick up hitch-hikers
- Carry a gun or knife for protection
- Keep a gun at home for protection
- Critize or argue with strangers
- Live or work at night in a high-crime area
- Seek entertainment at night in high-crime areas or bars.

[1] 3 or more [2] 1 or 2 [3] None [4] Not sure — 16

26. Have you had a hysterectomy? (Women only) [1] Yes [2] No [3] Not sure — 17

27. How often do you have Pap Smear? (Women only)
[1] At least once per year [2] At least once every 3 years [3] More than 3 years apart
[4] Have never had one [5] Not sure [6] Not applicable — 18

28. Was you last Pap Smear Normal? (Women only) [1] Yes [2] No [3] Not sure [4] Not applicable — 19

29. Did your mother, sister or daughter have breast cancer? (Women only) [1] Yes [2] No [3] Not sure — 20

30. How often do you examine your breasts for lumps? (Women only)
[1] Monthly [2] Once every few months [3] Rarely or never — 21

31. How many times have you completed this computerized Health Risk Appraisal Questionaire?
(Enter number 0 = Never 1 = Once etc.) — 22

32. Current Marital Status [1] Single (Never married) [2] Married [3] Separated
[4] Widowed [5] Divorced [6] Other — 23

33. Schooling completed (One choice only) [1] Did Not graduate from high school [2] High School
[3] Some College [4] College or Professional Degree — 24

34. Employment Status [1] Employed [2] Unemployed
[3] Homemaker, Volunteer or Student [4] Retired, Other — 25

35. Type of occupation (SKIP IF NOT APPLICABLE)
[1] Professional, Technical, Manager, Official or Proprietor [2] Clerical or Sales
[3] Craftsman, Foreman or Operative [4] Service or Laborer — 26

HEALTH RISK APPRAISAL
DATE: 10-26-82

YOUR HEALTH RISK DATA HAVE BEEN ANALYZED AND THE RESULTS ARE SUMMARIZED BELOW AS THEY RELATE TO THE 12 MOST FREQUENT CAUSES OF DEATH FOR WHITE MALES AGED 43.

RANK	CAUSE OF DEATH	CHANCES OF DYING PER 100,000 WITHIN THE NEXT 10 YEARS			
		COL.1 AVERAGE	COL.2 APPRAISAL	COL. 3 ACHIEVABLE	COL.2-COL.3 DIFFERENCES
1	ARTERIOSCLEROTIC HEART DISEASE	2111	13538	5097	8441
2	LUNG CANCER	514	771	616	155
3	CIRRHOSIS OF THE LIVER	369	738	369	369
4	SUICIDE	267	267	267	0
5	NON-MOTOR VEHICLE ACCIDENTS	240	240	240	0
6	MOTOR VEHICLE ACCIDENTS	238	502	242	260
7	STROKE	206	1148	604	544
8	INTESTINAL CANCER INCL. RECTUM	125	101	30	71
9	HOMICIDE	108	54	54	0
10	CHRONIC BRONCHITIS AND EMPHYSEMA	93	139	97	42
11	PNEUMONIA	83	91	74	17
12	DIABETES	70	237	50	187
	ALL OTHER CAUSES	1708	1708	1708	0
	ALL CAUSES OF DEATH	6132	19534	9448	10086

	ACTUAL	APPRAISED	ACHIEVABLE	DIFFERENCE
AGE:	43	56.2	47.8	8.4

FOR HEIGHT 73 INCHES AND MEDIUM FRAME, 274 LBS. IS APPROXIMATELY 60% OVERWEIGHT - - - DESIRABLE WEIGHT IS 171 LBS.

********** COMPLIANCE **********

* AVERAGE CHANCES OF DYING ARE BASED ON 1975-1977 U. S. MORTALITY DATA. (CDC VERSION 1.1)
* APPRAISED AGE (OR "HEALTH AGE") IS AN ESTIMATE OF HOW HEALTHY YOU ARE COMPARED TO OTHERS OF YOUR RACE AND SEX.
* ACHIEVABLE AGE IS AN ESTIMATE OF HOW HEALTHY YOU COULD BE BY MAKING THE FOLLOWING CHANGES IN YOUR CONDITION/LIFESTYLE:

