
Texas Employees Group Benefits Program Annual Report FY18

Employees Retirement System of Texas

FEBRUARY 2019



ERS
EMPLOYEES RETIREMENT
SYSTEM OF TEXAS

Employees Retirement System of Texas

Executive Director

Porter Wilson

Board of Trustees

I. Craig Hester, Chair
Ilesa Daniels, Vice-chair
Douglas Danzeiser
Cydney Donnell
James Kee, Ph.D.
Catherine Melvin



200 E. 18th Street
Austin, Texas 78701
www.ers.texas.gov
February 2019

Table of Contents

- Overview** **Section 1**
- What Benefits Do We Offer?** **Section 2**
- Whom Do We Serve?** **Section 3**
- Cost Trends** **Section 4**
- Best Practices** **Section 5**
- Spotlight: Being a Smart HealthSelectSM Texas Consumer** **Section 6**
- Cost Management and Fraud Prevention** **Section 7**
- Performance Monitoring** **Section 8**
- Appendix** **Section 9**

Overview



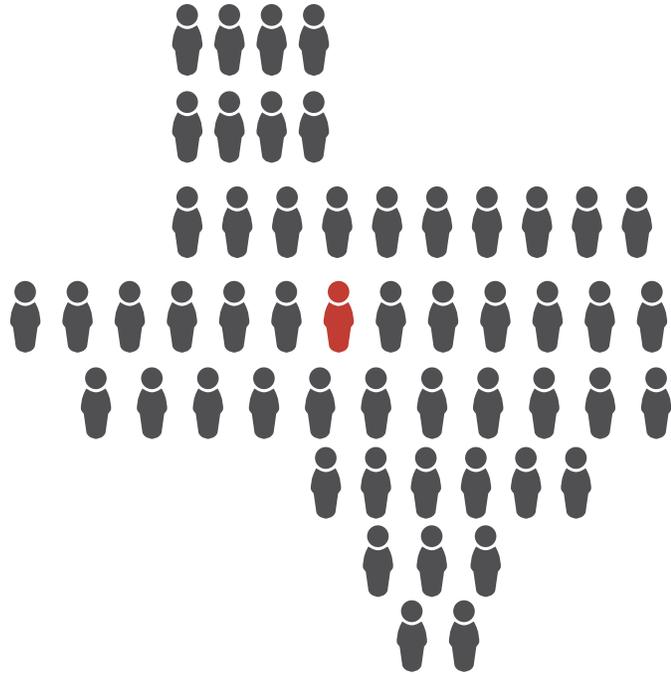
FY18 highlights

The Texas Employees Group Benefits Program (GBP) health insurance covers more than half a million Texans

That's one in 53 Texans

The number of state and higher education employees, retirees and their family members enrolled in GBP benefits almost equals the population of El Paso!

A primary objective for offering health and retirement benefits is to attract and retain a qualified workforce to serve the State of Texas.



Per capita, HealthSelectSM insurance premium contribution rates increased 0.75% in FY18 and 0.47% in FY19

Keeping plan costs reasonable is a joint responsibility.

Who is responsible for establishing policy for the health insurance program?

Texas Legislature			ERS Board of Trustees	
Eligibility	Contribution Strategy	Appropriations	Professional Management	Plan Design
Who is eligible for insurance coverage	How the cost is shared	How the cost is funded	How contracting and cost management save the plan money	How benefits ensure quality, provide choice and align incentives with health risks

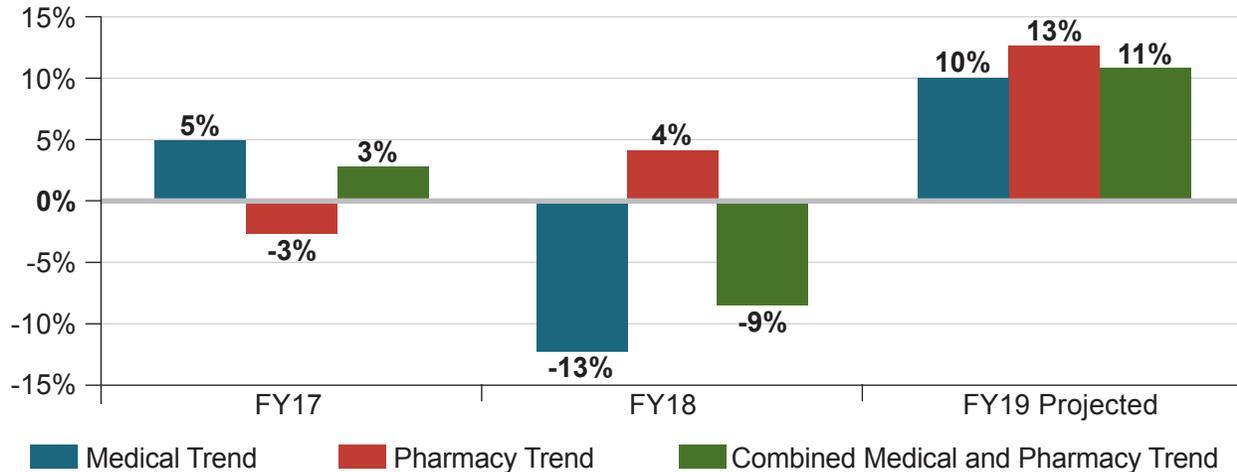
The new third-party administrator and pharmacy benefit manager contracts generated an estimated \$630 million in FY18 savings

	Third-party Administrator (TPA) Contract	Pharmacy Benefit Manager (PBM) Contract
Program	HealthSelect of Texas	HealthSelect Prescription Drug Program and HealthSelect Medicare Rx
Awarded to	Blue Cross and Blue Shield of Texas	UnitedHealthcare Services, Inc. (referred to as OptumRx)
Total Projected Savings*	\$2.1 billion over six years	\$1.6 billion over six years
Factors Driving Savings	More competitive provider reimbursement rates and savings on the administrative fee	Better ingredient cost guarantees and higher rebates

*Projected savings is larger than initially anticipated and is likely to be updated annually to reflect plan experience.

The self-funded HealthSelect plans saw favorable FY18 experience

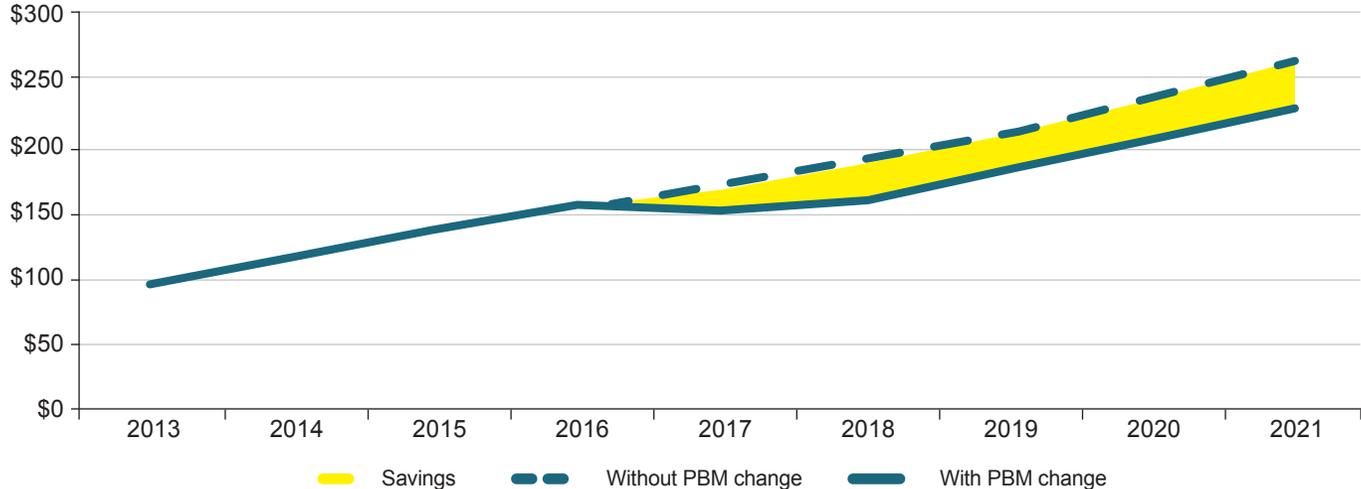
Medical trend was negative as a result of the new contract with Blue Cross and Blue Shield of Texas (BCBSTX). After a reduction in FY17 pharmacy costs due to a new contract with UnitedHealthcare Services, Inc. (referred to as Optum Rx), FY18 pharmacy trend rose to 4%. See Appendix for FY19-21 projection.



After a reduction in FY17 pharmacy costs, the FY18 pharmacy trend rose to 4%.

In FY18, the trend continued to be negative in the first part of the year, but returned to levels in line with historic trends after January 1, 2018.

Pharmacy Cost Trend (per participant per month)

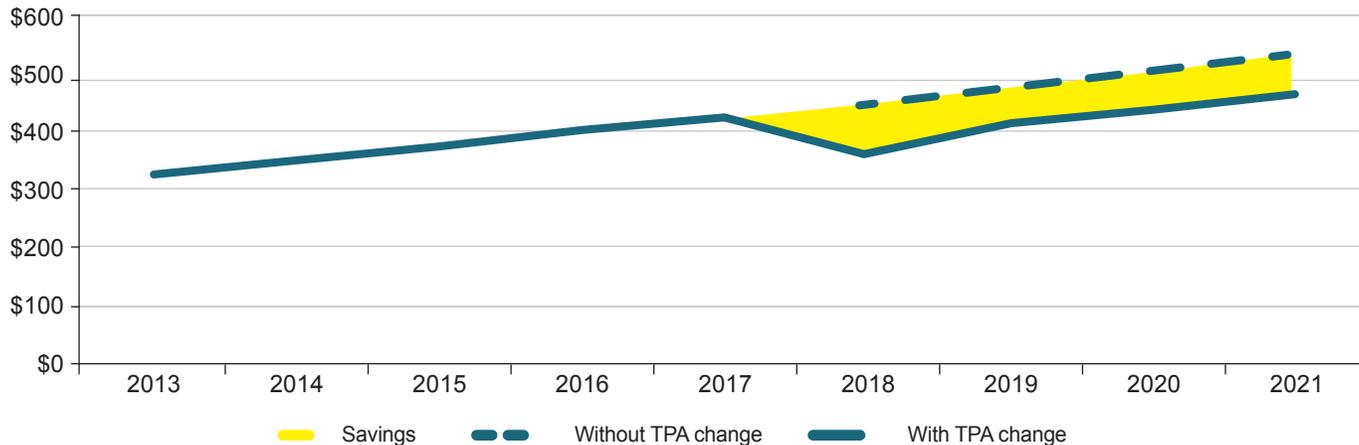


Amounts are gross amounts; they do not include rebates.

After switching to Blue Cross and Blue Shield of Texas in FY18, the HealthSelect medical cost decreased by 13%

The new third-party administrator brought significant savings to HealthSelect as a result of more competitive provider reimbursement rates and administrative fee savings. Early in FY18, savings were also realized, primarily due to unusually low utilization. Cost is expected to rise in FY19 as utilization levels return to normal.

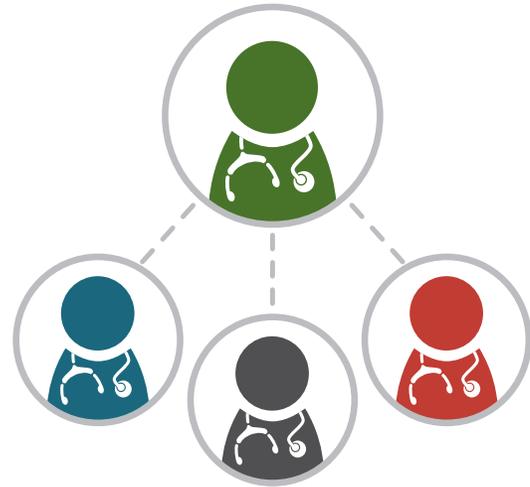
Medical Cost Trend (per participant per month)



The HealthSelect of Texas point-of-service plan design controls cost and helps keep the plan affordable.

The plan highly values an established relationship with a primary care physician (PCP), who gets to know the participant, their medical history and lifestyle.

- When members select the point-of-service plan, they and any covered dependents also select a PCP in order to receive the highest level of benefits (in-network).
- A PCP coordinates a participant's care, including management of any referrals needed to see a specialist. Referrals are required to receive in-network benefits.



86% of HealthSelect of Texas participants have designated a PCP, which is more than in previous years.

HealthSelect is cost-efficient, with low administrative expenses

3¢ HealthSelect* spends less than 3 cents of every dollar on administrative costs.

*includes medical and pharmacy benefits

Average monthly administrative expenses are less than half of the average for large private-sector plans



Private sector
administrative expenses

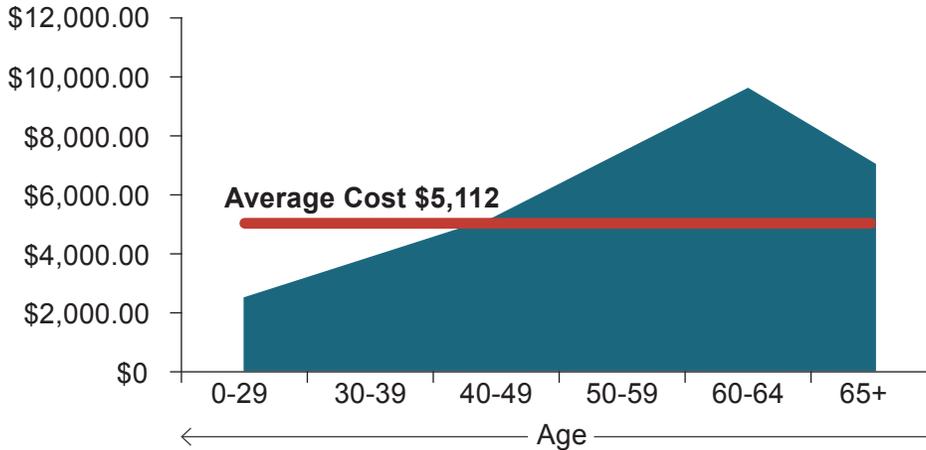


HealthSelect
administrative expenses

GBP participants benefit from a large risk pool

ERS spreads health care costs across all 534,000 participants, keeping the plan affordable for everyone.

HealthSelect average annual claims cost by age group
(all medical and pharmacy claims, FY18)



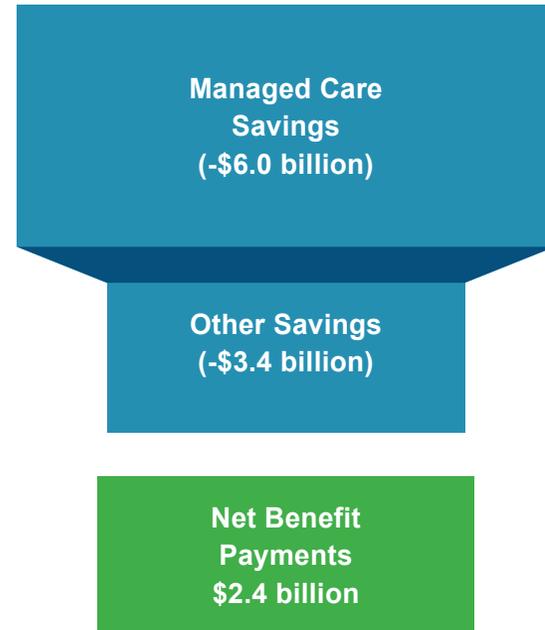
Averaging costs among the members keeps the plan affordable for all

Cost management practices reduced HealthSelect costs by \$9.4 billion last year

Employee health insurance costs the State of Texas more than \$2 billion, so it's important to get the most out of every dollar.

As a result of strategic and effective contracting, the plan paid \$2.4 billion in medical costs instead of the \$11.8 billion that could have been billed without active plan management.

\$11.8 billion potential plan cost



Tobacco premium contributions totaled \$12.6 million in FY18

- In FY18, ERS collected \$12.6 million in tobacco premium contributions from more than 35,000 participants who self-certified as tobacco users.
- Starting in FY14, all adult participants are assumed to be tobacco users unless they certify they are not. Participants who fail to certify their tobacco use or non-use must pay the \$30 tobacco-user monthly premium, which has a monthly cap of \$90 per family.
- Participants who certify as tobacco non-users face possible expulsion from health coverage if found to be using tobacco.
- HealthSelect provides access to tobacco cessation programs, including coverage of recognized prescription drugs that can help participants stop tobacco use and improve their health.

In FY18, 9% of adults enrolled in the GBP paid the tobacco-user premium contribution of \$30 a month.

Based on national tobacco prevalence statistics, ERS estimates there could be roughly 69,000 adults in the GBP who smoke cigarettes.



