

2016



GROUP BENEFITS PROGRAM
COMPREHENSIVE ANNUAL REPORT



Employees Retirement System of Texas

FEBRUARY 2017



ERS
EMPLOYEES RETIREMENT
SYSTEM OF TEXAS

EMPLOYEES RETIREMENT SYSTEM OF TEXAS

Executive Director

Porter Wilson

Board of Trustees

I. Craig Hester, Chair

Douglas Danzeiser, Vice-Chair

Ilesa Daniels

Cydney Donnell

Brian D. Ragland

Jeanie Wyatt

200 E. 18th Street
P.O. Box 13207
Austin, Texas 78711-3207

www.ers.state.tx.us

February 2017

Table of Contents

EXECUTIVE SUMMARY	1
<i>The self-funded plan has low administrative costs</i>	2
Scope of the Report	2
I. THE STATE OF THE HEALTH OF THE GBP	3
Who can enroll in the Group Benefits Program?	3
<i>Fast Facts about GBP Members</i>	3
Member Health Matters	4
<i>Common chronic conditions</i>	5
<i>Spotlight on Diabetes</i>	5
II. COST TREND AND THE MARKET ENVIRONMENT	7
The self-funded plan benefits from a large risk pool.	7
GBP health care cost trend	7
Utilization: high-cost claimants and service trends.	8
<i>Emergency care: freestanding facilities vs. hospital-based care</i>	8
<i>Hospital-based providers</i>	8
Member cost share leveraging	9
<i>Specialty drugs and member cost share leveraging</i>	9
Inflation in the Drug Program	9
<i>Generic Drug Incentives Work</i>	10
III. COST MANAGEMENT OVERVIEW	11
Components of the Cost Management Chart	14
<i>Screening for Ineligible Charges</i>	14
<i>Line 2. Utilization management</i>	14
<i>Line 4. Prepayment claims editing</i>	14
<i>Reductions to Eligible Charges</i>	14
<i>Lines 6a-6b. Managed care savings</i>	14
<i>Lines 6c-6e. Participant cost sharing</i>	15
<i>Lines 6f-6h. Coordination of benefits</i>	15
<i>Refunds, Rebates and Subsidies</i>	15
<i>Line 8a. Prescription drug program rebates</i>	15
<i>Line 8b. Federal revenue – Medicare Part D</i>	15
<i>Line 8c. Subrogation</i>	16
<i>Lines 8d-8e. Audit refunds</i>	16
Preventing and Investigating Fraud	17
<i>Dependent eligibility audit (DEA)</i>	18

Table of Contents

IV. BENEFITS OVERVIEW	19
Background on GBP Vendor Performance Monitoring	19
<i>Certified Texas Contract Manager</i>	19
<i>Contract Monitoring Strategy</i>	19
<i>Monitoring of the MAPR</i>	20
<i>Monitoring Performance Guarantees</i>	20
Overview of Health Plans	23
<i>HealthSelect of TexasSM</i>	23
<i>Consumer Directed HealthSelect of TexasSM (NEW)</i>	23
<i>Health Savings Account (as of December 31, 2016)</i>	23
<i>Regional Health Maintenance Organizations (HMOs)</i>	24
Retiree Health Insurance	24
<i>The Medicare Advantage (MA) option</i>	25
<i>HealthSelect Medicare AdvantageSM</i>	25
<i>KelseyCare Advantage</i>	25
Prescription Drug Benefits	26
<i>HealthSelect Prescription Drug</i>	25
<i>HealthSelect Medicare RxSM</i>	25
Voluntary Benefits	27
<i>Dental</i>	27
<i>State of Texas Vision - NEW</i>	29
<i>Disability Insurance: Texas Income Protection PlanSM</i>	30
<i>Life and Accidental Death & Dismemberment Insurance</i>	31
<i>Term Life Insurance</i>	31
<i>TexFlex</i>	33
V. WELLNESS AND DISEASE MANAGEMENT PROGRAMS	35
Wellness and Disease Management Programs by plan	36
<i>HealthSelect of Texas Wellness and Disease Management Programs</i>	36
<i>Care management program enrollment increased in FY16</i>	36
<i>Regional Health Maintenance Organizations Wellness Programs</i>	40
<i>Medicare Advantage Wellness Programs for retirees</i>	40

Table of Contents

VI. VENDOR CONTRACTING AND OVERSIGHT	41
<i>Controlling costs through managing the network.</i>	41
<i>Contracting activities in response to SB20 and recommendations of the State Auditor and Sunset Commission</i>	41
<i>Addressing Member Concerns and Understanding of Processes</i>	42
<i>The ERS Grievance Appeals Process.</i>	42
<i>Mediation Rights</i>	44
VII. BEST PRACTICES.	45
Solution Sessions – a transparent approach to evaluating new ideas	45
<i>Formalizing policies to ensure alignment with strategic priorities.</i>	45
Value-based incentive design (VBID).	46
<i>Tobacco premium contributions yielded \$13.8 million in FY16</i>	46
Alternative Payment Models.	47
<i>Patient-Centered Medical Homes – A Blueprint for Better Care and Lower Cost</i>	47
<i>Savings are shared with providers</i>	48
Evaluated ideas in the planning stages	48
<i>Episode-based bundled payments.</i>	48
<i>Maximizing Coordination with Social Security Disability Benefits</i>	48
Ideas that ERS evaluated but did not implement	48
<i>Expansion of onsite nurse practitioner or wellness clinics.</i>	48
<i>Defined contributions for Medicare retirees, with access to a “connector-model” marketplace</i>	49
VIII. CONCLUSION.	51
<i>The GBP has a significant impact on the Texas economy.</i>	51
<i>Without cost management, the state’s insurance contribution would more than triple.</i>	51
Potential Strategic Actions to Achieve Program Goals	53
<i>Appropriations Options</i>	53
<i>Marketplace Options</i>	54
<i>Plan Design Options</i>	55
Partnerships with other entities	56
Looking ahead	56
<i>Sunset Commission Review</i>	56
<i>The future of the Affordable Care Act is uncertain.</i>	56
<i>Prescription drug costs are an ongoing challenge in light of expensive new treatments</i>	57
<i>ERS will continue to proactively manage retiree costs</i>	57
<i>Strategic Priorities.</i>	58

Table of Contents

APPENDIX A: Impact of the ACA on the GBP 59

APPENDIX B: Financial Status of the Group Benefits Program, FY16 60

APPENDIX C: Landmark Events in the History of the GBP 61

APPENDIX D: Glossary of Terms 63

**APPENDIX E: Sunset Review Recommendations Related
to Group Benefit Plan 65**

Executive Summary

A primary objective for offering health and retirement benefits is to attract and retain a qualified workforce to serve the State of Texas. The State Auditor estimates the value of the state's health insurance and retirement benefit package to be roughly a third of total compensation. When asked, employees consistently name health insurance as their most valued benefit.

The Texas Legislature determines who is eligible for benefits, and sets the contribution strategy and the funding level. Insurance benefits are funded on a pay-as-you-go basis each biennium and are subject to change based on the amount of appropriated funding.

The Employees Retirement System of Texas (ERS) has managed health insurance benefits for employees and retirees for the state since 1976. In order to maintain competitive health insurance benefits, ERS must anticipate and balance the cost of health care benefits against appropriated funding and cost sharing with health plan participants.

The ERS Board of Trustees designs and contracts for the insurance options offered under the Texas Employees Group Benefits Program (GBP) umbrella. The GBP is a cost-efficient program that provides more than half a million public employees, retirees and their eligible dependents with competitive, comprehensive insurance benefits, including health, dental, vision, short- and long-term disability, life and accidental death and dismemberment.

Employee health insurance is a significant expense for the State of Texas, so it is important to get the most out of every dollar. ERS staff professionally manages the GBP benefit plans, setting and enforcing high performance standards to slow the benefit cost trend and ensure that strong measures are in place to prevent fraud and abuse.



The GBP spends about \$9 million a day in health care costs.

That's \$375,000 an hour

\$6,250 a minute

\$104 a second

Professional management and legislative support allowed ERS and the state to continue to offer competitive benefits at a reasonable cost in FY16.

FY16 HIGHLIGHTS

- Lowered total HealthSelect charges by \$7.2 billion through effective cost management programs.
- Awarded a new pharmacy benefit manager contract for January 1, 2017, projected to save the plan an additional \$1 billion over the six-year term.
- Continued to expand the HealthSelect provider network across the state, with 20% more providers added to the network since FY13.
- ERS has more than doubled the amount of Medicare Part D subsidies it collected since implementing the HealthSelect Medicare Rx program in 2013, from \$235 million through FY12 to \$505 million through FY16.
- The Dependent Eligibility Audit process produced a 10 to 1 return on investment for the program, with a net savings of \$34 million since 2012.
- Implemented a new State of Texas Vision benefit.
- Implemented Consumer Directed HealthSelect, a high-deductible health plan with a health savings account.
- Enrolled about 14,500 members — with nearly 53,000 pounds lost — in Real Appeal, an online weight loss and nutrition support group to promote healthy habits.
- Helped 603 HealthSelect of Texas members skip the medical office with Virtual Visits on their mobile devices and computers.
- Collected \$13.8 million in additional tobacco premium contributions from more than 38,000 participants.

The self-funded plan has low administrative costs.

HealthSelectSM of Texas (HealthSelect), a self-funded point-of-service insurance plan, is the basic health and prescription drug plan offered to participants since 1992 and the GBP's largest program. ERS reduced HealthSelect plan charges by \$7.2 billion in FY16 through managing benefit cost trends, increased subsidies for the Medicare prescription drug program, and innovative risk-sharing arrangements with providers.

According to federal standards, the GBP is an extremely cost-efficient plan. Administrative costs for large, private health plans nationwide are estimated at 10.2 cents per dollar.¹ The HealthSelect program spends only three cents per dollar on administrative costs with the other 97 cents going to pay health care claims.



HealthSelect spends 97 cents of every dollar on health care claims.

Scope of the Report

ERS manages the GBP so the state can continue to offer competitive benefits within budgeted funds. As required by statute,² this report provides a thorough accounting of the cost management and fraud control measures employed by ERS for the self-funded health insurance plan.

In response to the Sunset Advisory Commission agency review of ERS under consideration during the 2017 legislative session, ERS has expanded this year's report to cover all insurance programs offered under the GBP umbrella. There is special coverage of GBP cost drivers, the state of the health of GBP membership, and ERS' strategic approach to tailoring benefit coverage to member needs. There is a discussion of how ERS evaluates new ideas, manages the contracting process, and measures the performance of its vendors. Finally, the conclusion highlights legislative issues that could impact the successful management of the plan in the coming biennium.

This report provides in-depth analysis of cost trends only for participants enrolled in the state's self-funded HealthSelect medical and prescription drug plans. Medicare cost trends are reported only for the subset of Medicare participants enrolled in the HealthSelect plan, and not those enrolled in Medicare Advantage.

¹ "The 80/20 Rule: How Insurers Spend Your Health Insurance Premiums," CMS, Center for Consumer Information and Insurance Oversight, 2013, page 8. <https://www.cms.gov/CCIIO/Resources/Files/Downloads/mlr-report-02-15-2013.pdf>

² Texas Insurance Code, Section 1551.061 requires the "ERS Board of Trustees to submit a written report each year to the Governor, Lieutenant Governor, Speaker of the House of Representatives, and Legislative Budget Board concerning the coverages provided and the benefits and services being received by all participants under this chapter. The report must include information about the effectiveness and efficiency of managed care cost containment practices and fraud detection and prevention procedures."

I. The State of the Health of the GBP

I. The State of the Health of the GBP

Who can enroll in the Group Benefits Program?

The GBP provides health insurance coverage for more than half a million employees, retirees and eligible family members for the following employers:

- State agencies and public institutions of higher education (except the University of Texas System and Texas A&M),
- Texas County and District Retirement System and Texas Municipal Retirement System and
- Community Supervision and Corrections Department and the Windham School District.

About 82% of participants enroll in HealthSelect, 13% in Medicare Advantage and 5% in HMOs. In 2012, the state began automatically enrolling Medicare-primary retirees in HealthSelect Medicare Advantage at age 65 with the option to switch back to the traditional HealthSelect plan. About 74% of Medicare-primary participants are enrolled in Medicare Advantage plans.

Figure 1: 95% of employees and 50% of retirees enroll in HealthSelect of Texas (August 31, 2016)

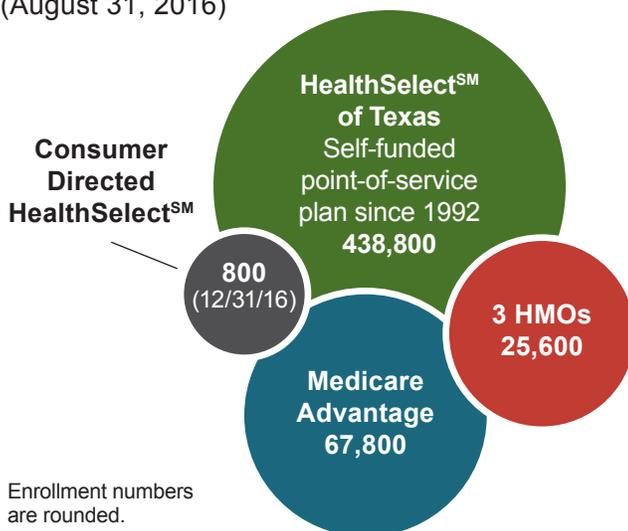
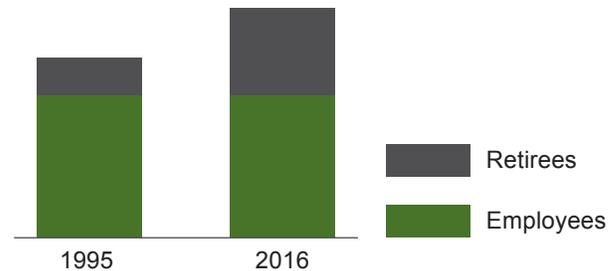


Figure 2: Enrollment growth since 1995 is almost entirely due to growth in the retiree population

GBP member enrollment (not including dependents)



	1995	2016	% Change
Employees	209,026	216,820	3.7%
Retirees	41,556	105,469	153.8%
Total	250,582	322,289	28.6%

Fast Facts about GBP Members

Over the past 20 years, overall enrollment of retirees in the GBP has grown 154%, compared to a 3.7% increase in overall enrollment of employees. There are no indications that growth in the retiree population will slow.

The typical member enrolled in a GBP health insurance plan is 47 years old.

The average employee earns about \$51,000 a year, but salaries vary by gender, place of employment and plan choice.

The average retiree enrolled in GBP health insurance receives about \$25,000 per year in state annuities.

Employees and pre-65 retirees are most likely to enroll in HealthSelect. Medicare retirees (age 65+) are more likely to enroll in a Medicare Advantage plan.

In general, there are more women than men enrolled in the program. About 1/3 of members enroll dependents and 30% work in higher education.

Retirees who are younger than 65 worked for the state about four years longer than did retirees age 65 and older.

Higher education employees earn about \$12,200 a year more than state employees. Male employees earn about \$9,400 a year more than female employees. Salary influences health coverage choices and spending patterns. Female state employees are more likely to have children who are uninsured or on CHIP.

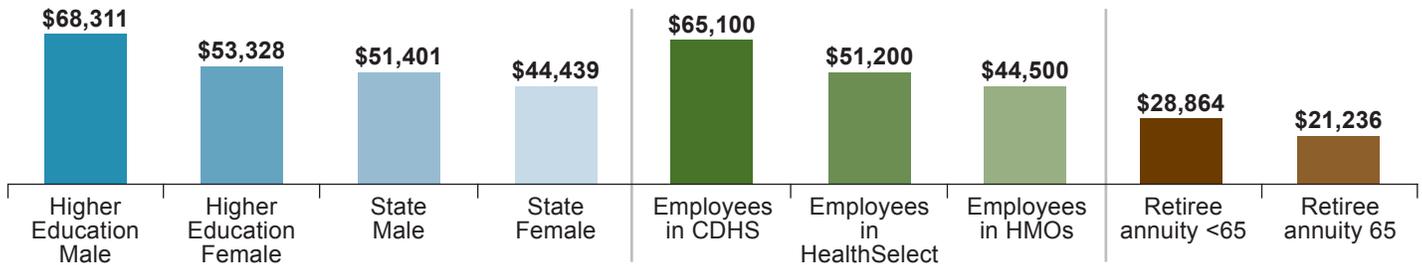
Figure 3: Typical Member Enrolled in GBP Health Insurance

	Active Employees	Pre-65 retirees	65+ retirees	All members ¹
Total number	216,626	33,687	71,789	322,102
Average member age	45 years	59 years	73 years	47 years
Average dependent age	25 years	37 years	67 years	28 years
% who enroll dependents	37%	31%	25%	34%
Gender	57% female 43% male	54% female 46% male	52% female 48% male	56% female 44% male
Tenure	9 years	25 years	21 years	13 years
Place of employment	68% state 32% higher ed	85% state 15% higher ed	71% state 29% higher ed	71% state 29% higher ed
Monthly gross pharmacy cost ²	\$132 month	\$228 month	\$372 month	\$162 month
Monthly medical cost	\$450 month	\$630 month	\$224 month	\$452 month

¹ "All Members" in this table includes employees and retirees only. It does not include other enrollees, such as survivors, COBRA participants, former board members, and other miscellaneous categories of participants.

² Pharmacy costs are gross, before rebates and subsidies, the bulk of which would be attributable to Medicare primary retirees.

Figure 4: Salaries vary by gender, employment, and plan choice; Annuities vary by age

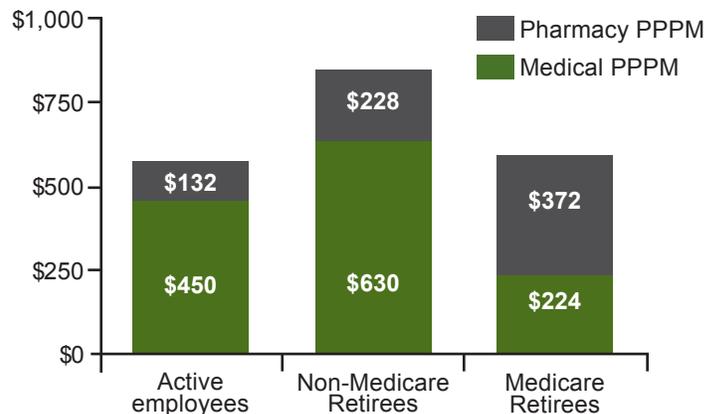


Member Health Matters

ERS regularly analyzes insurance claims data to identify health trends so that wellness and disease management programs, health incentives and communications can be targeted toward the special needs of the GBP population. A few high-level findings about the health of the HealthSelect population:

- Medical costs are highest in the non-Medicare retiree group, and pharmacy costs are highest among Medicare retirees³,
- Eight out of 10 of the highest cost HealthSelect claims are for dependents; six of those are newborns and
- The most expensive group for the plan is participants age 55 to 64.

Figure 5: Medicare retirees have higher drug costs; non-Medicare retirees have higher medical costs (HealthSelect, per participant per month costs, FY16)



³ Pharmacy costs in Figures 3 and 5 are gross, before rebates and subsidies. The bulk of these savings would apply to the pharmacy costs for Medicare-primary retirees.

Figure 6: Medical spending on Top 5 Chronic Conditions⁴
 Non-Medicare primary participants HealthSelect, FY16

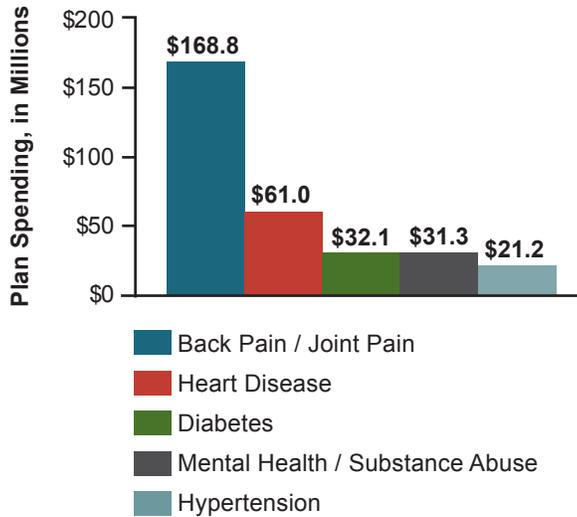
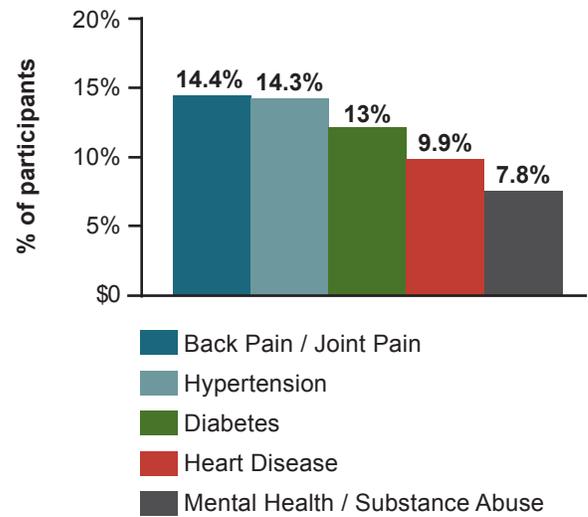


Figure 7: Incidence of Top 5 Chronic Conditions⁴
 Non-Medicare primary participants HealthSelect, FY16



Common chronic conditions

The top five chronic conditions among HealthSelect non-Medicare primary participants are the same conditions you will see on any national list. As seen in Figures 6 and 7, hypertension and back and joint pain have equally high prevalence, but hypertension is the

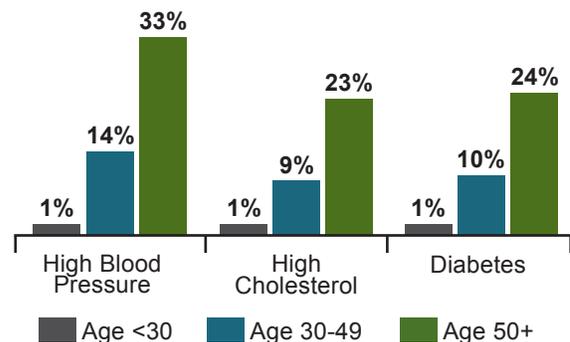
least expensive to manage, while back and joint pain is the costliest. Figure 6 does not include pharmacy costs because of the difficulty matching conditions with prescription drug claims, therefore, total spending on these conditions is understated.⁴

Spotlight on Diabetes

With age, the risk increases for common chronic conditions such as high blood pressure, high cholesterol, and diabetes. An area of special concern for ERS and the subject of a 2016 interim report is the growing problem of diabetes among state employees. HealthSelect claims show that one in four non-Medicare primary participants age 50 and older have diabetes.

HealthSelect paid \$796 million in claims for participants with diabetes in FY16, which represents 31% of all HealthSelect costs. This includes all medical and pharmacy costs for all health conditions for this group, not just for diabetes.

Figure 8: One in four HealthSelect participants age 50 and older have diabetes
 (Prevalence of chronic conditions by age group, non-Medicare primary population, FY16)



⁴ Plan spending on medical claims only; pharmacy claims not included because diagnostic codes are not currently associated with prescription drug data. Participants are counted in each category for which they had a medical claim. Some participants may appear in more than one category.

Top 5 conditions defined by Agency for Healthcare Research and Quality:

- **Hypertension** includes Essential Hypertension and Hypertension with Complications
- **Back Pain / Joint Pain** includes Osteoarthritis, Spondylosis, Intervertebral Disc Disorders, Rheumatoid Arthritis and Related Disorders
- **Heart disease** includes Disorders of Lipid Metabolism
- **Diabetes** includes Diabetes Mellitus without Complications, and Diabetes Mellitus with Complications
- **Mental Health / Substance Use** includes Mood Disorders (e.g., Depression), Anxiety Disorders, Substance- and Alcohol-related Disorders.

Primary-condition diabetics have 44% more emergency room visits and 110% more inpatient admissions. They have longer hospital stays and more hospital readmissions.

Antidiabetics is the fastest growing drug class prescribed to HealthSelect participants – both in number and in cost.

Physical inactivity and obesity are strongly correlated with the development of Type 2 diabetes. In recognition of that fact, in April 2016, ERS implemented Real Appeal, a popular “lifestyle intervention program” aimed at helping employees lose weight and develop healthy habits. This program is free of charge to the nearly 14,500 participants who signed up in FY16.

Diabetes prevalence among HealthSelect participants varies significantly regionally, with the San Antonio area and southern border regions leading the way.

Four state agencies in particular, have higher than average diabetes prevalence:

- Health and Human Services Commission,
- Department of Aging and Disability Services,
- Texas Department of Criminal Justice
- Department of State Health Services

Figure 9: HealthSelect spends an extra \$8,525 per year for a diabetic, compared to a non-diabetic (includes all health care costs)

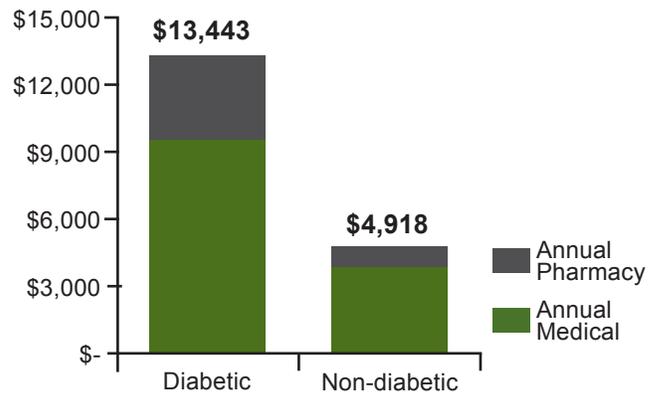
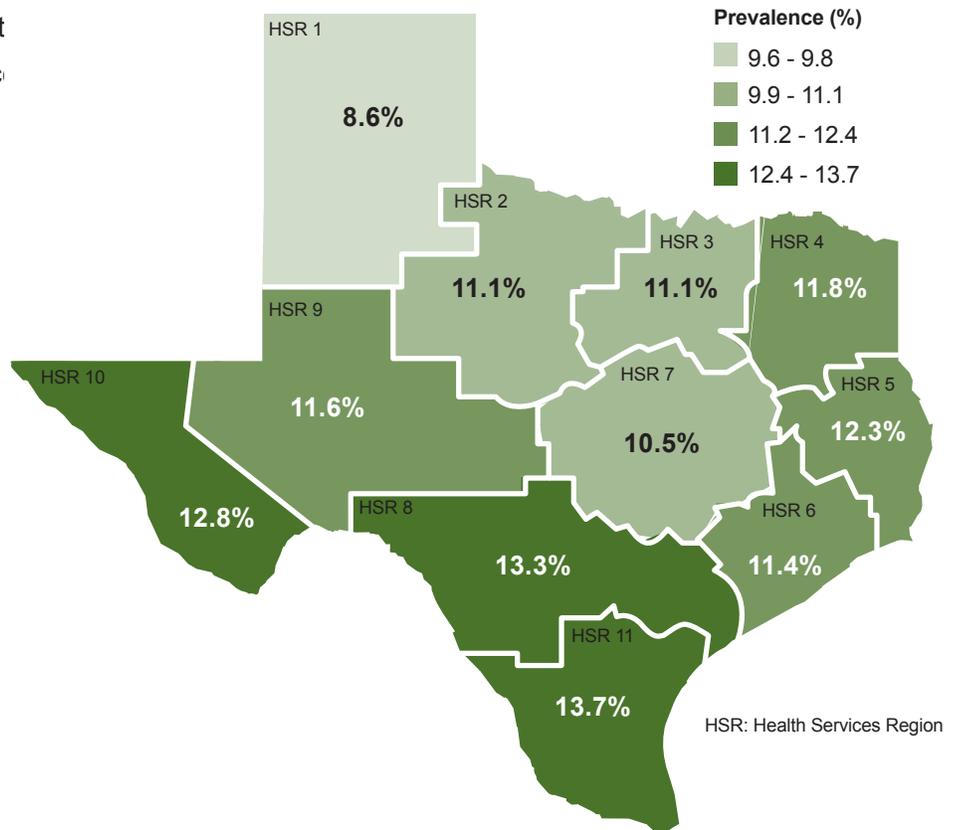


Figure 10: Prevalence of diabetes is highest on the south Texas border regions (Medicare Primary excluded, FY2016 with 3 months runout)



II. Cost Trend and the Market Environment

II. Cost Trend and the Market Environment

The self-funded plan benefits from a large risk pool

HealthSelect is a self-funded benefits plan, meaning that member and state contributions fund all the benefits paid by the plan. Therefore, the state and the participants – not an insurance carrier – assume financial responsibility and bear the risk for paying for all the benefits used.