SMOKING	FROM:	STILL SMOKES 20+	TO:	STOPPED SMOKING
BP:SYST	FROM:	166 MM.	TO:	140 MM.
BP:DIAS	FROM:	110 MM.	TO:	88 MM.
ALCOHOL	FROM:	7-24/WEEK	TO:	3-6/WEEK
WEIGHT	FROM:	274 LBS.	TO:	196 LBS.
SEATBELT	FROM:	25-74%	TO:	75-100%
RECTEXAM	FROM:	NO ANNUAL EXAM	TO:	ANNUAL EXAM AFTER 40

****

* NOTE -- HOMICIDE RISK IS PARTLY BASED ON HIGH-RISK ACTIVITIES INCLUDING USE OF WEAPONS, ENCOUNTERS WITH STRANGERS AND THE AMOUNT OF CONTACT WITH HIGH-CRIME AREAS.

* NOTE -- SUICIDE RISK IS PARTLY BASED ON ANSWERS TO QUESTIONS ABOUT PHYSICAL HEALTH, LIFE SATISFACTION, SOCIAL TIES, HOURS OF SLEEP, RECENT LOSS OR MISFORTUNE AND MARITAL STATUS.

CAUSE OF DEATH	CONDITION	APPRAISAL: AS APPRAISED	APPRAISAL: PARTIAL RISK	APPRAISAL: TOTAL RISK	ACHIEVABLE: ACHIEVED	ACHIEVABLE: PARTIAL RISK	ACHIEVABLE: TOTAL RISK
ARTERIOSCLEROTIC HEART DISEASE	BL.PRESS	166/110	1.6/4.8		140/ 88	1.2/2.8	
	DIABETES	NOT DIABETIC	0.9		NOT DIABETIC	0.9	
	WEIGHT	274	1.9		196	1.0	
	EXERCISE	RECOMMENDED	0.6		RECOMMENDED	0.6	
	SMOKING	STILL SMOKES 20+	1.5		STOPPED SMOKING	0.7	
	FH/HEART	NO	1.0	6.41	NO	1.0	2.41
LUNG CANCER	SMOKING	STILL SMOKES 20+	1.5	1.50	STOPPED SMOKING	1.2	1.20
CIRRHOSIS OF THE LIVER	ALCOHOL	7-24/WEEK	2.0	2.00	3-6/WEEK	1.0	1.00
SUICIDE	S-SCALE	AVERAGE RISK	1.0		AVERAGE RISK	1.0	
	ALCOHOL	7-24/WEEK	1.0	1.00	3-6/WEEK	1.0	1.00
MOTOR VEHICLE ACCIDENTS	ALCOHOL	7-24/WEEK	2.0		3-6/WEEK	1.0	
	MILES/YR	13000	1.3		13000	1.3	
	SEATBELT	25-74%	0.9		75-100%	0.8	
	DRUG USE	RARELY OR NEVER	0.9	2.11	RARELY OR NEVER	0.9	1.02
STROKE	BL.PRESS	166/110	1.6/4.8		140/ 88	1.2/2.8	
	DIABETES	NOT DIABETIC	0.9		NOT DIABETIC	0.9	
	SMOKING	STILL SMOKES 20+	1.2	5.57	STOPPED SMOKING	1.0	2.94
INTESTINAL CANCER INCL. RECTUM	RECT-GRO	HAS NOT HAD	0.9		HAS NOT HAD	0.9	
	RECTEXAM	NO ANNUAL EXAM	1.0		ANNUAL EXAM AFTER 40	0.3	
	RECT-BLD	NO BLOOD IN STOOL	0.9	0.81	NO BLOOD IN STOOL	0.9	0.24
HOMICIDE	ARGUMENT	SAW OR IN 0-1/YEAR	0.5		SAW OR IN 0-1/YEAR	0.5	
	LIFESTYL	AVERAGE RISK	1.0	0.50	AVERAGE RISK	1.0	0.50
CHRONIC BRONCHITIS AND EMPHYSEMA	SMOKING	STILL SMOKES 20+	1.5	1.50	STOPPED SMOKING	1.0	1.05
PNEUMONIA	ALCOHOL	7-24/WEEK	1.0		3-6/WEEK	1.0	
	SMOKING	STILL SMOKES 20+	1.2		STOPPED SMOKING	1.0	
	EMPHYSEM	DOES NOT HAVE	0.9	1.10	DOES NOT HAVE	0.9	0.90
DIABETES	WEIGHT	274	3.5		196	0.8	
	FH/DIAB	NO	0.9	3.40	NO	0.9	0.72