35,720 self-certified tobacco users

At a Glance



Average HealthSelect
premium rate increase over
2018-19 biennium:
0.61% per year



Number of medical
claims paid:
5.6M

HealthSelect

of Texas

Average annual
HealthSelect cost per
participant:
\$5,112



Savings from cost
management practices:
\$9.4B



Increase in generic drug
dispensing rate over last 9 years:
22 percentage points



Cost of member-only rate with
cost-management savings:
\$620

At a Glance



Cost of member-only monthly rate
without cost-management savings:
\$3,017



Number of virtual visits
since copay was eliminated:
25,029 (471% increase)

GBP

Payments to doctors, hospitals,
pharmacies and other care
providers across Texas:
\$2.6 billion



Hospital spend as a percentage of
HealthSelect costs: **45%**



Percentage of GBP participants who
live in Texas: **97%**

What Benefits Do We Offer?



...about our plans

HealthSelect of Texas has been the primary health plan for state agency employees since 1992

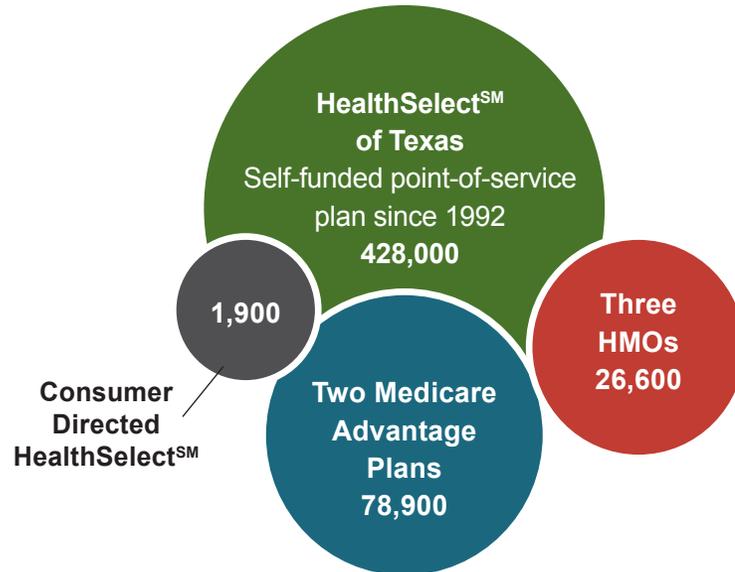
ERS has administered insurance benefits for state agency employees and retirees since 1976.

The ERS Board of Trustees designs and contracts for the insurance options offered under the Texas Employees Group Benefits Program.

Employees are enrolled in HealthSelect of Texas after a 60-day waiting period, but may opt out or switch to another plan.

80% of all participants enroll in HealthSelect of Texas

August 31, 2018



The GBP provides a choice of benefits

 Health Benefits	 Health Benefits for Retirees Enrolled in Medicare	 Optional Add-on Benefits
HealthSelectSM	HealthSelectSM of Texas	Dental Plans
<ul style="list-style-type: none"> • Point-of-service plan • Consumer directed health plan • Out-of-state plan • Prescription drug program 	<ul style="list-style-type: none"> • Medicare Advantage preferred provider organization (PPO) • Secondary plan • Employer group waiver plan (EGWP) 	<ul style="list-style-type: none"> • Dental PPO • Dental HMO • Dental Discount Plan
Health Maintenance Organizations (HMOs)	HMOs	Vision Insurance
<ul style="list-style-type: none"> • 3 Regional HMOs in Houston, San Antonio, and central Texas areas 	<ul style="list-style-type: none"> • Medicare Advantage HMO in Houston area • 3 Regional HMOs in Houston, San Antonio, and central Texas areas 	Optional Life, AD&D Insurance Long-term, Short-term Disability

Who administers GBP insurance benefits?

The ERS Board of Trustees designs and contracts for the insurance options offered under the GBP.

For **self-funded benefit plans**, such as HealthSelect of Texas, ERS manages third-party administrators (TPAs) that administer the benefits. The GBP is responsible for the administrative costs and the portion of claims costs as defined by the plan.

For **fully insured plans**, such as the HMOs, ERS contracts with and pays premium to insurance carriers that are responsible for the administrative costs and the portion of claims costs as defined by the plan.

Prescription drug benefits are administered by pharmacy benefit managers (PBMs) contracted by ERS.

TPA and PBM services generally include:

- Accessible, high-quality provider network
- Customer service and claims processing
- Disease management and wellness programs
- Communications and website
- Data analysis and reporting, utilization review and actuarial services

Differences between self-funded and fully insured health plans

	Self-Funded	Fully Insured
GBP Plans	HealthSelect of Texas; Consumer Directed HealthSelect; dental PPO; short-and long- term disability; vision	HMOs; Medicare Advantage plans (except for pharmacy); dental HMO; optional life and AD&D
Financial Risk	Shared by employer and employees who pay for the plan	Borne by insurance carrier. No out-of-network benefits*
Provider Networks	Lower cost for staying in-network; higher cost for going out-of-network*	Must use in-network provider to receive services, unless one is not available* MA PPO – see any provider who accepts Medicare
Contract	ERS contracts with third-party administrator for network access, claims processing and other services	ERS contracts with an outside carrier to provide insurance for participants
Plan Design	Established by ERS staff and the Board of Trustees	Established by ERS staff and the Board of Trustees, subject to state and federal requirements specific to the plan
Claims Payments	GBP insurance fund reimburses TPA for eligible claims	GBP uses contributions to pay premiums; the insurance company pays for eligible claims

*Does not apply to hospital emergency room

GBP health insurance choices – FY18 benefit highlights

	HealthSelect of Texas (point-of-service plan)	Consumer Directed HealthSelect (HDHP)	Regional Health Maintenance Organizations (HMOs)	Medicare Advantage (MA) PPO or HMO
Administrator/ Insurance Carrier	Blue Cross and Blue Shield of Texas		Community First Health Plans; Scott and White; KelseyCare powered by Community Health Choice	Humana Insurance Company for HealthSelect MA PPO; KelseyCare Advantage MA HMO
In-network Deductibles	\$50 prescription drug deductible per person	\$2,100 individual; \$4,200 family	\$50 prescription drug deductible per person	\$50 prescription drug deductible per person
Referrals Needed for Specialty Care?	Yes	No	Subject to HMO rules	No
Member-Only Premium Contribution	\$622 state \$0 employee \$0-\$311 retiree	\$622 state \$0 employee \$0-\$311 retiree	\$242 - \$611 state \$0 employee \$0-\$305 retiree	\$266 - \$622 state \$0-\$162 retiree
Family Premium Contribution	\$1,217 state \$595 employee \$595 - \$1,203 retiree	\$1,217 state \$535 employee \$535 - \$1,144 retiree	\$473 - \$1,194 state \$463 - \$584 employee \$463 - \$1,181 retiree	\$273 - \$1,217 state \$273 - \$643 retiree
Tax-free Savings Accounts	Health care flexible spending account (FSA)	Health savings account (HSA); limited purpose FSA	FSA	Eligible members may use accumulated HSA balances to pay medical expenses

Consumer Directed HealthSelect

Beginning September 1, 2016, GBP members can select coverage through Consumer Directed HealthSelect, a high-deductible health plan (HDHP) with a portable tax-advantaged health savings account (HSA).

Consumer Directed HealthSelect has lower dependent premiums than HealthSelect of Texas. The state also contributes monthly to the enrolled member's HSA: \$45 for member-only coverage or \$90 for family coverage. HSA account balances stay with the member and can be used for current or future health care costs. HSAs with more than \$2,000 can be invested. Funds are not subject to taxes if used for eligible health care expenses.

Unlike the HealthSelect point-of-service plan, Consumer Directed HealthSelect allows participants to see specialists without a referral. Members are responsible for paying the full cost of health care (except preventive care) and prescriptions until they reach their annual deductible.



2018 Deductible (includes prescriptions)	Individual Coverage	Family Coverage
In-network	\$2,100	\$4,200
Out-of-network	\$4,200	\$8,400

Tax-free health savings accounts

Consumer Directed HealthSelect members may open a health savings account (HSA) with Optum Bank. HSAs have three tax advantages: contributions are tax-free; funds used to pay for eligible medical expenses are not taxed; and earnings on HSA funds can grow tax-free. Medicare enrollees cannot contribute to an HSA but may use HSA funds. At age 65, accountholders can use HSA funds for any reason without penalty, but funds are subject to income tax when used for ineligible expenses. Consult with a tax advisor for more information.

HSA contributions and maximums for 2018

	Individual Coverage	Family Coverage
Annual Maximum Contribution	\$3,450	\$6,900
Annual State Contribution	\$540 (\$45 monthly)	\$1080 (\$90 monthly)
Annual Maximum Participant Contribution , add \$1,000 “catch-up” contribution for age 55 and older	\$2,910	\$5,820

HSA Activity (1/1/2018-8/31/2018)	
Number of Accounts Active	1,068
Average Account Balance	\$1,150
Average Employee Monthly Contribution	\$208

Health insurance is also available to eligible retirees

In addition to the HealthSelect and traditional HMO plans, the GBP offers Medicare-enrolled retirees two Medicare Advantage (MA) options with lower dependent premiums:

- **HealthSelect Medicare Advantage** (statewide MA PPO plan)
- **KelseyCare Advantage** (MA HMO plan in the Houston area)

When GBP retirees and their dependents reach age 65 and become eligible for Medicare coverage, GBP health insurance (except for GBP MA plans) becomes a secondary payer to Medicare. By enrolling in a Medicare Advantage plan, a retiree with dependent coverage will pay lower premiums.



75%

of Medicare-eligible retirees and their eligible spouses enrolled in the MA plans, while the rest remained in HealthSelect or a traditional HMO.

All enrolled health plan participants have prescription drug coverage

HealthSelectSM Prescription Drug Program. All HealthSelect participants not enrolled in Medicare receive drug benefits through the HealthSelect Prescription Drug program. On January 1, 2017, the contract transitioned to UnitedHealthcare Services, Inc., referred to as Optum Rx.

HealthSelect Medicare Rx On January 1, 2013, HealthSelect Medicare Rx, a self-funded employer group waiver program with a wraparound feature (EGWP + Wrap) became available for most Medicare-primary participants. An EGWP + Wrap program wraps around the Medicare drug benefit to ensure that Medicare drug benefits are consistent with traditional HealthSelect drug benefits. On January 1, 2017, the contract transitioned to United Healthcare Services, Inc. (Applies to the GBP MA HMO.)

HMOs provide both health and prescription coverage to participants.



Prescription drug copays

	30-day retail	90-day retail	90-day mail order
Tier 1 - mostly generic	\$10	\$30	\$30
Tier 2 - mostly brand-name	\$35	\$105	\$105
Tier 3 - Non-preferred brand-name	\$60	\$180	\$180

30-day supply of maintenance medication:
\$45 for Tier 2 & \$75 for Tier 3

The GBP includes a range of voluntary benefits

Members pay 100% of the cost for voluntary benefit programs in which they enroll.
There is no employer contribution.

Coverage	Plan Type	Funding	TPA/Insurer	FY18 Enrollment
Dental	PPO	Self-funded	HumanaDental Insurance Co.	318,604
	HMO	Fully insured	DentiCare, Inc. (subsidiary of Humana)	119,917
State of Texas Dental Discount Plan SM	Discount (non-insurance) program	NA	Careington International	9,902
Vision	Vision benefits	Self-funded	Superior Vision Services	186,443
Optional Life (not including dependent life)	Group term insurance	Fully insured*	Minnesota Life Insurance Co.	214,961
Voluntary AD&D	Group term insurance	Fully insured	Minnesota Life Insurance Co.	129,478
Texas Income Protection Plan (Disability Insurance)	Short-term	Self-funded	ReedGroup	112,962
	Long-term	Self-funded		86,623
TexFlex Flexible Spending Accounts	Health care, limited, dependent "day" care and commuter	NA	WageWorks	50,412

*Plan pays claims up to threshold.

Dental and vision

The GBP offers three optional dental benefit programs and vision coverage:

- **State of Texas Dental Choice Plan** a national preferred provider organization (PPO)
- **HumanaDental DHMO**, a dental health maintenance organization (DHMO) plan with a Texas network
- **State of Texas Dental Discount Plan**, a non-insurance discount program offering discounts on dental treatment and services at participating providers
- **State of Texas Vision**, administered by Superior Vision, which covers a portion of the cost of contact lenses or eyeglasses each year as well as discounts for LASIK surgery

STATE OF TEXAS
DENTAL CHOICE



Humana

 STATE of TEXAS
Dental Discount Plan

STATE OF TEXAS
VISION



FY18 flexible spending accounts (FSAs)



ERS offers four tax-advantaged savings options

Health Care Reimbursement	Limited Purpose Health Care	Dependent Care Reimbursement	Commuter Reimbursement
§125 Reimbursement Plan	§125 Reimbursement Plan	§125 Reimbursement Plan	§125 Reimbursement Plan
Maximum contribution: \$2,600 annually	Maximum contribution: \$2,600 annually	Maximum contribution: \$5,000 or \$2,500 annually depending on tax filing status	Qualified parking benefit: \$255 monthly Qualified transit benefit: \$255 monthly
Examples of eligible expenses include: <ul style="list-style-type: none"> • Copays • Dental expenses • Eyeglasses/LASIK/contacts • Medical supplies • Some OTC products 	Available to Consumer Directed HealthSelect SM participants for eligible: <ul style="list-style-type: none"> • Vision expenses • Dental expenses 	Eligible expenses: <ul style="list-style-type: none"> • Day care for eligible dependent children or adults 	Eligible expenses, parking: <ul style="list-style-type: none"> • Parking* Eligible expenses, transit: <ul style="list-style-type: none"> • Mass transit* • Vanpool*
\$500 allowable carry-over	\$500 allowable carryover	Eligible for grace period	Not subject to forfeiture
Subject to forfeiture	Subject to forfeiture	Subject to forfeiture	
Accounts: 46,378	Accounts: 74	Accounts: 3,636	Accounts: 304

*commuting to and/or from work

Optional life and accidental death & dismemberment (AD&D) insurance

GBP health coverage for active employees includes \$5,000 of Basic Group Term Life Insurance with \$5,000 of AD&D coverage at no cost to the employee. Each retiree participating in a GBP health plan is automatically enrolled for \$2,500 Basic Group Term Life Insurance at no cost to the retiree.

When hired, an employee may elect **Optional Group Term Life Insurance** at one or two times annual salary without evidence of insurability (EOI). An election at three or four times annual salary requires EOI. The combined amount of this insurance may not exceed \$400,000 with a corresponding amount of AD&D coverage.

Optional Term Life insurance is also available to retirees, subject to maximum amounts based on age. AD&D coverage is not available to retirees.

ERS contracts with Minnesota Life Insurance Co., known as Securian Financial™, to administer basic and optional life and AD&D.



As members age, Optional Term Life coverage is reduced by a certain percentage, but not reduced to less than \$10,000. Retirees can choose a \$10,000 Fixed Optional Life Insurance plan, instead of a term life plan.

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 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 the coverage is in effect when they retire. The AD&D coverage is not available for dependents of retired employees.

Voluntary AD&D insurance

Available only to active employees and their dependents, voluntary AD&D insurance is available in incremental amounts up to \$200,000. An employee is not required to be enrolled in optional Group Term Life insurance coverage to enroll in voluntary AD&D.



Disability insurance

Texas Income Protection PlanSM is 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 and his or her family through a period without the employee's salary income, when the employee is determined by a doctor to be totally disabled.

Summary of insurance benefit changes in FY18 and FY19

Premium changes for health insurance

As of September 1, 2018:

- 0.47% increase for HealthSelect plans
- 5.4% increase for the Scott and White Health Plan
- 0.8% increase for KelseyCare powered by Community Health Choice
- 7.5% increase for Community First Health Plans

As of January 1, 2019:

- 10% decrease for KelseyCare Advantage, MA HMO coverage
- For HealthSelect Medicare Advantage, MA PPO coverage
 - 0.47% increase for member-only rate
 - 1.3% decrease for member and spouse coverage
 - 1.5% decrease for member and child coverage
 - 2.2% decrease for member and family coverage

Health Plan Changes (Fiscal Year 2018 – present)

FY18	HealthSelect of Texas HealthSelect Out-of-State	<p>Removed the \$10 copay for in-network 24/7 virtual visits for medical care</p> <p>Reduced the copay (from \$40 to \$25) and removed the \$75 limitation on visits to an in-network Airrosti provider, a medical group that focuses on non-surgical treatment of injuries</p> <p>Increased the copay for emergency care at an out-of-network freestanding emergency room (not affiliated with a hospital) from \$150 to \$300</p>
	HealthSelect of Texas Consumer Directed HealthSelect HealthSelect Out-of-State HealthSelect Secondary	<p>Added new benefit: a second virtual weight loss / diabetes prevention program, Naturally Slim, at no cost to the participant</p>
	HealthSelect Out-of-State HealthSelect Secondary	<p>Split the prior HealthSelect Out-of-Area plan into HealthSelect Out-of-State and HealthSelect Secondary plans. The HealthSelect Out-of-State plan is available to employees, non-Medicare eligible retirees, and their dependents who live or work outside of Texas. HealthSelect Secondary is available to Medicare-eligible retirees and their Medicare-eligible dependents</p>

Health Plan Changes (Fiscal Year 2018 – present) continued

FY18	HealthSelect Secondary	Removed all copays previously in place to better allow this plan to coordinate with Medicare coverage
	Medicare Advantage plans	Added new benefit: telemedicine for medical care. Participants in this plan can now have a medical telemedicine visit at no cost to them
	HealthSelect of Texas Consumer Directed HealthSelect HealthSelect Out-of-State HealthSelect Secondary	Changed reimbursement method for all care at out-of-network freestanding emergency rooms (not affiliated with a hospital) from billed charges to the out-of-network allowable amount
	Prescription Drug Programs for: HealthSelect of Texas Consumer Directed HealthSelect	Added new benefit: allowed for certain preventive vaccinations at an in-network retail pharmacy through the pharmacy plan at no cost to participants. (Coverage for this already existed under the medical plans.)