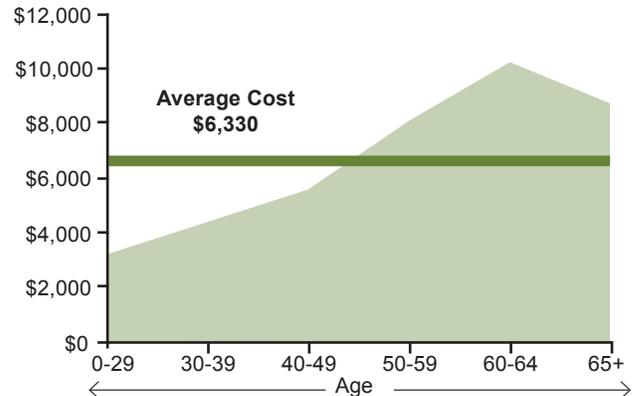
More than 500,000 employees, retirees and their dependents are grouped together in the GBP “risk pool,” sharing in savings when costs go down and shouldering more responsibility when costs go up. The size of the group brings predictability to budgeting, creates economies of scale, and ensures that one catastrophic illness does not dramatically change the average cost of coverage in any given year.

Having many healthy people in the group may lower the average cost, but health issues are unpredictable and anyone can have an expensive, unforeseen health

event. Costs are distributed among plan members so that HealthSelect remains affordable for members when they need it the most.

Figure 11: ERS averages costs so the plan stays affordable for the group

(HealthSelect average annualized claims cost by age group, all medical and pharmacy claims, FY16)



GBP health care cost trend

Over the past 10 years, the GBP annual health benefit cost trend has averaged 6.8%. A change in the benefit cost trend is different than a change in expenditures. A change in expenditures simply shows how much more the plan paid for a specific service or demographic subgroup, whereas benefit cost trend is a complex measure of the increase in the average cost of coverage, which is influenced by many factors that drive health plan costs.

It is important to note that the cost drivers described in this section are not unique to the GBP, as they mirror cost drivers for other health plans in Texas and the United States. The major components of the benefit cost trend are increases in:

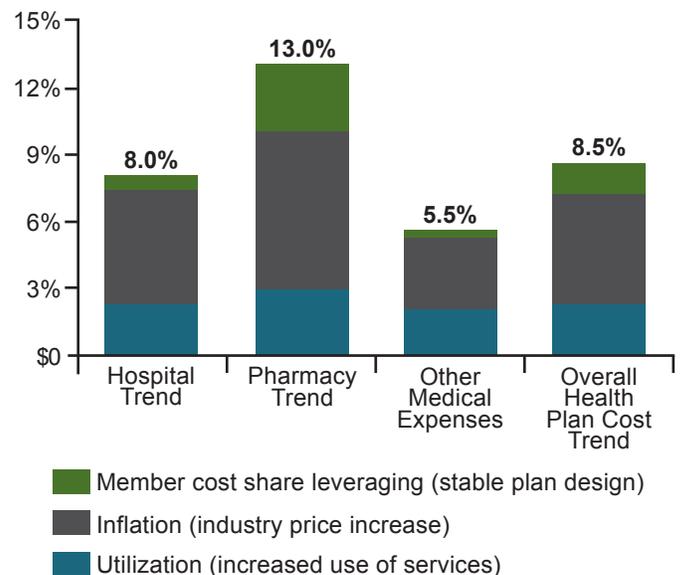
- utilization, driven by how often members go to the doctor, get services, or fill prescriptions,
- the cost per unit of care, driven by inflation and more complex care, also known as service intensity and
- member cost share leveraging, driven by the plan paying a larger share of total costs while member copays stay the same.

These three components may fluctuate to varying degrees each year. In the most recent year, inflation in prescription drug prices was the major contributor to the

trend. Other factors that influence the cost trend are the aging population, the impact of plan design changes, or other actions taken by the plan to control costs.

The benefit cost trend is rising for each service sector – hospital, pharmacy, and other medical services – but for different reasons. This is illustrated in Figure 12 and in the examples that follow.

Figure 12: Inflation is driving costs in the health plan (projected HealthSelect benefit cost trends, FY17-19)

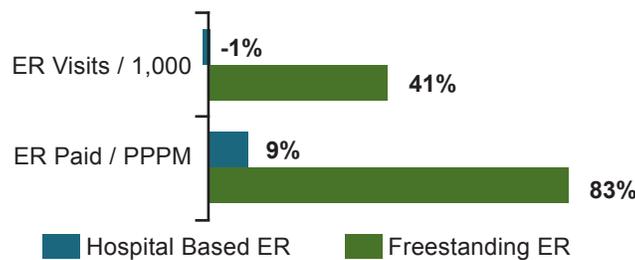


Utilization: high-cost claimants and service trends

Nationally, as with HealthSelect, there is a high concentration of health care spending among a small percentage of the population. According to the National Institute on Healthcare Management, 1% of the U.S. population accounts for nearly 23% of overall health care spending, and 5% are responsible for 50% of spending.⁵ This spending pattern is distinctly pronounced in the HealthSelect drug program, where 10% of participants are responsible for 90% of the costs.

The HealthSelect TPA follows high-cost cases (defined as more than \$100,000) and intervenes when possible to help coordinate care and avoid excess costs. In FY16, the number of high-cost cases (per 1,000 participants) increased 13.7%, and the amount paid per participant per month for a high-cost claimant grew 13.5%.

Figure 13: Changes in cost and use of HealthSelect emergency room care (compared to FY15)



Emergency care: freestanding facilities vs. hospital-based care

One costly service trend is increased utilization and costs for emergency room (ER) care, especially at freestanding ERs. A freestanding ER is a facility licensed by the state to provide 24-hour emergency services to a patient at the same level as a hospital-based emergency room. Most freestanding ERs in Texas are for-profit facilities.

Figure 14: Non-specified chest pain is the #1 reason to visit the ER

	Billed per visit	Allowed per visit	Plan paid per visit
Hospital-based ER	\$8,648	\$3,938	\$2,260
Freestanding ER	\$6,844	\$5,959	\$4,982

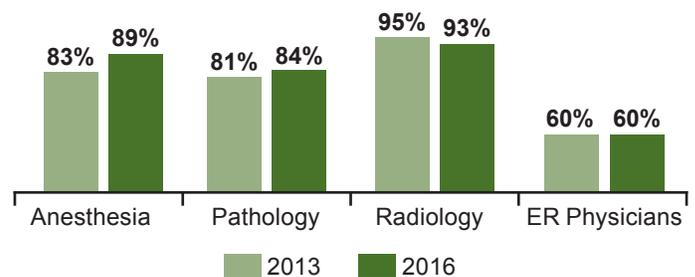
Freestanding ERs are not attached to a hospital, although they may be owned by a hospital. They are typically located in convenient, high-visibility retail centers and are often mistaken by patients for urgent care facilities. When this happens, patients are often

surprised by the \$150 emergency room copay, instead of the \$50 urgent care copay they were expecting.

Despite efforts to contract with a wide range of emergency facilities, many freestanding emergency rooms are not contracted with HealthSelect. When a contract is in place, both the plan and the member will benefit from negotiated network discounts in the form of reduced prices.

When a freestanding ER is not in the network, HealthSelect pays a greater portion of the claim than it does for a claim at a network facility. Members may also be exposed to balance billing when they choose non-network providers.

Figure 15: Change in the % of HealthSelect network hospitals with contracted hospital-based providers



Hospital-based providers

Another service provider that drives costs for the plan and plan members is the hospital-based provider. While HealthSelect has made contracting inroads with anesthesiologists and pathologists, there is continued resistance among ER physicians to contract.

This is confusing for members who can't choose which ER doctor sees them in the emergency room. It also increases the risk that they will be balance billed for non-network services. Even when members visit network hospitals, they can still be seen by non-network hospital-based providers. In a true emergency scenario - like a heart attack - the plan will reimburse 100% of the cost of the visit, but in a non-emergency situation, the member may be balance billed.

Figure 16: Example of member cost share leveraging in the HealthSelect pharmacy program
When total drug cost increases 100%, cost to the plan increases 200%

	FY15	FY16	Percent increase
Total Drug Cost	\$50	\$100	100%
Member Copay	\$25	\$25	0%
Plan Cost	\$25	\$75	200%

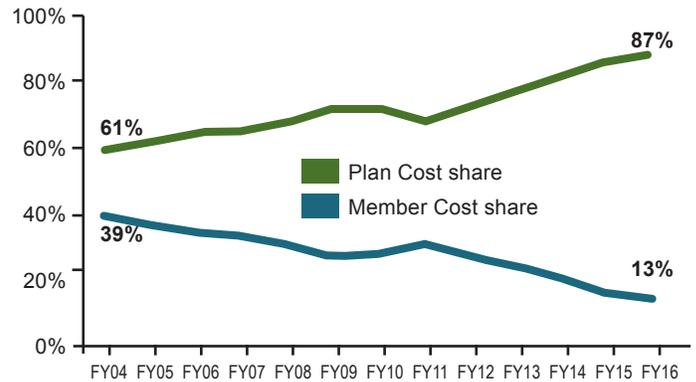
³ National Institute on Health Care Management, "Healthcare's 1%: The Extreme Concentration of Healthcare Spending," November, 2014.

Member cost share leveraging

HealthSelect manages costs in the prescription drug program with a “three-tier” copay structure. A 30-day prescription for a generic drug is \$10, a preferred brand-name drug is \$35 and a non-preferred brand-name drug is \$60. Because member copays are a fixed-dollar amount and have not increased since 2011, each time the total cost of a drug increases, the plan pays the entire cost increase. (see Figure 16)

The impact of member cost-share leveraging is especially clear in the drug plan, where the member cost share has dropped from 39% of the total cost in FY04, to 13 percent of the total cost in FY16. This is partly attributable to ERS’s reduction of the generic copay from \$15 to \$10 in FY15.

Figure 17: Member cost share in the prescription drug plan has dropped from 39% to 13% in 12 years (member and plan share as a % of total HealthSelect drug cost, FY04-FY16)



Specialty drugs and member cost share leveraging

Specialty drugs are expensive medications prescribed for chronic and/or life threatening conditions.

They often require special storage, handling and administration and involve a significant degree of

patient education, monitoring and management. The plan paid \$294 million in FY16 for more than 70,000 specialty claims, representing 32% percent of total drug plan cost for less than 1% of all prescriptions. In FY01, specialty drug spending represented just 2.7% of total drug plan cost.

Figure 18: Top 10 Costliest Drugs for HealthSelect in FY16 (in millions)

Drug Name	Type	Therapeutic Use	Plan Cost in Millions FY15	Plan Cost in Millions FY16
1. Humira 	Specialty	Rheumatoid Arthritis	\$29.4	\$42.5
2. Enbrel 	Specialty	Rheumatoid Arthritis	\$22.5	\$26.3
3. Novolog 	Brand	Diabetes	\$20.6	\$24.8
4. Lantus 	Brand	Diabetes	\$23.4	\$22.3
5. Harvoni 	Specialty	Hepatitis C	\$30.6	\$17.7
6. Victoza 	Brand	Diabetes	\$14.1	\$17.4
7. Lyrica 	Brand	Seizures	\$11.0	\$13.6
8. Crestor 	Brand	High Cholesterol	\$13.2	\$13.1
9. Januvia 	Brand	Diabetes	\$9.9	\$12.3
10. Advair 	Brand	Asthma	\$10.1	\$11.3

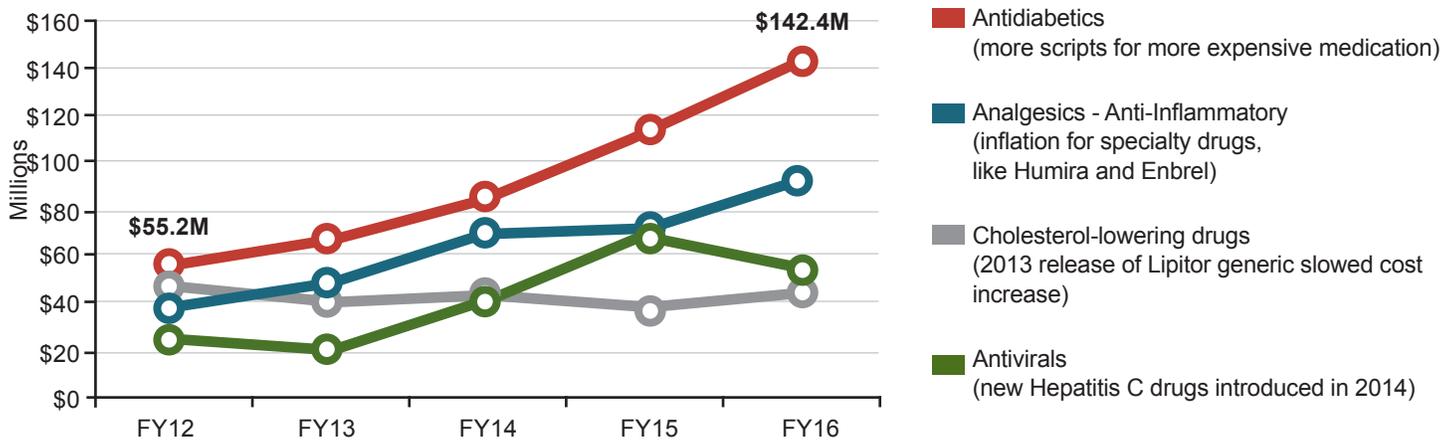
Inflation in the Drug Program

HealthSelect has seen across-the-board increases in the cost of drugs for many years. Utilization is growing as plan membership ages, but of greatest concern is the upward pressure on costs due to uncontrollable price inflation in the pharmaceutical industry. This is a problem for both specialty drugs and brand name drugs.

Figure 19 shows the impact of cost and use of medication for common chronic illnesses on the plan. By far, antidiabetic drugs are the fastest growing therapeutic class of drugs for the HealthSelect plan.

Figure 19: Anti-diabetics are the fastest growing drug class for HealthSelect?

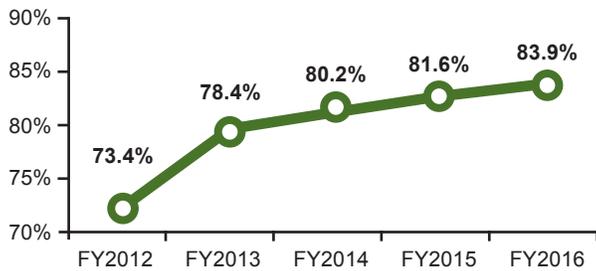
(FY11-FY16, in millions)



Generic drug incentives work

ERS educates participants about how to get the best value from their health benefit. One way of doing that is by using generic drugs whenever possible. On September 1, 2014, ERS reduced the price of a 30-day supply of a generic drug from \$15 to \$10, bringing the GBP more in line with other plans and further incentivizing the use of generics.

Figure 20: HealthSelect generic dispensing rate has increased 10% in 5 years



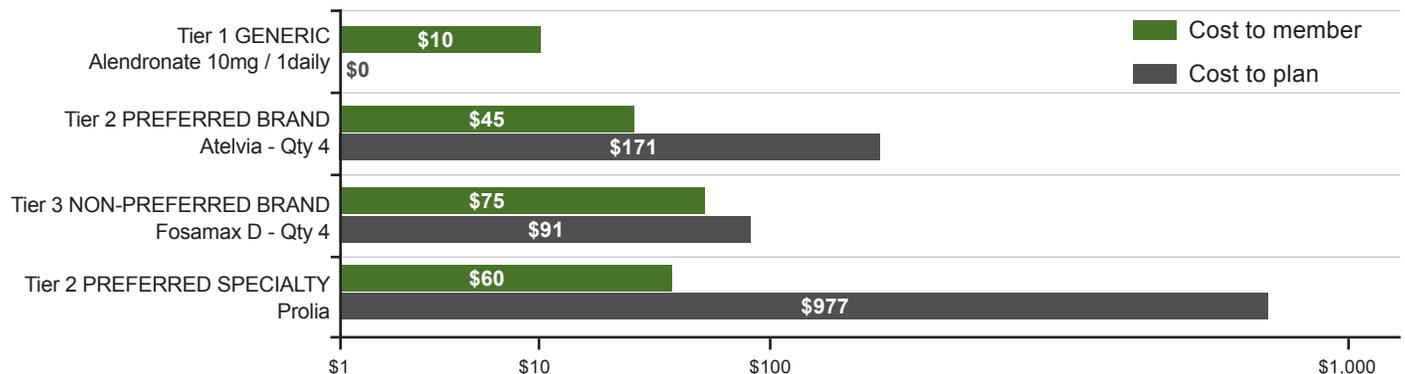
In a 2014 survey of 136,000 GBP-eligible state and higher education employees, 67% of all respondents said they had asked their doctor for a generic drug in the past year. In the past five years, the generic dispensing rate for the plan has increased 10%. However, with the regular release of new and improved drug therapies, demand continues to increase, especially with the aging population, where generic options for treating complex chronic health conditions are not always available.

Requiring step therapy with some treatment plans allows doctors to test the effectiveness of a generic drug before graduating their patients to more expensive brand-name or specialty drugs. In some situations, the more expensive medications may deliver better results, but they also may expose patients to increased health risks, where the cost impact to the plan is evident.

Figure 21 shows the dramatic cost savings of using a generic osteoporosis drug rather than a brand name or specialty drug.

Figure 21: How Does Choosing a Generic Medication Compare to Other Options?

Four Osteoporosis Medications, 30-day supply, Retail



In FY15, HealthSelect began to require step therapy for certain therapeutic classes of drugs, such as anti-inflammatories and medications that reduce high blood pressure.

III. Cost Management Overview

ERS and its vendors proactively manage plan costs to reduce the impact of cost increases on the state and its workforce as much as possible. It's a balancing act to maintain a high level of benefits while controlling costs. Total FY16 cost-management reductions for HealthSelect were \$7.2 billion. The individual impact of these savings is significant – without cost-management programs, the FY16 member-only contribution would have been \$2,085 a month, rather than \$574.

The ERS Board of Trustees controls insurance costs in two ways: plan design and professional management of the program.

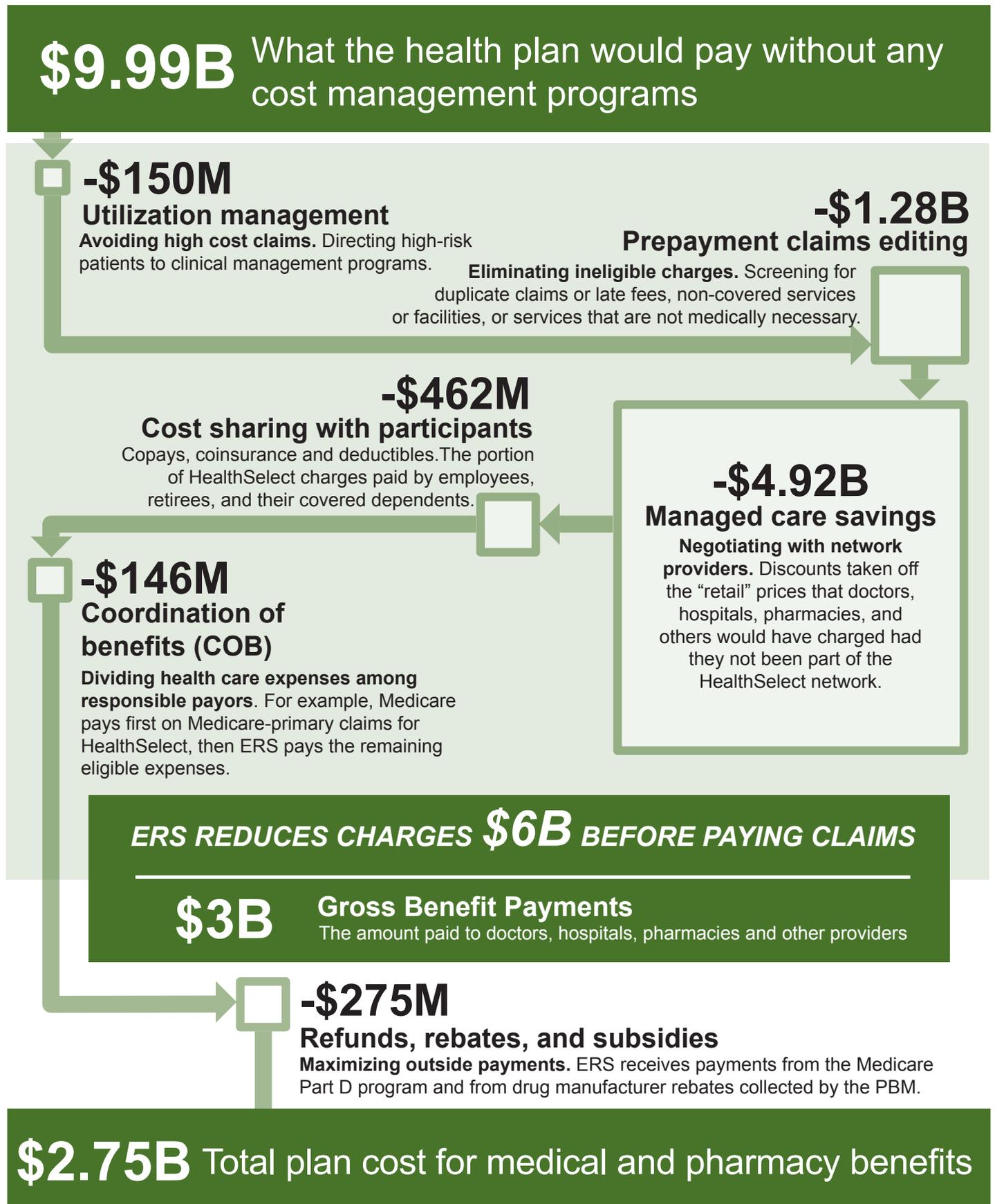
- The “plan design” is most visible to the people who rely on the plan. It determines what is covered and how much participants pay in deductibles, copays, and coinsurance. For example, starting September 1, 2014, ERS lowered generic drug copays from \$15 to \$10 for a 30-day supply.

- The “professional management” of the plan includes such things as cost management and fraud control programs, contracting arrangements with providers, and disease management and wellness programs. TPAs are responsible for the day-to-day health care management of the plan.

ERS contracts with a TPA, UnitedHealthcare, to manage HealthSelect medical benefits, and as of January 1, 2017, with OptumRx, a pharmacy benefit manager (PBM) to manage HealthSelect prescription drug and HealthSelect Medicare Rx benefits. Before January 1, HealthSelect prescription drug benefits were administered by Caremark and HealthSelect Medicare Rx drug benefits were administered by SilverScript, a Caremark subsidiary.

This section of the report focuses on the professional management of HealthSelect – the important ways that ERS and the HealthSelect vendors work behind the scenes to control costs.

Figure 22: High-level overview of the process followed to reduce HealthSelect charges by \$7.2 billion in FY16



Totals may not add due to rounding.

Figure 23: Texas Employees Group Benefits Program, HealthSelect Cost Management Charge Reductions, FY16*

1. Considered Charges plus Estimated Cost Avoided			\$9,990,355,369
2. Estimated Cost Avoided			
a. Medical	\$	86,195,661	
b. Pharmacy		64,094,571	150,290,232
3. Considered Charges			\$9,840,065,137
4. Less ineligible charges (prepayment claims editing)			(\$1,283,461,335)
5. Eligible Charges			\$8,556,603,802
6. Less Reductions to Eligible Charges			
a. PDP Charge Reductions	\$	966,404,840	
b. Provider Discounts and Reductions		3,955,802,210	
c. Medical Copayments and Deductibles		119,859,608	
d. Medical Coinsurance		209,529,678	
e. PDP Cost Sharing		132,505,914	
f. Coordination of Benefits - Medical - Regular		24,119,396	
g. Coordination of Benefits - Medical - Medicare		120,869,711	
h. Coordination of Benefits - PDP		667,757	(5,529,759,114)
7. Gross Benefit Payments			\$2,745,148,479
8. Refunds, Rebates and Guarantees			
a. PDP Rebates	\$	196,914,139	
b. Federal Revenue - Medicare Part D		69,185,558	
c. Subrogation		6,506,065	
d. Pharmacy Audit Refunds		1,070,782	
e. PBM Audit Refunds		947,106	(274,623,650)
9. Net Benefit Payments			\$2,752,221,038

*Amounts taken from:

- (1) Annual Statistical Review prepared by UnitedHealthcare,
- (2) Annual Experience Accounting prepared by Caremark and SilverScript,
- (3) HealthSelect Prescription Drug Plan data, and
- (4) ERS FY16 CAFR (Federal Revenues).

Components of the Cost Management Chart

Pages 14-16 provide a detailed explanation for each line item in the financial chart on page 13.

Screening for ineligible charges

Line 2. Utilization management

Medical and pharmacy utilization management programs helped the plan avoid an estimated \$150.3 million in charges in FY16. Utilization management is a forward-looking process that identifies potentially high-cost claims that could be handled in a more appropriate way, and directs high-risk patients to clinical management programs. This process ensures that prescribed services align with best practice standards. One example is the redirection of transplant surgeries to Centers of Excellence, which was estimated to avoid nearly \$20 million in charges in FY16. Utilization management also includes such things as wellness and disease management programs, which are covered in more detail in Section V of the report.

Line 4. Prepayment claims editing

HealthSelect further trims costs by screening for ineligible charges through prepayment claims editing, a process that weeds out duplicate claims, eliminates charges that exceed benefit limits, and ensures that HealthSelect doesn't pay for services that are not medically necessary. In FY16, this lowered plan costs nearly \$1.3 billion.

Prepayment claims editing is an essential part of the GBP's fraud, waste, and abuse program, as it also prevents the payment of potentially fraudulent or abusive claims. Any claims that fail the editing process are individually reviewed by claims processors, the medical review unit, and/or the TPA's Fraud, Waste and Abuse division. The independent auditor tests prepayment edits as part of the annual claims audit and verifies that the edits are appropriately applied.

1. Considered charges plus estimated cost avoided	\$9,990,355,369
2. Estimated cost avoided due to utilization management	(\$150,290,232)
3. Considered Charges	\$9,840,065,137
4. Less charges eliminated through prepayment claims editing	(\$1,283,461,335)
5. Eligible Charges	\$8,556,603,802

Reductions to eligible charges

After eliminating ineligible charges, the plan applies a series of cost management strategies to the \$8.6 billion in remaining eligible charges. Managed care, participant cost sharing and coordination of benefits saved the GBP \$5.5 billion of the remaining eligible charges in FY16.