********** END **********

* RISK FACTORS ADAPTED FROM "HOW TO PRACTICE PROSPECTIVE MEDICINE", DRS. ROBBINS AND HALL, METHODIST HOSPITAL OF INDIANA.
* COMPUTER PROGRAM DEVELOPED BY THE CENTER FOR HEALTH PROMOTION AND EDUCATION, CENTERS FOR DISEASE CONTROL, DHHS. (V1.1,XYZ)

NOTE: HEALTH RISK APPRAISAL IS STILL IN ITS EARLY STAGES OF DEVELOPMENT. ITS MAIN VALUE IS ITS POTENTIAL FOR SHOWING THE RELATIVE HEALTH RISKS ASSOCIATED WITH THE LIFESTYLE OF A PARTICULAR INDIVIDUAL. SINCE IT IS A DEVELOPMENTAL PROGRAM, IT SHOULD BE INTERPRETED BY A QUALIFIED HEALTH PROFESSIONAL.

EXHIBIT 5

1983 Metropolitan Height/Weight Table

TABLE 4

COMPARISON OF 1959 AND 1983 METROPOLITAN HEIGHT AND WEIGHT TABLES

MEN

Height (Without Shoes)		SMALL FRAME				MEDIUM FRAME				LARGE FRAME			
		1959	1983	Change Since 1959	Percent Change	1959	1983	Change Since 1959	Percent Change	1959	1983	Change Since 1959	Percent Change
Feet	Inches	Weight in Pounds (Without Clothing)											
5	1	105-113	123-129	18 16	17 14	111-122	126-136	15 14	14 11	119-134	133-145	14 11	12 8
5	2	108-116	125-131	17 15	16 13	114-126	128-138	14 12	12 10	122-137	135-148	13 11	11 8
5	3	111-119	127-133	16 14	14 12	117-129	130-140	13 11	11 9	125-141	137-151	12 10	10 7
5	4	114-122	129-135	15 13	13 11	120-132	132-143	12 11	10 8	128-145	139-155	11 10	9 7
5	5	117-126	131-137	14 11	12 9	123-136	134-146	11 10	9 7	131-149	141-159	10 10	8 7
5	6	121-130	133-140	12 10	10 8	127-140	137-149	10 9	8 6	135-154	144-163	9 9	7 6
5	7	125-134	135-143	10 9	8 7	131-145	140-152	9 7	7 5	140-159	147-167	7 8	5 5
5	8	129-138	137-146	8 8	6 6	135-149	143-155	8 6	6 4	144-163	150-171	6 8	4 5
5	9	133-143	139-149	6 6	5 4	139-153	146-158	7 5	5 3	148-167	153-175	5 8	3 5
5	10	137-147	141-152	4 5	3 3	143-158	149-161	6 3	4 2	152-172	156-179	4 7	3 4
5	11	141-151	144-155	3 4	2 3	147-163	152-165	5 2	3 1	157-177	159-183	2 6	1 3
6	0	145-155	147-159	2 4	1 3	151-168	155-169	4 1	3 1	161-182	163-187	2 5	1 3
6	1	149-160	150-163	1 3	1 2	155-173	159-173	4 0	3 0	166-187	167-192	1 5	1 3
6	2	153-164	153-167	0 3	0 2	160-178	162-177	2 −1	1 −1	171-192	171-197	0 5	0 3
6	3	157-168	157-171	0 3	0 2	165-183	166-182	1 −1	1 −1	175-197	176-202	1 5	1 3

