ERS®
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

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October 1, 2020

Chair Bonnen and Members of the House Select Committee on Statewide Health Care Costs,

The Employees Retirement System of Texas (ERS) is entrusted with administering benefits to help the State of Texas attract and retain a qualified workforce. These benefits include both health insurance and an employee/employer-funded pension. The mission of state government is critical – both to the economy of Texas and to the health and safety of its residents. Building and maintaining a strong workforce to achieve the Legislature's goals for the state requires offering competitive benefits.

For the coming biennium, the ERS health insurance program remains financially strong. Thanks to cost management initiatives and competitive contracting, ERS will not be requesting additional appropriations above its base funding level in order to maintain current health insurance benefits.

On the other hand, all three of the pension plans administered by ERS on behalf of the state are in funding distress and on a path to total fund depletion. Both the pension and health insurance benefits are critical parts of a comprehensive benefits package that agency employers rely on to build and maintain a qualified workforce. Ensuring the long-term viability of the pension plan is important to support the workforce that implements the critical functions of state government, as you set forth each session.

ERS looks forward to continuing to manage the state employee health plans in a manner that efficiently manages state funds and to working with the 87th Legislature to find a long-term funding solution for the ERS pension plans to best support your state employees in the work they do for the citizens of our great state.

Respectfully submitted,
Porter Wilson
Executive Director
Employees Retirement System of Texas

INTERIM CHARGE 1: *Examine the primary drivers of increased health care costs in Texas. This examination should include a review of:*

- *Current health care financing strategies;*
- *fragmentation of the care delivery administrative burden;*
- *population, health, and social factors that contribute to rising rates of chronic disease and poor health;*
- *insurance coverage and benefit design;*
- *lack of transparency in the cost of health care services;*
- *regional variations in the cost of care;*
- *consolidation and lack of competition in the provider and insurance markets;*
- *health care workforce capacity distribution; and*
- *fraud, abuse, and wasteful spending.*

INTERIM CHARGE 2: *Study the opportunities to better coordinate how public dollars are spent on health care.*

INTERIM CHARGE 3: *Identify emerging and proven delivery system improvements and sustainable financing models that could reduce the cost of health care.*

Background:

ERS health plan beneficiaries
ERS administers various health insurance benefits for more than a half million Texans through the Texas Employees Group Benefits Program (GBP). Health insurance is a primary employee benefit used by 117 state agencies, 46 public universities and 19 junior/community and technical colleges to attract and retain a qualified state workforce.

Health plan administration and management process
The State offers several self-funded plans for employees, retirees and their families: HealthSelect of Texas®, Consumer Directed HealthSelect℠, and the HealthSelect℠ of Texas and Consumer Directed HealthSelect Prescription Drug Programs. A self-funded plan means the employer assumes the financial risk for providing health care benefits to its employees, rather than having an insurance company assume the risk, as in a fully insured plan. Eight out of 10 health plan participants are enrolled in the HealthSelect of Texas point-of-service medical plan. For Medicare-primary participants, ERS offers the HealthSelect Medicare Advantage PPO Plan and the HealthSelect Medicare Rx EGWP + Wrap plan. The following table describes how responsibility for establishing health plan policy is allocated:

Texas Legislature			ERS Board of Trustees	
Eligibility	**Contribution Strategy**	**Appropriations**	**Professional Management**	**Plan Design**
Who is eligible for insurance coverage	How the premium 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

ERS uses a competitive bidding process to contract with third-party plan administrators (TPAs) to process medical claims and provide a network of health care providers with a very high standard for network adequacy. Currently, the average distance for a participant living in Texas to the nearest primary care physician (PCP) is 3.0 miles and the average distance to the nearest specialist is 3.2 miles. ERS contracts with a Pharmacy Benefits Manager (PBM) for administration of the self-funded prescription drug plan.

TPAs and PBMs are responsible for establishing robust networks, contracting for provider/pharmacy reimbursement rates, managing the plan formularies, and collecting drug manufacturer rebates. The current TPA for the HealthSelect medical plans is Blue Cross and Blue Shield of Texas. UnitedHealthcare Services, Inc. (OptumRx) is the current PBM for the HealthSelect of Texas and Consumer Directed HealthSelect Prescription Drug programs, as well as the HealthSelect Medicare Rx plan.

ERS makes use of in-house actuaries, consulting actuaries, and external vendors to monitor health care spending for cost trends by region, medical condition and to detect potential fraud, abuse and waste. ERS continuously analyzes the effectiveness and efficiency of cost containment practices. Per statute, these activities and relevant findings are detailed in the GBP Annual Report.