Health Plan Changes (Fiscal Year 2018 – present) continued

FY19 (through 1/1/2019)	HealthSelect of Texas Consumer Directed HealthSelect HealthSelect Out-of-State HealthSelect Secondary	Added new benefit: virtual visits for mental health care at the same cost as an in-network mental health office visit
	All HealthSelect plans and HMOs (except Medicare Advantage Plans)	Increased the total out-of-pocket maximums to the federal limits: \$6,650 per individual and \$13,300 per family Removed the \$1,000 maximum and replacement limits for hearing aids and cochlear implants for minors (85R House Bill 490) Removed coverage of elective pregnancy termination due to a criminal act (85R House Bill 214)
	Consumer Directed HealthSelect	To better align with the other HealthSelect medical plans, removed the out-of-network total out-of-pocket maximum for Calendar Year 2019.
	HealthSelect Medicare Advantage PPO	Added new benefit: coverage for virtual visits for mental health care at no cost

Dental and Vision Benefit Changes (Fiscal Year 2018 – present) continued

<p>FY19 (through 1/1/2019)</p>	<p>State of Texas Dental Choice PlanSM PPO plan</p>	<p>Increased annual individual maximum to \$2,000 (from \$1,500) for basic and restorative services</p> <p>Removed age limit for orthodontic services</p> <p>Removed exclusion and benefit limitations related to missing tooth replacement</p> <p>Removed coverage for out-of-network services at 40% once the benefit maximum is met</p>
<p>FY19 (through 1/1/2019)</p>	<p>State of Texas Vision</p>	<p>Members who decline GBP health coverage may apply the Opt-Out credit towards their vision insurance premium</p> <p>Reduced copay for annual eye exams from \$25 to \$15</p> <p>Changed frequency limitations from once within a 12-month period to once each plan year (same as fiscal year)</p>

Whom Do We Serve?



...about our members

Who can enroll in the GBP?

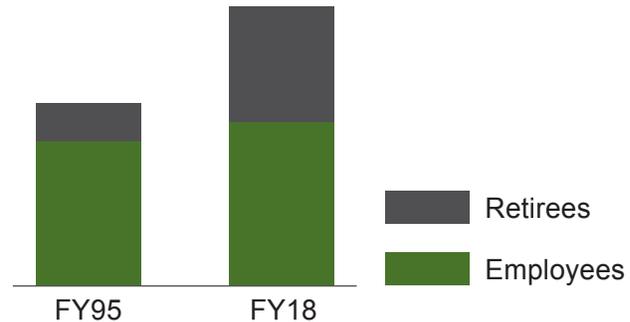
The GBP provides health insurance coverage and optional benefits to employees, retirees and eligible family members for state agencies and public institutions of higher education (except The University of Texas and Texas A&M University systems).

Of those enrolled in health insurance plans:

- The retiree population has grown 173% since 1995.
- The average age of a GBP member is 54.
- About one-third work in higher education.

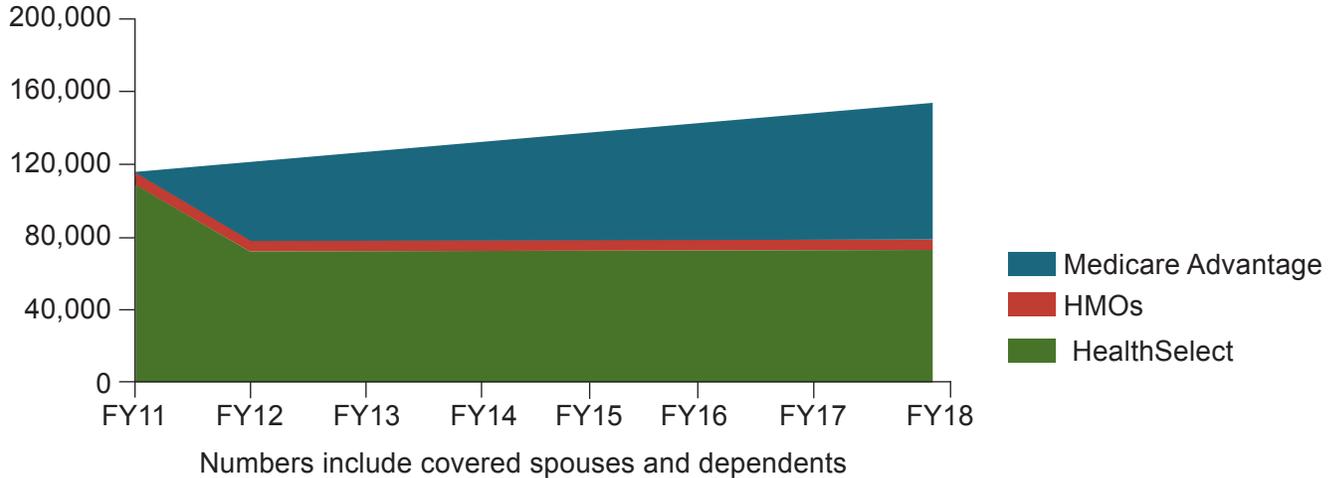
GBP health insurance enrollment (not including dependents)

	FY95	FY18	% Change
Employees	209,026	211,510	1%
Retirees	41,556	113,487	173%
Total	250,582	324,997	30%



Enrollment growth is almost entirely due to an increasing number of retirees.

Participation in retiree plans has shifted to Medicare Advantage since FY12



Retirees choosing MA plans saved \$53.7 million in dependent premiums in FY18.

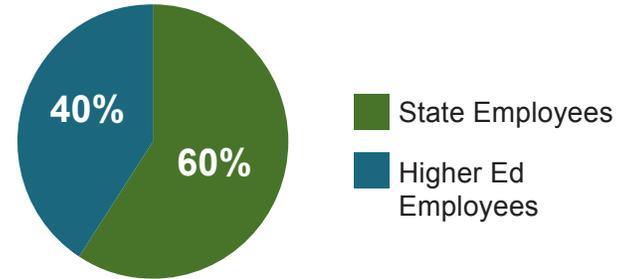
GBP insurance population demographics

	Active Employees	Pre-65 Retirees	65+ Retirees	All Members*
Total Number	211,510	34,162	79,325	324,997
Average Member Age	45 years	59 years	74 years	54 years
Average Dependent Age	22 years	39 years	67 years	29 years
% Who Enroll Dependents	38%	29%	25%	34%
Gender	58% female 42% male	54% female 46% male	53% female 47% male	56% female 44% male
Tenure	9 years	25 years	21 years	14 years
Place of Employment	67% state 33% higher ed	86% state 14% higher ed	71% state 29% higher ed	70% state 30% higher ed

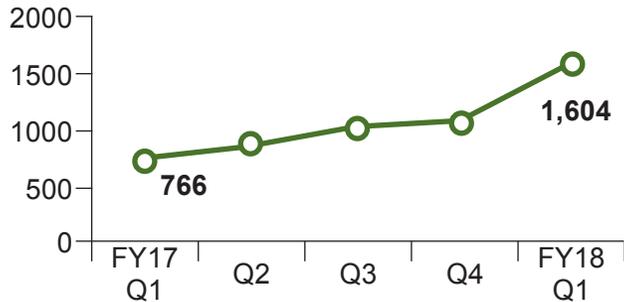
*Employees and retirees only, not including dependents, survivors, COBRA or other miscellaneous groups.

Characteristics of Consumer Directed HealthSelect enrollees

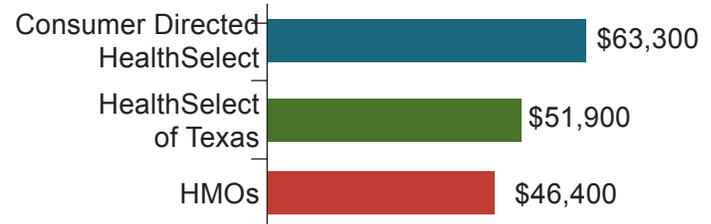
- 1,866 participants as of August 31, 2018
- 40% are higher ed employees, compared to 30% in other GBP health plans
- 47% male, compared to 43% in other plans
- 41 years old, compared to 50 years in other plans



Enrollment in Consumer Directed HealthSelect has more than doubled



Consumer Directed HealthSelect enrollees earn \$11,400 a year more than HealthSelect of Texas enrollees



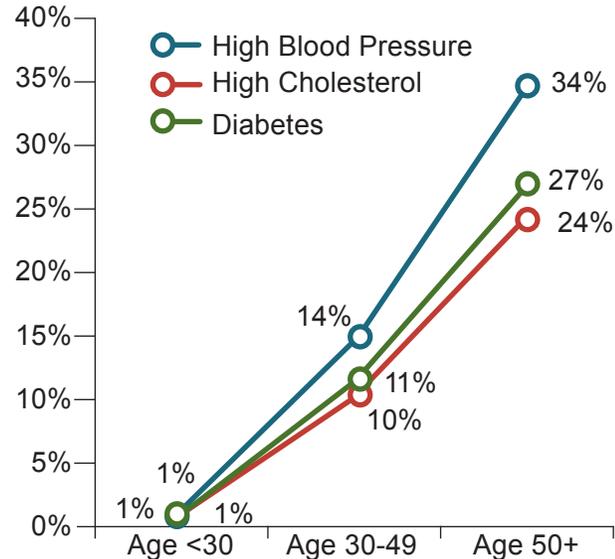
The risk for chronic conditions increases with age

With age, the risk increases for common chronic conditions such as high blood pressure, high cholesterol and diabetes

The average age of a GBP member (both employees and retirees) is 54.

Without treatment, diabetes can lead to other conditions and higher costs later.

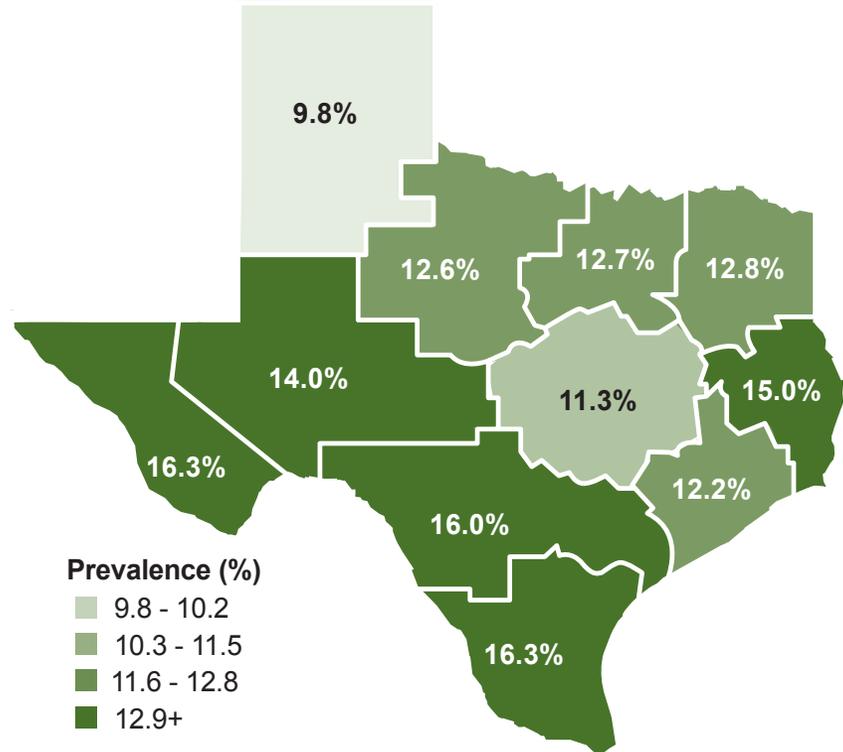
Percentage of HealthSelect population living with chronic conditions
(Medicare population not included, FY18)



Certain regions have higher rates of diabetes, and it continues to grow

Across all regions, diabetes prevalence among the top 10 agencies in Texas is highest among employees at the Health and Human Services Commission (13.8%) and the Department of Criminal Justice (13.2%).

*FY18 Medicare enrolled population excluded
Source: BCBSTX Healthcare Economics Team



Cost Trends



**...about the
marketplace**

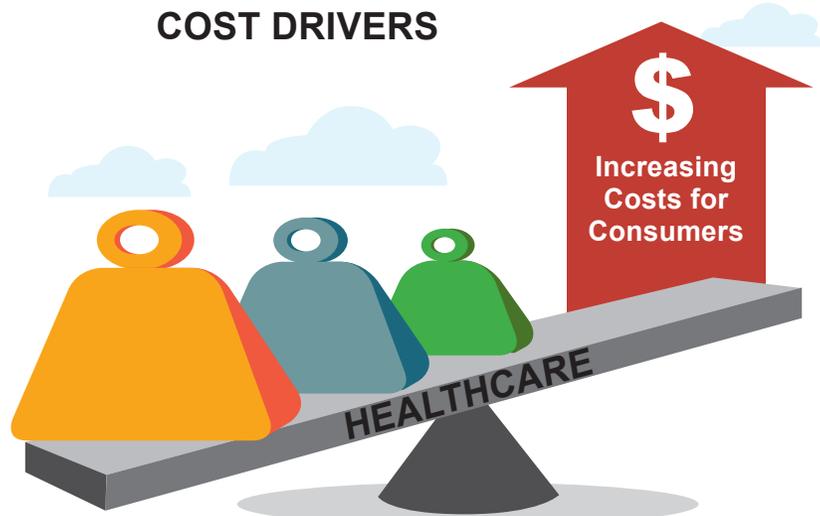
Price inflation is driving costs in the health plan

More than any other factor, price inflation is the most significant driver of health insurance costs in America.

This is seen, for example, when providers increase rates to treat insured patients, drug manufacturers raise the price of a popular drug, or a new drug comes to market.

Every employer who provides insurance is facing the same challenge. Rising prices in Texas mean higher costs, for the state, employees and retirees.

COST DRIVERS



RISING PRICES

- Market Power
- Medical Tech Advances
- Prescription Drug Costs

UNNECESSARY SERVICES

- Medical Harm
- Waste

LIFESTYLE FACTORS

- Chronic Diseases
- Obesity
- Smoking

Projected annual health FY19-21 plan cost trend is 7.3%

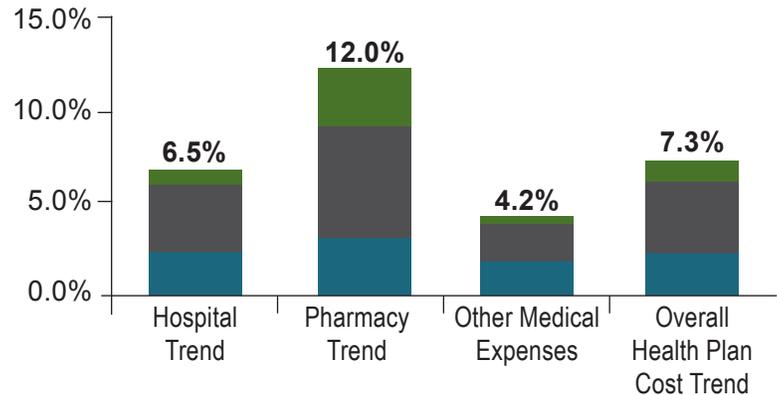
The major components of the benefit cost trend are increases in:

- utilization, driven by how often participants use services;
- inflation, driven by provider price increases and more complex care (also known as service intensity); and
- cost-share leveraging, driven by the plan paying more of the cost while member costs stay the same.



These cost drivers are common to all plans, not just HealthSelect.