WOMEN

Height (Without Shoes)		SMALL FRAME				MEDIUM FRAME				LARGE FRAME			
		1959	1983	Change Since 1959	Percent Change	1959	1983	Change Since 1959	Percent Change	1959	1983	Change Since 1959	Percent Change
Feet	Inches	Weight in Pounds (Without Clothing)											
4	9	90- 97	99-108	9 11	10 11	94-106	106-118	12 12	13 11	102-118	115-128	13 10	13 8
4	10	92-100	100-110	8 10	9 10	97-109	108-120	11 11	11 10	105-121	117-131	12 10	11 8
4	11	95-103	101-112	6 9	6 9	100-112	110-123	10 11	10 10	108-124	119-134	11 10	10 8
5	0	98-106	103-115	5 9	5 8	103-115	112-126	9 11	9 10	111-127	122-137	11 10	10 8
5	1	101-109	105-118	4 9	4 8	106-118	115-129	9 11	8 9	114-130	125-140	11 10	10 8
5	2	104-112	108-121	4 9	4 8	109-122	118-132	9 10	8 8	117-134	128-144	11 10	9 7
5	3	107-115	111-124	4 9	4 8	112-126	121-135	9 9	8 7	121-138	131-148	10 10	8 7
5	4	110-119	114-127	4 8	4 7	116-131	124-138	8 7	7 5	125-142	134-152	9 10	7 7
5	5	114-123	117-130	3 7	3 6	120-135	127-141	7 6	6 4	129-146	137-156	8 10	6 7
5	6	118-127	120-133	2 6	2 5	124-139	130-144	6 5	5 4	133-150	140-160	7 10	5 7
5	7	122-131	123-136	1 5	1 4	128-143	133-147	5 4	4 3	137-154	143-164	6 10	4 6
5	8	126-136	126-139	0 3	0 2	132-147	136-150	4 3	3 2	141-159	146-167	5 8	4 5
5	9	130-140	129-142	−1 2	−1 1	136-151	139-153	3 2	2 1	145-164	149-170	4 6	3 4
5	10	134-144	132-145	−2 1	−1 1	140-155	142-156	2 1	1 1	149-169	152-173	3 4	2 2

Note Prepared by Metropolitan Life Insurance Company

Source of basic data *Build Study, 1979*, and *Build and Blood Pressure Study, 1959*, Society of Actuaries and Association of Life Insurance Medical Directors of America.

EXHIBIT 6

Sample Application for the

"Healthy Texan Discount"

Application

HEALTHY TEXAN DISCOUNT

Name of Employee _____ Social Security No. ___-___-___ Agency Code _____

I (We) hereby apply for participation in the Healthy Texan Discount under the Texas Employees Uniform Group Insurance Program for ___ myself; ___ my insured spouse.

EMPLOYEE

NAME _____ Social Sec No: ___-___-___

STREET _____ Age_____ Sex ___M ___F

_____,TX_____ Blood Pressure ____/____
city zip

*Weight ___ Height: ___' ___"

_____
Attending Physician, Registered Nurse, Licensed Vocational Nurse, or other licensed health professional approved by the Texas Department of Health

* with shoes and clothing

SPOUSE

NAME _____ Social Sec No: ___-___-___

STREET _____ Age_____ Sex ___M ___F

_____,TX_____ Blood Pressure ____/____
city zip

*Weight ___ Height: ___' ___"

_____
Attending physician, Registered Nurse, Licensed Vocational Nurse, or other licensed health professional approved by the Texas Department of Health

* with shoes and clothing

I (We) have read the statement on the back of this form relating to attempting to defraud any health benefits plan offered under the Texas Employees Uniform Group Insurance Program (Article 3.50-2 §13A, Texas Insurance Code) and hereby certify that no person who is making application here now uses any tobacco product, nor have they used any tobacco product for the past 12 months. I further certify that all information on this form is true and correct to the best of my knowledge and belief.

_____ _____ _____
Signature Of Employee Date Witness

I certify that I have reviewed the information being submitted by the employee for a Healthy Texan Discount. I believe it to be true and correct to the best of my knowledge and belief.

_____ _____
Employee Supervisor Date

_____ _____
Spouse Date

_____ _____
Chief Executive Officer of Agency Date

ERS USE ONLY

Expulsion From Group Insurance Program

Sec. 13A. (a) After notice and hearing as provided by this section, the trustee may expel from participation in the Texas employees uniform group insurance program any employee, annuitant, or dependent who submits a fraudulent claim under or has defrauded or attempted to defraud any health benefits plan offered under the program.

(b) On receipt of a complaint or on its own motion, the trustee may call and hold a hearing to determine whether or not an employee, annuitant, or dependent has submitted a fraudulent claim under or has defrauded or attempted to defraud any health benefits plan offered under the Texas employees uniform group insurance program.

(c) A proceeding under this section is a contested case under the Administrative Procedure and Texas Register Act (Article 6252–13a, Vernon's Texas Civil Statutes).