Lines 6a-6b. Managed care savings

More than \$4.9 billion in cost reductions came from HealthSelect's managed care reimbursement arrangement. Managed care reduces costs for the plan through the TPA's and PBM's negotiation of discounted reimbursement rates with providers. About 80% of those reductions are from the medical side, and 20% are pharmacy discounts.

6a. Prescription drug program charge reductions	\$966,404,840
6b. Medical provider discounts and reductions	\$3,955,802,210

The TPA and PBM leverage their negotiating power in the Texas health care marketplace to reduce medical and pharmacy costs for participants and the plan. The \$4.9 billion in reduced charges represents the discount taken off the "retail" prices that doctors, hospitals, pharmacies, and other facilities would have charged the GBP and its participants had they not been covered by a managed care network.

Figure 24: Negotiated provider discounts have saved the State of Texas \$17 billion over the past four years

(HealthSelect FY13-FY16, in millions)

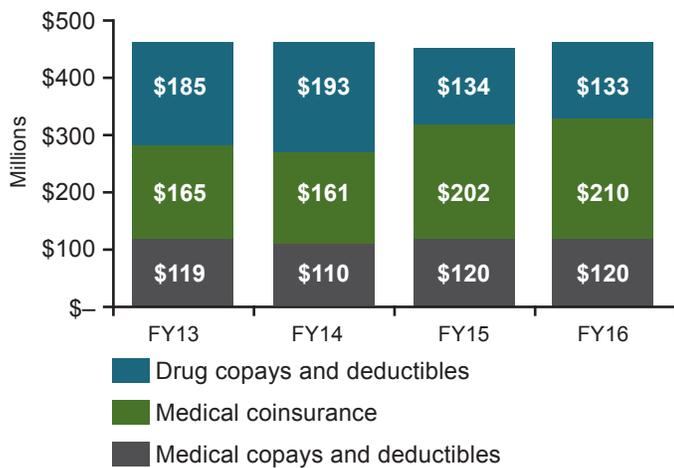


Lines 6c-6e. Participant cost sharing

Sharing costs with participants reduces charges that would otherwise be paid by the plan. In FY16, employees, retirees, and dependents paid \$462 million in out-of-pocket costs through coinsurance, deductibles, and medical and prescription drug copays.

6c. Medical copayments and deductibles	\$119,859,608
6d. Medical coinsurance	\$209,529,678
6e. PDP cost sharing	\$132,505,914

Figure 25: HealthSelect participant out-of-pocket costs have remained steady over the past four years (HealthSelect FY13-FY16, in millions)



Cost sharing should affect the amount of health care services used by reducing demand. The goal is to encourage people to get needed care, while taking an increased role in managing their own health and their out-of-pocket costs. HealthSelect covers all preventive services at no cost to the member.

Lines 6f-6h. Coordination of benefits

Another way to reduce eligible HealthSelect charges is coordinating the payment of claims with other health care payers. For example, when retired participants become eligible for Medicare, GBP medical benefits become secondary, which means that HealthSelect only pays eligible medical expenses after Medicare has processed the claim. In FY16, coordination with the Medicare program saved the GBP about \$121 million. Coordination with other insurance programs saved about \$25 million.

6f. Coordination of benefits - Medical – Regular	\$24,119,396
6g. Coordination of benefits - Medical – Medicare	\$120,869,711
6e. Coordination of Benefits - PDP	\$667,757

Refunds, rebates and subsidies

Line 8a. Prescription drug program rebates

Through arrangements with drug manufacturers, the HealthSelect PBM receives rebates based on the volume of various drugs dispensed under the prescription drug programs it administers. ERS' PBM contract requires the PBM to return all rebates to the GBP, including a guaranteed minimum. During FY16, ERS received nearly \$197 million in rebates, including manufacturer payments received through the Medicare Part D Coverage Gap Discount Program. ERS annually conducts an audit to confirm that 100% of all rebates were paid to the plan.

8a. PDP rebates	\$196,914,139
-----------------	---------------

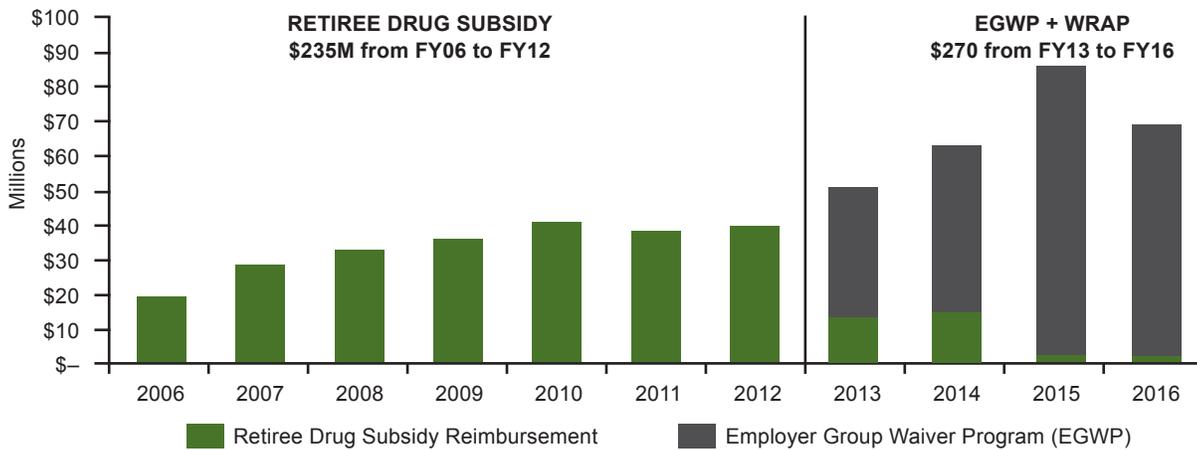
Line 8b. Federal revenue – Medicare Part D

Starting January 1, 2006, Medicare-primary individuals could enroll in a Medicare Part D prescription drug program, funded in part by the federal government. ERS chose to continue GBP prescription drug coverage for Medicare retirees and offset the cost with federal subsidies received under the Medicare Part D Retiree Drug Subsidy (RDS). Under RDS, the federal government reimbursed ERS for eligible retirees who stayed in the GBP instead of enrolling in Medicare Part D. From FY13-FY16, ERS collected RDS reimbursements of about \$269 million.

Effective January 1, 2013, ERS moved most Medicare-primary participants to HealthSelect Medicare Rx, administered by SilverScript. This self-funded EGWP+Wrap ensures that Medicare-primary retirees receive benefits at least equal to those of the traditional HealthSelect Prescription Drug plan within the GBP. From FY13-FY16, Medicare Part D subsidies through the EGWP program reduced HealthSelect costs by \$236 million.

8b. Federal Revenue (subsidy) - Medicare Part D	\$69,185,558
---	--------------

Figure 26: HealthSelect Medicare Rx has more than doubled Medicare Part D subsidies since FY13
 Medicare Part D revenues for HealthSelect (FY06-FY16) in millions



Line 8c. Subrogation

The subrogation program allows the plan to recover certain health-related expenses paid on behalf of a participant who has rights of recovery against a third party for negligence or any willful act resulting in injury or illness to the participant. Typically, such recoveries occur in connection with automobile accidents for which a third party is found liable. Subrogation recoveries saved the GBP \$6.5 million in FY16.

8c. Subrogation	\$6,506,065
-----------------	--------------------

Line 8d-8e. Audit refunds

As fiduciaries of the insurance program, ERS is also responsible for ensuring that the plan operates efficiently and delivers the best value to the state. Pharmacy and PBM Audits protect the financial integrity of the provider network and the plan through a sophisticated set of programs and procedures to deter fraudulent claims, protect against provider abuse, and ensure that network pharmacies comply with HealthSelect guidelines. These programs recouped about \$2 million in FY16.

The Retail Pharmacy Audit Program includes a sophisticated set of programs and procedures that:

- ensure participating pharmacies’ compliance with program guidelines,
- protect the financial integrity of the provider network and the PDP,
- deter fraudulent claim submissions and
- educate participating pharmacies about the correct procedures and program guidelines.

8d. Pharmacy audit refunds	\$1,070,782
----------------------------	--------------------

In addition to auditing the specific retail pharmacies, ERS contracts with an independent auditor to review claims and administrative services to ensure compliance with the PBM contract. This audit reviews all retail pharmacy and mail order claims.

As part of ERS’ transparent contract with the PBM, the independent auditor examines the rebate contracts between the PBM and pharmaceutical manufacturers to ensure that (a) 100% of all claims are billed to the pharmaceutical manufacturers, and (b) ERS receives 100% of all rebate dollars paid to the PBM based on claims experience.

8e. PBM audit refunds	\$947,106
-----------------------	------------------

Preventing and Investigating Fraud

Fraud prevention, detection, and investigation are integral components of the overall GBP cost management strategy. ERS takes the necessary steps to ensure that fraud and abuse are prevented or reduced, and that violators are dealt with appropriately. Fraud and abuse differ in important ways: fraud implies intent, whereas abuse may occur from provider or participant error.

- Fraud is an intentional deception or misrepresentation by a person who knows that the deception could result in some unauthorized benefit.
- Abuse is a transaction that results in unnecessary cost to the program. For example, when participants regularly use the emergency room for primary care. While this is not fraud, it does redirect resources away from true emergencies, and results in expensive and inappropriate charges to the plan.

ERS requires vendors to be diligent in their efforts to prevent, detect, and investigate fraud, abuse, and other improprieties. HealthSelect vendors have fraud, waste, and abuse divisions that investigate and refer suspected fraud cases to the proper criminal authorities and to ERS to enforce administrative penalties. When law enforcement intervention is not necessary, the TPA engages providers in a collaborative process to speed the recovery of overpayments.

Examples of anti-fraud and abuse methods include:

- annual auditing of provider claims for incorrect coding, double-billing, or falsified data,
- identifying and intervening in cases where abuse of certain drug categories is suspected,
- investigating potentially ineligible dependents through routine eligibility audits and
- requiring participants to pay for health care received outside the country before receiving plan reimbursement.

Figure 27: Fraud investigations are an ongoing concern for all health plans

The Fraud, Waste, Abuse, and Error (FWAE) team for the HealthSelect TPA – investigators, clinical review specialists, nurses, doctors, certified coders and analysts – actively watch claims and investigate fraud and abuse tips from multiple sources including members, providers, government agencies, news, etc. to detect and prevent fraud. Detection identifies suspect providers based on a review of their claims. Prevention safeguards the claims system against potentially abusive providers. Through medical records review, the TPA can deny or recover dollars for non-covered services. The TPA also uses an Advanced Analytics Lab to watch claims pre- and post-payments for suspect activity.

- In the last two years, FWAE identified over a dozen surgical centers and/or physicians who were performing bariatric procedures but masking them as hernia surgeries. HealthSelect covers bariatric surgery under very restricted conditions, so this is one way a provider might try to skirt the approval process by billing for a covered service such as a hernia repair. Through data analysis, patient interviews, and medical record review, FWAE was able to stop payment for misrepresented services and even shut down one offending surgery center in coordination with law enforcement officials.
- In 2016, FWAE identified a multimillion-dollar scheme involving physical therapy and chiropractic providers in Florida who were allegedly seeking out patients with “good insurance benefits” and paying these patients for their health information. The providers then proceeded to bill UnitedHealthcare for hundreds of visits, many of which never took place. Data analytics is working closely with FWAE to identify similar fraudsters targeting Texas.

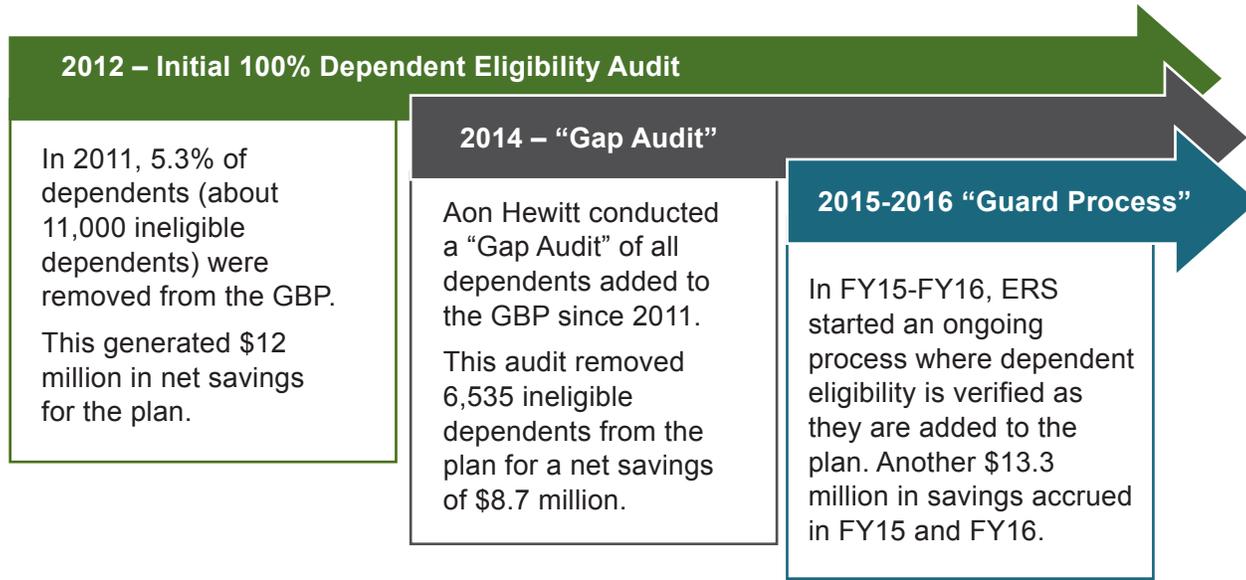
Dependent eligibility audit (DEA)

ERS has a fiduciary responsibility to manage health care costs and control fraud. Ineligible dependents increase the cost of health care to the state; therefore, removing ineligible dependents from the GBP reduces state contributions and plan costs.

ERS completed a successful 100% dependent eligibility audit in FY12 that asked all plan members

who cover dependents for documentation proving their eligibility for coverage. A second “Gap Audit” was conducted in 2014. Going forward, ERS continues to audit all new dependents as they are added to the plan through an ongoing “Guard Process.” The DEA process has produced significant net savings for the program of \$34 million since 2012, with a 10 to 1 return on investment.

Figure 28: Dependent eligibility audits saved the plan \$34 million for a 10 to 1 return on investment



IV. Benefits Overview

The State of Texas contracts with TPAs to manage its self-funded benefits plans. TPA contracts are bid and renegotiated on a regular schedule. Their services may include:

- creating a provider network,
- processing claims,
- disease management and wellness programs,

- communications and customer service,
- data analysis and reporting, utilization review, actuarial services and
- pharmacy benefits management.

In contrast, HMOs are fully-insured health insurance plans. In this model, the employer contracts with an insurance carrier to assume financial responsibility for claims and administrative costs.

Figure 29: About 82% of participants enroll in HealthSelect; 13% in Medicare Advantage; and 5% in HMOs. (GBP health insurance enrollment as of August 31, 2016)

	FY11	FY12	FY13	FY14	FY15	FY16
HealthSelect	496,992	437,473	436,012	436,084	436,430	439,628
Medicare Advantage	0	46,555	52,335	57,264	62,700	67,775
HMOs	29,570	25,866	25,367	24,627	23,949	25,597
TOTAL	526,562	509,894	513,714	517,975	523,079	533,000

Background on GBP Vendor Performance Monitoring

ERS contracts with providers to perform administrative services for the various programs offered within the GBP. Each contract defines the services and deliverables that are to be performed within the administration of the applicable benefit program. As such, each contract sets forth conditions whereby the vendor's failure to meet the contractual requirements may result in performance guarantee (PG) assessment(s) and/or liquidated damages.

Certified Texas Contract Manager

Members of the account management team within the Benefit Contracts Division monitor the GBP vendors' adherence to the contractual requirements. Each account management specialist is a Certified Texas Contract Manager (CTCM) as required by Texas Government Code, Section 2262.053 and the *State of Texas Procurement Manual*.⁶ To be eligible for CTCM

certification, the account manager must satisfy the following requirements: possess at least one year of contract management experience; complete the Contract Management segment courses administered by the Texas Procurement and Support Services provided by the Texas Comptroller of Public Accounts and pass a certification examination. Continuing education requirements are necessary to maintain the CTCM designation.

Contract monitoring strategy

Contract administration refers to the processes used to monitor vendor performance that occur after a contract is signed.⁷ Performance monitoring of the GBP vendors is a key aspect of the contract management responsibilities. The level and frequency of performance monitoring may vary based on the critical nature of the contract; however, the account manager follows a defined contract monitoring strategy developed for the GBP.

⁶ Texas State Comptroller of Public Accounts, State of Texas Procurement Manual, pg. 14. <http://www.comptroller.texas.gov/procurement/pub/manual/ProcurementManual.pdf>

⁷ State of Texas Contract Management Guide, version 1.14, 01-Sep-2015, page 15. <http://comptroller.texas.gov/procurement/pub/contractguide/contract-mgmt-guide-v1.14.pdf>

The overall strategy is organized on either a fiscal or calendar year basis, as appropriate, to align with the plan year of the benefit program. The key objectives of the contract monitoring strategy include, but are not limited to, the following:

- review and report the GBP vendor’s adherence in meeting the delivery points and maintaining acceptable customer service levels,
- initiate and track recommendations identified through applicable strategic planning and contract monitoring activities,
- review the methodology used by the GBP vendor in developing self-reported data reflected within the Monthly Administrative Performance Report (MAPR),
- review key metrics including adherence to specified service level agreements and performance standards,
- identifying opportunities to develop and deploy enhanced requirements (i.e. directives, strategic initiatives, plan design changes) and
- coordinating the engagement of a vendor compliance audit by an independent auditing firm selected by ERS through a competitive procurement process.

Monitoring of the MAPR

The MAPR is a customized tool that is specific to the applicable GBP program. The MAPR report reflects specific Contractual Agreement (Contract) performance areas and includes all PG standards. As such, the vendors must report their performance within each stipulated service or operational component.

Monitoring Performance Guarantees

The Performance Guarantees (PG) are formulated during the procurement process and specify the service expectations that the GBP vendor is to perform throughout the Contract period. A vendor’s failure to meet any requirement stipulated in the contract may result in a monetary performance assessment. The value of a performance assessment is determined by the severity of the violation. In some cases, ERS may waive the assessment if, for instance:

- the severity of the missed PG was minor,
- the issue had minimal or no participant impact,
- the vendor responded quickly to resolve the issue or
- ERS shared some responsibility in the issue.

Any instance of a missed performance metric requires that the vendor supply a corrective action plan for ERS’ review and approval.

The PG is an appendix to the Contract and is defined in two sections.

Section 1 provides the comprehensive listing of performance expectations with a description of the business-critical service functions to be performed by the GBP vendor. This section also provides the reporting frequency and the metrics for each listed business-critical service function.

Section 2 discloses the total dollar amount that the vendor has placed at risk (“amount at risk”) to ensure its contract performance meets or exceeds the service level standards set forth within the Contract. The amount at risk is a function of the contract value. Assessments for any single plan year will not exceed the total amount placed at risk. Figure 30 illustrates four severity levels assigned to each business-critical service function.

Figure 30: Performance Guarantee Criteria

Level of Severity	Definition	Allocation of Amount at Risk
Severity 1 – Emergency	Mission critical systems are down; a substantial loss of service; business operations have been severely disrupted; or a major milestone has not been met. In each situation, no immediate work-around that is acceptable to ERS is available.	50% of the aggregate annual amount at risk for each occurrence.
Severity 2 – Critical	A major functionality is severely impaired. Operations can continue in a restricted fashion; however, client and/or member service(s) are adversely affected.	25% of aggregate annual amount at risk for each occurrence.
Severity 3 – Moderate	Business operations have been adversely impaired in a moderate manner. A temporary work-around that is acceptable to ERS is immediately available.	<ul style="list-style-type: none"> • Occurrence 1 = 3% of aggregate annual amount at risk • Occurrence 2 = 5% of aggregate annual amount at risk • Occurrence 3 = 6% of aggregate annual amount at risk • Occurrence 4 = 9% of aggregate annual amount at risk
Severity 4 – Minor	Business operations have been adversely affected in a limited manner requiring a modification of current policies and/or processes.	2% of aggregate annual amount at risk for each occurrence

Figure 31: Contract Monitoring- Performance Guarantees Overview

The below table is a summary of the Total Performance Guarantees Assessed for FY16 & CY15

Plan	Vendor	Major Service Categories In which at least 1 PG is Not Met	Total Assessment
HealthSelect of Texas (Assessed in FY16)	UnitedHealthcare	Operations and Customer Service	\$217,094
HealthSelect Medicare Advantage Plan (Assessed in CY15)	Humana	Account Management, Customer Service and System & Data Management	\$16,500
HealthSelect of Texas Prescription Drug Program (Assessed in FY16)	CareMark	Operations and Customer Service	\$1,280,000
HealthSelect Medicare Rx PBM (Assessed in CY15)	SilverScript	Account Management, Customer Service, Operations and System & Data Management.	\$512,500
The State of Texas Dental Choice Plan (Assessed in FY16)	Humana	Customer Service and System & Data Management	\$200,000
Vision	Superior Vision Services	New benefit Performance monitoring began Sept. 1, 2016	\$0
Basic Life and Optional Term Life & AD&D; Voluntary AD&D	Minnesota Life, rebranded as Securian Financial Inc	Account Management	\$0
TIPP (Disability) Plan (Assessed in FY16)	Aon/Reed Group	Account Management, Customer Service and Operations	\$305,000
TexFlex (Assessed in FY16)	ADP, LLC	Account Management, Customer Service and System & Data Management	\$206,316

Overview of Health Plans

HealthSelect of TexasSM

The largest plan, **HealthSelect**, is a self-funded point-of-service health benefit plan with 82% of GBP health plan participants enrolled. On the first day of the month following a 60-day waiting period, eligible employees are automatically enrolled in HealthSelect unless they choose an HMO plan or waive coverage.

HealthSelect offers health coverage throughout Texas, the United States, and many parts of the international community. Under a self-funded program, the plan administrator, in this case ERS, receives all of the contributions from both the participant and the state, and uses those dollars to reimburse the TPA as claims are paid for medical services received by plan participants. The TPA is paid for administrative services, such as processing claims and maintaining provider networks, and does not profit from the amount of claims paid.

Since September 1, 2012, United Healthcare has served as the TPA for the HealthSelect plan. For the six-year TPA contract beginning September 1, 2017, the ERS Board of Trustees selected BlueCross and BlueShield of Texas (BCBSTX) as the TPA for the plan. Regular rebidding and negotiation of TPA contracts for all plans helps ERS ensure that health plan participants and the State of Texas are receiving the best possible value and service.

Consumer Directed HealthSelect of TexasSM (NEW)

As required by HB 966 (84R), beginning September 1, 2016, ERS offered a new self-funded health plan for active employees called **Consumer Directed HealthSelect (CDHS)**. With this high-deductible health plan, employees pay higher up-front costs for their health care, assuming more risk in exchange for a reduced monthly dependent premium and the opportunity to make pre-tax contributions to a portable Health Savings Account (HSA). The state also contributes a monthly amount to the HSA, from which the employee may pay for qualified medical expenses for themselves, spouses and dependents.

With the exception of preventive services, which are covered at 100%, participants pay the full cost of doctor visits, prescriptions and other health care costs until they reach the deductible, which renews on January 1 each year. Out-of-pocket maximums also apply.

Figure 32: Calendar Year Deductibles and Out-of-Pocket Maximums for 2017

(January 1 – December 31, 2017)

Description	Individual Coverage	Family Coverage
Annual in-network deductible	\$2,100	\$4,200
Annual out-of-network deductible	\$4,200	\$8,400
Annual in-network, out-of-pocket maximum*	\$6,550	\$13,100
Annual out-of-network, out-of-pocket maximum*	\$13,100	\$26,200

*Out-of-pocket maximums are based on federal regulations and are subject to change.

Once the deductible is met, the plan pays a percentage of health expenses:

- 80% for in-network health and prescription services (you pay 20%) and
- 60% for allowable out-of-network health and prescription services (you pay 40%).

Between September 1 and December 31, 2016, a total of 800 participants (432 members and 368 dependents) enrolled in the CDHS plan. In general, employees who chose the CDHS were seven years younger and earned \$13,000 more per year than the average employee enrolled in state health insurance.

Health Savings Account (as of December 31, 2016)

Current features of the HSA are:

- monthly contribution from the state for plan year 2017:
 - \$45 for an eligible individual (full-time employee or retiree) or
 - \$90 for an eligible family account,
- annual maximum contribution limits set by Internal Revenue Service for plan year 2017:
 - \$3,400 for individuals or
 - \$6,750 for a family,
- balance carryover over from one year to the next and
- portability, meaning the funds remain with the employee if the employee changes health plans or leaves state government.

Optum Bank is the TPA for the HealthSelect HSAs, meaning only HSAs with Optum Bank receive the monthly state contribution.

As of December 31, 2016, the state and employees enrolled in CDHS contributed \$265,810 to HSA accounts, and withdrew \$36,940 in distributions.

⁸Optum Bank HSA Summary, December 31, 2016

Figure 33: Consumer Directed HealthSelect Health Savings Account Activity as of December 31, 2016

HSA Activity 9/1/2016 - 12/31/2016	
Number of Accounts Active	408
Average Account Balance	\$651
Average Employee monthly contribution	\$300
Average Employer monthly contribution	\$64

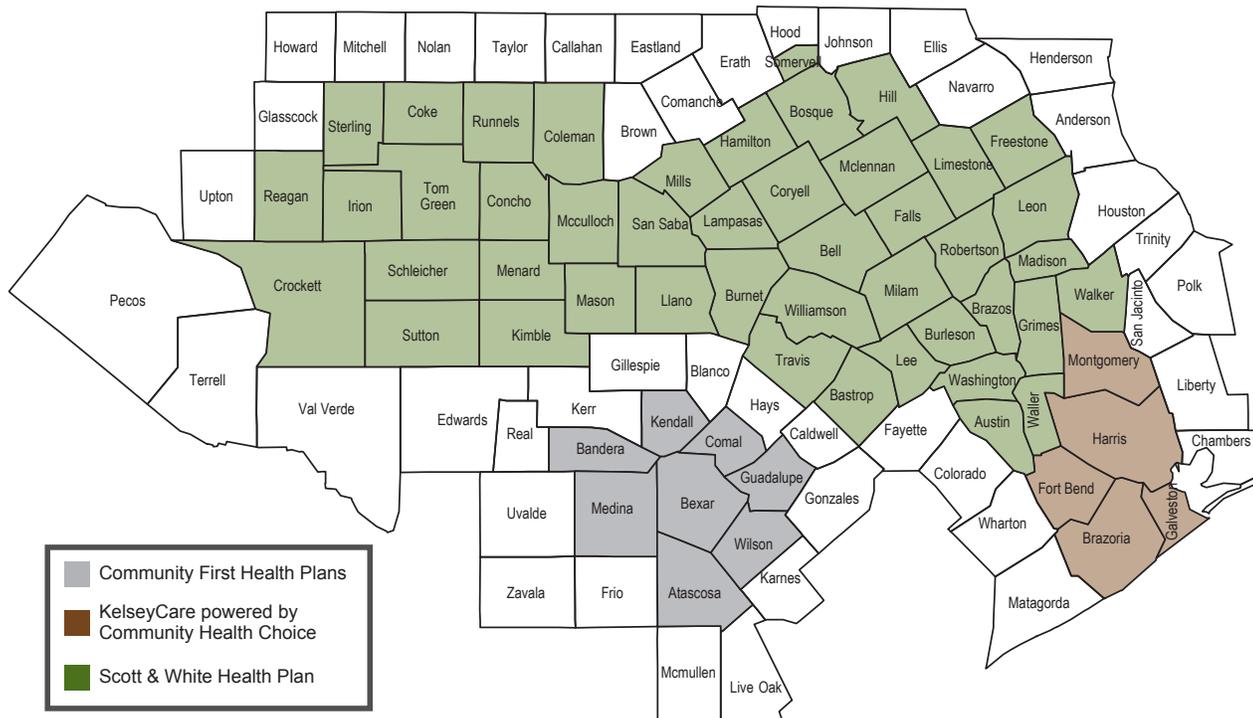
Regional Health Maintenance Organizations (HMOs)

In addition to the self-insured HealthSelect plan, the GBP health coverage also provides fully-insured plans through three HMOs for participants who live or work in a covered HMO service area:

- **Community First HMO**, in the San Antonio area
- **Scott & White HMO**, in the Central and West Texas area
- **KelseyCare powered by Community Health Choice**, in the Houston area

Roughly 5% of GBP insurance plan participants are enrolled in the HMOs.