State government health care collaboration

ERS participates in a number of collaborative projects with other state agencies to coordinate how public dollars are spent and identify potential improvements to health care delivery systems and financing models. One example, the "Cross-Agency Coordination on Healthcare Strategies and Measures" budget rider (86R HB 1, Article IX, Section 10.06), directed the Health and Human Services Commission, ERS, the Teacher Retirement System and Texas Department of Criminal Justice to share information in a common dashboard and collaborate, where possible, on approaches to improve value in their systems. The dashboard is being built and managed by The University of Texas Health Science Center Houston. Progress on this collaboration is detailed in the effort's first report, "Cross-Agency Coordination on Healthcare Strategies and Measures" (September 2020).

Health plan financing

Employee health insurance is funded through legislative appropriation and contributions by covered members, including both premium costs and health care costs, such as copays, deductibles and coinsurance. These costs for members are referred to as the member cost share. The state contributes 100% of the premium for a full-time employee's member-only coverage and 50% of the premium for eligible dependents; the member contributes 50% toward the total premium and is responsible for applicable out-of-pocket costs such as deductibles, co-pays and co-insurance. Per Texas Insurance Code Section 1551.211, ERS maintains a contingency reserve fund to offset short-term negative plan experience and avoid abrupt premium volatility.

Health plan cost experience

More than any other factor, price inflation drives health plan costs. Common to all plans, price inflation occurs when providers increase rates, drug manufacturers raise drug prices, or a new drug enters the market. Other benefit cost trend components include utilization driven by how often participants use services and the mix of services used, and member cost-share leveraging driven by the plan paying more while member fixed-cost copays remain the same.

Following the implementation of new vendor contracts for the HealthSelect medical and prescription drug plans, the plans experienced a reduction in costs, which is a one-time reset of the base cost. This occurred in

2017 with the implementation of a new pharmacy benefits manager contract and in 2018 with the implementation of a new third party administrator for medical benefits.

In addition, during fiscal year 2019, HealthSelect plans experienced lower-than-projected cost trends: a 3% increase in costs for the medical plan and a 7% increase in the pharmacy plan. Both plans were expected to return to historic trend increases beginning in FY20: a projected combined 7.3% increase for FY20-21. While the effects to the plans from the COVID-19 pandemic are not yet fully understood, preliminary analysis indicates a temporary net reduction to plan cost from lower utilization, which exceeds the direct cost of COVID-19 treatment and testing. Final plan cost and FY20 trend numbers will be available at the beginning of calendar year 2021.

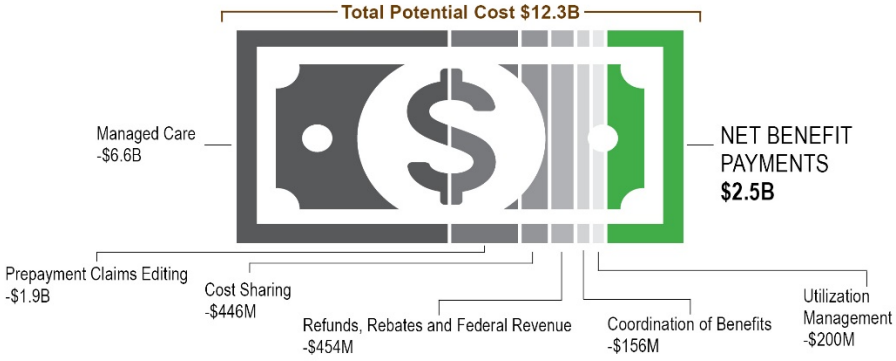
Cost containment initiatives

ERS manages plan costs in many ways, beginning with plan design and a competitive bidding process for TPAs, PBMs, and insurers. ERS secures the best value for state health care dollars by competitively bidding contracts to administer the medical and pharmacy plans. In 2017, ERS awarded new contracts projected to save the plan $2.8 billion in costs for the HealthSelect medical plans and $1.6 billion in costs for the HealthSelect pharmacy plans over the six-year terms of the contracts.

ERS leverages a large and diverse risk pool to keep coverage costs affordable for participants and the state. Due to the large plan size, ERS is able to obtain competitive contract terms with the TPAs and PBM, paying less than 3 cents of every dollar on administrative costs (FY19). Even with members consuming more health care as they age or become ill, coverage costs are averaged across approximately a half million plan participants of all ages and health statuses to provide a stable and manageable claims structure.

Savings to the HealthSelect pharmacy plans are due, in part, to manufacturer drug rebates negotiated by Optum Rx. Those rebates contribute to the $1.6B in savings expected over the six-year contract term. Rebates are used to offset plan costs and help keep contribution costs low for both the state and members, in addition to the broad use of generic drugs and strong medical oversight by primary care physicians.

