Texas Employees Group Benefits Program Annual Report FY19

Employees Retirement System of Texas

FEBRUARY 2020

ERS®
Employees Retirement System of Texas

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200 E. 18th Street
Austin, Texas 78701
www.ers.texas.gov
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Reporting required by Texas Insurance Code, Section 1551.061

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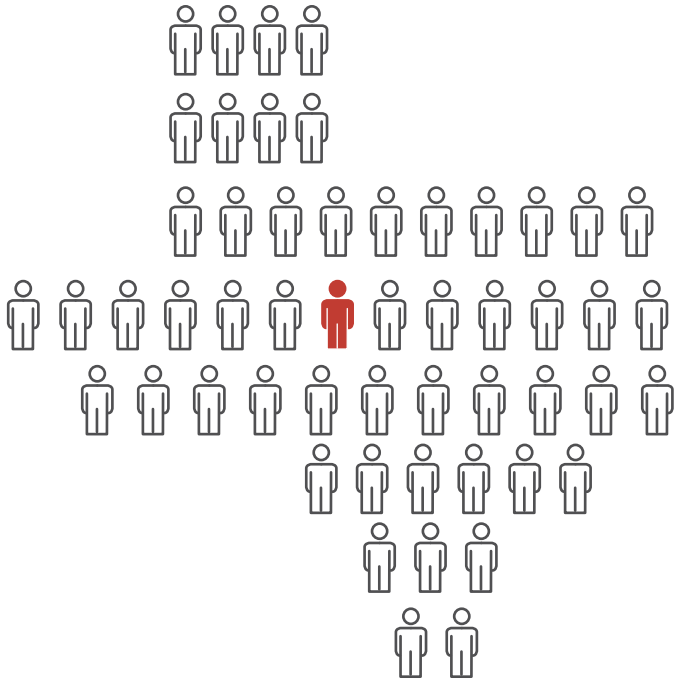
FY19 highlights

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 the City of El Paso!

The State of Texas needs a qualified workforce, and a strong benefits package helps to attract and retain the right people.



HealthSelect insurance premium contribution rates increased 0.47% in Fiscal Year (FY) 2019 and are not expected to change in FY20

Keeping plan costs reasonable is a shared 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

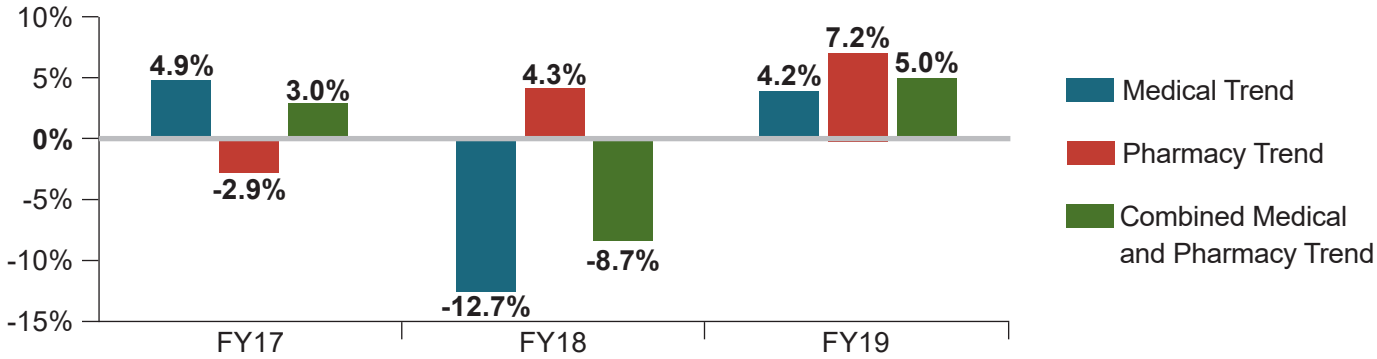
The current third-party administrator (TPA) and pharmacy benefit manager (PBM) contracts continue to generate savings, an estimated $653M in FY19

	TPA Contract	PBM Contract
Program	HealthSelect of Texas®	HealthSelect℠ Prescription Drug Program and HealthSelect℠ Medicare Rx Plan
Awarded to	Blue Cross and Blue Shield of Texas	UnitedHealthcare Services, Inc. (referred to as OptumRx)
Total Projected Savings*	$2.8 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 are larger than initially anticipated and are adjusted annually based on actual experience.