Industry price increases continue to be the primary cost driver
(projected HealthSelect benefit cost trends, FY19-21)

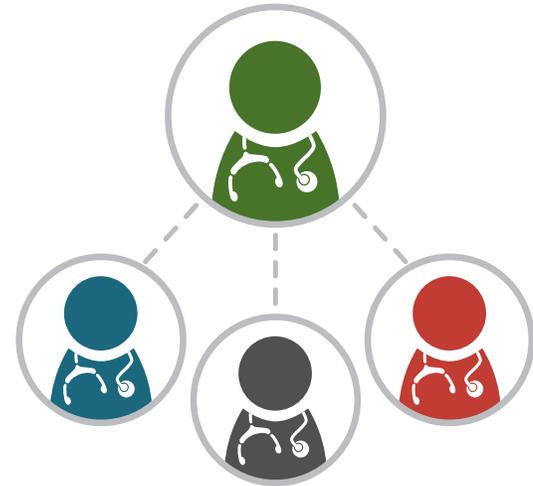


- Cost-Share Leveraging (Stable Plan Design)
- Inflation (Industry Price Increase)
- Utilization (Increased Use of Services)

The HealthSelect of Texas point-of-service plan design controls cost and helps keep the plan affordable.

The plan highly values an established relationship with a primary care physician (PCP), who gets to know the participant, their medical history and lifestyle.

- When members select the point-of-service plan, they and any covered dependents also select a PCP in order to receive the highest level of benefits (in-network).
- A PCP coordinates a participant's care, including management of any referrals needed to see a specialist. Referrals are required to receive in-network benefits.



86% of HealthSelect of Texas participants have designated a PCP, which is more than in previous years.

Hospital spend represents 45% of HealthSelect costs

With the TPA change beginning in FY18, hospital costs are lower but are still a large portion of costs. ERS spent more than \$1.15 billion in FY18 on hospital costs, including emergency rooms and inpatient and outpatient facilities.

Hospital spend is expected to increase by about \$115 million a year in FY19-21.

Consolidations and mergers of hospital systems have reduced capacity and diminished competition, impacting GBP negotiating power in the marketplace.



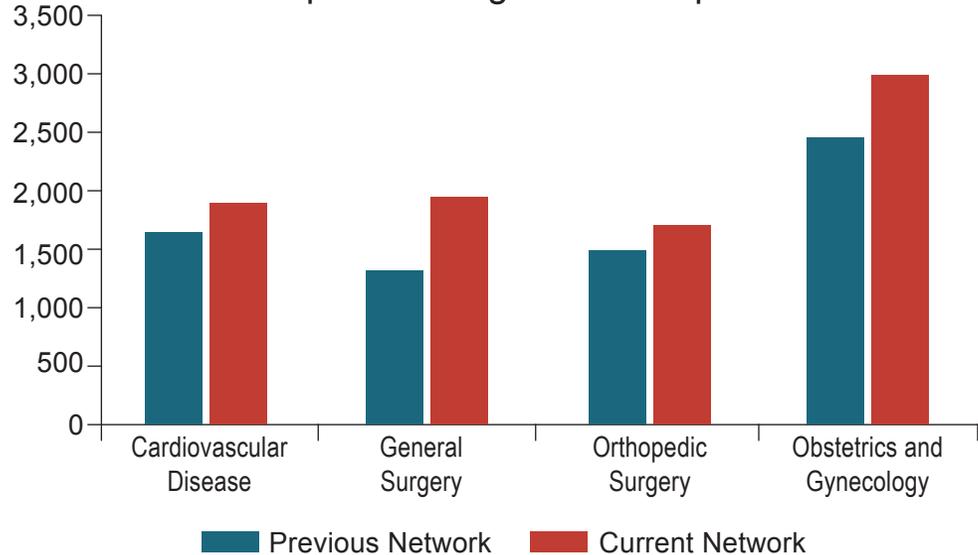
Access to high quality providers continues to grow

The creation of the broad HealthSelect-specific network offers provider choice to HealthSelect participants.

The network includes more PCPs and high-volume specialists than before.

The number of PCPs in the current network is 14,266, a 15% increase compared to 12,414 in the previous network at the time of network transition.

HealthSelect network now provides more options in high-volume specialties



Rider 15: freestanding emergency rooms (FSERs)

Before FY18, increased use of out-of-network, freestanding emergency rooms (FSERs), especially for non-emergency conditions, had a noticeable impact to plan cost. FSER cost is typically higher than that of a hospital-based emergency department.

In response to a rider passed by the 85th Legislature, ERS took several steps to reduce FSER cost.

- Beginning January 1, 2018, HealthSelect plans stopped paying billed charges to out-of-network FSERs. HealthSelect plans now pay an allowed amount to these facilities, similar to use of a contracted allowable rate for payment to a hospital-based emergency department.
- On September 1, 2017, ERS imposed a \$300 copay on out-of-network freestanding ER visits for HealthSelect of Texas and HealthSelect Out-of-State plans.

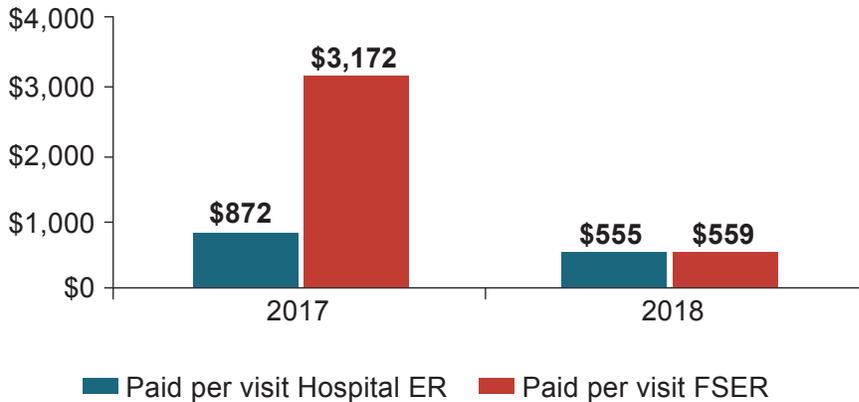


A HealthSelect participant who receives a balance bill from an out-of-network FSER for an amount exceeding \$500 may request mediation from the Texas Department of Insurance.

FY18 changes to out-of-network FSER reimbursement reduced costs by \$23.5 million.

ERS is on track to meet or exceed the biennial savings required in General Appropriations Act Rider 15 (\$26.1 million in GR and \$42.2 million in All Funds).

The average amount HealthSelect paid per visit to freestanding ERs decreased significantly in CY 2018 (January - June)



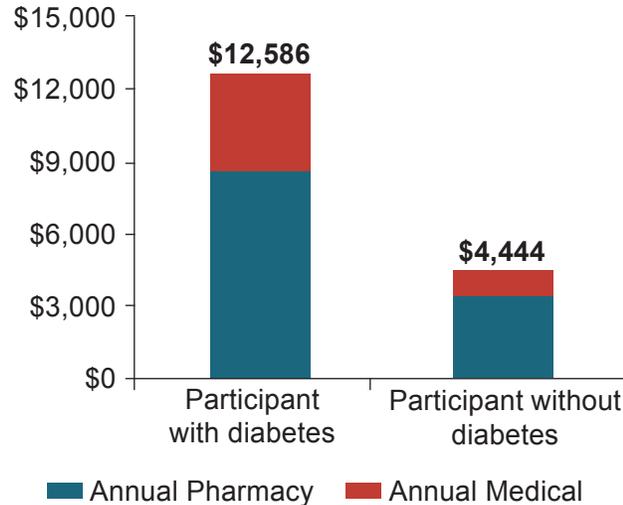
HealthSelect paid \$588 million on diabetes-related health care claims in FY18

While 13% of HealthSelect participants have diabetes, spending on this group represents 27% of all HealthSelect costs.

In FY18, HealthSelect spent an extra \$8,142 for a participant with diabetes, compared to a participant without diabetes.

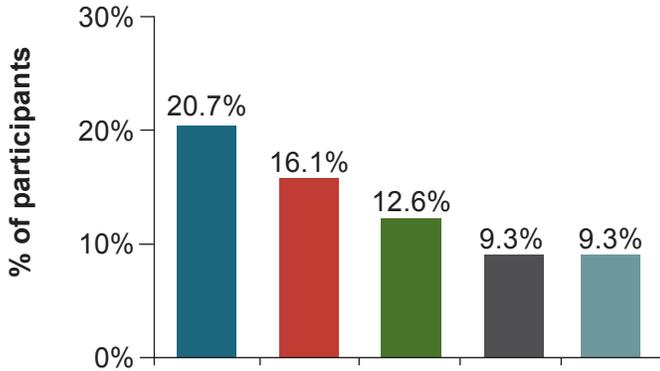
In FY18, participants with diabetes had 53% more emergency room visits and 129% more inpatient admissions. They tend to have longer hospital stays and more hospital readmissions. This is partially due to the need to manage additional conditions like heart disease, for which diabetes is a significant risk factor.

In FY18, HealthSelect spent an extra \$8,142 for a participant with diabetes, compared to a participant without diabetes

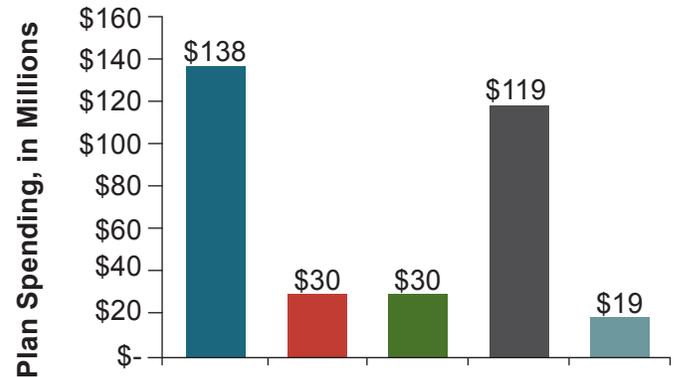


Back and joint pain are the most expensive chronic medical conditions in the HealthSelect plans

Prevalence of top 5 chronic medical conditions as a percentage of HealthSelect population



Medical spending on top 5 chronic conditions*



■ Back Pain/ Joint Pain ■ Hypertension ■ Diabetes ■ Heart Disease ■ Mental Health/ Substance Abuse

*Plan spend accounts for medical claims only; pharmacy claims not included. Participants are counted in each category for which they had a medical claim. Some participants may appear in more than one category.

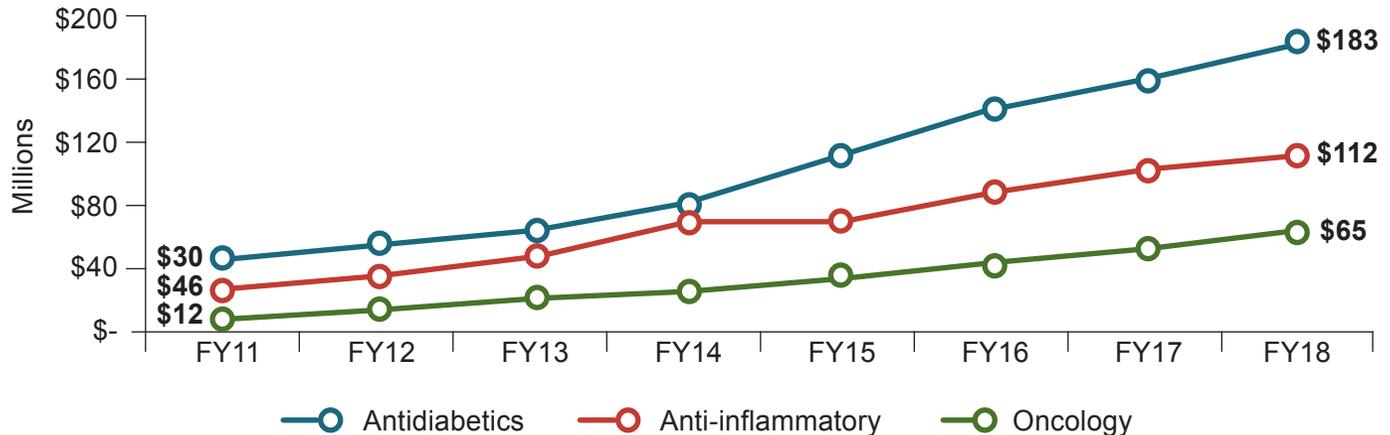
Source: BCBSTX

The top three highest cost drug therapy classes

The diabetic drug therapy class is the fastest growing. Six of the top 10 prescription drugs, in terms of plan spend, treat diabetes.

Factors driving increases include drug prices and utilization.

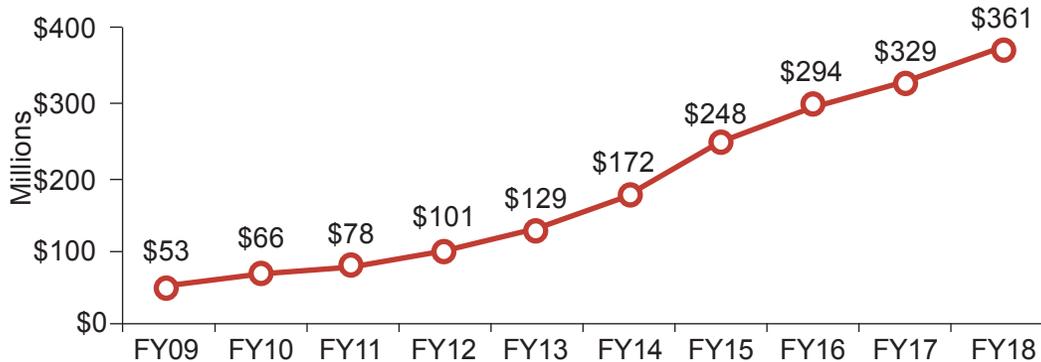
Top drug therapy classes, by plan cost



Specialty drugs represent 1% of prescriptions filled and 38% of prescription drug spend

In part, the increased spend is due to new drugs added to market in recent years. The plan paid \$361 million in FY18 for approximately 90,000 specialty claims.

Specialty drug costs have increased 600% in 10 years

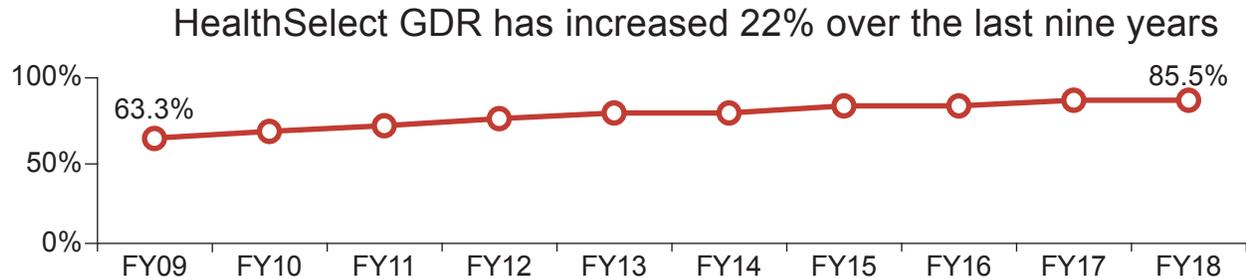


Top Five Specialty Conditions

- Inflammatory
- Neoplasms
- Antivirals (Hepatitis C & HIV)
- Multiple Sclerosis
- Psoriasis

Choosing generic drugs over brand-name drugs lowers costs to both the plan and the participant.

Historically, each percentage point increase in the generic dispensing rate (GDR) was associated with a drop of 2.5% in gross pharmacy cost.*



Higher GDRs are important, because generics consistently produce lower prescription drug costs, resulting in savings for the plan and lower out-of-pocket costs for the participant. A generic drug works in the same way and provides the same clinical benefit as its brand-name version. Generic drugs approved by the Federal Drug Administration are generally sold only after a patent protecting the brand-name expires. If patients have questions about whether a generic is appropriate, they should talk with their doctor.

*National Center for Biotechnology Information, 2010

Best Practices



**...successes and
new programs**

Changing the Script: a collaborative approach to the opioid epidemic

Changing the Script was created by ERS as a unique, collaborative approach to address the opioid epidemic through a comprehensive health plan strategy.

- It is intended to drive a unified benefit plan solution among HealthSelect vendors, administrators and health plan experts.
- It is not intended to influence care of patients who are in active cancer treatment, palliative care or end-of-life care.

Changing the Script is a comprehensive health plan strategy to:

- Help prevent dependency before it starts
- Stop progression to opioid misuse, abuse and addiction
- Treat and support chronic utilizers on the path to recovery
- Promote savings and quality of care

Changing the Script (continued)

- **ERS established a plan-specific project group** that engages regularly to share ideas, actions, data and solutions. The group includes HealthSelect experts from the following areas:
 - ✓ Medical
 - ✓ Pharmacy
 - ✓ Behavioral health
- **HealthSelect implemented CDC guidelines** through the pharmacy benefits manager opioid risk management program. Member education is a critical piece of this strategy.
- **The plan design was adjusted** to allow open access to all medication assisted therapies (MATs) without prior authorization or other obstacles.
- **Behavioral health access expanded** September 1, 2018, giving HealthSelect participants the ability to schedule mental health appointments via virtual visits (Doctor on Demand and MD Live).