Figure 34: Map of HMO Coverage in Texas



Retiree Health Insurance

Most state and local government employers offer health insurance benefits to their Medicare-primary retirees. Many private employers do not. Some employers offer

a Medicare Advantage (MA) plan; others give retirees a set amount of money to buy a Medigap or Medicare Supplement policy on the open market.⁹

⁹ Medicare Part A is free at age 65 as long as you have paid into Medicare for at least 40 quarters of your working career. Otherwise, you are charged a monthly premium.

The Medicare Advantage (MA) option

When GBP retirees and their dependents reach age 65 and become eligible for Medicare-primary coverage, they are automatically enrolled in HealthSelect Medicare Advantage (HealthSelect MA), with the option to switch back to HealthSelect or an HMO at any point during the plan year. A GBP member enrolled in an MA plan does not have traditional Medicare or HealthSelect coverage. Retirees with an MA plan do not need a Medigap policy.

In FY16, about 74% of Medicare-primary retirees and their Medicare-primary spouses remained in the MA plans, while the rest chose HealthSelect or an HMO. For the entire calendar year 2016, members choosing GBP Medicare Advantage plans over HealthSelect saved nearly \$42 million on premium contributions for dependent coverage.

HealthSelect Medicare AdvantageSM

HealthSelect Medicare Advantage is a Medicare Advantage Preferred Provider Organization (MA PPO) option that has been available since January 1, 2012. Under this plan, medical-only benefits are available for the enrolled population. A PPO differs from a point-of-service plan (like HealthSelect), in that it does not require participants to obtain a referral from their primary care doctor to see a specialist.

KelseyCare Advantage

KelseyCare Advantage is a regional Medicare Advantage Health Maintenance Organization (MA HMO) that has been available in eight counties within the greater Houston area since September 1, 2011. Currently, the MA HMO provides medical-only benefits to the enrolled population.

To get the most from their GBP benefits, Medicare-primary participants in all GBP health plans must have Medicare Part A (hospital) and Part B (other medical) coverage. Part A is free for Medicare-primary participants. The average Part B premium for 2017 is \$109 a month. Part B premiums increase for retirees with higher incomes.

HealthSelect coordinates benefits with Medicare to pay most expenses not paid by Medicare. When retirees use doctors who accept Medicare, they have very low out-of-pocket costs under both HealthSelect MA and HealthSelect.

Benefits offered to GBP retirees under HealthSelect MA are comparable to regular HealthSelect benefits, but the MA premiums are less expensive for the state and for the retiree because Medicare subsidizes a large portion of participant medical expenses. MA plan participants continue to receive prescription drug coverage through HealthSelect Medicare Rx.

Monthly Administrative Performance Report (MAPR) Heat MAP Summary HealthSelect Medicare Advantage

Humana Insurance Company - Calendar Year 2015

Description		Assessment Frequency	01-2015	02-2015	03-2015	04-2015	05-2015	06-2015	07-2015	08-2015	09-2015	10-2015	11-2015	12-2015
ACCOUNT MANAGEMENT	Notice of Operational changes	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Written notice of changes	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Communication materials: quality	Any Incident	100%	100%	100%	100%	83%	100%	100%	100%	100%	100%	100%	100%
	Communication materials: timeliness	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Program reporting	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Annual enrollment attendance	Any Incident										100%	100%	
CUSTOMER SERVICE	Respond to written correspondence	Quarterly		100%			100%		100%	100%	100%	100%	100%	100%
	Response online or escalated inquiries	Quarterly		100%			100%		100%	100%	100%	100%	100%	100%
	Manage ID card mail-outs	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Answer 80% of calls within 30 seconds	Quarterly		83%			87%			58%			98%	
	Manage call blockage below 0.5%	Quarterly		<0.05%			<0.05%			<0.05%			<0.05%	
OPERATIONS	Total Claims Response Rate	Not a PG	99.0%	99.0%	99.0%	99.0%	99.3%	99.3%	99.0%	99.3%	99.3%	99.4%	99.1%	99.3%
	Adherence to CMS Program Parameters	Any Incident	100%	100%	100%	100%	100%	<100%	100%	100%	100%	100%	100%	100%
SYSTEMS & DATA MANAGEMENT	Process eligibility files accurately, timely	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	<100%	<100%	100%
	Resolve file or transaction errors accurately, timely	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Provide timely notification of file or transaction errors	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	<100%	<100%	100%
	Ensure website availability	Annual												100%

HEAT MAP COLOR LEGEND

No applicable activity.	Performance met standards.	Performance did not meet standards; PG assessment waived.	Performance did not meet standards; not a PG metric.	Performance did not meet standards; PG assessment pending.	Performance did not meet; PG assessed and received.
-------------------------	----------------------------	---	--	--	---

Prescription Drug Benefits

GBP health plans include prescription drug coverage, although the coverage is provided in different ways. Each HMO provides both health and prescription coverage.

HealthSelect Prescription Drug program

All HealthSelect participants received benefits through the HealthSelect Prescription Drug program, administered by Caremark through December 31, 2016. Program administration transitioned to OptumRx, an affiliate of UnitedHealthcare, on January 1, 2017. This new contract is projected to save the plan \$1 billion over the next six years.

HealthSelect Medicare RxSM

Starting January 1, 2013, most Medicare-primary participants began receiving prescription drug benefits from HealthSelect Medicare Rx, a self-funded Employer Group Waiver Program with a wraparound feature (EGWP + Wrap) administered by SilverScript. Starting January 1, 2017, administration for HealthSelect Medicare Rx transitioned to Optum Rx, a subsidiary of UnitedHealthcare.

An EGWP + Wrap program is a Medicare Part D program containing a wraparound provision that ensures that retired employees will receive benefits at least equal to those of the traditional HealthSelect Prescription Drug plan within the GBP.

Monthly Administrative Performance Report (MAPR) Heat MAP Summary

HealthSelect Medicare Rx PBM

SilverScript Insurance Company - Calendar Year 2015

Description		Assessment Frequency	01-2015	02-2015	03-2015	04-2015	05-2015	06-2015	07-2015	08-2015	09-2015	10-2015	11-2015	12-2015
ACCOUNT MANAGEMENT	Annual participant satisfaction rate	Annually	97%											
	Program reporting	Monthly	100%	100%	100%	100%	100%	100%	<100%	100%	100%	100%	100%	100%
	Communication materials: quality, timeliness	Any Incident	100%	<100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Written notice of changes	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Annual enrollment attendance	Any Incident											100.0%	100.0%
CUSTOMER SERVICE	Respond to written correspondence	Quarterly	100%			100%			100%			100%		
	Response online and/or escalated inquiries	Quarterly	100%			100%			100%			100%		
	Manage ID card and/or welcome kit mail-outs	Any Incident	<100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Manage replacement ID card mail-outs	Not a PG	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Manage calls to dedicated toll-free number	Quarterly	91%			91%			87%			81%		
	Answer 80% of calls within 30 seconds	Monthly	94%	92%	81%	92%	87%	90%	86%	91%	77%	79%	76%	83%
	Manage call blockage below 0.50%	Quarterly	0.00%			0%			0%			0%		
OPERATIONS	Process claim payments, accuracy	Annually	100%											
	Process claim payments, timeliness	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Dispensing rate, accuracy	Annually	100%											
	Dispensing rate, timeliness	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Dispensing rate, timeliness	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Adjudication of claims	Monthly	<100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	<100%
SYSTEMS & DATA MANAGEMENT	Ensure claims system availability	Annually	99.9%											
	Process eligibility files accurately, timely	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Provide timely notification of file or transaction errors	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Resolution of File Transfer/Transaction Errors	Any Incident	100%	100%	100%	100%	100%	100%	<100%	100%	100%	100%	100%	100%
	Ensure website availability	Annually	99.9%											
	Data to be Restricted to the United States	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

HEAT MAP COLOR LEGEND

No applicable activity.	Performance met standards.	Performance did not meet standards; PG assessment waived.	Performance did not meet standards; not a PG metric.	Performance did not meet standards; PG assessment pending.	Performance did not meet; PG assessed and received.
-------------------------	----------------------------	---	--	--	---

Voluntary Benefits

The GBP offers a variety of optional add-on benefits that are funded through participant contributions not by state appropriations.

Figure 35: GBP Optional Insurance Plans As of August 31, 2016

Members pay 100% of the premiums for the optional insurance programs in which they enroll. There is no state contribution.

Coverage	Plan Type	Funding	Vendor	Enrollment
Vision (new)	Vision benefits	Self-funded	Superior Vision	117,125 (as of 9/1/2016)
Dental	PPO	Self-funded	Humana	299,886
	HMO	Fully insured	DentiCare, Inc. (subsidiary of Humana)	129,133
Optional Life	Group term insurance	Fully insured	Securian	326,584
Voluntary Accidental Death & Dismemberment	Group term insurance	Fully insured	Securian	133,454
Texas Income Protection Plan (Disability)	Short-term	Self-funded	ReedGroup	117,707
	Long-term	Self-funded		90,677

GBP Optional Benefit (non-insurance) FY16 - There is no state contribution.

Coverage	Vendor	Enrollment
State of Texas Dental Discount Plan SM	Careington International Corporation	9,300

Dental

The GBP offers three optional add-on dental benefits programs. Two of these are insurance plans:

- **State of Texas Dental Choice PlanSM** a self-funded Preferred Provider Organization (PPO), and
- **Humana Dental DHMO**, a fully insured Dental Health Maintenance Organization (DHMO) plan.

The **State of Texas Dental Choice Plan** PPO covers services in the United States, Canada, and Mexico if the participant resides in the United States. PPO participants may see any dentist, but receive a higher benefit by using a network provider. The dental insurance plans are funded through participant-paid premiums, co-payments, and deductibles for select services.

The **DHMO** is limited to dentists in the Texas service

area and requires participants to select a primary care dentist from a list of approved providers.

The **State of Texas Dental Discount PlanSM**, a non-insurance dental discount program, offers discounted prices on dental treatment and services at participating providers in the United States and the United Kingdom. Unlike insurance plans, there are no claim forms, copays, deductibles, annual maximums or limits on use. This plan is funded through participant-paid premiums.

Over the last five years, enrollment in the State of Texas Dental Choice Plan increased 25.7% (from FY2012 through FY2017). Enrollment in the DHMO decreased 17.44% for the same period, in part due to the introduction of the State of Texas Dental Discount Plan. Enrollment in the discount plan has increased 57.2% since its inception in Plan Year 2015.

Figure 36: Dental Benefit Enrollment – September 1, 2012 to September 1, 2017

Dental Plan	Enrollment FY2012	Enrollment FY2013	Enrollment FY2014	Enrollment FY2015	Enrollment FY2016	Enrollment FY2017
State of Texas Dental Choice Plan SM (PPO)	246,734	258,502	271,645	281,031	295,401	310,203
DHMO	151,757	145,835	142,463	135,586	128,118	125,283
State of Texas Dental Discount Plan SM (non-insurance option)	N/A	N/A	N/A	6,627	9,300	10,418
Total	398,491	404,337	414,108	423,244	432,819	445,904

Monthly Administrative Performance Report (MAPR) Heat MAP Summary
State of Texas Dental Choice Plan
 HumanaDental Insurance Company - Fiscal Year 2016

Description		Assessment Frequency	09-2015	10-2015	11-2015	12-2015	01-2016	02-2016	03-2016	04-2016	05-2016	06-2016	07-2016	08-2016	
ACCOUNT MANAGEMENT	Annual participant satisfaction rate	Annually	FY2016												
	Communication materials: quality, accurate, timely	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Annual enrollment attendance	Any Incident		100%	100%									100%	100%
	Grievances and Appeals: timely acknowledgement	Annually	99%												
	Grievance and Appeals: timely processing	Annually	99%												
	Written notice of changes	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Program reporting	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
CUSTOMER SERVICE	Respond to written correspondence	Quarterly	97%			97%			97%			97%			
	Response online, escalated inquiries	Quarterly	100%			100%			100%			100%			
	Manage ID card mail-outs	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	
	Answer 80% of calls within 20 seconds	Annually	82.3%												
	Manage call blockage below 0.5%	Quarterly	0%			0%			0%			0%			
OPERATIONS	Manage provider network; ensure network access	Annually	> 90%												
	Process claim pymts: financial accuracy (dollar basis)	Annually	99.8%												
	Process claim pymts: financial accuracy (claim count basis)	Annually	99.8%												
	Process paper (manual) claims timely	Annually	98.9%												
	Process provider claims payments timely	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
SYSTEMS & DATA MANAGEMENT	Process eligibility files timely - weekend processing	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	<100%	
	Process eligibility files timely - week day processing	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Ensure claims system availability	Annually	> 99.5												
	Resolve transaction errors: accurately, timely	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	<100%	
	Provide timely notification of file errors	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	<100%	
	Ensure website availability	Annually	99.8%												

Monthly Administrative Performance Report (MAPR) Heat MAP Summary
Dental Health Maintenance Organization
 HumanaDental Insurance Company - Fiscal Year 2016

Description		Assessment Frequency	09-2015	10-2015	11-2015	12-2015	01-2016	02-2016	03-2016	04-2016	05-2016	06-2016	07-2016	08-2016	
ACCOUNT MANAGEMENT	Annual participant satisfaction rate	Annually	FY2016												
	Communication materials: quality, accurate, timely	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Annual enrollment attendance	Any Incident		100%	100%									100%	100%
	Grievances and Appeals: timely acknowledgement	Annually	100%												
	Grievance and Appeals: timely processing	Annually	100%												
	Written notice of changes	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Program reporting	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
CUSTOMER SERVICE	Respond to written correspondence	Quarterly	98%			98%			98%			99%			
	Response online, escalated inquiries	Quarterly	100%			100%			100%			100.00%			
	Manage ID card mail-outs	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Answer 80% of calls within 20 seconds	Annually	82.3%												
	Manage call blockage below 0.5%	Quarterly	0%												
OPS	Manage provider network; ensure network access	Annually	> 90%												
SYSTEMS & DATA MANAGEMENT	Process eligibility files timely - weekend processing	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Process eligibility files timely - week day processing	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Ensure claims system availability	Annually	> 99.5												
	Resolve transaction errors: accurately, timely	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Provide timely notification of file errors	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Ensure website availability	Annually	99.8%												

HEAT MAP COLOR LEGEND

No applicable activity.	Performance met standards.	Performance did not meet standards; PG assessment waived.	Performance did not meet standards; not a PG metric.	Performance did not meet standards; PG assessment pending.	Performance did not meet; PG assessed and received.
-------------------------	----------------------------	---	--	--	---

State of Texas Vision - NEW

In response to the overwhelming interest of GBP plan participants, ERS began offering a vision plan on September 1, 2016. The State of Texas Vision Plan covers all or a portion of the cost of eyeglasses and contact lenses as well as discounts for LASIK. The plan is funded through participant-paid premiums and co-payments. As with other optional add-on benefits, the state does not contribute funds to this plan.

About 18% of eligible participants enrolled in State of Texas Vision in the first plan year. Participation is expected to increase in coming years. The table below includes enrollment numbers as of September 1, 2016. It does not include enrollment among retirees, who had the opportunity to enroll after September 1, 2016.

As the TPA for the State of Texas Vision Plan, Superior Vision Services, Inc. (Superior Vision) has focused on successfully offering an expanded provider network to State of Texas Vision participants. Superior Vision's national network provides member access to 46 of the top 50 optical retail chains across the country. There are over 6,800 in-network providers in Texas and over 68,000 network providers including optometrists, ophthalmologists and opticians across the country.

As a result of ongoing recruitment of State of Texas Vision Plan providers, Superior Vision reports adding 69 new network providers, nominated by participants since the contract was awarded. Additionally, they have other providers in various stages of the recruitment and contracting process. Eight of these providers are in underserved areas, ensuring that members in less populated areas of the state have a network provider.

Figure 37: State of Texas Vision Plan Enrollment – As of September 1, 2016

State of Texas Vision Plan	Enrollment FY2017	Total Eligible	% Enrolled
Members	62,556	344,822	18.1%
Dependents	54,569	309,781	17.6%
Total Participants	117,125	654,603	17.9%

Disability Insurance: Texas Income Protection PlanSM

The GBP offers an optional insurance coverage for short-term disability and long-term disability. These types of coverage can increase an employee's financial

security and assist an employee or his or her family through a period without the employee's salary income. The disability plans within the Texas Income Protection Plan (TIPP) are self-insured plans funded by the plan's participants. Certain higher education institutions also fund some portion of an employee's TIPP plan.

Monthly Administrative Performance Report (MAPR) Heat MAP Summary Texas Income Protection Program (TIPP) Reed Group Management, LLC - Fiscal Year 2016

Description		Assessment Frequency	09-2015	10-2015	11-2015	12-2015	01-2016	02-2016	03-2016	04-2016	05-2016	06-2016	07-2016	08-2016
ACCOUNT MANAGEMENT	Written notice of changes	Any Incident	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Communication materials: quality, timeliness	Any Incident	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Annual participant satisfaction rate	Annually	FY2015											
	Annual enrollment attendance	Any Incident											100.0%	100.0%
	Program reporting: timely and accurately	Quarterly		92.0%			96.0%			100.0%				100.0%
CUSTOMER SERVICE	Provide MBPDs timely, upon request (when applicable)	Not a PG					100%	100%			100%	100%		
	Manage Call Blockage Rate below 0.5%	Not a PG	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Manage Abandonment Rate below 5%	Not a PG	3.5%	3.9%	4.6%	2.9%	6.7%	12.5%	9.1%	5.5%	3.3%	3.3%	3.4%	2.7%
	Answer 80% of calls within 30 seconds	Quarterly		77%			69%			76%				82%
	Resolve participant complaints timely	Not a PG				100%						100%		100%
	Resolve ERS-reported complaints timely	Not a PG	100%			100%	100%	100%	100%	100%	100.0%	100%	100%	100%
OPERATIONS	Process STD claims within 10 days	Quarterly		93%			97%			93%			85%	
	Process residual STD claims timely	Not a PG	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Process LTD claims within prescribed days	Quarterly		88%			93%			98%			100%	
	Process residual LTD claims timely	Not a PG	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Process claim payments; financial accuracy	Quarterly		78%			85%			91%			92%	
SYSTEMS & DATA MANAGEMENT	Process eligibility files accurately, timely	Quarterly		100.0%			100.0%			100.0%			100.0%	
	Ensure website availability	Annually							100.0%					
	Ensure claims system availability	Annually							100.0%					
	Resolve errors, unprocessed transactions	Quarterly		100.0%			100.0%			100.0%			100.0%	
	Provide timely notification of file errors	Annually							100.0%					
	Data to Be Restricted to the United States	Any Incident	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

HEAT MAP COLOR LEGEND

No applicable activity.	Performance met standards.	Performance did not meet standards; PG assessment waived.	Performance did not meet standards; not a PG metric.	Performance did not meet standards; PG assessment pending.	Performance did not meet; PG assessed and received.
-------------------------	----------------------------	---	--	--	---

Life and Accidental Death & Dismemberment Insurance

Term Life Insurance

Participating employees who elect GBP health coverage are automatically enrolled in \$5,000 Basic Group Term Life Insurance and \$5,000 Basic AD&D coverage. Each participating retired employee in the GBP is automatically enrolled in \$2,500 Basic Group Term Life Insurance. AD&D coverage is not available to retired employees.

Active employees can also enroll in Optional Group Term Life Insurance and AD&D coverage based on their salary. When newly hired, an employee may apply for Optional Term Life Insurance at one or two times annual salary without Evidence of Insurability (EOI). An election of Optional Term Life Insurance at three or four times annual salary requires EOI. The combined amount of Optional Group Term Life Insurance may not exceed \$400,000 with a corresponding amount of AD&D coverage. As directed by statute, ERS informs participants about the benefits of life insurance coverage.

Optional Group Term Life Insurance is also available to retirees. However, specific rules governing the maximum amounts available are dependent on date of retirement. Beginning at age 70, Optional Term Life coverage is reduced for both active and retired employees based on age:

Age 70-74	65%
Age 75-79	40%
Age 80-84	25%
Age 85-89	15%
Age 90 and over	10%

Dependent Term Life Insurance coverage with AD&D coverage

Employees may purchase \$5,000 of Dependent Group Term Life Insurance and \$5,000 of AD&D for each listed eligible dependent.

Participating retirees may retain \$2,500 of Dependent Group Term Life Insurance, as long as they retire with an active policy. The AD&D coverage is not available for dependents of retired employees.

Accidental Death & Dismemberment

Available only to active employees and their dependents, Voluntary Accidental Death and Dismemberment is a separate insurance program. For an additional premium, employees can enroll in AD&D coverage in incremental amounts up to \$200,000. An employee is not required to enroll in Optional Group Term Life Insurance coverage in order to have Voluntary AD&D coverage. EOI is not required for Voluntary AD&D.

Monthly Administrative Performance Report (MAPR) Heat MAP Summary
Basic and Optional Term Life, Accidental Death and Dismemberment Plans
 Minnesota Life Insurance Company - Fiscal Year 2016

Description		Assessment Frequency	09-2015	10-2015	11-2015	12-2015	01-2016	02-2016	03-2016	04-2016	05-2016	06-2016	07-2016	08-2016	
ACCOUNT MANAGEMENT	Written notice of changes	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Process claim payments timely	Monthly	100%	99.4%	100%	100%	100%	99.3%	99.5%	99.8%	99.7%	99.3%	100%	99.8%	
	Communication materials: approval process	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	<100%	100%	
	Communication materials: dissemination	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Communication materials: quality	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Communication materials: timeliness	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	ERS-specific website: quality	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Answer 80% of calls within 20 seconds	Monthly	99.9%	96.0%	96.6%	95.9%	94.1%	96.4%	93.0%	94.8%	97.1%	95.0%	93.0%	90.8%	
	Manage call blockage below 0.5%	Quarterly	0.0%			0.0%			0.0%			0.0%			
	Manage EOI underwriting process	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Program reporting	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	GBP-specific website: availability	Annually	99.8%												
	GBP-specific website: quality	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Annual enrollment attendance	Any Incident	100%	100%									100%	100%	100%
	Manage grievance process	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
CUSTOMER SERVICE	Maintain a designated Customer Service Unit	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
OPS	Process claim payments accurately	Annually	100%												
	Process EOI applications accurately	Annually	98.8%												
SYSTEMS & DATA MANAGEMENT	Ensure claims system availability	Annual	100%												
	Process eligibility files accurately, timely	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Resolve transaction errors accurately, timely	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Provide timely notification of file or transaction errors	Any Incident	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		

HEAT MAP COLOR LEGEND					
No applicable activity.	Performance met standards.	Performance did not meet standards; PG assessment waived.	Performance did not meet standards; not a PG metric.	Performance did not meet standards; PG assessment pending.	Performance did not meet; PG assessed and received.

TexFlex

Employees save on their federal income and payroll taxes by participating in TexFlex. TexFlex flexible spending accounts (FSAs) enable employees to pay out-of-pocket health and dependent care costs using pre-tax dollars. The state does not appropriate funds for the TexFlex program. Operating expenses and administrative costs are covered by monthly fees charged to participants.

TexFlex has four types of accounts:

- flexible spending accounts (FSA) for qualified health expenses,
- flexible spending accounts (FSA) for qualified dependent day care expenses,
- a new limited flexible spending account (LFSA) for qualified vision and dental expenses and
- a new commuter spending account (CSA).

The FSAs are voluntary programs in which employees may choose how much to contribute, up to a certain allowable maximum. Participating employees contribute a portion of each paycheck into accounts for qualified expenses for health and dependent day care, vision and dental expenses, and costs incurred for an employee's commute to and from work. The Internal Revenue Service sets rules for which expenses qualify for reimbursement from the account. Qualified expenses paid through these accounts are not taxed. TexFlex offers employees the use of a debit card equal to the account balance, which they can use to pay qualified expenses at the time of service.

An LFSA was created in FY16 for those enrolled in Consumer Directed HealthSelect and a Health Savings Account (HSA). Under Internal Revenue Service rules, those participating in an HSA are ineligible to participate in a health care flexible spending account, but may contribute to the LFSA for eligible dental and vision expenses only.

Figure 38: Tax-advantaged spending accounts

	Health Care / Limited Purpose Flexible Spending Account	Dependent Care Account	Commuter Spending Account
Annual Maximum Contribution	\$2,550 per participant	\$5,000 per household	\$3,060 for parking \$3,060 for transit
Fund Availability	Full annual amount available when contributions begin	Funds available monthly as they are added to TexFlex account from paycheck	Funds are available monthly as contributions are made from paycheck and posted to the TexFlex account
Carryover of Funds	Up to \$500 of unused funds can be carried over from one plan year to the next when you are actively employed. You can still contribute up to \$2,550 for that plan year.	No carryover of funds from one plan year to the next. However, you have a 2-½ month grace period after the end of the plan year in which you can incur new claims using previous plan year funds.	Funds carryover month-to-month while actively employed.

Monthly Administrative Performance Report (MAPR) Heat MAP Summary

TexFlex Program

ADP, LLC - Fiscal Year 2016

Description		Assessment Frequency	09-2015	10-2015	11-2015	12-2015	01-2016	02-2016	03-2016	04-2016	05-2016	06-2016	07-2016	08-2016	
ACCOUNT MANAGEMENT	Fiscal year forfeiture report	Annually	100%												
	Annual participant satisfaction rate	Annually	Pending												
	Program reporting	Monthly	100.0%	<100%	<100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Communication materials: quality	Any Incident	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	<100%	100.0%	<100%	
	Communication materials: timeliness	Any Incident	100.0%	100.0%	100.0%	<100%	<100%	<100%	100.0%	100.0%	<100%	100.0%	<100%	<100%	
	Written notice of changes	Any Incident	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	<100%	100.0%	100.0%	100.0%
	Annual enrollment attendance	Any Incident	<100%												
CUSTOMER SERVICE	Respond to written correspondence	Quarterly	100.0%			100.0%			100.0%			100.0%			
	Response online or escalated inquiries	Quarterly	100.0%			100.0%			100.0%			100.0%			
	Response research requests	Quarterly	100.0%			100.0%			100.0%			100.0%			
	Answer calls within 30 seconds	Quarterly	71.0%			49.0%			87.4%			53.6%			
	Manage call blockage below 0.5%	Quarterly	0.0%			0.0%			0.0%			0.0%			
OPERATIONS	Process paper claim reimbursements	Monthly	99.0%	99.0%	99.0%	100.0%	99.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Manage debit card mail-outs	Monthly	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Process claim payments accurately	Monthly	100.0%	99.8%	99.4%	100.0%	100.0%	100.0%	99.8%	99.0%	100.0%	100.0%	100.0%	100.0%	
	Process claim payments timely	Monthly	99.9%	99.8%	100.0%	100.0%	100.0%	100.0%	99.5%	99.0%	100.0%	100.0%	100.0%	100.0%	
SYSTEMS & DATA MANAGEMENT	Interface with GBP Vendors	Not a PG	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Ensure claims system availability	Annual	100.0%												
	Unscheduled Computer Down Time	Annual													
	Ensure website availability	Annual	100.0%												
	Process eligibility files accurately, timely	Any Incident	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Provide timely notification of file or transaction errors	Any Incident	<100%	<100%	<100%	<100%	<100%	<100%	100.0%	100.0%	100.0%	100.0%	100.0%	<100%	
Resolve file errors accurately, timely	Any Incident	<100%	<100%	<100%	<100%	<100%	<100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

HEAT MAP COLOR LEGEND

No applicable activity.	Performance met standards.	Performance did not meet standards; PG assessment waived.	Performance did not meet standards; not a PG metric.	Performance did not meet standards; PG assessment pending.	Performance did not meet; PG assessed and received.
-------------------------	----------------------------	---	--	--	---

1

V. Wellness and Disease Management Programs

The State of Texas provides health insurance so that its workforce is healthy, present and productive. Poor employee health results in greater expenses for employers and employees in both time and money. GBP participants who understand their state of health and ways to boost their health, who undergo preventive screenings, recommended immunizations, medical procedures and treatments, and who are compliant with their prescribed medications and treatments are more likely to have better health outcomes and lower health costs over time.