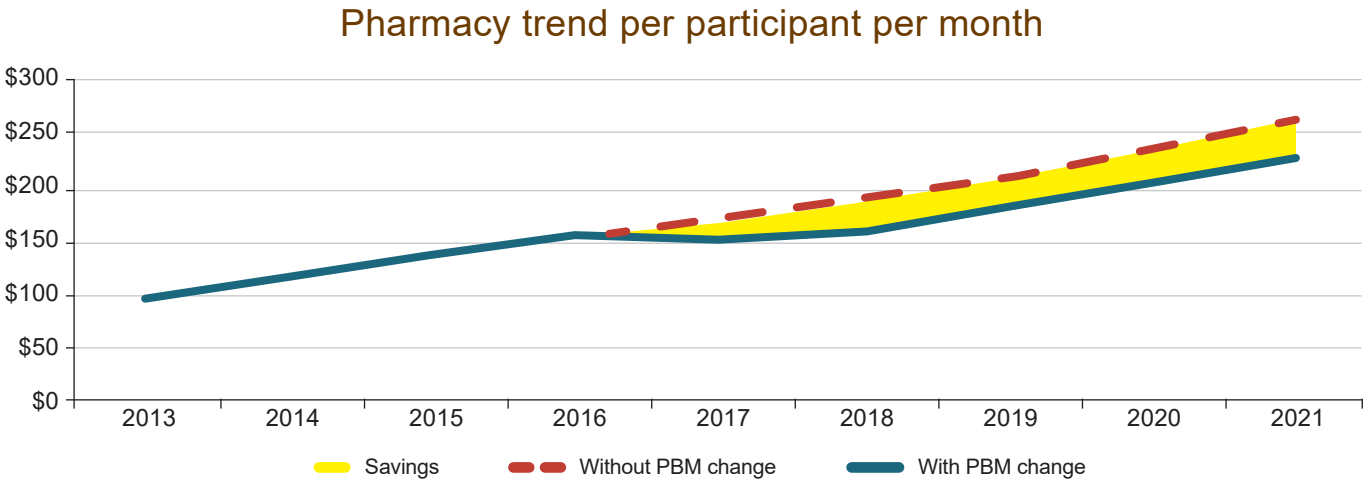
The self-funded HealthSelect plans experienced lower than expected FY19 cost trends

The plans saw one-time reductions in FY17 pharmacy costs and FY18 medical costs due to new contracts with UnitedHealthcare Services, Inc. (referred to as OptumRx) and Blue Cross and Blue Shield of Texas. Subsequently, FY18 pharmacy trend was 4.3% and FY19 pharmacy trend was 7.2%. FY19 medical trend was 4.2%. See Appendix for FY20-21 projection.



After a reduction in FY17 pharmacy costs, the FY18 and FY19 pharmacy trend continued to remain lower than historic trends

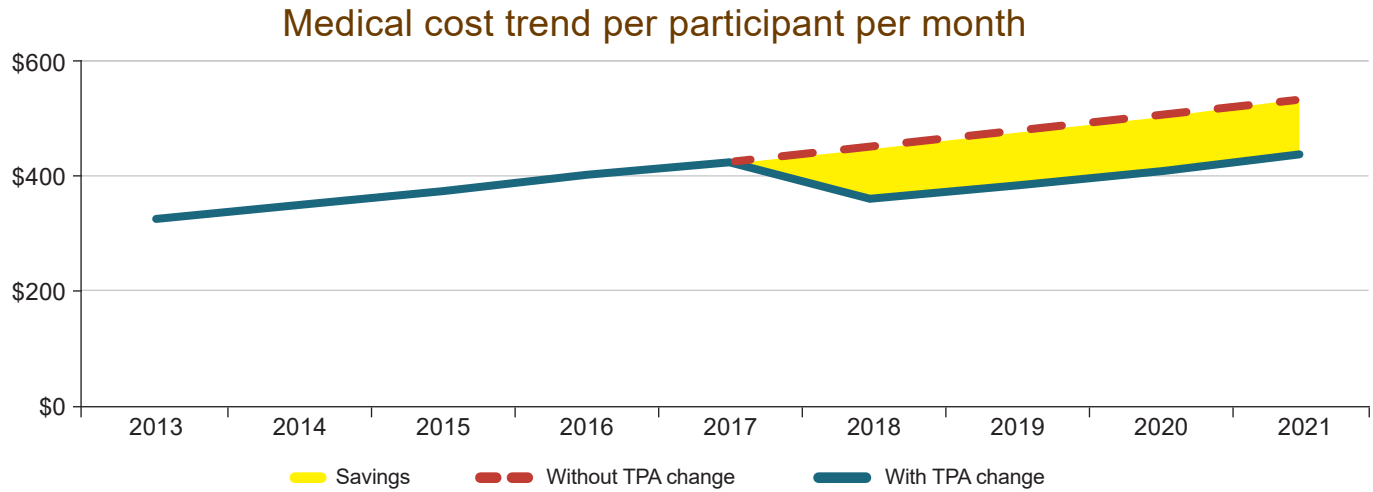
After the transition to the pharmacy benefit manager (PBM) OptumRx on January 1, 2017, the FY17 pharmacy trend was negative and has remained lower in FY18 and FY19 than historic trends. It is expected to return to levels in line with historic trends in FY20 and future years.



Amounts are gross amounts; they do not include rebates.

After changing the HealthSelect of Texas administrator in FY18, the medical plan saved $811M over two years

After changing to Blue Cross and Blue Shield of Texas in FY18, medical costs declined 13% as a result of more competitive provider reimbursement rates and savings on the administrative fee. At 4.2%, the FY19 medical trend was lower than expected, but is expected to return to levels in line with historic trends in FY20 and future years.