Changing the Script (continued)

Initial results show early success in reducing the number of opioid utilizers comparing the period of January through October in both 2017 and 2018.

	Short-Acting Opioids	Long-Acting Opioids
Total Utilizers	-28.8%	-59.8%
Treatment-Experienced*	-42.2%	-56.3%
New-to-Therapy**	-36.6%	-92.5%

* Treatment-experienced utilizers with opioid prescriptions > 15 days supply within most recent 120-day claim history

** New-to-therapy utilizers without opioid prescriptions > 15 days supply within most recent 120-day claim history

ERS Wellness Promotion

ERS is committed to the development of the healthiest state workforce in the country through wellness initiatives designed to reduce health care costs. Improved health may lead to lower absenteeism and improved productivity.

Health happens in all the spaces in which we work, live and play, not just in a doctor's office. Recognizing this, ERS develops programming by building partnerships with agency leadership, wellness liaisons, benefits coordinators and front-line state employees.



ERS wellness promotion

FY18 Accomplishments

- Established metrics to measure employee engagement in HealthSelect wellness initiatives and annual screenings
- Developed communication platforms to disseminate wellness information, including monthly “Idea Exchange” meetings, wellness articles, and educational wellness seminars.
- Began designing regional wellness initiatives targeted at state employee populations with identified opportunities for measurable short-term wellness metric improvements.

ERS implemented a second pre-diabetes prevention program in FY18

Available at no cost to eligible participants enrolled in HealthSelect of Texas or Consumer Directed HealthSelect with a BMI of 23 or higher.

natura)(ySlim®

Naturally Slim (NEW)

Online program that uses clinicians and coaches who teach participants how to lose weight and improve health. Focuses on behavior modification - how and when a person eats versus what a person eats.

Real
Appeal®

Real Appeal

Online weight-loss program that uses coaches to motivate participants to get active and lose weight. Focuses on tracking food and provides education on specific aspects of weight loss, such as calorie intake and physical activity.

Dependent eligibility audits save an estimated \$7 million annually

Removing ineligible dependents from the GBP reduces state contributions and claims costs. ERS continues to verify new dependents as they are added to the plan.

2012 – Initial 100% Dependent Eligibility Audit

In 2011, 5.3% of dependents (about 11,000 ineligible dependents) were removed from the GBP.

This generated \$12 million in net savings for the plan.

2014 – “Gap Audit”

Aon Hewitt conducted a “gap audit” of all dependents added to the GBP since 2011.

This audit removed 6,535 ineligible dependents from the plan for a net savings of \$8.7 million.

2015-2018 “Guard Process”

Since FY15, ERS has followed an ongoing process where eligibility is verified as dependents are added to the plan.

This process produces estimated savings of \$7 million per year.

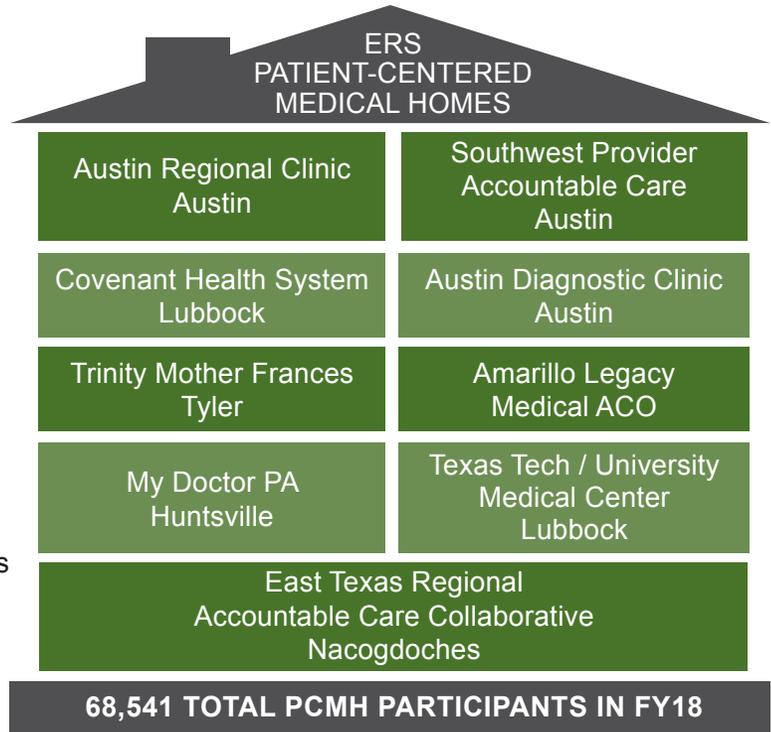
Patient-centered medical home (PCMH) participants cost less than non-PCMH participants

Typical PCMH practices:

- focus on ongoing relationship with a personal primary care physician,
- use evidence-based medicine and clinical decision-support tools, and
- provide enhanced access, such as open scheduling and expanded hours.

From FY11 to FY17, PCMH practices saved the plan \$79.4 million. Practices received \$17.4 million in shared savings payments, in addition to their contracted reimbursements for medical care. Savings for FY18 have not yet been finalized.

HealthSelect has nine PCMH partners with more than 68,000 participants



HealthSelect's value-based contracting arrangements reward quality.

Value-based contracting incentivizes providers through alternative payment arrangements to manage costs by meeting quality and accountability standards.

Examples of value-based contracting

- About one in six HealthSelect participants is seeing a doctor affiliated with a patient-centered medical home (PCMH).
- PCMH's may qualify for shared savings payments by reducing costs and meeting quality metrics.
- Physician performance contracts include efficiency measures, such as writing a certain percent of appropriate generic prescriptions, or referring to in-network labs.
- Hospital performance-based contracts may hinge reimbursement on reducing avoidable admissions, or on meeting expected "length-of-stay" targets for hospital visits.



Value-based incentive plan design (VBID) incentivizes patients through cost-sharing to make positive choices

VBID can be used as a carrot or a stick, either to encourage patients to make healthier choices, or to steer them toward more cost-effective providers.

VBID examples

- Reducing generic drug copays from \$15 to \$10
- Requiring the use of Centers of Excellence for transplants and bariatric surgeries
- Charging an extra \$30 monthly premium for tobacco users
- Offering diabetes prevention programs at no cost to participants

New in FY18

- Imposing a \$300 copay on each visit to an out-of-network freestanding emergency room
- Offering medical virtual visits at no cost to HealthSelect of Texas participants
- Adding a second pre-diabetes prevention program, Naturally Slim, at no cost to the participant
- Allowing participants to receive covered vaccinations at an in-network retail pharmacy using their pharmacy card

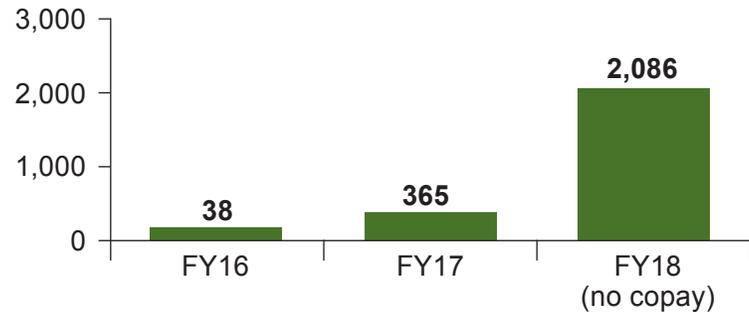
The number of virtual visits increased fivefold when ERS eliminated the copay in FY18

Virtual visits connect participants with a licensed physician directly through their mobile devices or computers.

With the elimination of the copay for HealthSelect of Texas participants, virtual visits increased significantly from FY17 to FY18, with a total of 25,029 visits, compared to 4,383 visits for the previous fiscal year. The satisfaction rating remains high at 4.9 on a five-point scale.

The visits are convenient and cost-effective for participants and lower cost to the plan.

Average virtual visits per month



On September 1, 2018, ERS added virtual visits for mental health at the same benefit level as an in-network office visit (\$25 copay for HealthSelect of Texas participants).

ERS holds regular Solution Sessions to consider new ideas

Each idea is prioritized against ERS' strategic plan and carefully evaluated for inclusion in the Group Benefits Program.

Entity	Presentation Date	Product/Service
Rx Savings Solutions	October 18, 2017	Web-based software that provides pharmacy transparency and participant engagement
Jellyvision	February 21, 2018	ALEX, an interactive benefits decision support tool to assist members with selecting benefits
Concierge Benefit Services	May 16, 2018	Supplemental benefits program offerings to provide gap coverage and engage employees in wellness programs
Healthcare Bluebook	August 22, 2018	Online shopping solution that provides transparency in health care cost and quality information to participants

Spotlight: Being a Smart HealthSelect Consumer



**...getting the most out
of the HealthSelect of
Texas plan and avoiding
unexpected costs**

HealthSelect of Texas is a point-of-service plan

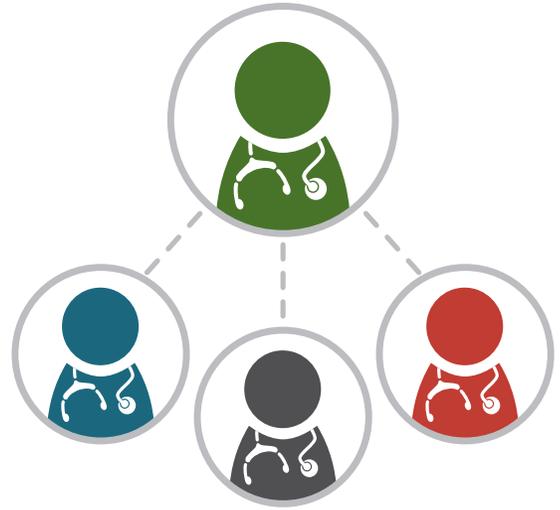
Participants must designate a PCP with the plan and get referrals to specialists.

- In order to receive the highest level of benefits (in-network), HealthSelect participants must designate a PCP.
- A PCP coordinates a participant's care, including management of any referrals needed to see a specialist.

Referrals are not required for:

- Chiropractic visits
- Covered vision care, including routine and diagnostic eye exams
- Mental health counseling
- OB/GYN visits
- Occupational therapy, physical therapy or speech therapy*
- Virtual visits, urgent care centers or convenience care clinics

* Treatment plans beyond the initial visit for occupational therapy, physical therapy and speech therapy require prior authorization.



Here are some tips for using your medical benefits

✔ Know Your Benefits

Call a Blue Cross and Blue Shield of Texas (BCBSTX) Personal Health Assistant to ask questions about your medical benefits and to verify coverage. Or go online to **www.healthselectoftexas.com** and register or log in to Blue Access for MembersSM

✔ Stay in the Network

The HealthSelect network includes more than 50,000 health care providers across Texas. You'll pay less if you see a network provider. To find out if your provider is in-network, go to the Find a Doctor/Hospital page on **www.healthselectoftexas.com**.

✔ Coordinated Care

Let your primary care physician (PCP) manage your care, referrals, prior authorization, medications and more.*

✔ Get Preventive Care

Get preventive care from your in-network doctor. When you see an in-network doctor, preventive care is covered at no cost to you.

✔ Talk to Your Primary Doctor

Before you see a specialist, talk to your primary care physician (PCP) and if needed, get a referral and/or prior authorization for certain services.*

✔ Know Your Options for Care

Your benefits include options for low-cost, quality care including virtual visits, retail health clinics and urgent care centers. A BCBSTX Personal Health Assistant can talk through your options.

*HealthSelectSM Secondary participants are not required to get a referral or prior authorization before getting care. Call a BCBSTX Personal Health Assistant to find out if your plan requires a referral or prior authorization

Avoid common mistakes that can lead to unexpected medical bills

When you need to see a specialist...



DON'T visit a specialist without a referral on file (HealthSelect of Texas only)



DO have your PCP file a referral with HealthSelect before you visit a network specialist. **DO** make sure that referral will still be active when scheduling future visits.

- You don't need referrals for:
- Covered vision care, including routine and diagnostic eye exams
- OB/GYN visits
- Mental health counseling
- Chiropractic visits
- Occupational therapy and physical therapy
- Virtual visits, urgent care centers and convenience care clinics

When you need lab work (such as a pap smear) or imaging (such as an MRI or x-ray)



DON'T assume your provider ordering lab work will automatically send it to an in-network lab

DO ask the provider ordering lab work which lab is being used, and find out if the lab is in-network before your visit or before the sample collected by your provider is sent to the lab.

DON'T assume the test your provider is ordering is covered by your insurance.

DO find out how much you might owe for the test before you agree to it.

DON'T assume your provider is sending you to an in-network imaging center.

DO make sure an imaging center is in-network before you visit. If your provider refers you to one that is not in-network, ask your provider to send you to one that is in-network.

When you are scheduling surgery...



DON'T assume that the surgical facility is in-network or that all of the providers assisting with your surgery are in-network.

DO make sure that the surgical facility is in-network before scheduling surgery.

DO make sure all providers who will assist, such as an anesthesiologist or surgical assistant, will also be in-network. If they are not, ask your doctor for other options.

DON'T assume that any samples collected during your surgery will be sent to an in-network lab for testing.

DO ask the provider if lab work is anticipated and find out if the lab is in-network. If not, ask your doctor for other options.

DON'T wait to be billed without knowing what charges to expect.

DO ask your doctor, facility and any other providers (including labs, anesthesiologist, assistant surgeons, etc.) to give you the amounts they will or could bill you. You can find out what an in-network provider charges for a service by contacting your plan.



Disclaimer:

The following examples of possible billed charges and allowed amounts are for illustrative purposes only and may not reflect the true cost or allowed amount for a specific health care service, which varies depending on provider, date of service, and location.

Yolanda has an appointment with an in-network orthopedic surgeon.

Yolanda is a 35-year-old HealthSelect participant who has an appointment with an orthopedic surgeon for her knee pain. Having checked with the plan in advance, she knows she will pay a \$40 copay to this in-network specialist as long as she gets a referral from her PCP. Without the referral, she would be responsible for more of the cost even though the specialist is in-network, because the claim would be processed as out-of-network.

Yolanda will pay more of the cost without a PCP referral to an in-network specialist.

	In-network with a referral	In-network without a referral = Out-of-network benefits	
Allowed amount	N/A	\$120	
Deductible	N/A	\$500	
Copay	\$40	N/A	
Coinsurance	N/A	\$120 (40% of allowed amount) if deductible has been met	
Yolanda's Total Cost	\$40	\$120 if deductible HAS NOT been met	\$48 if deductible HAS been met



Smart Consumer Tip:

Check with the specialist to make sure a PCP referral was received (or has not expired) before your office visit. If it is not on file, contact your PCP immediately.

David visits an orthopedic surgeon and did not check network status.

David is a 40-year-old HealthSelect participant who visited an out-of-network orthopedic surgeon. David did not check the provider's network status in advance and did not ask his PCP for a referral. If David had selected an in-network specialist and obtained the PCP referral, he would have paid a \$40 copay for the office visit. Because he did not, David pays a much larger portion of the cost.

David is responsible for out-of-network specialist cost:

	Out-of-network cost based on deductible status	
Billed charges	\$250	
Allowed amount	\$120	
Coinsurance	\$48 (40% of allowed amount) if deductible has been met	
Plus balance bill potential	\$130 (\$250 minus \$120)	
Potential Total	\$250 If \$500 deductible HAS NOT been met	\$178 If \$500 deductible HAS been met and balance-billing applies



Smart Consumer Tip:

With the large volume of quality in-network specialists available, ask your PCP for a referral to an in-network specialist, or call (800) 252-8039 for help.

Henry received an unexpected medical bill, following his surgery.

Henry is a 50-year-old HealthSelect participant who had his first outpatient surgery at an in-network facility. The surgery is typically covered at 80% if only in-network providers provide services.

Henry took the necessary steps to avoid receiving an unexpected bill. He spoke to his surgeon's office in advance of the surgery to make sure only in-network providers would be involved. During his scheduled pre-surgical (pre-op) visit to the facility, Henry reiterated that he wanted ONLY in-network providers due to the extra cost of an out-of-network provider.

After the surgery, Henry received an unexpected bill from a surgical assistant who was not in the network. What are Henry's next steps to eliminate or at least lower the bill?



Smart Consumer Tip:

In this case, call the surgeon's office and facility to remind them of the conversations about in-network providers only. If it is not resolved at that point, call BCBSTX (the HealthSelect administrator), advise them of the situation and ask them why you received the bill. Ask for their help. You can appeal an out-of-network bill for services at an in-network facility. Refer to "ERS' Participant Guide to the Appeal Process" at ers.texas.gov. In certain cases, if the bill is \$500 or more (not including your applicable deductible, copay, and coinsurance), you may request mediation from the Texas Department of Insurance.

Sarah thinks acupuncture resolved her pain, but learned she is responsible for the cost of her treatments.