The GBP offers many voluntary wellness programs to help participants improve their health, manage a disease or condition, and potentially slow the growing cost of health care benefits. ERS supports and promotes wellness in the following ways.

Ensuring employees have wellness benefits through health insurance plans. HealthSelect, HealthSelect MA, and the HMOs all have extensive wellness offerings available to employees, retirees, and their families.

Conducting research on patterns of chronic illness. ERS studies whether people are taking their medications for chronic illnesses and where they are getting care – for example, do they go to the emergency room when they have an asthma attack, or are they going to their primary care doctor before it is an emergency?

Focusing our plan design to encourage people to get the care they need, when they need it. Preventive care is available at no cost to participants. The program also keeps generic drug costs and primary care copays low to make sure everyone can afford to go to the doctor and take the medications they need. HealthSelect participants may also speak with a registered nurse at any time using a free, 24-hour hotline.

Educating active employees and retirees about wellness programs. ERS provides multi-channel communications about wellness and the tools that are available to help participants manage their health. Our vendors use direct mail, online communications, telephone outreach, face-to-face meetings, and benefit fairs.

Working with employers to promote wellness. ERS and the HealthSelect TPA are working with state and higher education employers to identify opportunities to engage state employees, wellness coordinators, and

state agencies in wellness activities and incentives. We also help plan wellness activities and events throughout the year.

ERS hired a Health Promotion Administrator in February 2015 to work with wellness coordinators at state agencies and higher education employers encouraging greater use of the wellness resources available to HealthSelect members. A large part of this role is to help agencies and higher education employers launch wellness programs and enhance existing programs.

In addition, ERS has piloted wellness initiatives and encouraged state agencies to implement the piloted offerings. In October and November 2015, ERS piloted onsite biometric screenings to share best practices with other state agencies and high education employers. In 2015 ERS also piloted a four-month blood pressure awareness initiative and provided interested agencies a toolkit to help wellness coordinators implement it.

In 2016, ERS began organizing and hosting quarterly “Wellness Coordinator Idea Exchange” meetings in an effort to create a community forum for wellness coordinators. Meetings focus on available wellness resources, community resources, and provide time for wellness coordinators to network.

ERS was instrumental in planning the 2015 State Agency Wellness Conference, sponsored by the Department of State Health Services, and was invited to present to the attendees. ERS was also asked to coordinate a wellness presentation at the June 2016 Texas State Human Resources Association meeting. In June 2016 ERS offered and began helping the statewide wellness coordinator at the Department of State Health Services (DSHS) plan the 2017 statewide physical activity challenge for state employees.

ERS is currently working with the HealthSelect TPA to create and distribute Agency Wellness Profiles to the 10 largest agencies, with their top five chronic conditions and their employees’ level of engagement with wellness resources. Custom profiles cannot be provided to smaller agencies due to privacy requirements under HIPAA regulations, although regional information may eventually be available. Eventually the goal is to stratify the level of wellness programs at agencies to help measure success as ERS works for greater engagement with wellness resources and programs.

Wellness and Disease Management Programs by plan

HealthSelect of Texas Wellness and Disease Management Programs

With about 440,000 people, or 82% of GBP health plan participants, enrolled in HealthSelect of Texas, the plan's wellness programs have the largest potential impact of the GBP plans. According to the HealthSelect TPA, savings due to all of these programs was more than \$86 million in FY 16.

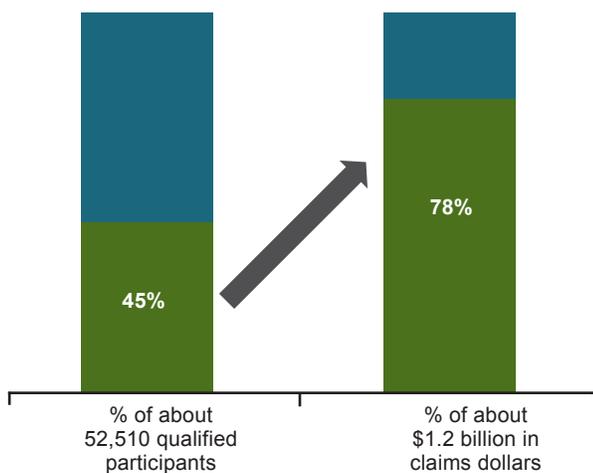
Care management program enrollment increased in FY16

Engaging in a care management program helps participants better manage complex or chronic conditions. With a care management program, chronically ill participants are more likely to proactively manage their health by going to their doctors, monitoring their conditions with appropriate diagnostic tests, and taking their medications. They are less likely to be hospitalized or visit the emergency room, compared to people with poorly managed health conditions. An overview of some of the care management programs is available at the end of this section.

About 45% of the 52,000 eligible high-risk participants are actively engaged in a care management program. While this may seem low, this group is responsible for 78% of the \$1.2 billion in costs for the eligible high-risk group. So while 100% participation has not been achieved, the plan is engaging the right people in care management programs.

Figure 39: HealthSelect successfully targets the highest risk participants for care management programs

(Enrolling the highest risk 45% of qualified participants targets 78% of the claims spend for that group)



Online wellness program Rally® boosts employee participation in health risk assessments

Between January and November 2016, roughly 14,600 HealthSelect participants completed health risk assessments (HRAs). More than 11,000 of those were completed through the online wellness program, Rally, which launched in May. The number of HealthSelect participants completing Rally HRAs in seven months is nearly double those completed in all of 2015. More than 97% of all HRAs were completed by employees. The goal of the health assessments is to educate participants about the current state of their health and simple ways to make positive changes.

Rally participants have access to unique tools for improving their health and lifestyle. Using the Rally4Health application from a mobile device or a computer, participants engage with Rally in several ways. Based on their health assessments, participants can learn their Rally AgeSM, a number that compares a participant's "health age" with their actual age. Rally also uses health assessments to provide individualized lifestyle plans, including suggested "Missions," which can include physical, emotional, and financial health, as well as social and community connections. The top five Missions most utilized by HealthSelect registrants are:

- cook at home more,
- be grateful each day,
- focus on fruits and veggies,
- stretch every day and
- walk 2,000 steps every day.

Since May 1, 2016, roughly half of the 14,000 who registered with Rally joined a Mission, but only 4% of all Rally registrants completed a Mission. However, the more than 500 participants who completed a Mission achieved an average of 10 completed Missions for a total of 5,400 through November 2016. Completed activities within Rally are rewarded with Rally Coins that participants may use to collectively contribute to selected charities. Each time Rally hits the coin goal for a charity across its book of clients, including ERS, Rally contributes \$4,000 to that charity. On June 30, 2016, for instance, ERS participants donated 51,413 coins toward the American Heart Association's goal of \$3.1 million coins, triggering a \$4,000 donation from Rally to that charity.

Telephonic Wellness Coaching programs are showing more engagement

A personalized behavior change program, telephonic wellness coaching assists participants in making healthy lifestyle choices, which can improve their quality of life and enhance workplace performance. Wellness coaches provide help with:

- Tobacco Cessation
- Weight Management
- Diabetes Lifestyle
- Exercise, including musculoskeletal
- Heart Health Lifestyle
- Nutrition
- Stress

In FY16, roughly 2% of HealthSelect participants (9,988) were identified as qualified to participate in these programs, up 25% from 8,014 in FY15. All qualified participants were invited to participate, and 43% of qualified participants enrolled. Corresponding with the increase in qualified participants, program enrollments also have increased by 19% from 3,640 in FY15 to 4,321 in PY16, with the largest enrollments in the Weight Management, Nutrition and Diabetes Lifestyle programs.

Figure 40: Outcomes for the Weight Management telephonic wellness coaching program

	Prior	Current
% Enrollees Lost Weight	13.3%	11.7%
Lost 1-5% Body Weight	87.2%	82.0%
Lost 6-9% Body Weight	7.8%	11.0%
Lost 10%+ Weight	5.0%	7.0%
Average Weight Loss (pounds per Enrollee who lost weight)	8.3	9.8
Total Weight Loss (pounds per Enrollee who lost weight)	1,169	1,683
Average % Body Weight Reduction	3.7%	4.3%

Real Appeal proves popular for weight loss

As of April 1, 2016, Real Appeal is a new online weight loss program available to eligible HealthSelect of Texas participants not enrolled in Medicare Part B – employees, retirees and their covered dependents ages 18-75 (excluding Medicare-primary participants) – with a body mass index (BMI) of 23 or higher.

Available at no additional cost to eligible participants, Real Appeal is a 52-week program providing tools, resources, and weekly online group coaching for guidance and support. After participating in the

first group session, a Real Appeal Success Kit that includes tools and resources, such as step-by-step guides, a scale, workout DVDs, a resistance band and pedometer, easy-to-use cooking tools, and a blender, is delivered to the participant.

Between April 1, 2016 and August 31, 2016, 14,465 HealthSelect participants enrolled in Real Appeal with:

- nearly half (6,931) reported weight loss, totaling 52,649 pounds,
- the average weight loss was 7.6 pounds and
- 90% of those enrolled are or were considered at risk for diabetes, cardiovascular disease or other related conditions and the average satisfaction rating by participants is 4.84 out of 5.

Figure 41: While participation in HealthSelect wellness programs is low, enrollment in many programs has increased

	FY15	FY16	Change
Care Management Programs	91,691	102,181	+12%
Care Management Programs: High-Risk participants contacted* (52,510 participants qualified)	19,770	24,030	+22%
Care Management Programs: Low- to Moderate-Risk participants** (185,778 participants who qualified)	71,921	78,151	+9%
Participants who completed Health Risk Assessment	6,384	14,596	+129%
NurseLine (66% of callers redirected from the ER)	967	675	-43%
Virtual Visits	N/A	603 since 1/1/16	N/A
Rally	N/A	14,000+ since 5/1/16	N/A
Real Appeal	N/A	14,645 since 4/1/16	N/A
Telephonic Wellness Coaching Programs	3,640	4,321	+19%
Tobacco Cessation	87	126	+45%

* Contacted by phone

** Contacted by phone and mailings

24-Hour NurseLine usage dropped 43% from FY15 to FY16

Participants in a HealthSelect plan may speak with a nurse at any time for no additional costs. The “Nurse Advocate” can assist participants with a range of topics, including:

- understanding treatment options,
- answering medication questions,
- choosing appropriate medical care,
- locating other available local health resources,
- finding a doctor, hospital or specialist who is in-network or is accepting new patients and
- scheduling an appointment.

NurseLine usage dropped in FY16, due to reduced advertising for the program.

Health4Me™ mobile app

For HealthSelect participants, the UnitedHealthcare Health4Me app provides access to critical health information from a smart phone. Participants can search for physicians or facilities, view claims, member ID card, account balances and benefit plan details. Health4Me app is available for download in the app store for iPhones or Google Play for Androids.

Virtual Visits expanded access to health care

On January 1, 2016, ERS began offering a new alternative to in-office visits for HealthSelect participants with Virtual Visits. Using the Health4Me mobile app or a computer, participants who need non-emergency medical attention can visit with a licensed physician from any place at any time with an audio/visual connection.

Virtual Visits allows participants to see and talk to a doctor in the virtual provider network in a matter of minutes, without an appointment or referral. For a \$10 copay, a participant can avoid unnecessary visits to the ER and may be treated for common, non-emergency conditions, including:

- bladder infection/ urinary tract infection,
- bronchitis,
- cold/flu,
- diarrhea,
- fever,
- migraine/headaches,
- pink eye,

- rash,
- sinus problems,
- sore throat and
- stomach ache.

HealthNotes reminder program closes care gaps

HealthSelect identifies gaps in care when a participant does not take an expected action, such as refill a medication. To close that gap, HealthSelect mails reminders called “HealthNotes” to the participant or, in some cases, to the provider. In FY16, for example, HealthSelect sent 158,972 HealthNotes on potential medication adherence issues. Of those, 73,676 (46%) medication adherence issues were resolved. Of 76,782 HealthNotes mailed to those about missed therapy interventions, 44,878 (44%) were resolved.

Overview Care Management Programs

HealthSelect offers more than a dozen care management programs to support participants with certain conditions and diseases. These are sometimes referred to as clinical management programs. For participants with complex medical conditions or health needs, including transplants, cancer, congenital heart disease, kidney disease, bariatric services and neonatal care, UnitedHealthcare offers Centers of Excellence networks and specialized care management services. Patients with complex medical conditions are more likely to receive better care when treated by specialized physicians in high-performing facilities treat them. Specialized care can lead to shorter hospital stays, higher success rates, fewer complications, faster recoveries and lower costs.

► Maternity Support Programs

The Healthy Pregnancy Program supports those who are pregnant or considering pregnancy with 24-hour access to experienced nurses at a toll-free phone number, information to help identify risks and special needs, and other materials to support pregnancy through every stage, including delivery.

Neonatal Resource Services works with the Healthy Pregnancy Program to identify high-risk pregnancies. Specialized neonatal nurse consultants direct participants to appropriate care facilities, and provide education and ongoing support services to care for the participant and baby after they are discharged from the care facility.

► *Treatment Decision Support (TDS)*

A specialized nurse works directly with participants to help them make informed medical decisions by educating them on various treatment options related to specific conditions. The purpose is for participants and their physicians to achieve the best possible results, with the least complications, at the lowest possible cost to both participants and the plan. TDS nurses steer participants to UnitedHealth Premium providers (i.e., providers who have met UnitedHealth's stringent quality and efficiency criteria and demonstrated adherence to evidence-based medicine) or one of UnitedHealth's Centers of Excellence networks.

Participants may receive TDS for the following conditions and procedures:

- musculoskeletal: Back pain; knee replacement; hip replacement,
- men's health: Benign prostate disease; prostate cancer,
- women's health: Breast cancer; benign uterine conditions, including hysterectomy,
- heart disease: Coronary disease; angina; angioplasty; coronary artery bypass graft (CABG) and
- obesity: Bariatric surgery.

► *Disease Management*

Participants can receive personal support for chronic conditions, complex health care needs and treatment decisions through the following care management programs:

- Asthma Program,
- Bariatric Resource Services Program,
- Cancer Resource Services Program,
- Chronic Obstructive Pulmonary Disease Program,
- Comprehensive Kidney Solution,
- Coronary Artery Disease Program,
- Diabetes Management Program,
- Heart Failure Program and
- Transplant Resource Services and Congenital Heart Disease Services.

Each program is designed to improve the quality of care, lower costs, and ensure a personalized participant experience based on national guidelines and evidence-based medicine. The whole-person approach to disease management includes behavioral health, comorbidity management and prescription drug management.

Disease Management programs provide participants and their providers with the information they need to make the best decisions and achieve optimal outcomes, including guidance to quality and efficiency designated physicians and Centers of Excellence networks.

Each program shares several common components, regardless of condition, that contribute to overall effectiveness and results. These include identifying and engaging participants, monitoring treatment plan compliance, supporting needed lifestyle modification changes, evaluating and improving the care received and providing personalized ongoing support to ensure the best possible quality of life for each participant.

► *HealthSelect Behavioral Health Support*

The HealthSelect behavioral health benefit includes counseling and substance abuse recovery services to help participants effectively manage stressful and challenging situations around a wide variety of issues such as:

- alcohol abuse,
- anger management,
- anxiety and stress,
- compulsive spending or gambling,
- coping with grief and loss,
- depression,
- domestic violence,
- drug abuse,
- eating disorders and
- medication management.

Health Discount Program

The Health Discount Program offered through the HealthSelect TPA provides discounted programs and services, such as laser eye surgery, cosmetic dentistry, health club memberships, weight loss programs and fitness wear. Discounts range from 10% to 25% with partners such as Danskin, Jenny Craig® and Global Fit. This program is administered through HealthAllies, Inc.

Vision Care Discounts

For those not participating in the State of Texas Vision plan, HealthSelect offers discounts on frames, lenses and laser eye surgery through a number of providers in Texas.

Regional Health Maintenance Organizations' Wellness Programs

Wellness resources are also available to the participants covered by one of the three regional HMOs offered in the GBP.

Community First HMO (San Antonio area) and **Scott & White Health Plan** (Central and West Texas area) offer the following wellness features to participants in the plans:

- disease management programs for those with chronic conditions,
- online health management and medical information resources,
- discounts on gyms, massage therapy, acupuncture and vitamins,
- coaching for weight loss, nutrition, smoking cessation and stress,
- 24-hour nurse line and
- vision and hearing discounts.

KelseyCare powered by Community Health Choice (Houston area) offers care management programs for asthma, diabetes, and high-risk pregnancy in addition to access to phone assistance, known as KelseyCare Concierge, during weekday business hours for:

- scheduling appointments and selecting physicians,
- finding nearby clinic locations,
- information about specific services available at each clinic location and
- addressing questions and concerns regarding the KelseyCare plan.

Medicare Advantage Wellness Programs for retirees

Retirees enrolled in one of the two Medicare Advantage plans have access to tailored wellness resources.

HealthSelect Medicare Advantage Plan (MA PPO) administered by Humana

Health Risk Assessments (HRAs) were completed by 74% of newly eligible participants through June of PY16.

Health Alerts were generated for more than 50,000 participants through June of PY16. Of those receiving a Health Alert, 68% were fully compliant by the end of the reporting period, an increase of 6% over the same period in 2015.

Clinical programs help participants avoid acute hospital admissions by managing certain conditions, including diabetes, coronary artery disease and congestive heart failure, cancer, musculoskeletal, asthma and Chronic Obstructive Pulmonary Disease (COPD). Nearly 22,000 participants enrolled in a clinical program between January and June of Plan Year 2016. One in three HealthSelect MA participants and 91% of all eligible participants interacted with the largest program, Humana Chronic Cares Program, at least once, which is a 17% increase over the prior year. These programs have helped reduce acute hospital admissions by 13% since 2013.

- Humana Chronic Cares Program: 18,890
- Senior Case Management: 83
- At Home Transitions: 1,233
- Post Discharge Care Coordination: 1,295
- End Stage Renal Disease/CKD Program: 186
- Transplant Management Program: 108

Go365 online wellness program is similar to the Rally program offered through HealthSelect of Texas.

SilverSneakers fitness program offers unlimited access to more than 13,000 gyms and fitness centers nationwide, as well as more than 70 types of fitness classes at parks, recreation centers, and clubs. Participation in SilverSneakers has steadily increased from 17% of HealthSelect MA participants in PY14 to 20% as of June 30, 2016.

Humana Active Outlook walking program is available through the Humana Guidance Centers in Austin and San Antonio for seniors who meet weekly for instructor-led group walks.

Quitnet Tobacco cessation program includes nicotine replacement therapy, phone counseling and online support.

WellDine delivers precooked meals to participants after an overnight stay in a hospital or skilled nursing facility.

KelseyCare Advantage (MA HMO)

Participants may enroll in the Healthy for Life program for access to:

- MyKelseyOnline to conveniently schedule appointments and send messages to your doctor,
- Healthy Living eNews monthly email newsletter and
- health information centers and group classes with free information on important health topics.

VI. Vendor Contracting and Oversight

VI. Vendor Contracting and Oversight

Managed care reduces costs for the plan through the negotiation of discounted reimbursement rates with providers who agree to participate in the network. ERS contracts with vendors to process medical and prescription drug claims and build and maintain provider networks. The plan saved nearly \$5 billion in FY16 by negotiating discounts with a broad network of providers. Instead of using standard contracts the plan develops and administers customized GBP contracts in the best interests of the participants, programs, and the state.

The TPA contract, currently managed by UnitedHealthcare, will transition to BlueCross BlueShield of Texas on September 1, 2017. The prescription drug benefit programs transitioned from Caremark to OptumRx, an affiliate of UnitedHealthcare on January 1, 2017. The managed care savings represent the discounts taken from the “retail” prices that doctors, hospitals, pharmacies, and other providers would have charged the GBP had they not been covered by a managed care network.

Controlling costs through managing the network.

The HealthSelect medical TPA continues to expand the network to ensure that participants have access to a broad network of providers across the state. This is evidenced by an increase in the proportion of in-network paid claims from 89.5% of the total in FY13 to 91.4% in FY16. As a managed care plan, HealthSelect requires participants to stay “in network” to receive the highest level of benefits. Benefits are designed to save the plan and participants money by offering financial incentives to use contracted providers.

HealthSelect provides three levels of coverage:

- **Network coverage** means a participant must see a contracted primary care physician (PCP) or “gatekeeper” for specialist referrals or extra services such as lab work, X-rays, or MRIs.
- **Non-network coverage** refers to services provided by non-contracted providers. Participants can receive services from out-of-network providers, but they will generally pay more for such services.
- **Out-of-area coverage** refers to coverage outside of Texas or when Medicare coverage is primary. Out-of-area coverage does not require the selection of a PCP or the use of referrals. These services also cost the participants more.

ERS works closely with the TPA to monitor and manage HealthSelect network usage to identify and address gaps in network coverage. If a gap is identified, ERS works to fill those gaps through prioritizing the TPA’s contracting efforts, and in some cases, contracting directly with the provider.

Contracting activities in response to SB20 and recommendations of the State Auditor and Sunset Commission

In November 2014, the State Auditor’s Office (SAO) released an audit report of ERS’ HealthSelect procurement process. Shortly thereafter, the 84th Legislature enacted Senate Bill 20 (SB20), a comprehensive contracting bill, applicable to state agencies, including ERS. The General Appropriations Act (GAA) also included various new contracting requirements applicable to ERS. In November 2016, the Sunset Commission directed ERS management to make additional improvements to its contracting processes.

Consistent with ERS’ fiduciary responsibility, ERS has worked to comply with the requirements of both SB20 and the GAA, and to implement the SAO Audit Report and Sunset Commission recommendations. Consistent with these efforts, on April 1, 2016, ERS established the Office of Procurement and Contract Oversight (OPCO).

The purpose of creating OPCO was to centralize and standardize ERS’ procurement activities (including planning, solicitation drafting, evaluation, and award) and contract oversight (from implementation through contract termination or completion). OPCO assumed responsibility for drafting and updating, as necessary, agency-wide policies and procedures governing procurement process, including the HealthSelect procurement and contract oversight process. Purchasing personnel were then transferred from the Finance division to OPCO effective September 1, 2016 to complete the function’s consolidation. OPCO continues to develop additional policies and procedures consistent with and in support of state regulations, procurement best practices, and ERS’ fiduciary duty to the trust.

OPCO's efforts to comply with SAO's recommendations include, but are not limited to:

- Ensuring purchasers are involved in the planning and procurement of all contracts. As stated, ERS' Purchasing personnel are now part of OPCO. Additionally, all of OPCO's staff is currently certified or seeking certification as a Certified Texas Purchaser (CTP) or Certified Texas Procurement Manager (CTPM).
- Ensuring CTCMs are involved in the planning, procurement and monitoring of contracts. All of OPCO's staff are or are currently seeking such certification.
- Adopting bid protest procedures. Effective December 2015, ERS adopted rules governing bid protest procedures.
- Improving the Scoring Tool and evaluation process to address concerns relating to best value and mathematical accuracy. OPCO has developed a new Scoring Tool to address these concerns and has refined the evaluation process.

Regarding the Sunset review, the formation of OPCO addressed a primary concern that ERS' procurement and contracting processes were decentralized, causing issues with process standardization. Sunset also recommended that ERS implement contract term dates in agency contracts except in limited circumstances. OPCO works with the business divisions to determine appropriate contract terms on all contracts, both new executions and renewals. OPCO has also created a review, approval, and documentation process for any new contracts exceeding the Contract Management Guide's recommended four-year term.

OPCO's processes also account for legislative changes from the last session, including SB20 and reporting requirements included in the GAA. To address SB20 requirements for best-value sign-off of formal solicitations and resulting contracts by the Director of Procurement, ERS designated a Director of Procurement, now the Director of OPCO, on September 1, 2015. The Director developed processes to ensure appropriate best-value sign off on solicitations and contracts. OPCO also rolled out policies consistent with new ethics and conflict of interest disclosure requirements, enhanced contract and performance monitoring provisions, and reporting requirements. OPCO is working to comply with the Legislative Budget Board contract reporting requirements now applicable to ERS. ERS has also been timely in submitting the notification and solicitation process information required under the HealthSelect-specific GAA rider.

Addressing Member Concerns and Understanding of Processes

GBP participants may sometimes disagree with an insurance administrator's grounds for denying a claim or with the methodology used for determining claims payments. ERS continuously works to improve all member communications and ensure that participants understand the process for appealing insurance decisions. As a result of the Sunset Commission review, ERS is reviewing communications and participant engagement related to the grievance and appeals processes, as well as general member education to help members avoid out-of-network charges and costs not covered by their health insurance plans.

The ERS Grievance Appeals process

For most GBP programs, a member's first action to appeal a coverage decision is made to the TPA responsible for administering the program under contract by ERS; this is referred to as the **First Internal Appeal** process. Appeal rights for various coverage issues are generally described in claims communications to the member from the TPA.

After a member has exhausted their appeal rights with the TPA, an appeal can often be made to ERS directly for further review of the issue; this is referred to as the **Second Internal Appeal** process. Review of grievance appeals regarding questions of allowable amount or eligible expense issues are reviewed by Benefits Contracts staff. All other appeals to ERS must be considered by the ERS Grievance Committee, which includes staff from multiple agency business divisions, including: Benefit Contracts; Customer Benefits; Office of the General Counsel; and the Executive Office.

ERS does not hear appeals related to all benefit programs. Currently, participants may appeal to ERS regarding a decision denying payment in whole or in part within the following self-funded plans:

- HealthSelect,
- HealthSelect Prescription Drug program,
- State of Texas Dental Choice Plan preferred provider organization (PPO),
- Life insurance,
- Voluntary Accidental Death & Dismemberment (AD&D) and
- Texas Income Protection Plan (TIPP) benefits (the disability income benefits plan).

The Texas Insurance Code does not give ERS authority to review Health Maintenance Organization (HMO) and Medicare Advantage plan claims and benefit denials. This restriction also applies to the HumanaDental DHMO. Participants enrolled in an HMO, Medicare Advantage plan, or the HumanaDental DHMO, may appeal to the HMO, Medicare Advantage plan, or the DHMO in which they are enrolled.

Since 2012, the number of appeals received by ERS has fluctuated considerably, and represents a small fraction of claims paid in a year. During the 2016 plan year, for instance, roughly 5.7 million HealthSelect claims were paid on behalf of members and participants.