(d) At the conclusion of the hearing, if the trustee issues a decision that finds that the accused employee, annuitant, or dependent submitted a fraudulent claim or has defrauded or attempted to defraud any health benefits plan offered under the Texas employees uniform group insurance program, the trustee shall expel the employee, annuitant, or dependent from participation in the program.

(e) An appeal of a decision of the trustee under this section is under the substantial evidence rule.

(f) An employee, annuitant, or dependent expelled from the Texas employees uniform group insurance program may not be insured by any health insurance plan offered by the program for a period of five years from the date the expulsion from the program takes effect.

EXHIBIT 7

Actuarial Report

JOHN M. BRAGG AND ASSOCIATES, INC.
ACTUARIAL CONSULTANTS

ATLANTA
SUITE 1010
WEST PEACHTREE ST., N. W.
ATLANTA, GEORGIA 30308
(404) 898-1510

TORONTO
SUITE 108
2175 MARINE DRIVE
OAKVILLE, ONTARIO L6L 5L5
(416) 827-0445

SEP 13 1984

September 12, 1984

Mr. William P. Daves, Jr.
Chairman, Subcommittee on Wellness
Governor's Task Force on State Employees Health Insurance
1110 San Jacinto Boulevard
Austin, Texas 78786

Dear Mr. Daves:

The primary purposes of this report are:

(1) to unblend the monthly premium rates, for fiscal 1985, of the Employees Uniform Group Insurance Program, (Plans 1 and 2) so that Preferred and Regular rates emerge; and

(2) to estimate the percentage of employees, in each rate group, which qualifies for the Preferred status.

The results are summarized in Table 1. Details as to the methodology are included in this report.

It is our honor to be of service to the State of Texas in this important endeavor.

Yours Sincerely,

John M. Bragg and Associates, Inc.

John M. Bragg, FSA, ACAS

JMB:nbk

Table 1

Texas Employees Uniform Group Insurance Program

	Monthly Premium Rate	Unblended Rates		Estimated Percentage who Qualify	
		Preferred	Regular	Pure	Adjusted*
Plan 1					
Employee Only	$99.30	$82.10	$116.11	42.2%	49.4%
Employee & Spouse	218.68	161.37	248.47	24.8%	34.2%
Employee & Children	180.42	164.73	196.70	43.9%	50.9%
Employee & Family	266.80	230.31	284.40	22.9%	32.5%
				38.3%	46.0%
Plan 2					
Employee Only	$ 82.92	69.97	95.92	43.0%	50.1%
Employee & Spouse	159.01	121.77	178.22	24.6%	34.0%
Employee & Children	121.33	109.06	134.33	44.5%	51.4%
Employee & Family	201.82	170.92	217.70	24.5%	33.9%
				36.3%	44.2%
Overall % who qualify as Preferred (estimated).				37.1%	44.9%

*assumes a conservatism factor of 12½%.

Table 2

Texas Employees

Percentages who Qualify Under Rules

Age	(1) Tobacco Rule		(2) Build Rule		(3) Blood Pressure Rule		(4) No Overlap Rule		(5) Mean Overlap Rule	
	M	F	M	F	M	F	M	F	M	F
25	48.7%	60.9%	48.3%	79.9%	77.0%	92.0%	18.1%	44.8%	33.4%	52.8%
30	49.5%	62.4%	37.6%	74.5%	73.0%	87.0%	13.6%	40.4%	31.5%	51.4%
35	50.2%	64.0%	37.6%	74.5%	69.0%	83.0%	13.0%	39.6%	31.6%	51.8%
40	50.0%	65.7%	33.7%	64.3%	57.0%	75.0%	9.6%	31.7%	29.8%	48.7%
45	49.6%	67.5%	33.7%	64.3%	55.0%	69.0%	9.2%	29.9%	29.4%	48.7%
50	49.3%	69.1%	32.9%	55.0%	50.0%	50.0%	8.1%	19.0%	28.7%	44.1%
55	49.0%	71.1%	32.9%	55.0%	46.0%	43.0%	7.4%	16.8%	28.2%	44.0%
60	50.9%	77.2%	34.6%	49.4%	43.0%	37.0%	7.6%	14.1%	29.2%	45.7%
65	52.7%	86.4%	34.6%	49.4%	39.0%	34.0%	7.1%	14.5%	29.9%	50.5%

Comments:

The no-overlap rule (4) assumes that the tobacco rule, the build rule, and the blood pressure rule are mathematically independent of each other. (4) is the product of (1), (2), and (3).