When Sarah's HealthSelect in-network chiropractor suggested she see an acupuncture practitioner for her shoulder pain, she assumed insurance would cover it. Sarah could not find an acupuncturist in the network, so she decided to visit a nearby acupuncturist, expecting to receive out-of-network benefits. Feeling better after her acupuncture treatments, Sarah submitted her claims to HealthSelect, confident the successful treatments would be covered as an out-of-network benefit.

Sarah's claims were denied because acupuncture is not a covered service, as defined in the plans' Master Benefit Plan Document. There are underlying reasons why the plan excludes certain services, including those considered to be experimental, investigational or not medically necessary.



Smart Consumer Tip:

Before receiving services, refer to Section 7 of HealthSelect's Master Benefit Plan Document (MBPD) to learn about services the plan will not cover. The MBPD is available under the Publications menu at healthselectoftexas.com. If Sarah has a TexFlex account, acupuncture may be considered an eligible service allowing for reimbursement from that account. She should contact WageWorks with questions.

Where to go for medical care as a HealthSelect of Texas participant



Virtual Visits — \$0 (Average Out-of-Pocket Cost)

Get non-emergency medical care when you need it. Connect by phone or video to a board-certified doctor anytime, wherever you are. Medical virtual visits are available at no cost to you if you are enrolled in HealthSelect of Texas.



Doctor's Office — \$ (Average Out-of-Pocket Cost)

Generally the best place to go for non-emergency care such as health exams, routine shots, colds and flu. Your doctor knows you and your medical history and can treat you, and refer you to a specialist if needed.



Retail Health Clinic — \$\$ (Average Out-of-Pocket Cost)

Often located in stores and pharmacies to provide convenient, low-cost treatment for minor medical problems. Walk-in clinics can be a lower out-of-pocket cost than urgent care.



Where to go for medical care as a HealthSelect participant (continued)



Urgent Care Provider —\$\$\$ (Average Out-of-Pocket Cost)

Often used when your doctor's office is closed and you need immediate, but non-emergency care such as X-rays and stitches.



Hospital Emergency Room —\$\$\$\$\$ (Average Out-of-Pocket Cost)

Any life-threatening or disabling health issue is a true emergency. You should go to the nearest hospital ER or call 911. You may receive multiple bills for services such as hospital facility, laboratory fees and for each provider you see such as the emergency room doctor, radiologist, pathologist or anesthesiologist.



Freestanding Emergency Rooms —\$\$\$\$\$\$ (Average Out-of-Pocket Cost)

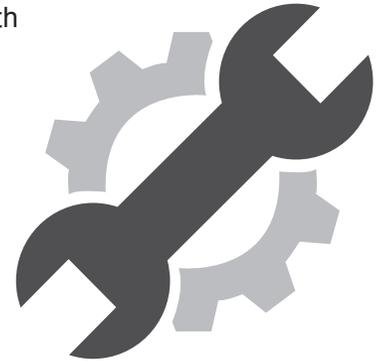
Most freestanding emergency room facilities and providers are out-of-network, so your share of the bill will be significantly higher. These facilities can be confused with urgent care centers or with small hospital ERs. You will recognize a freestanding ER because it will have an Emergency or ER sign and will not be attached to a hospital.



Handy Tools

BCBSTX, the administrator for HealthSelect, has tools to help you find the care you need while avoiding surprise medical bills and unnecessary delays.

- ✔ **BCBSTX Personal Health Assistants** are available by phone at (800) 252-8039, Monday-Friday 7 a.m. – 7 p.m. and Saturday 7 a.m. - 3 p.m.
- ✔ **Nurseline** is available 24/7 to answer questions about where to go for care or medical concerns. (800) 581-0368
- ✔ **Health Select Mental Health Support Line** is available 24/7 for mental health care crises and support. (800) 442-4093
- ✔ **BCBSTX HealthSelect Provider Finder*** is an online directory to network providers. Visit www.healthselectoftexas.com, click Find a Doctor/Hospital, select the box that applies to your coverage, and select your ZIP code



*to download the mobile app, text BCBSTXAPP to 33633

Handy Tools continued

- ✔ **Blue Access for Members (BAM)* online account** at www.healthselectoftexas.com allows participants to find network providers, estimate costs, see claims, and more

- ✔ **HealthSelect of Texas medical plan website*** and **ERS website** both provide information about medical benefits. The HealthSelect site, under the Publications and Forms tab, includes the Guide to Medical Benefits and the more detailed Master Benefit Plan Document
 - www.healthselectoftexas.com
 - www.ers.texas.gov

- ✔ **HealthSelect of Texas Prescription Drug Program (PDP) website** and **ERS website** both provide information about pharmacy benefits. The HealthSelect PDP site includes the Master Benefit Plan Document
 - www.healthselectrx.com
 - www.ers.texas.gov



*to download the mobile app, text BCBSTXAPP to 33633

How a BCBSTX Personal Health Assistant can help you:

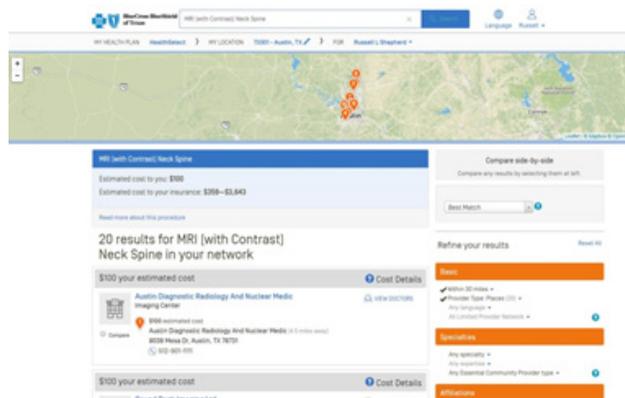
- ✔ Answer questions about benefits
 - Assist with prior authorizations and referrals
 - Provide information about HealthSelect programs and benefits
- ✔ Explain health care costs and options for care
 - Locate in-network options
 - Schedule or cancel appointments
- ✔ Help you use self-service tools
- ✔ Connect you to other resources
 - Clinicians
 - Community resources



Blue Access for MembersSM (BAM) Participant Portal

BAM Portal Features:

- Registration immediately available once your coverage is effective
- View your claims, download EOBs
- Find in-network doctors, hospitals and providers
- Select or change a primary care physician
- Check costs of doctors and services covered under your plan
- Download a temporary ID card
- Confirm prior authorizations and referrals are in place

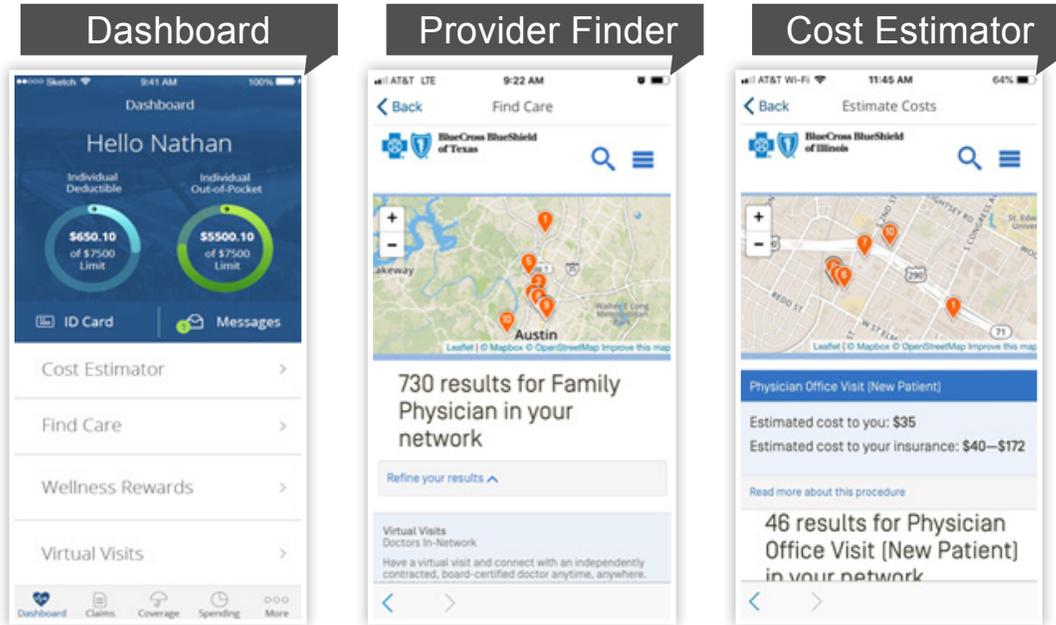


www.healthselectoftexas.com

To download the mobile app, text BCBSTXAPP to 33633.

Mobile Access

BCBSTX Mobile App – Text BCBSTXAPP to 33633



The appeals process

In FY18, ERS published the ERS Participant Guide to the Appeal Process for the GBP insurance plans. Additional information about the appeals process can be found in the guide at <https://ers.texas.gov/PDFs/GBP-Appeal-Process-Precedent-Manual.pdf> and in the Master Benefit Plan Document on the vendor's website.

For most GBP programs, a participant's first action to appeal a coverage decision is made to the TPA under contract by ERS to administer the program; this is referred to as the **First Internal Appeal** process. If the participant is not satisfied with the TPA's response to their First Internal Appeal, they can file a **Second Internal Appeal** to the TPA. Appeal rights for various coverage issues are described in claims communications to the participant from the TPA.

After a participant has exhausted their appeal rights with the TPA, an eligible participant may make certain appeals to ERS directly for further review of an appeal related to coverage of a health care service. This is referred to as the **Second Internal Appeal** to ERS.

Review of grievance appeals regarding questions of allowable amount or eligible expense issues are reviewed by ERS' Director of Group Benefits. All other eligible appeals to ERS are considered by the **ERS Grievance Committee**, which includes staff from multiple agency business divisions, including: Group Benefits; Customer Benefits; Office of the General Counsel; and the Executive Office.



Important deadlines apply throughout the appeals process.

Second internal appeals to ERS

ERS does not consider appeals related to all benefit programs. Currently, participants may appeal to ERS regarding a decision denying payment (in whole or in part) for services within the following plans, most of which are self-funded:

- HealthSelect of Texas' In-Area, Out-of-State, and Secondary plans
- Consumer Directed HealthSelect
- State of Texas Dental Choice
- Life Insurance
- Accidental Death & Dismemberment
- Texas Income Protection Plan (short- and long-term disability insurance)

ERS does not review HMO, including the HumanaDental DHMO, and Medicare Advantage plan claims and benefit denials. Participants in these fully insured plans appeal to the insurer.

Since 2013, the number of appeals received by ERS has fluctuated considerably, and represents a small fraction of claims paid in a year. During the 2018 plan year, for instance, roughly 5.6 million HealthSelect medical claims were paid on behalf of participants.

Second Internal Appeals to ERS										
Fiscal Year	Number of Grievances by Insurance Type								Total	% Change
	HealthSelect	EOI*	Disability	Life	Dental	TexFlex	Other**			
FY13	522	12	123	12	11	N/A	8	688		
FY14	319	3	36	7	15	N/A	1	381	-45%	
FY15	239	4	18	9	12	N/A	1	283	-26%	
FY16	403	3	11	8	9	N/A	0	434	53%	
FY17	460	2	26	6	12	9	0	515	19%	
FY18	280	0	17	13	12	1	9	332	-36%	

*Evidence of insurability is for the disability and life insurance plans only, and is the underwriting a vendor performs to determine if someone is eligible for insurance coverage

**Includes Premium Waiver and Accelerated Life grievances and requests for exceptions to the plan.

Cost Management and Fraud Prevention

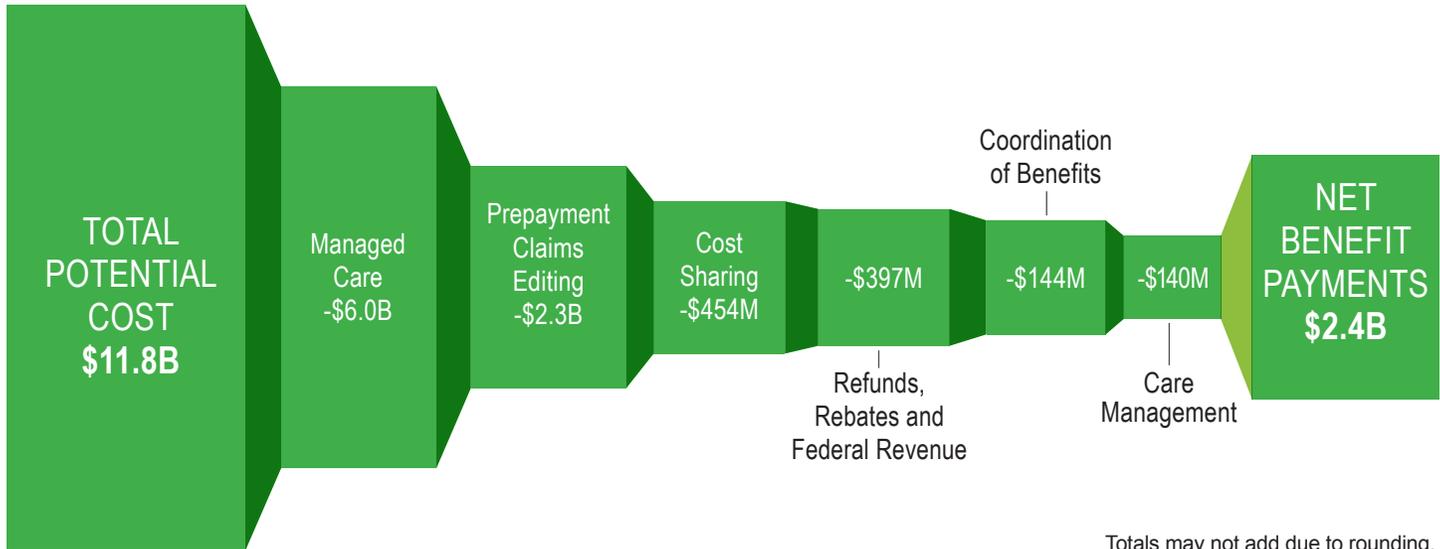


...about our strategies

HealthSelect reduced plan cost by \$9.4 billion in FY18

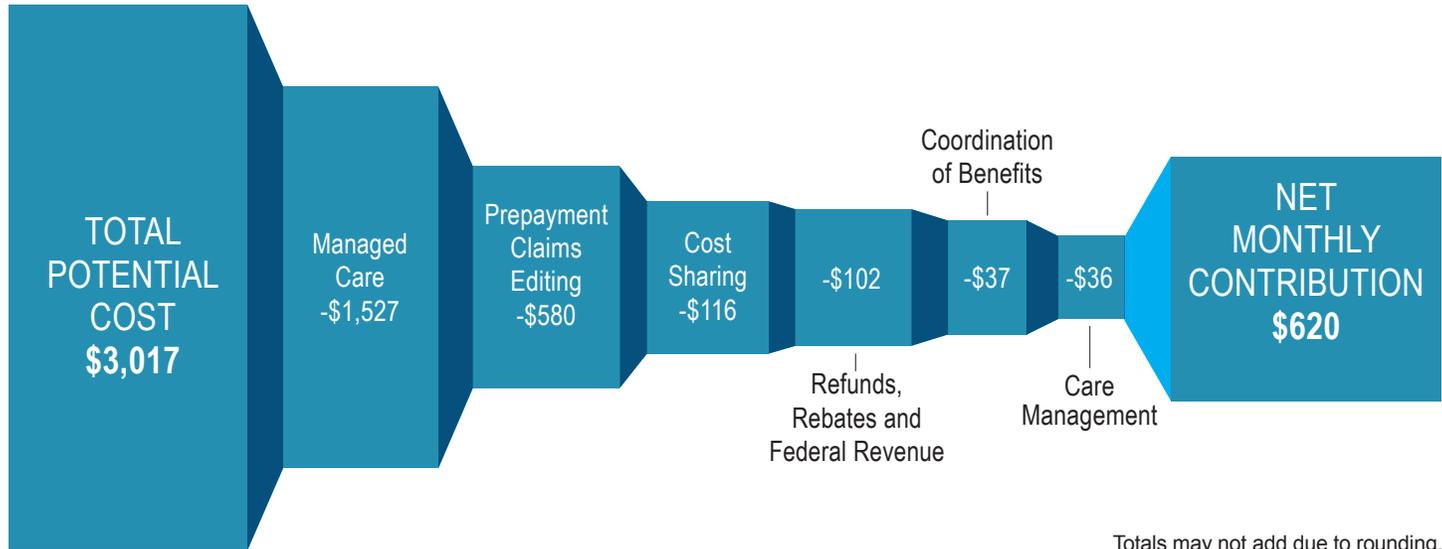
Employee health insurance costs the State of Texas more than \$2 billion a year – so it's important to get the most out of every dollar.

ERS staff professionally manages GBP benefit plans, setting and enforcing high performance standards to slow the benefit cost trend.