Figure 42: Second-Level Appeals to ERS

Fiscal Year	# of Grievances by Insurance Type						Total	% Change
	HealthSelect	EOI*	Disability	Life	Dental	Other**		
FY2012	166	10	63	18	5	9	271	
FY2013	522	12	123	12	11	8	688	154%
FY2014	319	3	36	7	15	1	381	-45%
FY2015	239	4	18	9	12	1	283	-26%
FY2016	403	3	11	8	9	0	434	53%

*Evidence of Insurability,(EOI): the underwriting a vendor performs EOI to determine if someone is eligible for insurance coverage

**Includes Prescription Drug Program, Premium Waiver, Accelerated Life and Exception Request grievances

When ERS upholds an appeal denial at the second appeal level, appellants may often pursue various forms of further external, independent review depending on the insurance product and issue in question, including: review by the State Office of Administrative Hearings (SOAH); review by an Independent Review Organization (IRO), a health care provider independent of the plan and certified by the Texas Department of Insurance (TDI) and mediation by the Texas Department of Insurance.

Second Internal Appeals relating to the following programs may be made to SOAH:

- State of Texas Dental Choice PlanSM
- Life Insurance
- Voluntary Death & Dismemberment
- Texas Income Protection PlanSM
- EOI Determinations

Second Internal Appeals relating to issues of medical judgment or rescission of coverage may request from HealthSelect an external review from an IRO.

Mediation Rights

Mediation rights were created by the 81st Legislature in 2009 with the passage of House Bill 2256 by then-Representative Hancock. The bill created Chapter 1467 of the Insurance Code to allow certain health plan enrollees the ability to request mediation of certain non-network claims.

This Chapter stipulates that mediation rights apply to:

- (1) A preferred provider benefit plan offered by an insurer under Chapter 1301; and
- (2) An administrator of health benefit plan, other than a health maintenance organization plan, under Chapter 1551.

In 2015, the 84th Legislature passed Senate Bill 481 by Senator Hancock to make the following changes to Chapter 1467:

- add assistant surgeons to the types of facility-based physicians subject to the mediation,
- require a clear explanation of the mediation process in communications from the provider to the enrollee and
- lower the minimum claim subject to mediation from \$1,000 to \$500.

Participants in the HealthSelect plan may file a mediation request with TDI if:

- their out-of-pocket obligation to a non-network hospital-based physician (radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon) is greater than \$500 after payment of any annual deductible and coinsurance amounts relating to their claim and
- the medical services were provided in a network hospital.

Mediation requests to TDI grew substantially during FY16, but the number and proportion of mediation requests from ERS members both declined.

Figure 43: Mediation requests to the Texas Department of Insurance

	FY 2013	FY 2014	FY 2015	FY 2016
# Mediation Requests	43	686	977	1,500
# ERS Mediation Requests	13 (30% of total)	455 (66% of total)	474 (49% of total)	451 (30% of total)

VII. Best Practices

ERS is recognized by its peers for innovative practices and proactive management of the GBP. ERS always endeavors to align benefit offerings with member and employer needs, and to provide members with additional choices when opportunities exist to add value. At the same time, ERS works to ensure that benefits are consistent with, and complementary to, regulatory environments and market trends.

ERS regularly conducts literature reviews and benchmarking studies, consults with industry experts, solicits ideas from member and provider associations, participates in state and national health policy roundtables, and meets with stakeholder groups. Over the past decade, ERS has also conducted four major benefits surveys of plan participants.

Solution Sessions – a transparent approach to evaluating new ideas

In 2012, while conducting a comprehensive study for the Texas Legislature on the sustainability of state employee benefit programs, ERS developed a new, transparent process for reviewing potential business ideas called “Solution Sessions.” Potential vendors who have ideas that could save money, enhance benefits, or contribute to the long-term sustainability of the program are invited to present ideas to ERS directors and decision-makers during an hour-long formal presentation.

A Solution Session is open to the public and live-streamed over the internet. Dozens of presentations have been recorded and posted on the ERS external website. After each presentation, ERS staff conducts an internal debrief to evaluate the uniqueness of the idea and whether it has potential to add value to existing program(s). ERS considers the potential impact to the member experience, whether the idea requires a financial investment or any operational changes.

ERS has implemented several Solution Session ideas; for example, an audit-type service for reprocessing Medicare Part D Retiree Drug Subsidy claims; the Employer-Group Waiver Program; and Tel-Care, a digital tracking device for diabetics.

Formalizing policies to ensure alignment with strategic priorities.

In FY16, ERS reviewed the Solution Sessions process for improvements. Responsibility for managing the Solution Sessions was transferred to the enterprise level, to an executive team focused on policy, planning, and performance. This team led the directors through a comprehensive look-back at the new business ideas presented over the past five years, to evaluate and rank each idea based on strategic, financial, operational and stakeholder considerations.

Figure 44: Ideas Brought by Vendors ERS

- Wellness initiatives (nutrition, tobacco cessation, weight management programs),
- Disease management programs (condition or population-specific carve outs),
- Onsite services (health clinics, biometric screenings, health risk assessments),
- Health data analytics tools (enhanced interfaces for dash-boarding and high-level claims reporting),
- Health benefits transparency tools (platforms with customized health cost and benefits information for participants),
- Voluntary benefits (whole life, income replacement plans, hearing or legal insurance),
- Value-added networks and services (customized pharmacy, radiology, laboratory or surgery networks) and
- Audit and fraud control services (auditing of health or drug claims, or of vendor performance).

After a guided facilitation exercise, the ERS policy and performance team conducted a blind ranking exercise, so that the directors could “grade” each idea on a scaled instrument, using agreed upon measures. Scoring the instrument provided the directors with valuable information about which ideas should be the focus of the coming biennium.

The ultimate goal of this process is to ensure that agency resources can be focused on developing concepts with the potential for greatest benefit to the member and to the long-term sustainability of the plan. The group decided to continue hearing new vendor ideas for value-based incentives and audit opportunities, and to put an extra strategic focus on disease management, wellness, and health data analytics capabilities for the coming biennium.

The executive office continues to finetune the Solution Sessions policies and procedures, to ensure that:

- the process for conducting and documenting meetings with potential vendors meet all regulatory guidelines,
- ERS communications with potential vendors are clear and consistent and
- new business ideas are regularly evaluated against organizational strategic priorities.

Value-based incentive design (VBID)

More employer-based health plans are adopting innovative practices to create best value through incentive-based structures that share more accountability with patients and providers. VBID incentivizes patients through cost sharing, and incentivizes providers through alternative payment arrangements to achieve high quality outcomes at a lower cost.

According to a 2017 survey of employers by the National Business Group on Health, about half of surveyed employers currently incorporate VBID into their plan designs.¹⁰ By 2018, Medicare projects that half of all doctor and hospital payments will be made through alternative payment models such as bundled payments, Patient Centered Medical Homes (PCMHs) or Accountable Care Organizations (ACOs).¹¹

ERS uses VBID plan design in numerous ways:

- Offering free access to Real Appeal, a virtual lifestyle intervention program to support weight loss and teach healthy habits,

- Reducing generic drug copays from \$15 to \$10 per month,
- Providing diabetic supplies free of charge,
- Charging \$50 for an urgent care copay, compared to \$150 for emergency room visits,
- Charging an extra \$100 copay for high-cost radiology services (e.g. MRIs) and
- Using Centers of Excellence for transplant and bariatric surgeries.

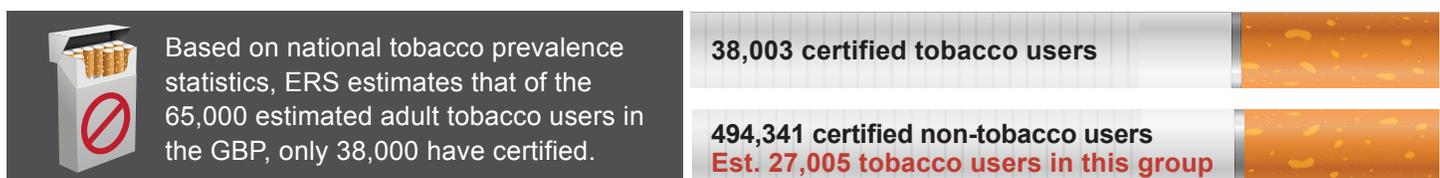
Tobacco premium contributions yielded \$13.8 million in FY16

Premium incentives that penalize unhealthy behaviors are a common VBID strategy. The 82nd Legislature enacted a tobacco user premium contribution that took effect January 1, 2012. The program was designed to encourage and support people to stop using tobacco, by covering tobacco-cessation medications and offering voluntary tobacco-cessation support programs. Certified tobacco users pay an extra contribution of \$30 a month, up to \$90 per household.

The 83rd Legislature authorized ERS to mandate tobacco certification of all participants starting with FY14 annual enrollment. Those who failed to certify as a non-user were assumed to be tobacco users and were charged the monthly tobacco premium contributions until they informed ERS they were no longer using tobacco.

In FY16, ERS collected \$13.8 million in tobacco premium contributions from more than 38,000 participants who certified as tobacco users, out of an estimated 65,000 potential tobacco users. This means that just under 60% of the expected number of adult tobacco users in the GBP have self-certified their tobacco use, based on a national adult prevalence rate of 15.2%.¹² Participants who fail to certify as tobacco users face possible expulsion from the program if caught using tobacco.

FIGURE 45: 58% of the projected adult tobacco users in the GBP volunteered to pay the tobacco-user premium contribution of \$30 a month in FY16



¹⁰ National Business Group on Health's Large Employer 2017 Health Plan Design Survey.

¹¹ Japson, Bruce, "employers Slowly Adopt Value-Based Health Benefit Designs, Forbes, August 19, 2016.

¹² Current U.S. prevalence of cigarette smoking status among adults aged 18 and over is 15.2% according to Summary Health Statistics: National Health Interview Survey, 2015, Table A-12a, page 1 of 9. There are 427,683 adult participants in the GBP (age 18 or older) as of August 31, 2016.

HealthSelect offers free tobacco-cessation coaching programs, which have historically attracted extremely low participation. Only 126 participants enrolled in the voluntary HealthSelect tobacco-cessation program in FY16.

HealthSelect provides coverage for prescription drugs like Chantix and bupropion, both prescribed to help people quit using tobacco. In FY16, about 3,300 Chantix prescriptions were filled by about 1,600 non-Medicare primary participants, at a net cost to the plan of about \$909,000. However, it takes 12 weeks for Chantix to be effective and only one in four utilizers filled enough prescriptions for 12 full weeks of Chantix therapy. As with any medication, the plan is informed only if the prescription was filled, not if it was taken.

Alternative Payment Models

Another VBID strategy is to use alternative provider reimbursement strategies to incentivize them to improve quality and lower costs. HealthSelect, like most employer-based plans, has historically paid claims under a “fee-for-service” (FFS) reimbursement strategy. FFS tends to reward doctors who prescribe more diagnostic tests and perform more procedures, not doctors who focus on low-cost preventive care and patient wellness.

Moving away from FFS requires paying medical providers in new ways that reward them for reducing costs while continuing to meet quality standards. State and federal legislative initiatives now encourage insurers to explore alternative payment systems that reward providers for reducing costs and improving quality outcomes.

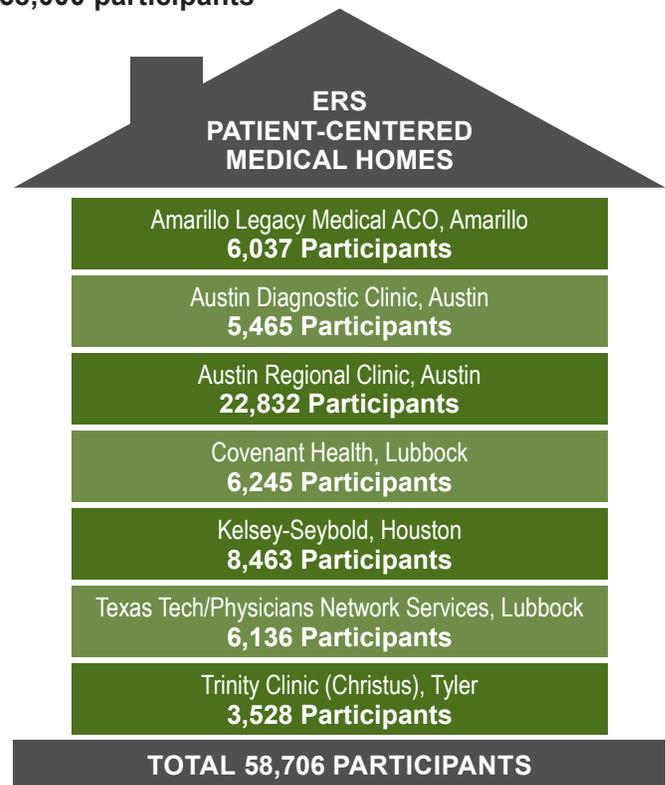
Patient-Centered Medical Homes – a blueprint for better care and lower cost

Between 2011 and 2016, ERS partnered with seven large clinically integrated physician group practices across the state to create Patient-Centered Medical Homes (PCMH) projects, which now treat more than 58,000 HealthSelect participants.

The PCMH model is a provider team made up of an integrated multi-specialty practice. This model generally:

- focuses on wellness and establishing an ongoing relationship with a personal primary care physician,
- uses advanced information technology – such as electronic health records,
- uses evidence-based medicine and clinical decision-support tools to ensure quality standards are met,
- provides enhanced access, such as open scheduling and expanded hours and
- awards shared-savings payments to the provider group when quality standards and cost targets are met.

Figure 46: HealthSelect has seven Patient-Centered Medical Home projects with more than 58,000 participants



Savings are shared with providers

In addition to its regular FFS payments, HealthSelect pays each PCMH a negotiated monthly capitation payment for those participants who have selected the medical home as their primary care coordinator. The capitation payment incentivizes enhanced care coordination not found in the standard FFS practice.

ERS also sets performance targets, designed to reduce the health benefit cost trend while meeting quality standards of care. The PCMH projects have successfully reduced the health benefit cost trend below their performance targets.

Through January 2017, the PCMH projects produced a net savings to the state of \$72.5 million while the practices received \$14.7 million in shared savings payments, in addition to their reimbursements for medical care. FY16 savings were \$11.9 million with \$3.4 million in shared savings payments.

Evaluated ideas in the planning stages

Episode-based bundled payments.

One concept that ERS plans to implement is the idea of episode-based bundled payments, in which one episode-of-care payment covers all the care a patient receives in the course of treatment for a specific illness, condition or medical event. Under the current fee-for-service payment system, for example, when a participant gets a knee replacement he receives separate bills from every provider along the way – the orthopedist, the hospital, the surgeon, the anesthesiologist, outpatient therapists, etc.

In contrast, with episode-based bundled payments, a single, bundled payment can be negotiated to include all physician, inpatient and outpatient care for a surgery, pregnancy and delivery, or heart attack. The episode payment is normally lower than the combined cost of separate fee-for-service payments. These arrangements can also use shared-savings incentives, where the plan may agree to share the additional savings from the bundled episode with the provider. The cost of potential complications are also usually covered under the bundled payment, which provides added incentive for quality care, because the provider will bear those extra costs if complications occur.

Maximizing coordination with Social Security Disability Benefits

Because participants age 50 to 64 (those not yet eligible for Medicare) have some of the highest costs for HealthSelect, it is imperative that ERS find new ways to

control costs without sacrificing quality and access for that group. One idea brought to ERS by a vendor, is to identify participants who may be disabled and receiving Social Security Disability benefits. A vendor would identify these individuals, and then help them file the necessary paperwork to enroll in the Medicare health insurance coverage they are entitled to under federal law. Once they are enrolled in Medicare health coverage, then HealthSelect will start paying secondary on their claims, thus reducing the overall cost to the HealthSelect plan. ERS believes there may be a number of participants, especially dependent spouses, who are unaware that they are eligible for Medicare coverage.

Ideas that ERS evaluated but did not implement

For the purposes of this report, ERS is providing two examples of the type of in-depth analysis that goes into evaluating potential ideas, whether they are implemented or not. Before resources can be devoted to developing, bidding, implementing and managing a new idea or program, ERS must conduct its due diligence to ensure that a new program or benefit will meet member needs, add to the long-term sustainability of the health plan, and be a cost-efficient use of state taxpayer dollars.

Expansion of onsite nurse practitioner or wellness clinics

In 2006 – the GBP established an onsite clinic at the Texas Commission on Environmental Quality (TCEQ) through a nurse practitioner pilot project. Ten years later, the TCEQ clinic continues to operate and is a popular benefit among employees. TCEQ paid to build out the clinic and it has continued an arrangement with the Austin Regional Clinic for a nurse practitioner and supervising physician, paid for with TCEQ's operating budget.

The TCEQ clinic is a hub for wellness activities and is also used to provide onsite management of chronic illness. However, in the initial pilot program in 2006, GBP costs increased, as members who would not normally go to the doctor sought care at the clinic and were referred to their doctor. Since then, both vendors and agencies have approached ERS with the idea of expanding the onsite clinic idea to more state agencies. This idea is not without merit, but there are some legislative and funding barriers that are addressed in the conclusion of the report.

PROS	CONS
<p>Budget Issues</p> <p>An onsite clinic could reduce costs long-term by identifying chronic illnesses earlier in the disease process.</p> <p>Member Impact</p> <p>By seeking onsite care, employees with contagious illnesses may reduce the risk of spreading illness among their coworkers.</p> <p>The TCEQ nurse practitioner prevented a serious cardiac event by identifying an employee’s symptoms early and sending him to the hospital.</p> <p>Policy Issues</p> <p>An onsite clinic could reduce absenteeism as employees would not have to take time off to see a health provider.</p> <p>The clinic becomes a hub for wellness activities and can provide onsite management of chronic illness.</p> <p>Operational Issues</p> <p>TCEQ and the State Capitol have experience with onsite clinics and can serve as models for implementation.</p> <p>Large campus employers, such as DSHS, HHSC, DADS, and DFPS have expressed strong interest in this idea and a willingness to share the cost of a clinic at the HHSC complex in north Austin.</p> <p>Other concentrated areas of state workers could benefit from the economies of scale.</p>	<p>Budget Issues</p> <p>Health plan costs could go up, as members who would not normally go to the doctor seek care at the clinic and may be referred to their doctor and incur a health plan charge.</p> <p>From the plan’s perspective, a majority of savings come to the employer through reduced employee absenteeism and increased employee morale, and to the employee, through waived copays.</p> <p>Any savings to health plan would be long term and the return on investment would be difficult to calculate.</p> <p>Policy Issues</p> <p>ERS does not have oversight or control of the onsite clinics as no funding is allocated to the GBP to support the concept.</p> <p>GBP Trust Fund dollars may not be diverted to benefit one small subset of the population, or to reduce state agency personnel costs.</p> <p>Operational Issues</p> <p>Additional cost to the employer to build out the clinic and maintain the contract.</p> <p>Administration of TCEQ onsite clinic contract is difficult for ERS due to separation of agencies.</p> <p>ERS has little or no effective remedies if employer does not meet payment schedule.</p> <p>Contract administration is complicated if done by health plan. For the TCEQ clinic, ERS is a pass-through for the onsite clinic, but ERS does not receive any administrative fee for being the pass-through.</p>

Defined contributions for Medicare retirees, with access to a “connector-model” marketplace

Under this option, the state’s contribution for Medicare retirees would become a fixed monthly deposit to a Health Reimbursement Account (HRA). ERS would contract with a vendor to provide the connector model and ERS would administer the HRA. A connector model is similar to an exchange where multiple insurance plans are sold in a centralized location, except that the vendor provides benefit advisors to help people negotiate the marketplace. Plans in the connector model would be underwritten on an individual basis. Medicare retirees would use the subsidy to buy an insurance product that suits their

individual needs through a “Medicare Exchange” or connector model vendor. If a Medicare retiree did not spend his/her entire subsidy toward a premium, s/he could accumulate a balance in the HRA and use the money for other medical expenses.

Due to the added administrative cost and geographic cost variations around the state, Medicare retirees could potentially pay significantly more for coverage that is not as good as what they have now. After reviewing this proposal in 2012 and again in 2016, ERS concluded that because 74% of Medicare-primary retirees with the GBP are already enrolled in Medicare Advantage plans, the potential disruption and financial burden for retirees outweighed any potential savings for the plan.

PROS	CONS
<p>Budget Issues</p> <ul style="list-style-type: none"> Increases in retiree contributions would be at the discretion of the Legislature, rather than driven by increases in the GBP health care cost trend. The Legislature could set the amount of the employer’s defined contribution at any amount it wants. If the contribution never rose, the projected OPEB cost would be decreased significantly, because OPEB factors in the future increases in the cost of coverage. <p>Impact on Members</p> <ul style="list-style-type: none"> Retirees would have more plan options to choose from. Insurance available in the exchange would have to be comparable to the GBP benefit. Retirees could use any money in their HRAs they don’t spend on premiums and apply it toward other medical expenses. <p>Policy Issues</p> <ul style="list-style-type: none"> Private sector plans have moved in this direction, so it would address the public perception that state retiree benefits are more generous than those in the private sector. This option has been implemented in at least one other state (Nevada). This is a preferred alternative to the elimination of Medicare retiree benefits. This concept is already being debated at the national level, as an idea for a defined contribution has been proposed for the Medicare program. 	<p>Budget Issues</p> <ul style="list-style-type: none"> Because ERS already implemented Medicare Advantage, savings would not be substantial. TRS’ attempt to implement an HRA ended because the HRA administrative fee was too high. With grandfathering, immediate impact on employer savings is limited. Presumably would have greater immediate impact on projected OPEB costs. Taking Medicare retirees out of the risk pool would mean changing the rating model, which could increase the cost for other members who would no longer be subsidized by Medicare-primary retirees. <p>Impact on Members</p> <ul style="list-style-type: none"> It could change costs for retirees on a fixed income. Retirees believe their insurance benefits are a promise from the state (although not guaranteed in statute), which could potentially lead to litigation. Removing ERS from the administration of the insurance benefit could confuse retirees about which plan to choose, where to go with problems with enrollment, claims, or other administrative issues. <p>Policy Issues</p> <ul style="list-style-type: none"> Not grandfathering could create a “rush to retirement,” which would negatively affect employers and the pension fund. About 20% of the state workforce is eligible to retire in the next five years. <p>Legal Issues</p> <ul style="list-style-type: none"> Under the Age Discrimination in Employment Act (ADEA) administered by the Equal Employment Opportunity Commission (EEOC) and the Department of Labor (DoL), employers must be careful when making benefit changes that benefit younger members at the expense of older members. (Age 40 is the cutoff). All options relating to retiree coverage must be thoroughly vetted for issues with the ADEA. <p>Operational Issues</p> <ul style="list-style-type: none"> Grandfathering would add to administrative complexity of the plan and increase operational costs.

VIII. Conclusion

ERS lowered health plan costs by \$7.2 billion in FY16 through tough cost-management practices, aggressive negotiation of contracts, and low administrative overhead. HealthSelect administrative costs represent less than three cents of every health plan dollar. Proactive cost management is an imperative measure in the face of growing utilization of health care, new technology and more expensive treatments, an aging plan membership, increasing rates of chronic diseases and limited resources.

Successful management and legislative support of the program allowed the GBP to avoid benefit changes for the FY16-17 biennium. But the future will continue to present some difficult challenges for ERS, state lawmakers, and especially for the employees, retirees and their families who count on these health insurance benefits.

The GBP has a significant impact on the Texas economy

One in 52 Texans – over half a million state and higher

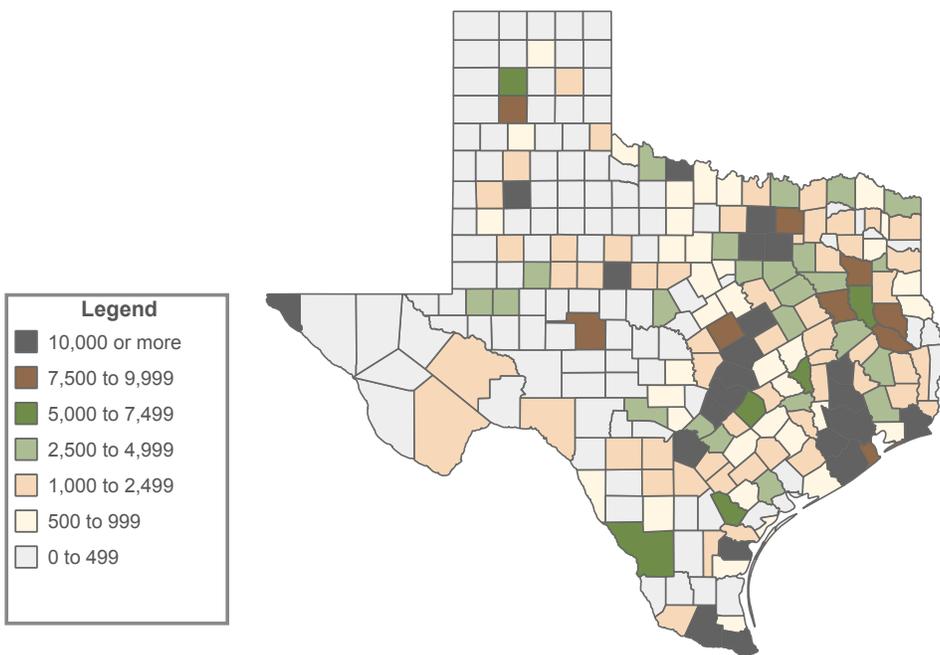
education employees, retirees and their families - are currently enrolled in ERS health coverage, in every area of the state. It is important to recognize the economic impact that the plan has on local health providers.

The GBP currently spends about \$9 million a day on health care claims. HealthSelect, with 83% of total GBP membership, paid \$2.8 billion in health payments last year to doctors, hospitals, and pharmacies across Texas.

Without cost management, the state's insurance contribution would more than triple

In FY16 the member-only contribution rate for was \$574 per month. Figure 47 demonstrates the financial impact that cost management programs had on the monthly contribution rate for member-only coverage during FY16. Without cost-management programs, the monthly contribution rate for member-only coverage would have been \$2085.

Figure 47: HealthSelect has a significant economic impact on the Texas economy
Number of ERS program participants and annuitants by county for previous fiscal year



Map based on ERS Program Participants and Annuitants (enrolled in GBP) by Member Eligibility County. Color shows details about Participant Count Groups. The data is filtered on Month, which keeps Previous FY End. The view is filtered on 254 valid Texas Counties.

Figure 48: Texas Employees Group Benefits Program, HealthSelect FY16, cost containment impact on the member only rate

	Annual Amount		Required Monthly Revenue for Member-only Coverage	
1. Considered Charges plus Estimated Cost Avoided	\$9,990,355,369		\$2,084.73	
2. Estimated Cost Avoided				
a. Medical	(\$86,195,661)		(\$17.99)	
b. Pharmacy	(64,094,571)	(150,290,232)	(13.37)	(31.36)
4. Ineligible Charges	(1,283,461,335)		(\$267.83)	
6. Reductions to Eligible Charges				
a. PDP Charge Reductions	(\$966,404,840)		(\$201.66)	
b. Other Facility & Professional Discounts & Reductions	(3,955,802,210)		(825.48)	
c. Medical Copayments and Deductibles	(119,859,608)		(25.01)	
d. Medical Coinsurance	(209,529,678)		(43.72)	
e. PDP Cost Sharing	(132,505,914)		(27.65)	
f. Coordination of Benefits – Regular	(24,119,396)		(5.03)	
g. Coordination of Benefits – Medicare	(120,869,711)		(25.22)	
h. Coordination of Benefits – PDP	(667,757)	(5,529,759,114)	(0.14)	(1,153.91)
8. Refunds, Rebates and Guarantees				
a. PDP Rebates	(\$196,914,139)		(\$41.09)	
b. Federal Revenue – Medicare Part D	(69,185,558)		(14.44)	
c. Subrogation	(6,506,065)		(1.36)	
d. Pharmacy Audit Refunds	(1,070,782)		(0.22)	
e. PBM Audit Refunds	(947,106)	(274,623,650)	(0.20)	(57.31)
9. Net Benefit Payments	\$2,752,221,038		\$574.32	\$574.32 Monthly Member Rate

Potential Strategic Actions to Achieve Program Goals

In an effort to encourage a forward thinking, strategic approach to managing GBP costs and benefits, the Sunset Commission directed ERS to recommend to the Legislature any policy or statutory changes that could help ERS achieve program goals. In the report, Sunset staff wrote: “ERS would consider and communicate to the Legislature not only ideas for controlling costs, but also what level of benefits will continue to attract workers and how to ensure the program’s sustainability over time.”