The mean overlap rule (5) is the average of the tobacco rule and the no-overlap rule. This is our best estimate of the percentages who qualify when all these rules are used.

Principal Assumptions

The principal assumptions were as follows:

(1) To achieve Preferred status, an individual must qualify under all three rules:

abstinence from any form of tobacco for 12 months
weight satisfying the 1983 Metropolitan Height and Weight Tables
blood pressure not greater than 140/90.

(2) In cases where employee and spouse are both covered, both must qualify as above.

(3) Three categories were excluded from the unblend: covered dependent children, maternity coverage, and basic term life and AD & D coverage. Premiums for these categories were removed prior to the unblend; the unblend was then accomplished; premiums for the three categories were then added back to achieve the final result.

(4) The unblend was based on suitable premiums supplied to us (the 1985 fiscal year premiums); it was designed to reproduce the same total amount of premium income as the supplied premiums - subject to the assumptions made. A conservatism factor was included.

Detailed Assumptions

(a) The methodology is that which is described in the 1982 Bragg Report: "The Effect of Smoking/Nonsmoking on Health Insurance Costs". The Texas State Board of Insurance possesses a copy of that Report.

(b) Essentially, the method depends on the following:

p, which is the ratio complement of the proportion which qualifies as Preferred;

R, which is the ratio of Regular to Preferred morbidity claim cost for the particular Plan and cell; and

l, which is a conservatism factor. This is designed to deal with possible misclassification for any reason; it is discussed on pages 30-34 of the above-mentioned Report. An l factor of 12½% was used in this case.

(c) Proportions who qualify were first obtained, for each rule separately, by age and sex. Details are in Table 2.

(d) The proportion qualifing under the tobacco rule was based on data for a major Canadian life insurance company (which operates not only in Canada but in most States, including Texas) - medical and paramedical examined policies, issued 1978. The data are the same as in column (1) of page 5 of our 1982 Report, but are adjusted so as to be based on "all tobacco", rather than "cigarettes".

(e) The proportion qualifying under the height and weight rule was determined by applying the 1983 Metropolitan tables to data contained in the 1979 Build Study published by the Society of Actuaries and the Association of Life Insurance Medical Directors of America. The assumption was made that 25% of the individuals would be able to qualify under the large frame rule, and the balance under the small frame rule.

(f) The proportion qualifying under the blood pressure rule was determined from (1) U.S. Health and Nutrition Survey (Hanes) 1974; (2) Medical Risks (Singer and Levinson) 1976; and (3) Framingham Study Section 26 - Government Printing Office 1970.

(g) The proportion qualifying under the "no-overlap" rule was determined by multiplying the 3 separate probabilities for the 3 separate rules; this treated each rule as mathematically independent. However, there is a high likelihood that if a person qualifies under the tobacco rule he/she will tend to qualify under the other rules also; full compliance with this theory could be called the "full-overlap" rule. As a reasonable estimate, we have assumed that the proportion who will qualify will be the mean of the full-overlap results and the no-overlap results. These estimates are shown in the last column of Table 2.

(h) Very detailed information was available to us concerning the age and sex distribution of the employees by plan and rate classifications (see Health Exhibits 1 and 2 herein). These were used to weight the proportions in order to arrive at the estimated proportions which qualify (pure) which are shown in the second last column of Table 1.

(i) In the case of the "employee and spouse" and "employee and family" classifications, two adults must <u>both</u> qualify under the rules. We first of all assumed that the spouse is the same age as the employee. We then used the mean-overlap approach. In other words the probability that the pair will qualify is the average of (i) the probability that the employee alone will qualify and (ii) the mathematical probability that both will qualify.

(j) The ratios "R" (i,e. the ratios of Regular to Preferred morbidity) were taken from Table III AA on page 25 of our 1982 Report, for Medical Expense insurance; however, they were appropriately weighted by age and sex in accordance with information available (see (h) above). As is discussed in our 1982 Report (pages 14-16), the R values are not very sensitive to change, except by age and sex - which has been reflected

We concluded that the R values is Table III AA, although based on Smoking/ Nonsmoking only, would be suitable for the Regular/Preferred analysis called for by this report.