Without cost management, the HealthSelect member rate would be almost 5 times higher

In FY18, the member-only contribution rate was \$620 per month. Without cost management programs, the member-only rate would have been more than \$3,000 per month.



Totals may not add due to rounding.

GBP cost management and cost containment detail

1. Considered Charges Plus Estimated Cost Avoided		\$	11,779,126,158
2. Estimated Cost Avoided			(139,794,657)
3. Considered Charges			11,639,331,501
4. Less Ineligible Charges (Prepayment Claims Editing)			(2,264,436,072)
5. Eligible Charges			9,374,895,429
6. Less Reductions to Eligible Charges			
a. PDP Charge Reductions	\$	1,247,296,956	
b. Provider Discounts and Reductions		4,713,147,632	
c. Medical Copayments and Deductibles		122,093,268	
d. Medical Coinsurance		207,997,049	
e. PDP Cost Sharing		124,099,990	
f. Coordination of Benefits - Medical - Regular		10,954,114	
g. Coordination of Benefits - Medical - Medicare		132,060,049	
h. Miscellaneous Medical Reductions		737,778	(6,558,386,836)

7. Gross Benefit Payments		\$	2,816,508,593
8. Refunds, Rebates and Federal Revenue			
a. PDP Rebates	\$	317,165,258	
b. Federal Revenues - Medicare Part D		74,492,785	
c. Subrogation		5,682,021	(397,340,065)
9. Net Benefit Payments		\$	2,419,168,529

*Data sources:

- (1) Annual Experience Accounting reports prepared by UnitedHealthcare and BCBSTX
- (2) Annual Experience Accounting prepared by PBMs
- (3) HealthSelect Prescription Drug Program data
- (4) ERS FY18 Comprehensive Annual Financial Report (Federal Revenues)

Utilization and care management, consumerism, virtual visits and other programs avoided nearly \$140 million in plan costs

Line 2: Utilization management controls costs through clinical programs for high-risk patients.

1. Considered charges plus estimated cost	\$11,779,126,158
2. Estimated cost avoided due to utilization and care management	(\$139,794,657)
3. Considered charges	\$11,639,331,501

In FY18, BCBSTX utilization management saved 7,637 inpatient days, reducing cost by an estimated \$29.8 million.



Prepayment claims editing prevented \$2.3 billion in payments

Line 4: Prepayment claims editing

Prepayment claims editing is an essential part of the fraud and abuse prevention program.

This process weeds out duplicate claims, eliminates charges that exceed benefit limits, and ensures that HealthSelect does not pay for services that are not medically necessary.

3. Considered charges	\$11,639,331,501
4. Less charges eliminated through prepayment claims editing	(\$2,264,436,072)
5. Eligible charges	\$9,374,895,429

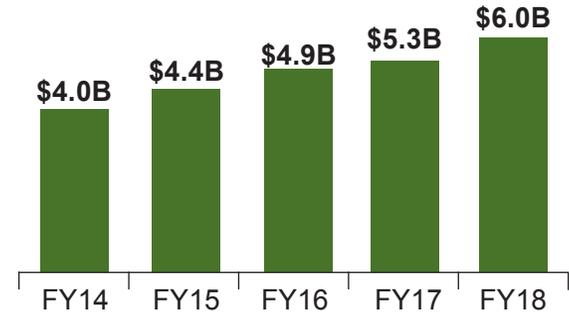
The GBP saved \$6 billion with negotiated provider discounts

Lines 6a and 6b: Managed care savings

ERS leverages its power in the marketplace by negotiating for discounts off the "retail" prices that would have been charged for services without a managed care network.

Managed care savings	
6a. Prescription drug program charge reductions	(\$1,247,296,956)
6b. Medical provider discounts and reductions	(\$4,713,147,632)
Subtotal	(\$5,960,444,588)

Managed care discounts saved the state more than \$24 billion over five years



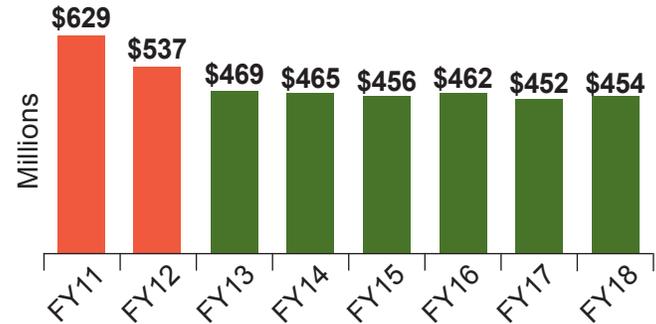
Participants paid \$454 million in deductibles, copays and coinsurance

Lines 6c-6e: Participant cost-sharing

Cost-sharing encourages participants to take an increased role in managing their own health and their out-of-pocket costs. HealthSelect pays eligible preventive care services.

Participant cost-sharing savings	
6c. Medical copayments and deductibles	(\$122,093,268)
6d. Medical coinsurance	(\$207,997,049)
6e. PDP cost-sharing	(\$124,099,990)
Subtotal	(\$454,190,307)

The member's out-of-pocket cost has remained steady for six years



The plan saved \$143 million by coordinating benefits and other reductions

Lines 6f-6h: Coordination of benefits

- When a participant has another source of health insurance, ERS coordinates benefits with the other payer to ensure that costs are shared appropriately.
- For example, when retirees are eligible for Medicare, GBP benefits become secondary, meaning HealthSelect pays eligible medical expenses only after Medicare processes the claim.

Different rules apply to Medicare Advantage plans.

Coordination of benefits savings	
6f. Coordination of benefits - medical – regular	(\$10,954,114)
6g. Coordination of benefits - medical – Medicare	(\$132,060,049)
6h. Miscellaneous Medical Reductions	(\$737,778)
Subtotal	(\$143,751,941)

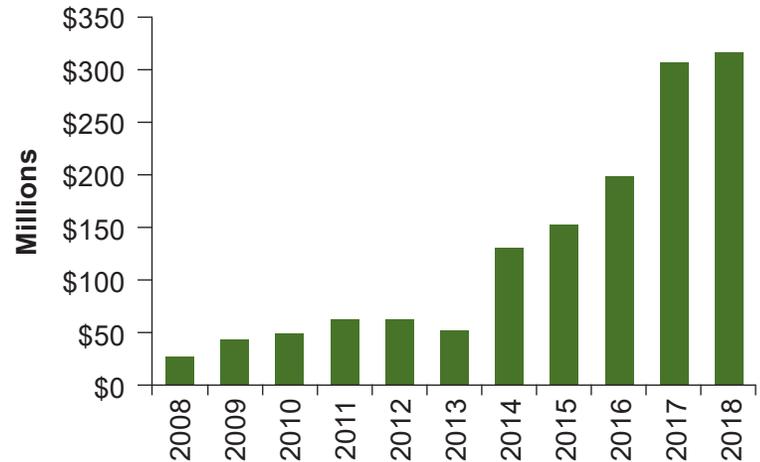
ERS saved \$317 million through drug rebates in FY18

Line 8a: Prescription drug program rebates

- FY18 drug rebates continue to grow
- Through arrangements with drug manufacturers, the HealthSelect PBM receives rebates based on the volume of various drugs dispensed under its programs.
- The PBM contract requires the PBM to return 100% of all rebates to the GBP, with a guaranteed minimum.

Drug rebate savings	
8a. PDP rebates	(\$317,165,258)
Subtotal	(\$317,165,258)

PDP Rebate Savings

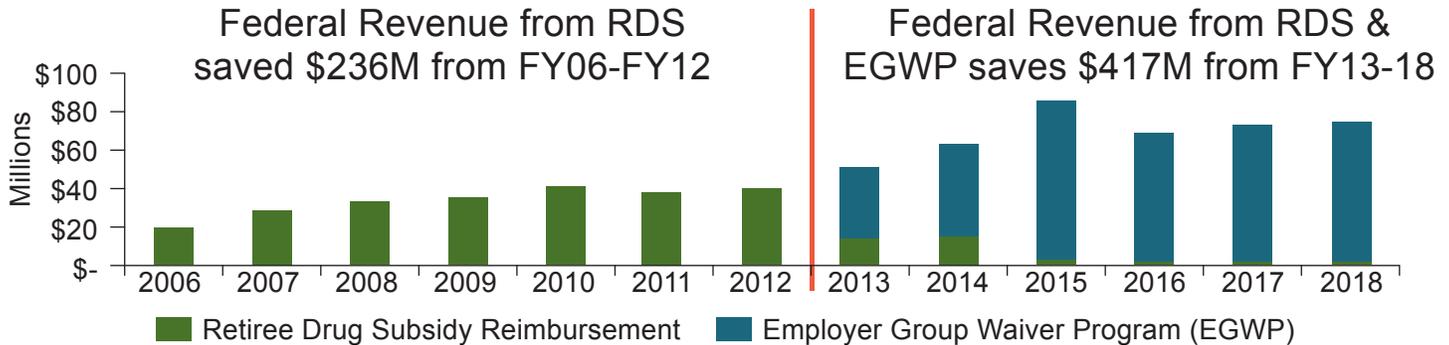


PDP rebates include payments under Medicare Part D Coverage Gap Discount Program of \$189 million from 2013-18.

ERS more than doubled Medicare Part D revenues since implementing the EGWP + Wrap program

Line 8b: Federal revenues

Medicare Part D savings	
8b. Federal revenues – Medicare Part D	(\$74,492,785)
Subtotal	(\$74,492,785)



The plan has collected \$653 million in total Federal Revenue under Medicare Part D since 2006.

ERS protects Medicare participants by offering a ‘wraparound’ plan that provides benefits that are nearly identical to those provided to other HealthSelect participants.

The GBP saved \$5.7 million through subrogation

Line 8c: Subrogation

- Recovery of benefits the plan has paid when a party is or may be found to be responsible

Subrogation savings	
8c. Subrogation	(\$5,682,021)
Subtotal	(\$5,682,021)

Fraud investigations are an ongoing focus for all plans

The Special Investigations Department (SID) of Blue Cross and Blue Shield of Texas (BCBSTX) detects and investigates health care fraud schemes through proactive data analysis, hotlines, information sharing and collaboration with other BCBS plans, other insurers and law enforcement. SID has a dedicated Data Intelligence Unit (DIU) and Investigative Groups, which streamline BCBSTX's approach to reducing health care fraud.

Data analysis used to identify potential fraud includes detecting providers with average allowed amount per patient greater than the mean for all diagnosis and procedure combinations. Another strategy identifies prescribers causing potential patient harm, using medical and pharmacy (controlled substances) data. BCBSTX also uses SID overpayment data to identify providers who may be committing fraud, waste or abuse, based on historical patterns.

Some of the schemes identified include billing for medically unnecessary/improperly documented services, experimental/investigational/unproven procedures, inflated hours, services not rendered and services for family members.

Fraud investigations (continued)

During 2017 and 2018, SID continued investigations into multiple rural hospitals and labs for potential pass-through billing of urine drug tests. Additionally, multiple providers were identified for their aberrant billing of amniotic membrane grafts. SID continues collaboration with multiple areas across the enterprise to address these issues.

ERS also contracts with an external auditor to analyze annually the TPA's performance related to:

1. Contract requirements
2. TPA's internal standards
3. Industry standards
4. Previous year audit results (if applicable)

Performance Monitoring



**...about our program
oversight**

Participant satisfaction with the GBP plans

GBP Name	Vendor Name	Plan Year	Satisfaction Rating
HealthSelect plans	BCBSTX	2018	77.7%
HMO	KelseyCare powered by CHC	2018	92.0%
HMO	Scott & White	2018	90.4%
HealthSelect MA PPO	Humana Insurance	2017	94.0%
MA HMO	KelseyCare MA HMO	2017	91.6%
HealthSelect Prescription Drug Program (PDP)	UnitedHealthcare / OptumRx	2017	92.0%
HealthSelect Medicare Rx Plan (EGWP)	UnitedHealthcare	2017	97.0%
Dental Choice PPO	HumanaDental	2018	99.0%
Dental HMO	DentiCare/Humana Dental	2018	100.0%
State of Texas Vision	Superior Vision	2018	93.0%
TexFlex	WageWorks	2018	77.9%

All contracts have performance guarantees

A performance guarantee (PG) assessment and/or liquidated damages are triggered when a vendor fails to meet certain contractual conditions.

The monetary value of a PG assessment depends on the severity of the violation. PG metrics are formulated from regulatory standards and industry best practices. Each PG is then risk-rated using risk-assessment modeling and assigned a PG severity level.

Performance outcomes are based on a snapshot in time. A missed performance guarantee does not mean that the issue was not resolved or corrected.

Any instance of a missed performance metric requires the TPA/insurer to supply a corrective action plan for ERS' review and approval.

Performance guarantee criteria

Level of Severity	Definition	Allocation of Amount at Risk
Severity 1 – Emergency	Mission-critical systems are down, there is 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 services 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

Performance Reporting FY18

HealthSelect plans, *administered by Blue Cross and Blue Shield of Texas*

- Blue Cross and Blue Shield of Texas (BCBSTX) became the new HealthSelect third-party administrator (TPA) effective September 1, 2017 (FY18) and the contract is effective through August 31, 2023.
- The TPA transition included development of the HealthSelect provider network.
- The new TPA paid approximately 5.24M medical claims in FY18.
- Performance guarantees were met for Emergency (severity level 1) and Critical (severity level 2) categories; assessments did not apply.
- Performance guarantees were not met for Moderate (severity level 3) and Minor (severity level 4) categories; assessments did apply.

Performance Reporting FY18

HealthSelect plans, *administered by Blue Cross and Blue Shield of Texas*

Severity Level	PG Category	Vendor Performance Results	PG Assessments	PG Requirement	PG Actual
3	Moderate PG	17 Moderate PGs Missed	Financial Accuracy Rate of Claims 7 PGs assessed (7 of 12 months)	99% rate each month	Range 90.75% - 98.54%
			Pre-Service Appeal Processing 1 PG assessed (1 of 12 months)	15 day turnaround 95% of the time	93.30%
			Post-Service Appeal Processing 1 PG assessed (1 of 12 months)	30 day turnaround 95% of the time	92.31%
			Rate of Claims Processed Timely 7 PGs assessed (7 of 12 months) Waived: 1 PG (October 2017)	98% of claims processed in 22 business days or less each month	Range 87.96% - 92.76% 97.93%

Performance Reporting FY18

HealthSelect plans, *administered by Blue Cross and Blue Shield of Texas*

Severity Level	PG Category	Vendor Performance Results	PG Assessments	PG Requirement	PG Actual
4	Minor PG	90 Moderate PGs Missed	Communication Materials 76 PGs assessed (7 of 12 months) Waived: 9 minor communication material PGs waived September 2017	100% of communication materials pre-approved by ERS and reflect quality and accuracy. PGs missed are measured by exception, per occurrence or incident	<100% of communication materials were approved before being mailed to participants
			Reporting Requirements 4 PGs assessed (4 of 12 months)	100% timely receipt required	50% - 90.91% timely

Performance Reporting FY18

Regional HMOs

- The HMO plans are required to adhere to performance standards defined in each contract. Failure to meet performance standards may result in performance assessments.
- Each HMO met performance standards and participant satisfaction rates remained positive.

Performance Guarantee Assessments CY17

HealthSelect Medicare Advantage PPO, *administered by Humana Insurance Company*

- Performance guarantees were met for Emergency (severity level 1) and Critical (severity level 2) categories; assessments did not apply.
- Performance guarantees were not met for Moderate (severity level 3) and Minor (severity level 4) categories; assessments did apply.

Severity Level	PG Category	Vendor Performance Results	PG Assessments	PG Requirement	PG Actual
3	Moderate PG	Moderate PG	File Transfer Error Notification PG assessed (1 of 12 months)	100% file error notification within 4 hours required	92.3% notification within 4 hours
4	Minor PG	1 Minor PG Missed	Reporting Requirements Waived: 1 PG waived with actual rate of 88.9% (May 2017)	100% timely receipt required	88.9% timely

Performance Guarantee Assessments CY17

KelseyCare Medicare Advantage HMO, *administered by KelseyCare*

- Performance guarantees were met for Emergency (severity level 1), Critical (severity level 2) and Moderate (severity level 3) categories; assessments did not apply.
- Performance guarantees were not met for Minor (severity level 4) category; assessments did apply.

Severity Level	PG Category	Vendor Performance Results	PG Assessments	PG Requirement	PG Actual
4	Minor PG	1 Minor PG Missed	Reporting Requirements 1 PG assessed (1 of 12 months)	100% timely receipt required	<100% timely delivery

Performance Guarantee Assessments FY18

HealthSelect Prescription Drug Program (PDP), *administered by UnitedHealthcare Services Inc. / OptumRx*

- Performance guarantees were met for Emergency (severity level 1) and Critical (severity level 2) categories; assessments did not apply.
- Performance guarantees were not met for Moderate (severity level 3) and Minor (severity level 4) categories; assessments did apply.