With this in mind, this section includes a number of suggestions that would require either legislative action or support to implement. ERS is not advocating for these changes, and in fact, recognizes that many of them simply shift costs to members. The most preferred options are those that use cost sharing in a targeted way to add value to the program and encourage healthy behaviors.

Included in this section are ideas for contribution strategies, plan design changes, and incentive structures that have been successfully employed by other public and private sector plans. There is also a discussion of some regulatory issues that affect competition in the marketplace that would require governmental intervention to make a change.

Appropriations Options

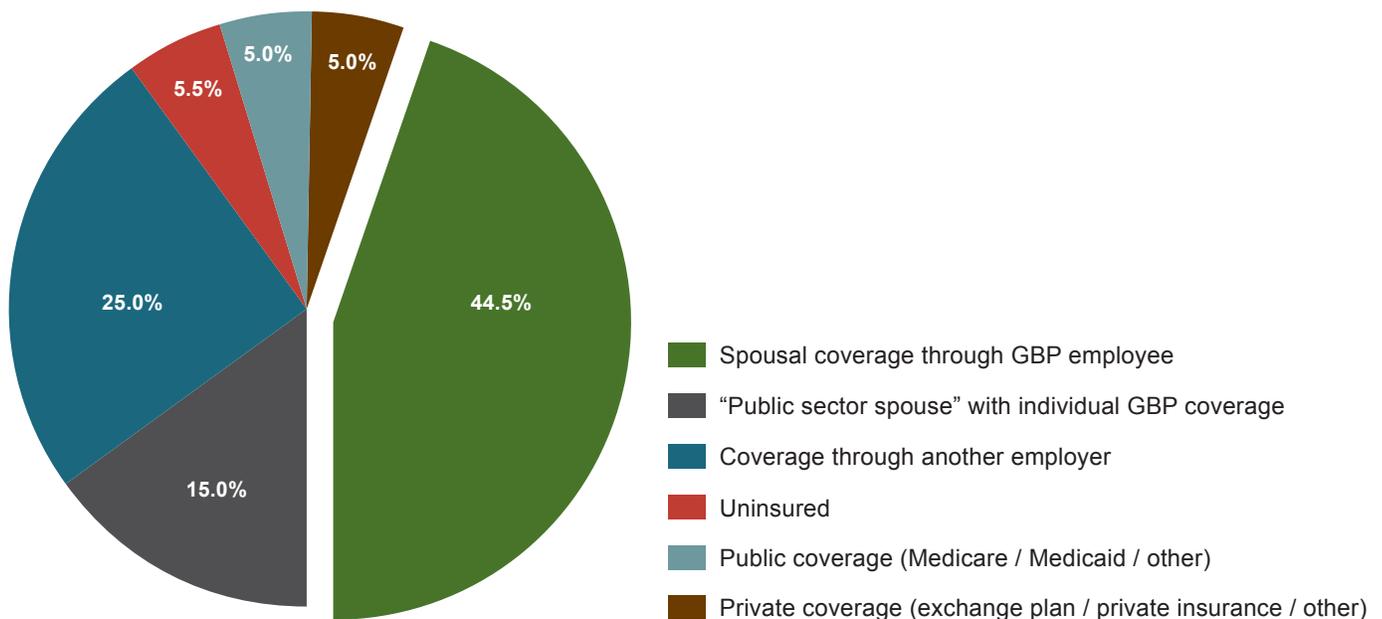
Charge spouses a higher premium when they have access to their own employer’s insurance. As a group, some of the most expensive HealthSelect participants are dependent spouses. Spouses are more expensive because they tend to be older and sicker than other groups. Employees and retirees are also more likely to add their spouses on to their GBP coverage when they have expensive health problems or when their spouse’s employer’s insurance is less generous than the state’s.

In a 2011 survey, 26% of HealthSelect members self-reported that their dependents have access to other employer-based health care coverage, but use GBP as their primary source of insurance coverage.

In a 2014 survey, ERS found that just under half of the employees with GBP-eligible spouses have added them to their GBP coverage.

Many private and public sector employers are now charging a spousal surcharge to those who have other options. The State of Kentucky’s reasoning behind adding the surcharge was simple: “It’s not the state’s job to subsidize other employers by taking on the insurance costs of their most expensive employees.”

Figure 49: Source of insurance coverage for GBP-eligible spouses
(based on 2014 ERS survey of 136,000 GBP-eligible state employees)



Charge pre-Medicare retirees the equivalent of a Medicare Part B premium. Retirees in general have higher overall costs than active employees, and pre-Medicare retirees have the highest medical costs. While ERS has successfully implemented multiple strategies to maximize program dollars for Medicare retirees, through coordination of benefits, Medicare Advantage, and the EGWP + Wrap program, it has been harder to find ways to manage pre-Medicare retiree costs. In recognition of their higher medical costs, some employers have started collecting the equivalent of a Medicare Part B premium from pre-Medicare retirees. The Legislative Budget Board made a similar recommendation to the 79th Legislature in the Government Effectiveness and Efficiency Report in 2005. It should be noted that this is a pure cost-shifting measure, but it focuses cost shifting on a population who is known to use more resources.

Provide start-up funding for state agencies to host onsite medical clinics. Large campus employers, such as HHSC, DSHS, DADS, and DFPS have expressed strong interest in creating and sharing the cost of an onsite medical clinic at the HHSC complex in north Austin. Other concentrated areas of state workers could also benefit from the economies of scale experienced by TCEQ, the State Capitol, and Travis County, who already have experience with different levels of onsite clinics and can serve as models for implementation.

Although this idea has merit, there are financial and potential statutory barriers to moving forward. The primary concern is that ERS may not divert GBP trust funds away from the self-funded claims pool for the

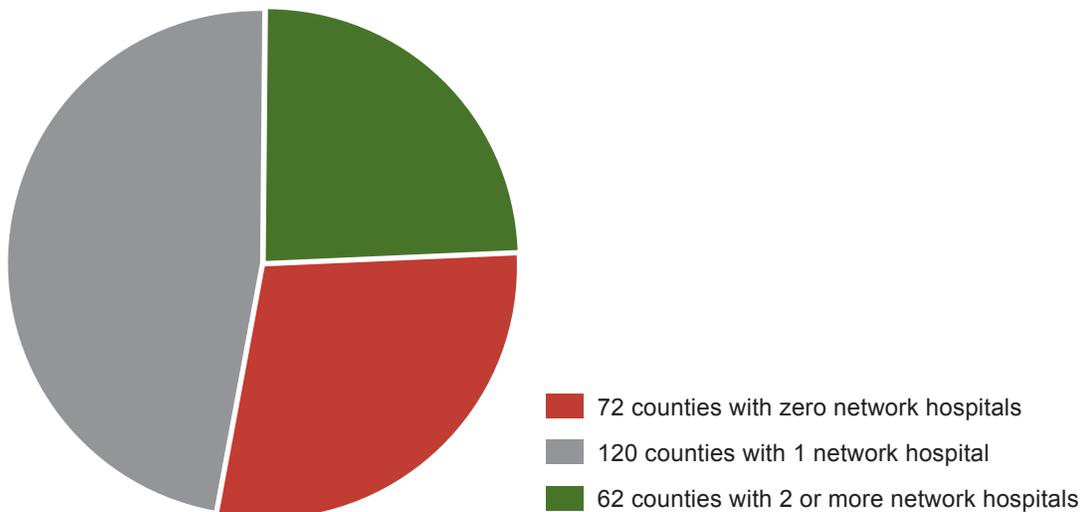
sole benefit of one state agency or a limited set of agency employees. The state may want to consider investing in on-site clinics by providing one-time “start-up” funds to build out clinics at state agencies with a sufficiently concentrated employee population and the desire to offer this benefit. Additional funding would also have to be appropriated to cover ERS’ administrative costs for managing the pass-through agreement with the TPA, and to cover staffing costs and liability issues, as there must be a qualified nurse-practitioner onsite, as well as a supervising physician.

Marketplace Options

Some potential legislative actions that could have a positive impact on ERS’ ability to manage benefits over time are:

- **Enacting Certificate of Need legislation** to require hospitals to get permission before building new facilities or making major expansions and
- **Addressing hospital antitrust regulations** to improve competition and drive down contracting costs in Texas. Consolidation and mergers of hospital systems have led to reduced capacity and diminished competition, which limits GBP negotiating leverage in provider contracting. Only 62 of the 254 Texas counties have more than one hospital, and 72 counties do not have a network hospital. In counties where there is only one hospital, HealthSelect is obliged to contract with those hospitals, whether they provide quality, cost-effective care or not.

Figure 50: Too many Texas counties lack a competitive choice among hospitals
HealthSelect FY16



Plan Design Options

While the ERS Board of Trustees could make the following plan design changes, they would require legislative support.

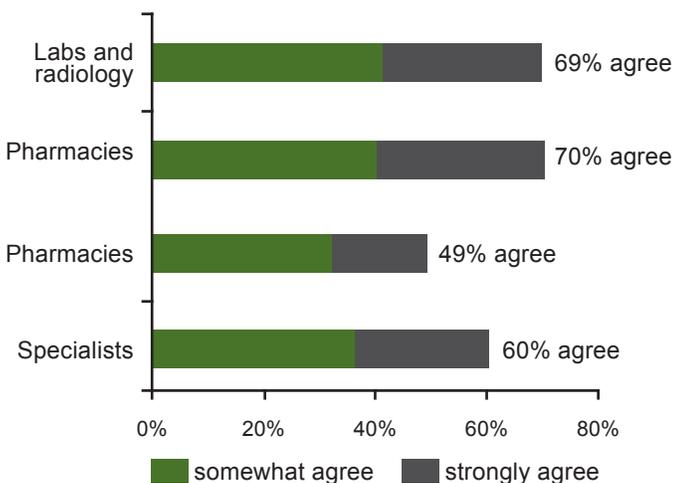
Create significantly smaller, high-performance networks and provide financial incentives to use those providers. High-performance networks are one way that an insurance plan can steer participants toward quality, cost-efficient care. In a high-performance network, certain types of providers are ranked based on cost and quality data, then participants can choose which doctors they want to see. If they choose a doctor that is not ranked as a high performer, they pay more.

A high-performance network means splitting benefits into three tiers and providing strong financial incentives for choosing providers in Tier 1.

- Tier 1 consists of high-performing providers,
- Tier 2 consists of the remaining in-network providers and
- Tier 3 consists of non-network providers.

ERS conducted a comprehensive member survey in 2010 with 45,000 responses. More people agreed with restricting the pharmacy, lab, radiology and specialist networks, while less than half were okay with restricting the hospital network. Those living in smaller cities and rural areas had strong concerns that limiting provider options would mean they would only have access to lower-quality, less experienced doctors.

Figure 51: GBP member opinions on creating smaller “high performance” networks
(based on ERS member survey in 2010)



Specialists are most often targeted for high-performance networks, in part because they tend to drive hospital admissions. High-performance physicians will often use high-performance hospitals. Individuals typically do not choose a hospital, they choose their physician who in turn directs them to a hospital.

Primary care physicians are excluded from high-performance networks to avoid disruption of established doctor-patient relationships. The use of high-performance networks has been slow to catch on due to the lack of information about quality standards. Providers and patients have also resisted the idea of restricted networks.

Build more targeted benefit-based copay strategies into the health plan to target chronic illness. In the long run, VBID strategies are an effective way for the plan to target specific problem cost drivers through plan design. The most frequently used VBID is the “benefit-based copay,” originally developed as a way to improve medication adherence by charging lower copays to patients who choose higher clinical-value drugs. Lowering out-of-pocket costs for targeted conditions – such as diabetes or high blood pressure – can make health care more accessible and affordable for some members.

The main obstacle is that VBID strategies require targeted upfront investments with the hope of lowered overall costs in the future. Plan costs could increase in the short term if identified participants use more care and fill more prescriptions as a result. Since the GBP is a pay-as-you-go plan, reducing out-of-pocket costs for some services would have to be offset by raising out-of-pocket costs for other services, or by increasing contributions. Identifying participants qualified for VBID through claims analysis may be perceived as intrusive and inclusion of certain illnesses or conditions for VBID benefits could be seen as unfair to some members (i.e., why is diabetes chosen over high blood pressure?).

Implement a deductible and give members a chance to “earn it back” through healthy activities.

This VBI strategy would require members to pay a small deductible in the HealthSelect plan (\$100 - \$200), then allow them to earn it back by taking a health risk assessment, getting a biometric screening, or enrolling in health education classes or disease management programs (when applicable). Not only would this align State of Texas benefits with other public and private sector plans, it would also provide ERS with some leverage to encourage healthy behaviors. Introducing a deductible would be a change for state employees and could meet with some resistance, but as long as they have the opportunity to earn it back, this would be an equitable way to share more costs and incentivize behavior change.

Partnerships with other entities

ERS actively builds strategic partnerships and collaborates with other state and higher education entities, to share ideas and conduct research to enhance the management of the benefits program. Examples of partnerships that ERS developed in FY16 include:

- Partnering with the Texas Diabetes Council (TDC) at DSHS to conduct an interim study on the prevalence of Type 2 diabetes in the state employee population, and to evaluate options for offering diabetes prevention programs, in response to HB1, Article I, Rider 14. The TDC staff and Council members provided subject matter expertise, research support, and a professional peer review of the final report, which was published August 31, 2016. One positive outcome of this project was the implementation of Real Appeal in April 2016, an online “lifestyle intervention program” to help participants lose weight and learn healthy habits. This program is now available at no cost to eligible HealthSelect participants.
- Collaborating with HHSC, TRS and TDCJ on an interim study on health care outcomes and data sharing among state funded health plans, in response to HB1, Article IX, Section 18.07. The underlying goal of the study was to determine whether standardized comparative data could illuminate the underlying forces that drive costs, provide greater insight into state-funded program performance, and create leverage for holding vendors, consumers, and providers accountable for health outcomes. In the process, agencies identified potential opportunities for building a cooperative data-driven approach to reporting on health performance indicators among systems. The interim report was published by HHSC in September 2016.

- Working with the State Comptroller of Public Accounts to develop a report on health care costs in Texas. ERS provided data analytics support for the report, which is due to be published in 2017.
- Conducting preliminary discussions with representatives from the Dell Medical School at The University of Texas at Austin to discuss new ways to deliver and pay for healthcare. While not yet operational, one idea was to establish a walk-in primary care clinic at the medical school for state employees. Also discussed were ideas for cooperating on population health management initiatives, bundled payments and primary care medical home models, which are currently used by ERS to help control health care costs.

Looking ahead

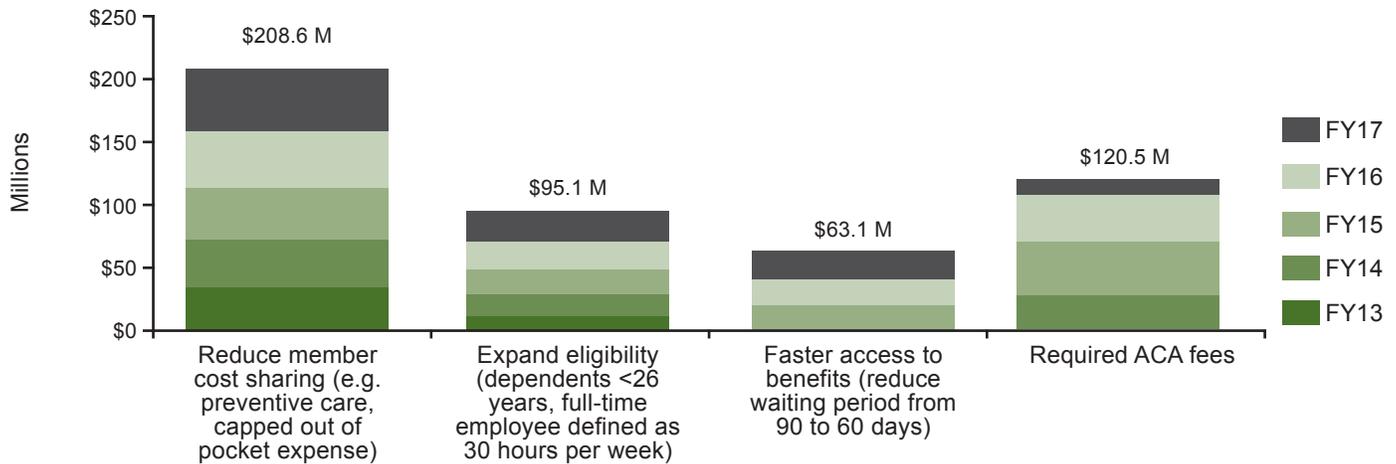
Sunset Commission Review

The Texas Sunset Commission performed a review of ERS in 2015-2016, recommending a slate of changes to enhance GBP management of and communication about the program. The GBP-related recommendations from the review focus on stronger communication and transparency with stakeholders; building a forward-thinking strategic approach to managing GBP benefits, providing more opportunities for GBP members to weigh in on their benefits offerings, and making the appeals process more transparent, inclusive, and easy to follow. For more information about these recommendations and ERS actions to address them, see Appendix E.

The future of the Affordable Care Act is uncertain

Total Affordable Care Act (ACA) related plan costs for FY16 were \$125 million. This will decline in FY17, as two significant ACA fees (the Transitional Reinsurance fee and the Health Insurance Provider fee) were recently terminated or suspended. Going forward, it's unclear what the impact of future ACA changes will be to the plan and to membership.

Figure 52: Over five years, the Group Benefits Program will have spent \$487 million on ACA-related costs (FY13-FY17)



Prescription drug costs are an ongoing challenge in light of expensive new treatments

ERS will continue to monitor the impact of specialty drug claims on plan costs, looking at who is at risk in the population that uses those drugs, and the unintended consequences on patient health of not using the drugs. The plan’s options for addressing prescription drug price inflation are limited. However, the HealthSelect plan is large enough in Texas to move market share to some extent, by adding more competitively priced drugs to the formulary. HealthSelect could remove particularly expensive medications from the formulary when a less expensive equivalent drug of similar efficacy is available.

ERS will continue to proactively manage retiree costs

While the number of active employees in the GBP is holding steady, the retiree population has more than doubled since 1995. In fact, a 26% growth in GBP membership over two decades is due entirely to the growing retiree population. Managing costs for an aging health plan is paramount. In the past several years, ERS has successfully implemented new medical and pharmacy plans for Medicare-primary participants. These initiatives continue to produce savings for the plan, and they reduce contributions for members with dependents enrolled in the Medicare Advantage plans.

Strategic Priorities

The primary mission of the GBP is to offer competitive benefits at a reasonable cost, to both the members and state. ERS endeavors to align benefits with member and employer needs, and to provide members with additional choices when opportunities exist to add value. ERS works to ensure that benefits are consistent with, and complementary to regulatory environments and market trends. ERS also strives to use data analytics to inform policy and provide actionable information to stakeholders with an interest in the health plan.

In the coming year, ERS will be implementing a new HealthSelect TPA contract, which was awarded to Blue Cross Blue Shield of Texas for a six-year term starting September 1, 2017. This contract is projected to reduce cost growth in the HealthSelect program by \$1.1 billion over the six year term of the contract.

In addition to the vigilant daily management of GBP programs, ERS will also use the newly improved Solution Sessions process to explore new ideas and ensure that agency resources are focused on concepts with the greatest potential to benefit the member and enhance the long-term sustainability of the plan. While continuing the focus on VBID and building alternative payment arrangements with providers, ERS will also look to enhance disease management, wellness and health data analytics capabilities in the coming biennium.

ERS looks forward to continuing its work with the 2017 Texas Legislature to find cost effective ways to offer benefits that not only provide a competitive advantage to state employers, but also demonstrate that the State of Texas values a healthy and productive workforce.

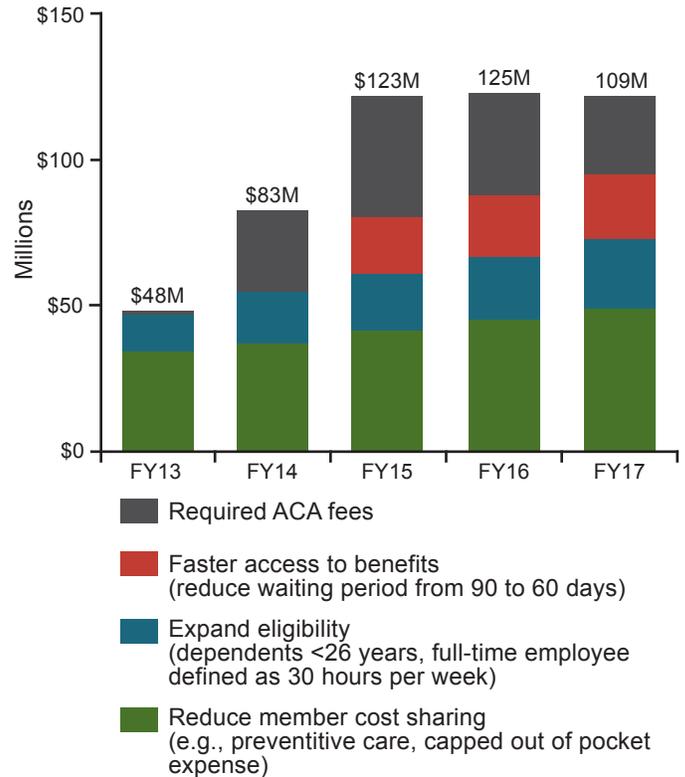
APPENDIX A: Impact of the ACA on the GBP

The Texas Legislature amended state law in 2011 and 2013 to bring the GBP into compliance with the requirements of the ACA. ERS has implemented all required ACA-related changes to date.

In FY16, the GBP plan spent nearly \$125 million on ACA-related costs; with about 70% of that toward increasing benefits and the other 30% toward fees. The Transitional Reinsurance Program fee terminated at the end of calendar year 2016, and pursuant to HR2029 (enacted December 18, 2015), the Health Insurance Providers Fee was suspended for calendar year 2017.

Under current law, ERS projects that ACA-related fees will be \$18 million lower than they would have been otherwise in FY17. It is unclear what other ACA changes are on the horizon. ERS will keep the Legislature apprised of the impact of such changes on its membership and on the financial status of the plan.

ACA-related costs for the GBP will decline in FY17



Projected additional plan cost FY13 - FY17 related to the ACA¹ (revised January 2016)

	Projected Plan Cost (\$millions) ²				
	FY13	FY14	FY15	FY16	FY17
1. Eliminate lifetime maximum for out-of-network services	\$0.3	\$0.3	\$0.3	\$0.4	\$0.4
2. Expand coverage to dependents to Age 26	\$12.4	\$13.4	\$15.4	\$17.2	\$19.0
3. Cover preventive care at 100%	\$26.4	\$28.2	\$31.7	\$34.1	\$36.8
4. Cover contraceptives at 100%	\$8.1	\$8.9	\$9.7	\$10.5	\$11.6
5. Reduce waiting period	\$0.0	\$0.0	\$19.3	\$20.9	\$22.9
6. Implement Maximum Member Cost Sharing	\$0.0	\$0.0	\$0.1	\$0.4	\$0.4
7. Change definition of full-time employee from 40 to 30 hours per Week ³	\$0.0	\$4.0	\$4.2	\$4.6	\$4.9
8. Patient Centered Outcomes Research Trust (PCORT) Fee ⁴	\$0.5	\$0.9	\$1.0	\$1.0	\$1.1
9. Transitional Reinsurance Program Fee ⁵	\$0.0	\$18.5	\$22.1	\$14.3	\$4.0
10. Health Insurance Provider Fee ⁶	\$0.0	\$8.8	\$19.1	\$21.8	\$7.4
Total	\$47.7	\$83.0	\$122.9	\$125.2	\$108.5

¹ Projected additional plan cost to the GBP for all employers and members.

² Projected plan cost represents costs incurred in fiscal year.

³ Amounts shown are projected additional employer contributions.

⁴ The PCORT fee helps fund the Patient Centered Outcomes Research Institute's research on the comparative effectiveness of medical treatments

⁵ The Transitional Reinsurance Program Fee is designed to spread financial risk across insurers to assist plans that attract individuals at risk for high claims costs. This fee does not affect the Medicare Advantage plans. It terminates after December 31, 2016.

⁶ Projected Health Insurance Provider Fees will fund premium tax subsidies for low-income people and their families who purchase insurance through the exchange. It will be permanent starting in Calendar Year 2014 and is paid by GBP insurers. HealthSelect and Community First HMO are exempt from this fee.

APPENDIX B: Financial Status of the Group Benefits Program, FY16

Texas Employees Group Benefits Program, Summary of Experience All GBP Health Plans (Based on experience through November 2016)			
\$Millions			
	FY15	FY16	Projected FY17
Revenue from State/Members			
Employer contributions for state agencies	\$1,653.1	\$1,801.5	\$1,954.5
Employer contributions for higher education	706.9	773.7	839.4
Employer contributions (other) ¹	67.7	72.5	78.7
<i>Employer Contributions – total</i>	2,427.7	2,647.7	2,872.6
Member contributions	455.1	485.9	514.1
Other revenue	219.9	280.9	368.9
Total Revenue	\$3,102.7	\$3,414.5	\$3,755.6
Health Care Expenditures	\$3,041.5	\$3,356.1	\$3,646.9
<i>Net Gain/(Loss)</i>	\$61.2	\$58.4	\$108.7
Fund Balance	\$440.5	\$498.9	\$607.6
Other Expenses Incurred Outside of the GBP Fund			
<i>Member cost-sharing (copays, coinsurance and deductibles)</i>	\$480.4	\$487.8	\$493.8

¹Non-state agencies

Category	Increased Use of Service	Industry Price Increases	Maintenance of Member Share	Total
Hospital	2.3%	5.1%	0.6%	8.0%
Other Medical Expense	2.0%	3.3%	0.2%	5.5%
Pharmacy	3.0%	7.0%	3.0%	13.0%
Total	2.4%	4.9%	1.2%	8.5%

The rates presented above represent the gross (underlying) health benefit cost trends prior to recognition of benefit, legislative and/or administrative changes that could be expected to impact health benefit cost.

APPENDIX C: Landmark Events in the History of the GBP

- 1975** **SB 18 CREATED THE TEXAS EMPLOYEES UNIFORM GROUP INSURANCE PROGRAM**
- ERS was charged with providing uniform health insurance and other optional coverages for state employees, retirees and eligible dependents.
-

- 1976** **HEALTH INSURANCE COVERAGE BEGAN FOR STATE EMPLOYEES, RETIREES, AND ELIGIBLE DEPENDENTS**
- three fully-insured indemnity plan choices for employees: high, medium, and low plans
 - retirees were enrolled in the equivalent of the high plan.