(k) Covered dependent children, which were excluded form the unblend (see 3 of Principal Assumptions) were considered to have the following premiums:

Plan 1: $81.12
Plan 2: $38.41

(l) Maternity coverage was evaluated using maternity claim costs from the 1974 Hospital Table, duly weighted by the known age and sex distribution. Female spouses were assumed the same age as their male employee husbands. A 10% loading for expenses were added. The following average maternity claims were assumed: Plan 1 $3,000; Plan 2 $2,400.

(m) Life insurance and AD&D (basic) was assumed to have a premium of $1.25.

(n) We assumed that the loading for expenses could be considered as a Uniform percentage for each of the 8 cells being unblended. This meant that the unblend could address the gross monthly premiums directly, without further adjustment.

The Question of Special Exceptions

Questions will arise, concerning persons who are unable to comply with the Preferred status rules, and yet are healthy enough to deserve such status. Such questions will never relate to tobacco use, since that rule must always be followed. It would seem that such questions should seldom if ever relate to the blood pressure rule. Such questions may however relate to the weight rule. Examples which come to mind include:

- amputees
- females who are temporarily overweight because of existing pregnancy
- persons who may be judged overweight but not obese

In judging such exceptions it is suggested that the principle of "immutability" be used. In other words, the individual is not able to qualify, for reasons beyond his control. It may be necessary to establish a continuing special committee to determine rules relating to such exceptions. It is our understanding that the Wellness Subcommittee has already done extensive work on the third point listed above.

We have assumed that the special exceptions will be few in number. In other words, they will be sufficiently uncommon so as to have no material effect on the assumptions we have made.

General Comments about Data and Methodology

Rate differences for life insurance, based on smoking/nonsmoking, are now very common. Such differences for health insurance represent a new field; no extensive data, historically based on such differences, exist in the Insurance Industry. Believing that organizations wish to achieve such rate differences, we have assembled, after several years of research, the best data and actuarial methodology known to us. Those data and that methodology have been employed for this report. In addition, we were able to employ, to great advantage, the fine statistical distributions, by age, sex, and plan classification available for the Texas employees plan.

As is true for actuarial projects generally, the results are dependent on the assumptions and methodology adopted. In the absence of certainties, best estimates are made. Assumptions, methodology, and estimates have been described herein, or in our 1982 Report to which references have been made.

Conservatism Adjustment

In making unblends of the nature, it is desirable in our opinion to include a conservatism adjustment, which has been described above (see b) As a result, the unblended premiums assume that 12½ % of the true Regular group will be misclassified, for whatever reason, as Preferred.

Reproduction of Total Premium

At the outset, the distribution between Preferred and Regular will be the same as at present. It is therefore important that the unblended rates produce the same total premium income as the blended rates. This is true for each of the 8 cells being unblended; it is in fact true using the conservatism "adjusted" percentages who qualify. (See Table 1, last column). An example will illustrate:

Plan 1, Employee plus Family

Blended Rate:				$ 266.80
Unblended Rates:				
Preferred	$ 230.31	(.325	)=	74.84
Regular	$ 284.40	(.675	)=	191.96
				$ 266.80

As time goes on, more and more employees may give up tobacco, achieve better weight, and control blood pressure. That no doubt is one of the major objections of the program. When that happens the program as a whole (because of better average health) should not require as much total premium income as it would have if those improvements had not taken place.

Conclusion

We trust that our report will be of assistance to the State of Texas in implementing the program. It is our honor to be of service to Texas in this important endeavor.

John M. Bragg and Associates, Inc.

John M. Bragg, FSA, ACAS

HEALTH EXHIBIT I

COMPREHENSIVE MEDICAL CARE - ACTIVE EMPLOYEES
FOR DECEMBER, 1982

EMPLOYEE AGE	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 & OVER	TOTAL	AVG AGE
***** PLAN 1 ******														
MALES*														
EMPLOYEE ONLY	195	1,301	1,420	1,274	876	581	615	674	670	467	0	0	8,073	37
EMPL & SPOUSE	17	107	139	133	79	67	161	365	559	441	1	0	2,069	49
EMPL/CHILDREN	6	54	138	236	305	249	193	129	61	42	0	0	1,413	40
EMPL & FAMILY	9	125	280	506	562	469	478	391	241	99	0	0	3,160	41
FEMALES*														
EMPLOYEE ONLY	152	1,541	2,198	1,833	1,225	959	1,081	1,231	1,446	1,100	2	0	12,768	40
EMPL & SPOUSE	6	56	104	67	53	49	104	159	218	161	0	0	977	47
EMPL/CHILDREN	15	242	514	645	502	417	300	201	100	34	0	0	2,970	37
EMPL & FAMILY	1	43	152	211	189	218	123	100	62	17	0	0	1,116	39
TOTAL*														
EMPLOYEE ONLY	347	2,842	3,618	3,107	2,101	1,540	1,696	1,905	2,116	1,567	2	0	20,841	39
EMPL & SPOUSE	23	163	243	200	132	116	265	524	777	602	1	0	3,046	49
EMPL/CHILDREN	21	296	652	881	807	666	493	330	161	76	0	0	4,383	38
EMPL & FAMILY	10	168	432	717	751	687	601	491	303	116	0	0	4,276	41