The bulk of savings to the HealthSelect medical plans is a result of competitive price agreements connected to the more than 50,000 providers that make up the HealthSelect network. Managed care discounts resulted in plan savings of $27 billion over the five-year period from FY15 through FY19. Without managed care, the total potential cost of the plan would have doubled in FY19. Managed care and other cost containment measures reduced plan costs from $12.3 billion in potential costs to $2.5 billion.



The HealthSelect point-of-service plan is built around the importance of an established primary care physician (PCP) in its plan design. To receive the highest level of benefits, the plan requires participants to choose a PCP who is responsible for coordinating patient care and managing referrals needed to see a specialist. By visiting a PCP for preventive and routine visits as recommended, PCPs assist participants in managing their health, which minimizes future cost to the plan. The PCP serves as the centralized source for a patient's medical history and healthcare needs, and also coordinates prior authorizations for certain services.

To incentivize disease management and prevention, the plan has removed financial barriers by instituting zero copays for certain diabetic supplies, weight management programs, and medical virtual visits (for most HealthSelect medical plans). Most recently, to encourage diabetic glucose level monitoring, the HealthSelect point-of-service plan now allows certain no-cost glucometers and test strips through the pharmacy benefit at no cost to members.

ERS also employs value-based payment structures that benefit both the plan participant and the health plan, outlined in the FY19 GBP Annual Report:

- Patient-centered medical homes (PCMHs) participate in a value-based payment program based on quality outcomes that result in savings shared with the providers. Today, nine practices across the state are in the PCMH program, treating more than 70,000 plan participants. These participants typically have lower health care costs than the average plan participant. PCMHs focus on the primary care model while also meeting patients' urgent care needs with extended and evening hours and effectively managing chronically ill and high-risk patients.

- The Episodes of Care Program is a value-based hip and knee replacement pilot program in the Houston area that was created to generate savings to the plan and improve health outcomes for participants receiving certain procedures.

In recent GBP annual reports, the "Best Practices" section details some of the successes of programs implemented by ERS. In addition, several examples of the newest ERS initiatives are listed below.

- With the onset of the COVID-19 pandemic, ERS and the HealthSelect TPA took steps to facilitate access to care. Plan modifications include temporarily waiving the patient cost share for all in-network medical and mental health care through virtual visits and telemedicine visits for a period of time. ERS also temporarily waived in-network referral requirements through May 31, 2020 to allow providers to focus on higher priority items and minimize participant and provider frustration during a time of upheaval in the healthcare industry.

- In addition to increased access to mental health services through virtual visits, the number of network mental health providers more than doubled with the recent expansion of the HealthSelect mental health network on September 1, 2020. The ease in finding a network provider is also simplified through use of the same contact information used by the health plan.

- The new HealthSelectShoppERS incentive program encourages health plan participants to shop for low cost, high quality in-network providers for certain elective medical services, such as CT scans and MRIs. HealthSelectShoppERS rewards smart consumerism by sharing the plan's cost savings with the member via an employer contribution incentive into a TexFlex health care flexible spending account (FSA) or limited purpose FSA.

- In partnership with the largest state agencies, ERS launched the Assess, Manage, and Prevent (AMP) initiative in FY19. By providing state agency leadership with actionable data on the health of their workforce, ERS works with state leadership to support increased employee engagement with preventive care, weight and lifestyle management programs, and online health assessments. Through AMP, ERS and employers support better prevention and condition management among their employees and families. The most prevalent chronic conditions among the covered population are: back and joint conditions, heart disease and diabetes -- conditions that can be managed, and in some cases, prevented, using health plan resources and programs that are the focus of the AMP initiative.

  The Department of Public Safety (DPS) is an example of early success for this initiative. After ERS shared the AMP goals and an agency "report card" on health activity engagement with DPS leadership, the agency extended their wellness incentive to cover more employees who get their annual check-up and engage with their health by completing an online health assessment. Now both non-commissioned and commissioned officers are able to earn time off for these activities, in accordance with Government Code 664. As a result of this policy change and encouragement from top agency leaders, hundreds more DPS employees have completed online health assessments in FY20 and the agency is seeing an uptick in enrollment in online weight management programs.

  This type of multi-agency cooperation and agency leadership support of healthy initiatives can help ERS manage the health care trend and make the state employee workforce a healthier and stronger workforce at a lower cost to Texans.

As referenced throughout this document, ERS publishes an annual report that includes further details on the health plan design, operations, cost management, funding and fraud prevention. The GBP Annual Report is published by February 1 of each year.