- LEGISLATURE APPROPRIATED THE SAME AMOUNT OF MONEY TO EVERY MEMBER TO SPEND ON INSURANCE**
- the first year, members received \$12.50 a month; any balance could be spent on dependent coverage.
-

- 1984** **GOVERNOR'S TASK FORCE ON STATE EMPLOYEE HEALTH INSURANCE RECOMMENDED A "SINGLE BENEFIT PLAN"**
- the Task Force found the multiple plan arrangement to be "unsustainable" due to adverse selection.
-

- 1985** **ERS CONSOLIDATED MULTIPLE PLANS INTO ONE**
- ERS consolidated plans, eliminated open enrollment and established evidence of insurability for late entrants
 - ERS implemented the second surgical opinion, preadmission testing for hospital stays, case management, and medical necessity claims review/ incentives for outpatient surgery.
-

- 1987** **FEDERAL LAW AUTHORIZED THE EXTENSION OF COBRA BENEFITS**
-

- 1989** **PRESCRIPTION CARD WAS ADDED**
- benefits were managed by the health plan administrator, and participants had two levels of copays for their medications.

TEXFLEX FLEXIBLE SPENDING ACCOUNT WAS ESTABLISHED FOR HEALTH CARE EXPENSES

- 1990** **22 HMOs WERE APPROVED FOR PARTICIPATION IN FY91**
- benefits were standardized and financial requirements strengthened to reduce adverse selection and ensure that participants were receiving benefits similar to those provided under the indemnity plan
 - by comparison, in FY16, only three non-Medicare HMOs participated in the GBP

FOR THE FIRST TIME, THE LEGISLATURE PROVIDED AN EXPLICIT CONTRIBUTION FOR DEPENDENT HEALTH COVERAGE

- 1991** **THE LEGISLATURE ADOPTED THE 100% MEMBER-ONLY, 50% DEPENDENT CONTRIBUTION FOR FY92**
-

1992 HIGHER EDUCATION (EXCEPT THE UNIVERSITY OF TEXAS AND TEXAS A&M) JOINED THE INSURANCE PROGRAM

ERS IMPLEMENTED HEALTHSELECT OF TEXAS

- a self-funded, managed care, point-of-service health benefit plan with a gatekeeper model
 - members must coordinate care and specialty referrals through their PCP.
-

1993 ENROLLMENT INCREASED 39.2% AFTER INSTITUTIONS OF HIGHER EDUCATION JOINED THE PROGRAM

HEALTHSELECT NETWORK HAD 3,000 PRIMARY CARE DOCTORS AND 8,600 NETWORK SPECIALISTS

- the network started in Austin, Dallas, Houston, and San Antonio and expanded to all Texas counties over the next seven years
 - by comparison, today the HealthSelect network has more than 13,000 PCPs and more than 46,000 specialists.
-

1996 HEALTHSELECT BEGAN COVERING ANNUAL VISION EXAM

2000 PRESCRIPTION DRUG BENEFIT WAS CARVED OUT

- Medco was the first Pharmacy Benefit Manager.
-

2001 HEALTHSELECT ADOPTED A THREE-TIERED COPAY STRUCTURE FOR PRESCRIPTION DRUGS

2003 A STATE BUDGETARY CRISIS RESULTED IN MID-YEAR PLAN DESIGN CHANGES

- \$600 million in cost shifting to members.
-

2008 IMPLEMENTED TRANSPARENT PBM CONTRACT WITH 100% PASSTHROUGH OF ALL REBATES

- new contract with Caremark saved \$288 million over four years.
-

100% DEPENDENT ELIGIBILITY AUDIT

2011

- Removed 5% of dependents and saved \$12.2 million.

FUNDING SHORTFALL LED TO FIRST PLAN DESIGN CHANGES IN SIX YEARS

- \$142 million in cost shifting to members.
-

**2012 LEGISLATURE IMPOSED AN EXTRA CONTRIBUTION OF \$30 PER MONTH FOR TOBACCO USERS
IMPLEMENTED MEDICARE ADVANTAGE PPO AND HMO FOR MEDICARE-PRIMARY PARTICIPANTS**

**2013 HEALTHSELECT IMPLEMENTED A NEW TPA CONTRACT FOR THE FIRST TIME IN 30 YEARS
IMPLEMENTED SILVERSCRIPT, A HEALTHSELECT MEDICARE DRUG BENEFIT FOR MEDICARE-PRIMARY PARTICIPANTS**

2014 IMPOSED STRICT PAYMENT RULES TO ADDRESS 250% COST INCREASE FOR COMPOUND DRUGS

2015 REDUCED COPAYS ON GENERIC DRUGS FROM \$15 TO \$10

2016 REBID HEALTHSELECT TPA AND PHARMACY BENEFIT MANAGER CONTRACTS

- New contracts projected to reduce cost growth \$2.1 billion over six years.
-

APPENDIX D: Glossary of Terms

Affordable Care Act (ACA): A federal statute signed into law by President Barack Obama on March 23, 2010, enacting significant regulatory reforms of the U.S. healthcare system.

Adverse selection: In health insurance, when multiple plans are offered, adverse selection occurs when people avoid buying higher levels of insurance benefits unless they are sure they will benefit from it.

Capitation: A fixed provider payment amount per person regardless of type or amount of health care services used.

Compound drugs: Compound drugs are specially formulated combinations of two or more medications made in compounding pharmacies.

Contingency fund: The amount of health plan assets that remain in the ERS Insurance Trust after all liabilities have been accounted for. The contingency fund's intended use is to cover unanticipated expenses arising from adverse fluctuations in claim costs or an unforeseen event such as a flu pandemic.

Contribution rate: The monthly amount that the employer and member must pay for health insurance coverage (expressed in dollars). The GBP rate, set by the ERS Board of Trustees, divides the actual health plan costs between employers and members based on the contribution strategy established by the Legislature.

Contribution strategy: Set by the Legislature; specifies the portion of total health plan costs paid by the employer (expressed as a percentage). Currently, the employer pays 100% of the cost for member-only coverage and 50% of the cost for dependent coverage.

Coordination of benefits (COB): Divides health care expenses among responsible payers, ensuring that HealthSelect doesn't pay claims that may be covered elsewhere.

Employer group waiver plan + WRAP (EGWP): A basic Medicare Part D program combined with a wraparound provision that brings the plan design up to par with current employer coverage. The EGWP allows plan sponsors to offset prescription drug costs incurred by plan members through federal subsidies.

Fee for service (FFS) reimbursement: A payment model in which providers are paid by each service they perform.

Fully insured plan: A plan in which the employer contracts with an insurance carrier to assume financial responsibility for claims and administrative costs.

Generic dispensing rate (GDR): The percentage of all filled prescriptions comprised of generic medications.

Grandfathering: Application of old rule applies to an existing group of participants (or situation) and a new rule applies to a future group of participants (or situation).

Health benefit cost trend: A complex measure of the annual rate of change in per capita payments to health care providers, including price inflation, the mix of services provided, and changes in health care utilization.

Health Insurance Provider Fee: ACA-required fee (starting January 1, 2014) that funds premium tax subsidies for low-income people and their families who purchase insurance through the exchange. HealthSelect and Community First HMO are exempt from this fee. Pursuant to federal action on December 18, 2015, the Health Insurance Provider fee will be suspended for calendar year 2017,

HMO plan: A pre-paid health program where healthcare services are provided through a closed provider network.

Health savings account (HSA): A tax-favored account that individuals use to pay qualified medical expenses; a tax-free way to save for expected health care expenses. HSAs are portable and funds are carried over without limit from year to year.

Managed care: A cost management practice that negotiates discounted reimbursement rates with providers who agree to participate in the network. Participants pay less for using network providers; they pay more for using out of network providers.

Medicare Advantage plan: A type of insurance plan that is provided by private insurance companies. It provides an option to traditional Medicare and Medicare supplement coverage with a single plan and administration.

Medicare Part A: This part of Medicare pertains to hospital insurance.

Medicare Part B: This part of Medicare pertains to other medical insurance.

Medicare Part D: This part of Medicare is a separate insurance policy just for prescription drugs.

Member cost share leveraging: When the benefit design consists of fixed copays, the plan will bear a larger share of cost increases over time, while member copays stay the same.

Patient Centered Outcomes Research Institute fee: This ACA-required fee helps fund research on the comparative effectiveness of medical treatments.

Point-of-Service (POS) plan: A type of managed care insurance plan where the member chooses a network primary care physician (a “gatekeeper”) who provides and directs all of his medical care, including specialist referrals. Members pay more if they choose out-of-network providers.

Pre-payment claims editing: Screening submitted charges for duplicate claims or late fees, non-covered services or facilities, or services that are not medically necessary.

Retiree drug subsidy (RDS): A federal program under Medicare Part D that subsidizes a portion of eligible-retiree drug costs. To receive subsidies, the plan sponsor must continue to offer employer-provided drug coverage to retirees who would have otherwise enrolled in Medicare Part D.

Risk pool: The total number of participants covered for health insurance through the GBP.

Risk pooling: The spreading of financial risks evenly among a large number of contributors to the insurance program.

Self-funded model: A model in which the employer and the participants—not an insurance carrier—assume direct financial responsibility for funding health care claims. Employers and employees pay for the plan and bear the risk that the revenue collected will be enough to pay all care claims during the year.

Specialty drugs: Expensive medications prescribed for complex chronic and/or life threatening conditions. They often require special storage, handling and administration, and they involve a significant degree of patient education, monitoring and management.

Step therapy: A cost containment policy that requires members to try less expensive drugs before the plan covers a more expensive brand name drug. Also called “Step Protocol.”

Subrogation: Allows the plan to recover certain health-related expenses paid on behalf of a participant who has rights of recovery against a third party for negligence or any willful act resulting in injury or illness to the participant.

Transitional Reinsurance Program Fee: An ACA-required fee that is designed to spread financial risk across insurers to assist plans that attract individuals at risk for high claims costs. This fee does not affect the Medicare primary participants including those enrolled in Medicare Advantage plans. It was terminated December 31, 2016.

Utilization: A measure of how often members go to the doctor, get services, or fill prescriptions.

Utilization management: A process that highlights cost drivers, identifies plan participants eligible for clinical management programs, and encourages coordination of care by ensuring that primary care doctors are involved in treatment decisions and prescribed services are aligned with best-practice standards.

Value based incentive design (VBID): This type of plan design aligns incentives with the clinical value (as opposed to acquisition cost) of the drug or service. Incentives can include monetary rewards, reduced premium shares, or lower deductibles and copays.

APPENDIX E: Sunset Review Recommendations Related to Group Benefit Plan

Appendix E contains descriptions of the nine Group Benefit Plan (GBP)-related Sunset recommendations and summaries of ERS actions taken through calendar year 2016. The agency continues to work on additional improvements and new, or refined, policies and procedures to continue addressing these issues to the benefit of the trust membership.

Issue 2: ERS Does Not Strategically Manage the Group Benefits Program (GBP) to Ensure Its Effectiveness and Plan for the Future.

Statutory Change 2.1 Require ERS to develop and regularly update a comprehensive annual report on the GBP.

“This recommendation would modify ERS’ existing annual report to include more comprehensive information about the GBP. In addition to the cost containment and fraud detection and prevention measures already required, the report would:

- include basic information about each benefit program, such as the number of participants, claims expenses, and administrative fees,
- summarize recent benefit additions and changes, and highlight any key benefits ERS evaluated, but did not implement,
- discuss trends in claims and other areas of interest ERS identifies,
- recommend any statutory changes needed to help ERS achieve its goals for the program and
- include any other information ERS determines appropriate.

Although ERS must ultimately adapt the GBP to the Legislature’s direction and appropriation, this recommendation would help ensure the agency has a forward-thinking, strategic approach for the GBP. ERS would consider and communicate to the Legislature not only ideas for controlling costs, but also what level of benefits will continue to attract workers and how to ensure the program’s sustainability over time.” – Sunset Advisory Commission Staff Report: Employees Retirement System of Texas, page 23.

Agency actions taken to address recommendation 2.1:

ERS agrees with the need to provide accurate, timely, comprehensive data on GBP operations to all stakeholders in order to facilitate informed and transparent discussions of the provision of workforce benefit services in Texas. Although the specific statutory requirements of the legislation will not be known until passed by the Legislature in mid-2017, ERS has incorporated elements of the recommendation into development of an expanded report for February 2017 publication.

Management Action 2.2: ERS should establish an advisory committee to obtain regular stakeholder and expert input on benefits.

“The ERS Board of Trustees should use its existing statutory authority to appoint a GBP advisory committee to get formal, ongoing input from members, employers, and industry experts on health insurance and other non-retirement benefits. ERS would have the flexibility to determine the committee’s appropriate makeup, but it should include active and retired ERS members, at least one employee from an institution of higher education, and individuals with expertise in the insurance field. This recommendation would ensure ERS consults regularly with members and employers before considering benefit changes, give members and employers a more active role in helping determine benefits, and ensure ERS gets advice from individuals with insurance expertise.” – Sunset Advisory Commission Staff Report: Employees Retirement System of Texas, page 23.

Agency actions taken to address recommendation 2.2:

The creation of a new advisory committee is a major structural development for the agency, requiring the coordination of many functional areas of the agency and the review, advisement, and approval of the Board of Trustees. As such, implementation of Recommendation 2.2 is a long-term project with an anticipated completion date during fiscal year 2018.

Management Action 2.3: Direct ERS to develop a process and clear criteria for evaluating changes to the GBP.

This recommendation would ensure ERS consistently evaluates potential changes to existing benefits and any new benefits to ensure they align with the agency's goals and priorities for the GBP. ERS would develop evaluation criteria based on ERS' goals for the program as outlined in the agency's strategic plan, and include considerations of costs, member expectations, employer needs, industry and market trends, and other factors ERS determines are necessary. ERS should also formally document its evaluation, decisions, and justification for all benefit changes the agency considers, and as described in Recommendation 2.1, summarize key changes in its annual report." – Sunset Advisory Commission Staff Report: Employees Retirement System of Texas, page 24.

Agency actions taken to address recommendation 2.3:

Over the years, ERS has made use of multiple processes to standardize robust vetting systems for considering changes and additions to the state's GBP plans. Ideas and suggestions for such changes can come from highly diverse sources – such as industry trends and research, current vendors and consultants, members, staff recommendations, legislators, other benefit systems' experiences, and potential future vendors – increasing the difficulty of funneling ideas through a single stream decision making process and providing consistent review and analysis or their anticipated impacts.

During fiscal year 2016, ERS executive staff re-established a single stream review and approval process applicable to all policy changes, additions, or deletions related to agency programs, including changes to the GBP structures. The Policy Group process requires that all program changes are written by a representative of the program recommending the change and reviewed and approved by the division leadership directly impacted. Policy summaries include: (1) a description of the issue under consideration; (2) a discussion of the known or expected positive outcomes and potential negative impacts; (3) a recommendation for action; and (4) an identification of the staff responsible for implementing the recommendation. The approved policy changes are presented to all agency division directors to facilitate a broad discussion of the potential implications of the change, before being considered for final approval by the Executive Director.

ERS also maintains a formal process for evaluation and consideration of policy changes and new benefit proposals, referred to as Solution Sessions, which are brought to the agency from external sources. Solution Sessions are presentations provided by external groups to explain or introduce benefit offerings not currently in use by Texas. The presentations are attended by representatives of the agency's major divisions as appropriate to the subject matter and made available through live web streaming to members of the public and legislative offices. As part of the effort to address the findings of Sunset Staff Recommendation 2.3, ERS leadership agreed that the Solution Session process should be streamlined, standardized, and cross-walked regularly against ERS strategic priorities. To that end, a more formal and rigorous decision making process is under development to evaluate Solution Session presentations. The new process will ensure greater documentation of discussions and evaluations of presented proposals using a standardized evaluation template, which will then be used to review proposals directly against the identified strategic priorities of the agency.

Issue 3: ERS' Benefit Decision Processes Lack Balanced Treatment and Full Information for Members.

Statutory Change 3.1: Require ERS to develop and implement a process that allows members to participate directly in the insurance appeal process.

"ERS should allow members to take a more active role in presenting their case and hearing opposing points during the insurance appeal process. ERS could ask members for more specific information about the situation that led to the appeal or allow members to directly address the group of ERS staff making insurance appeal decisions, either in person or by phone, to fully explain their situation and answer any questions ERS staff may have. This recommendation, along with others below, would help begin to change ERS' culture regarding member appeals, and help agency staff identify and solve issues that lead to insurance appeals." – Sunset Advisory Commission Staff Report: Employees Retirement System of Texas, page 29.

Agency actions taken to address recommendation 3.1:

ERS staff awaits finalization of the specific legislative direction of the 85th Texas Legislature to understand the appropriate statutory guidelines for implementation of this recommendation. Review and consideration of the operational and legal issues that may come into play to implement this recommendation are ongoing and will allow ERS staff to contribute to a discussion of the issue during the legislative process.

Statutory Change 3.2: Require ERS to establish a precedent or other type of manual for the insurance appeal process.

“Under this recommendation, ERS would create and use a manual to help document and guide the agency’s insurance appeal decisions. This manual should provide examples of previous decisions that were made in line with insurance plan requirements to provide useful comparable information to both the Grievance Review Committee and other ERS staff involved in the insurance appeal process. A precedent manual would help achieve more consistent decisions at each level of the appeal process and inform members about ERS’ appeal decisions. The manual would not bind ERS to these or any decisions, but rather provide guidance to agency staff and participants in the process on how ERS has considered similar facts in previous appeals.” – Sunset Advisory Commission Staff Report: Employees Retirement System of Texas, page 29.

Agency actions taken to address recommendation 3.2:

ERS staff awaits finalization of the specific legislative direction of the 85th Regular Texas Legislature to understand the appropriate statutory guidelines for implementation of this recommendation. Review and consideration of the operational and legal issues that may come into play to implement this recommendation are ongoing and will allow ERS staff to contribute to a discussion of the issue during the legislative process.

Management action 3.3: Direct ERS to more effectively educate members about choices and decisions that can lead to unexpected health insurance charges.

This recommendation would direct ERS to provide members with more information about the types of health insurance choices and decisions throughout the medical treatment process that can lead to appeals, including how to find out if healthcare services are out-of-network, over the allowable amount, or otherwise not covered. If the expectation is that members

know this level of information before agreeing to a medical test or procedure, ERS staff should make the information more readily available and understandable to members. ERS staff should also identify member education needs through its call center, member complaints, appeals, and meetings with vendors, and use this information to develop educational materials. This recommendation is not intended to have ERS reverse more denied appeals, but instead, reduce the number of denied claims by educating members on how to avoid out-of-network charges and costs not covered by their health insurance plans.

The information should be written in plain language and be easy to understand and find on the ERS website. For example, ERS should post examples of common decisions that can lead to unexpected charges on the insurance section of its frequently asked questions web page, as well as on its *Find a Doctor or Provider in Your Network* web page, and *HealthSelect’s Find a Doctor, Hospital, or other Facility* web page. ERS should add this information to existing print materials, like the enrollment guides, *Medical Benefits Member Guide*, and the *New Employees Benefit Guide for State Employees*. ERS should also provide members with real life examples illustrating decisions that often lead to insurance appeals on its website and direct members to those online examples in the print materials. Finally, ERS should work with agency benefit coordinators to disseminate this information to active state employees.” – Sunset Advisory Commission Staff Report: Employees Retirement System of Texas, page 30.

Agency actions taken to address recommendation 3.3:

ERS strongly agrees with the staff report’s finding that member communications and education efforts can continue to be improved, and the agency is committed to creating communications that increase member awareness and knowledge of benefit programs. The complex and dynamic nature of the modern health insurance environment creates a significant challenge for all plan sponsors trying to meet member education and information needs. However, ERS devotes considerable professional resources to the task of identifying information and education needs, developing communication materials, and evaluating, refining, and replacing publications as required. Some of these ongoing efforts include: external, independent review of the agency’s public website; identification of publication updates, redesigns, or content changes to reflect program operations; and reviewing benefit materials created by TPAs to ensure accuracy and clear messaging.

ERS publications constantly promote and support member healthcare decision making by communicating the impact of care decisions. For example, page 4 of the *2017 New Employee Benefits Guide* –contains basic information on the process and importance of selecting an in-network primary care provider, including the financial impact to the member (lower costs and 100% covered preventative care). The included, Employee health plans comparison chart on pages 22-23 also provides service cost information broken down by network, out-of-network, and out of area (designated for coverage of employees while out-of-state). ERS also includes regular reminders to members about primary plan structures that can result in increased medical costs through the monthly member newsletter, *News About Your Benefits*. The first article in the Sept 7, 2016 newsletter was entitled “*It Pays to Stay in the Network!*” and provided reminders of the financial advantage of staying in network as well as how to locate a doctor within the existing network.

ERS also incorporates member feedback on communications and educational materials received through various sources, including: the ERS contact center; appeals and grievance reviews; direct communications and complaints; and state employee associations and unions. For example, during the Sunset Commission public hearing in August, public comments made on behalf of an ERS retiree stated that several ERS publications were misleading in how they represented the applicability of the state’s non-occupational disability program, which was redefined by state statute in fiscal year 2003. ERS staff researched the claims and discovered that although the primary materials related to this program – such as the *Planning Your Retirement publication* – had been appropriately revised to reflect the changes, two publications – *Retirement Benefits for Elected State Officials* and *New Employee Benefits Guide* – containing brief mentions of the program could be misinterpreted to imply an incorrect application of the program. ERS legal and communications staff reviewed the related publications and approved edits that should more clearly and accurately define the program requirements in future publications.

These types of activities are constantly underway by staff in the Benefits Communications, Benefit Contracts, Customer Benefits, Office of the General Counsel, and Executive Office divisions of the agency. Because of the ongoing nature of meeting the educational and informational needs of members, ERS will never be entirely satisfied with the effectiveness of agency and vendor communications and is continually seeking improvement.

Management Action 3.4: Direct ERS to ensure balanced representation on the Grievance Review Committee of customer service and other staff.

“To ensure the committee members adequately balance the member’s interest with those of the agency and insurance vendors, ERS should increase the proportion of customer service staff on the Grievance Review Committee. Changing the committee’s membership should help improve ERS’ culture around the claims appeal process and provide balance to a process that tends to view issues more from the vendor’s perspective. This approach is not intended to skew appeal results in favor of members. The contracts are appropriately intended to keep costs in check while providing members necessary and quality healthcare. But the expectations of member knowledge and ability regarding coverage must be part of a balanced approach to decision making in the appeals process.” – Sunset Advisory Commission Staff Report: Employees Retirement System of Texas, page 30.

Agency Actions Taken to Address Recommendation 3.4:

At the time of the staff review of the Sunset Commission’s report, the ERS Grievance Review Committee (GRC) was composed of seven voting members and an administrator. The administrator is a staff member of the Benefit Contracts division that organizes and runs GRC operations but does not maintain voting rights during deliberations on member appeals. The seven voting members were comprised of: four employees of the Benefits Contracts Division; two employees of the Customer Benefits Division; and one attorney representing the Office of the General Counsel.

The following changes to the GRC structure were approved by executive management and implemented on October 1, 2016.

- Committee membership was reset to include a total of eight voting participants: three staff from Benefit Contracts, three staff from Customer Benefits, one employee representing the Executive Office and one attorney from the Office of the General Counsel.
- The committee refers split decisions of appeals and grievances under review to the ERS Deputy Executive Director (DED) for review and determination.

This recommendation has been fully implemented by ERS. Executive management will monitor the committee’s activities to ensure the intent of the recommendation and organizational changes continue to be met.

Management Action 3.5: Direct ERS to develop policies and procedures to govern reviews of Chapter 615 survivor benefit applications.

“To make the Chapter 615 review process more consistent, ERS should develop formal policies and procedures related to the agency’s review of Chapter 615 survivor benefit applications. The policies should clearly indicate under what circumstances the Medical Board and ERS staff review survivor benefit applications. ERS should train all staff involved in the review of Chapter 615 applications on the new policies and procedures, and ensure staff have a full understanding of the entire review process.” – Sunset Advisory Commission Staff Report: Employees Retirement System of Texas, page 30.

Agency Actions Taken to Address Recommendation 3.5:

ERS regularly reviews application and appeal processes for all areas of state employee benefits, and strongly believes in a continuous process of improvement. The Chapter 615 processes referenced in this recommendation are long standing and provide a formal and appropriate review of first responder survivor death benefits. However, in working with Sunset throughout the review, the Customer Benefits division did identify areas of the written policies and procedures that could be difficult to follow or interpret for those individuals not experienced with the administration of this program. Customer Benefits staff worked to clarify the policies and procedures related to this review to provide greater process description of applications requiring staff review. The clarifications also provide additional detail regarding certain specific types of Chapter 615 benefits application reviews. This recommendation has been fully implemented by ERS.

Management Action 3.6: Direct ERS to comprehensively track and analyze benefit application decision and appeals data.

“This recommendation would direct ERS staff to consistently track appeal and application decisions at every level, including aggregate information related to HMO programs and applications for over-age dependent insurance coverage handled by the HealthSelect vendor, and use the data to identify trends and make changes to the process to address problems. Tracking this data would allow ERS to analyze the information to know whether outsourced appeal and application processes are working, better evaluate vendor performance, and help ensure consistency in these processes to ensure members are treated fairly.” – Sunset Advisory Commission Staff Report: Employees Retirement System of Texas, page 31.

Agency Actions Taken to Address Recommendation 3.6:

Agency staff has targeted three processes for initial enhancement of data tracking and analysis: (1) Chapter 615 benefit applications; (2) internal grievance and appeals reviews; and (3) disability applications.

Chapter 615 & Disability: Expanded data tracking procedures and data points were developed by Customer Benefits program staff beginning in early spring 2016, and finalized in July, for disability and Chapter 615 benefit applications. These changes were a joint response to issues uncovered during the Sunset Commission review and a simultaneous internal audit of these programs. The process is complete and the programs are actively tracking the identified information moving forward.

Grievance and Appeals: Benefit Contracts division staff has similarly expanded previously developed and implemented tracking documents for the grievance and appeals process to capture more detailed information related to internal reviews, including: data on committee votes; disposition recommendations; dollar amounts of claims; demographic data on providers, geography, and applicable program or plan. The newly expanded tracking documents are complete and are actively in use.

ERS is working to develop additional processes throughout the agency that create stronger relationships between operational data and business decisions. Additionally, ERS has begun reviewing the processes and formats used by business divisions to report program status and performance outcomes to executive level leadership. The intention is for newly implemented tracking systems to feed into more robust and illustrative reports for use by division leadership and agency executive management in making operational decisions and allocating resources.

During fiscal year 2016, ERS assigned a multi-divisional workgroup to begin development and management of an agency data dashboard to consolidate and streamline demographic, financial, operational, and policy data available throughout the agency in a single web portal for use by agency management in both external reporting and internal decision making. The data dashboard has been created and is being populated with data from external requests and internal reporting. This effort is an ongoing project that will continue to develop over time.

Contact Information:

www.ers.state.tx.us

To call:

(877) 275-4377, toll-free

To visit:

200 E. 18th Street, Austin Texas 78701

To write:

P. O. Box 13207, Austin, Texas 78711-3207

The Group Benefits Program
Comprehensive Annual Report Report is produced by

ERS Executive Office

Dana Jepson, MPAff, Health Policy and Performance

Amy Chamberlain, Strategic Initiatives

ERS Benefit Contracts

Robert Kukla, Director

Blaise Duran, Research

ERS Benefits Communications

Michael Martinez, Designer

Rudd and Wisdom, Inc.

Philip S. Dial, FSA, Consulting Actuary



200 E. 18th Street • Austin, Texas 78701
www.ers.state.tx.us