HEALTH EXHIBIT 2

COMPREHENSIVE MEDICAL CARE - ACTIVE EMPLOYEES
FOR DECEMBER, 1982

EMPLOYEE AGE	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 & OVER	TOTAL	AVG AGE
***** PLAN 2 ******														
MALES*														
EMPLOYEE ONLY	306	1,450	1,324	1,217	1,031	765	826	760	618	378	2	0	8,679	37
EMPL & SPOUSE	26	326	381	224	149	186	388	741	863	570	0	0	3,834	47
EMPL/CHILDREN	6	100	325	601	740	563	402	229	104	35	0	0	3,105	39
EMPL & FAMILY	17	355	1,000	1,715	1,922	1,560	1,270	893	469	174	0	0	9,375	39
FEMALES*														
EMPLOYEE ONLY	323	1,593	1,609	1,784	1,423	1,033	897	769	619	299	0	0	10,669	36
EMPL & SPOUSE	21	183	185	114	75	82	161	215	218	93	0	0	1,347	42
EMPL/CHILDREN	31	518	1,124	1,200	964	558	358	197	131	31	0	0	5,112	34
EMPL & FAMILY	6	131	374	582	482	358	236	110	52	14	0	0	2,345	36
TOTAL*														
EMPLOYEE ONLY	629	3,043	3,233	3,001	2,456	1,798	1,723	1,549	1,237	677	2	0	19,348	36
EMPL & SPOUSE	47	509	566	338	224	268	549	956	1,081	663	0	0	5,181	45
EMPL/CHILDREN	37	618	1,449	1,801	1,704	1,121	760	426	235	66	0	0	8,217	36
EMPL & FAMILY	23	486	1,374	2,297	2,404	1,918	1,506	1,003	521	188	0	0	11,720	39

EXHIBIT 8

Resolution

Adopting the Report of the Wellness Subcommittee

R E S O L U T I O N

of the
Governor's Task Force on State Employee Health Insurance
Quality and Cost Containment

September 17, 1984

WHEREAS, the Governor's Task Force recognizes the importance of all forty-eight recommendations included in the Wellness Subcommittee's report; and

WHEREAS, there has been concern expressed about the limited time available to implement the financial incentive recommendation at the next bidding date; and

WHEREAS, certain members of the Task Force feel that

(a) surveys of employees, agency directors, and insurance carriers would be instructive in implementing the financial incentive recommendation, and

(b) administrative issues should be defined and addressed and the input of the Uniform Group Insurance Advisory Committee sought prior to implementing the financial incentive recommendation, and

(c) additional legal opinions and actuarial reports may also be necessary prior to implementation; and

WHEREAS, such information from the surveys, reports and opinions must be received in a timely enough manner to implement such discounts at the next bidding date;

NOW, THEREFORE BE IT RESOLVED, that the Task Force recommends an implementation committee be established to address the steps necessary to put the financial incentive in place at the earliest possible date; and

BE IT FURTHER RESOLVED, that the implementation committee be composed of one member from each of the following agencies: Employees Retirement System, State Board of Insurance, and Department of Health; and

BE IT FURTHER RESOLVED, that the members of the implementation committee be appointed by and serve at the pleasure of the agency head of the agencies which they represent; and

BE IT FURTHER RESOLVED, that the implementation committee bring its report on these issues to the Employees Retirement System Board in time to consider it before the next bidding cycle, and

BE IT FINALLY RESOLVED, that the Report of the Subcommittee on Wellness as amended is adopted by the Governor's Task Force on State Employee Health Insurance Quality and Cost Containment, and that this resolution shall be attached to and considered with the report.