Severity Level	PG Category	Vendor Performance Results	PG Assessments	PG Requirement	PG Actual
3	Moderate PG	2 Moderate PG's Missed	Timely Processing of Participant Paper Claims 2 PGs assessed (2 of 12 months)	100% in 5 business days required	68% - 79% were timely
4	Minor PG	4 Minor PG's Missed	Reporting Requirements 4 PGs assessed (4 of 12 months)	100% timely receipt required	<100% timely delivery

Performance Guarantee Assessments CY17

HealthSelect Medicare Rx Plan, *administered by UnitedHealthcare Services Inc.*

- Performance guarantees were met for Emergency (severity level 1), Critical (severity level 2) and Moderate (severity level 3) categories; assessments did not apply.
- Performance guarantees were not met for Minor (severity level 4) category; assessments did apply.

Severity Level	PG Category	Vendor Performance Results	PG Assessments	PG Requirement	PG Actual
4	Minor PG	12 Minor PG's Missed	Reporting Requirements 12 PGs assessed (12 of 12 months)*	100% timely receipt required	<100% timely delivery

*This information includes an update made following the December 11, 2018 meeting of the ERS Board of Trustees to correct data reported on that date.

Performance Reporting, FY18

State of Texas Dental Choice Plan, *administered by HumanaDental*

HumanaDental DHMO, *administered by Denticare, Inc. (an affiliate of HumanaDental Company)*

- HumanaDental performance guarantees were met for all performance standards. Assessments did not apply for the State of Texas Dental ChoiceSM plan.
- DentiCare, Inc. (an affiliate of HumanaDental) performance guarantees were met for all performance standards. Assessments did not apply for HumanaDental DHMO.

Performance Guarantee Assessments FY18

State of Texas Vision, *administered by Superior Vision Services, Inc.*

- Performance guarantees were met for Emergency (severity level 1) and Critical (severity level 2) categories; assessments did not apply.
- Performance guarantees were not met for Moderate (severity level 3) and Minor (severity level 4) categories; assessments did apply.

Severity Level	PG Category	Vendor Performance Results	PG Assessments	PG Requirement	PG Actual
3	Moderate PG	12 Moderate PGs Missed	Adjudication Rate of Clean Claims 10 PGs assessed (10 of 12 months)	100% adjudication rate within 15 business days	Range from 92.68% to 99.91%; one outlier month at 43.57%
			Rate of Claims Processed Timely 2 PGs assessed (2 of 12 months)	98% claims processed within 30 days	Range from 75.89% to 93.51%
4	Minor PG	1 Minor PG Missed	Reporting Requirements 1 PG assessed (1 of 12 months)	100% timely receipt required	75% Timely Delivery

Performance Guarantee Assessments FY18

Optional Term Life and AD&D, *administered by Minnesota Life Insurance Company*

- Performance guarantees were met for Emergency (severity level 1), Critical (severity level 2) and Moderate (severity level 3); assessments did not apply.
- Performance guarantees were not met for and Minor (severity level 4); assessment did apply.

Severity Level	PG Category	Vendor Performance Results	PG Assessments	PG Requirement	PG Actual
4	Moderate PG	2 Minor PGs Missed	Communication Materials 1 PG assessed (1 of 12 months)	100% of communication materials pre-approved by ERS and reflect quality and accuracy. PGs missed are measured by exception, per occurrence or incident	<100% of communication materials were approved before being mailed to participants
			Reporting Requirements 1 PG assessed (1 of 12 months)	100% timely receipt required	<100% delivered timely

Performance Guarantee Assessments FY18

TexFlex, administered by WageWorks

- Performance guarantees were met for Emergency (severity level 1) and Critical (severity level 2) categories; assessments did not apply.
- Performance guarantees were not met for Moderate (severity level 3) and Minor (severity level 4) categories; assessments did apply.

Severity Level	PG Category	Vendor Performance Results	PG Assessments	PG Requirement	PG Actual
3	Moderate PG	5 Moderate PGs Missed	Monthly Timely Processing 2 PGs assessed (2 of 12 months)	98% processing rate in 3 days	Processing rates in 3 days ranged from 42% to 86%
			Written Notice of Change 2 PGs assessed	Required to provide a written notice at least thirty (30) calendar days prior to any change in operations, administration, delivery, etc. that may otherwise affect ERS, the plan, and/or participants. PGs missed are measured by exception, per occurrence or incident	Failed to notify ERS prior to changes in file exchange process for CSA and FSA plans
			Written Correspondence Rate, Quarterly 1 PGs assessed	Participant written correspondence is to be resolved within 5 days, on average	> 5 days, on avg., Q4 2018

Performance Guarantee Assessments FY18

TexFlex, administered by WageWorks continued

Severity Level	PG Category	Vendor Performance Results	PG Assessments	PG Requirement	PG Actual
4	Minor PG	1 Minor PG Missed	Communication Materials 1 PG assessed (1 of 12 months)	100% of communication materials pre-approved by ERS and reflect quality and accuracy. PGs missed are measured by exception, per occurrence or incident	<100% of communication materials were correct

Performance Guarantee Assessments FY18

Texas Income Protection Program, *administered by ReedGroup LLC*

- Performance guarantees were met for Emergency (severity level 1) and Critical (severity level 2) categories; assessments did not apply.
- Performance guarantees were not met for Moderate (severity level 3) and Minor (severity level 4) categories; assessments did apply.

Severity Level	PG Category	Vendor Performance Results	PG Assessments	PG Requirement	PG Actual
3	Moderate PG	1 Moderate PG Missed	Financial Accuracy Rate of Claims, Quarterly 1 PG assessed	98% claims accuracy rate	97.29% claims accuracy rate, Q1 2018
4	Minor PG	1 Minor PG Missed	Interval Service Level, Quarterly 1 PG assessed	85% rate of calls are to be answered within 30 seconds	83.88% of calls were answered within 30 seconds, Q2 2018

Contract monitoring – Performance Assessments

Plan Name	Reporting Period	Vendor	Major Service Categories	PG Determination	
				Waiver	Assessment
HealthSelect SM of Texas and Consumer Directed HealthSelect	FY18	Blue Cross and Blue Shield of Texas	Communication materials	\$ 1,687,046.40	\$ 14,118,501.79
			Rate of Claims Processed Timely	278,654.64	3,994,049.90
			Financial Accuracy Rate of Claims Processed		3,436,740.61
			Reporting Requirements		743,079.04
			Pre-Service Appeals Turnaround Time		278,654.64
			Post-Service Appeals Turnaround Time		278,654.64
HealthSelect of Texas Prescription Drug Program	FY18	OptumRx	Reporting Requirements		16,819.49
			Accurate and Timely Processing: Paper Participant Claims		16,819.49
HealthSelect SM Medicare Advantage PPO	CY17	Humana Insurance Company	Notification of File Transfer Errors		39,000.00
			Reporting Requirements	26,000.00	

Contract monitoring – Performance Assessments

Plan Name	Reporting Period	Vendor	Major Service Categories	PG Determination	
				Waiver	Assessment
KelseyCare Advantage, Medicare Advantage HMO	CY17	KelseyCare Advantage	Reporting Requirements		\$ 1,560.00
HealthSelect Medicare Rx Plan	CY17	UnitedHealthcare Services, Inc	Reporting Requirements		165,264.00
State of Texas Vision	FY18	Superior Vision	Adjudication of Clean Claims		154,000.00
			Accurate and Timely Processing		28,000.00
			Reporting Requirements		4,000.00
Life Insurance & AD&D	FY18	Minnesota Life Insurance Company	Communication Materials		6,300.00
			Reporting Requirements		6,300.00

Contract monitoring – Performance Assessments

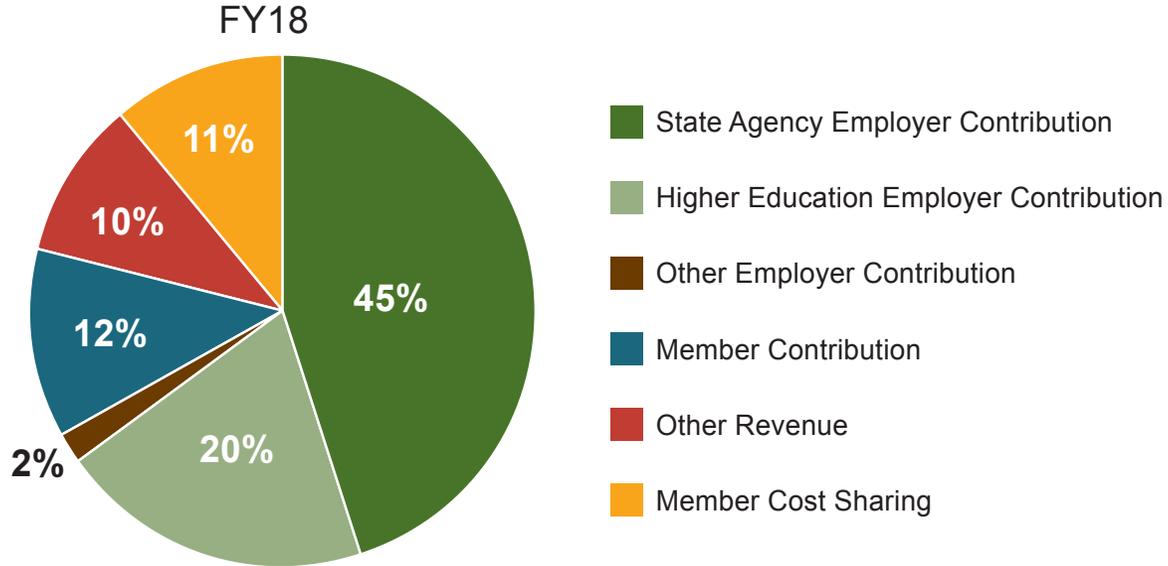
Plan Name	Reporting Period	Vendor	Major Service Categories	PG Determination	
				Waiver	Assessment
Careington Dental Discount Plan	FY18	Careington	Reporting Requirements		\$ 476.00
Texas Income Protection Program	FY18	ReedGroup LLC	Claims processing: financial accuracy		17,637.59
			Interval Service Level (ASA)		11,758.39
TexFlex	FY18	ADP / WageWorks Inc.	Accurate and Timely Processing		21,600.00
			Accurate and Timely Processing		36,000.00
			Written Notice of Change		21,600.00
			Written Notice of Change – CSA		6,264.00
			Communication Materials		14,400.00
			Written Correspondence Rate		21,600.00
TexaSaver 401(k) and 457 Program	FY18	Great-West / Empower	Notification of File Transfer Errors		200,000.00
			Resolution of File Transfer Errors		200,000.00
			Program reporting		16,000.00

Appendix



Financial Tables Legislative Update Looking ahead to FY19

Who pays for GBP health care benefits?



GBP spending by program, FY18

	Medical Spending	Pharmacy Spending	Administrative Cost	Total
HealthSelect	\$1,888,108,788	\$436,894,660	\$50,255,354	\$2,375,258,802
Scott and White Health Plan	\$83,259,724	\$16,330,787	\$8,600,720	\$108,191,231
KelseyCare powered by Community Health Choice	\$16,921,162	\$3,870,200	\$2,911,606	\$23,702,969
Community First Health Plans	\$15,358,274	\$3,870,944	\$2,762,681	\$21,991,900
Medicare Advantage HMO – KelseyCare	\$1,772,063	\$1,418,257	\$462,577	\$3,652,897
Medicare Advantage PPO – Humana	\$133,599,138	\$100,234,048	\$24,287,695	\$258,120,881
Total	\$2,139,019,150	\$562,618,897	\$89,280,633	\$2,790,918,679

For HealthSelect, MAHMO and MAPPO the pharmacy spending is reduced to account for revenue returned through drug rebates.

GBP spending by program, FY18 (continued)

Optional Program	FY18 Administrative Costs
TexFlex	\$1,227,229.70
State of Texas Dental Discount Plan SM	\$248,640.11
HumanaDental DHMO	\$2,334,865.95
State of Texas Dental Choice	\$3,271,771.00
Life Insurance Plans (all)	\$3,606,837.24
Texas Income Protection Plan (disability insurance)	\$5,942,029.19
State of Texas Vision	\$595,991.50

Projected health care cost trend for FY19-21

Category	Increased Use of Service	Provider Price Increases	Maintenance of Member Share	Total
Hospital	2.3%	3.6%	0.6%	6.5%
Other Medical Services	1.9%	2.1%	0.2%	4.2%
Gross Pharmacy	3.0%	6.0%	3.0%	12.0%
Total	2.4%	3.8%	1.1%	7.3%

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.

GBP Health Plan Financial Status

Summary of Actual and Projected* Health Plan Experience (through December 2018)									
\$Millions									
	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25**
	Projected								
Revenue									
State Contributions	\$2,875.0	\$2,895.2	\$2,947.5	\$3,003.8	\$3,061.1	\$3,119.6	\$3,179.2	\$3,239.9	\$3,301.8
Member Contributions	519.4	509.2	508.8	518.6	528.5	538.6	548.9	559.3	570.0
Other Revenue	388.1	422.7	489.1	561.7	639.5	688.9	737.0	783.2	827.3
Total Revenue	\$3,782.5	\$3,827.1	\$3,945.4	\$4,084.1	\$4,229.1	\$4,347.1	\$4,465.1	\$4,582.4	\$4,699.1
Health Care Expenditures	\$3,483.7	\$3,183.7	\$3,582.0	\$3,933.0	\$4,320.5	\$4,739.0	\$5,203.4	\$5,723.9	\$6,296.7
Net Gain (Loss)	\$298.8	\$643.4	\$363.4	\$151.1	(\$91.4)	(\$391.9)	(\$738.3)	(\$1,141.5)	(\$1,597.6)
Fund Balance	\$797.7	\$1,441.1	\$1,804.5	\$1,955.6	\$1,864.2	\$1,472.3	\$734.0	(\$407.5)	(\$2,005.1)
Other Expenses Incurred Outside of the GBP Fund									
Member Cost Sharing	\$478.0	\$481.0	\$485.5	\$494.8	\$504.2	\$513.9	\$523.7	\$533.7	\$543.9

* Assuming per capita funding remains at the FY19 level through FY25.

**Under this scenario, the GBP's invested assets would be fully depleted prior to the end of FY25. At that time, the GBP would be unable to pay expenses and would cease to operate. Therefore, the ending Fund Balance for FY25 is shown for illustrative purposes only.

FY18 legislative projects

- **Creating a new Group Benefits Advisory Committee (GBAC)** – In response to a Sunset Commission recommendation, the ERS Board of Trustees appointed a diverse group of state and higher education employees and retirees to the GBAC, to formalize and enhance participant input into Board decisions about GBP benefits and operations. The first GBAC held its first meeting in March 2018.
- **Data-sharing with other state agencies** – ERS worked with the Health and Human Services Commission, the Department of State Health Services, Teacher Retirement System of Texas and Texas Department of Criminal Justice to evaluate a new system for data-sharing among state-funded health care programs, with the goal of identifying cost and utilization outliers and sharing best practices. An analysis was reported to the legislature on May 1, 2018. The multi-agency group meets regularly to share health care strategies and challenges, in an ongoing effort to improve population health and find plan savings.
- **Evaluating the Consumer Directed HealthSelect plan** – ERS analyzed costs and utilization of the GBP's high-deductible health plan and health savings account, and modeled other cost-neutral options for high-deductible plans. The analysis was reported to the legislature on August 31, 2018.

FY18 legislative projects (continued)

- **Studying a method for collecting health outcomes data from participants** – In response to Senate Bill 55, ERS and the Teacher Retirement System of Texas conducted a cost-benefit study of establishing a patient-reported outcomes registry for musculoskeletal conditions. The study was reported to the legislature on December 1, 2018.
- **Contracting** – Revised centralized agency contracting policies to align with evolving state standards and requirements.
- **Appeals and Grievances** – Implemented changes to the insurance plan grievance and appeals process and to communications to enhance member understanding and engagement.

Looking ahead in FY19

FY19 Initiatives

- HealthSelect plans now offer scheduled virtual visits for mental health services, subject to copay & coinsurance amounts (implemented September 2018)
- Through arrangements with the University of Texas MD Anderson Cancer Center, implemented a patient navigator program and are offering a regional breast cancer screening program via mobile mammogram*
- Continue to grow participation in Patient Centered Medical Homes
- Evaluate options to build upon a recent doubling of enrollment in the Consumer Directed HealthSelect plan
- Implement in-network episode-based bundling program*

*Location-specific, as indicated

Looking ahead in FY19

Potential legislative changes needed

ERS' mission is to offer competitive benefits to enhance the lives of its members. Chapter 1552 of the Texas Insurance Code allows the agency to provide group long-term care insurance to members and certain of their dependents. Recent changes to long-term care products offered by insurance companies have resulted in the elimination of viable group offerings. Amending Chapter 1552 of the Texas Insurance Code is necessary to allow the GBP to offer individual, rather than group, long-term care policies to members.