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

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

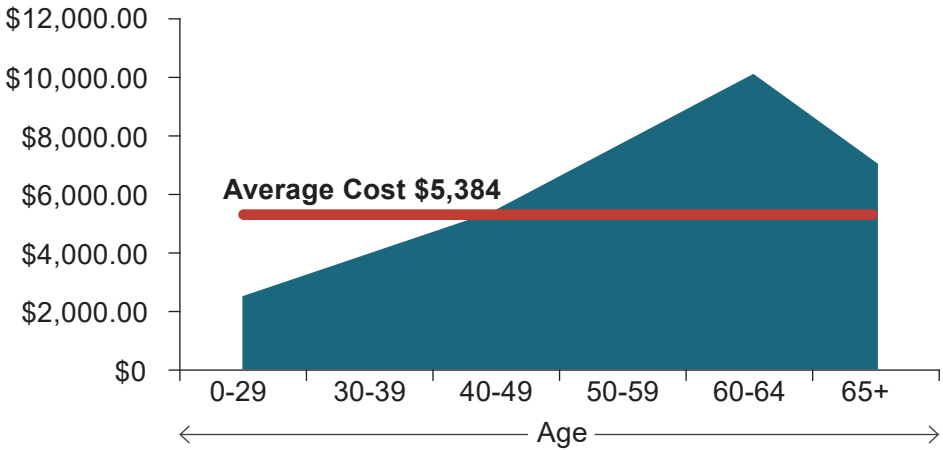
- When members select the point-of-service plan, they and any covered dependents also select a PCP in order to receive the highest level of benefits (in-network).
- A PCP coordinates a participant's care, including management of any referrals needed to see a specialist. Referrals are required to receive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

88% of HealthSelect of Texas participants required to designate a PCP have done so, which is more than in previous years.

HealthSelect participants benefit from a large risk pool

ERS spreads health care costs across nearly a half million participants, keeping the plan affordable for everyone.

HealthSelect average annual claims cost, per participant, by age group, all medical and pharmacy* claims, FY19



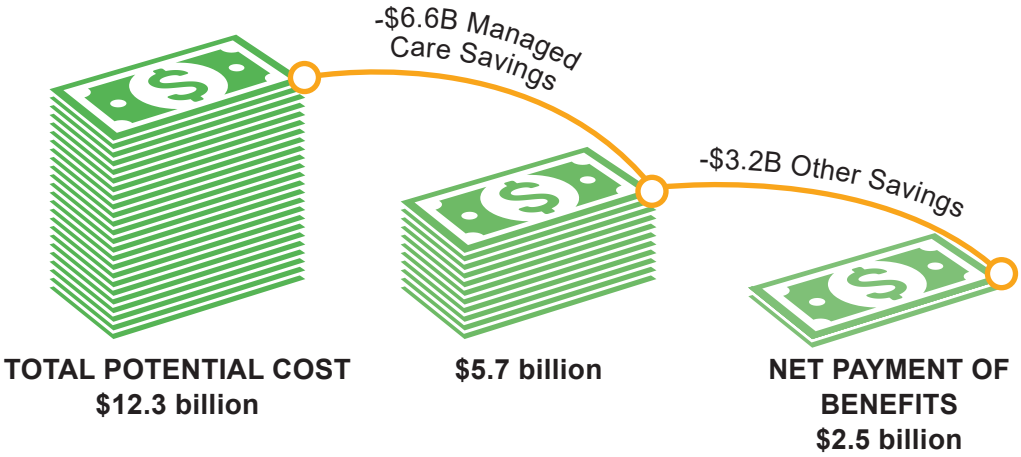
Averaging costs among the participants keeps the plan affordable for all.

*Pharmacy costs are net of rebates.

Effective cost management reduced HealthSelect costs by $9.8B in FY19

Employee health insurance cost the State of Texas more than $2 billion in FY19, so it's important to get the most out of every dollar.

As a result of strategic and effective contracting, the plan paid $2.5 billion in health care costs instead of the $12.3 billion that could have been billed without active plan management.



At a Glance

portion of every HealthSelect dollar spent on administrative costs

HealthSelect of Texas®

Average annual HealthSelect cost per participant: **$5,384**

Annual savings due to dependent eligibility audit: **$5M**

Number of medical claims paid: **5.8M**

Cost of member-only monthly rate without cost-management savings: **$3,025**

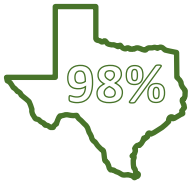
Cost of member-only rate with cost-management savings: **$623**

At a Glance

Savings from cost management practices: **$9.8B**

Number of medical and mental health virtual visits: **44,052** (78% increase over FY18)

Payments to doctors, hospital, pharmacies and other care providers across Texas: **$2.9 billion**



Percentage of GBP participants who live in Texas

Benefits We Offer

...about our plans

HealthSelect of Texas® has been the primary health plan for state agency and eligible public higher education employees since 1992

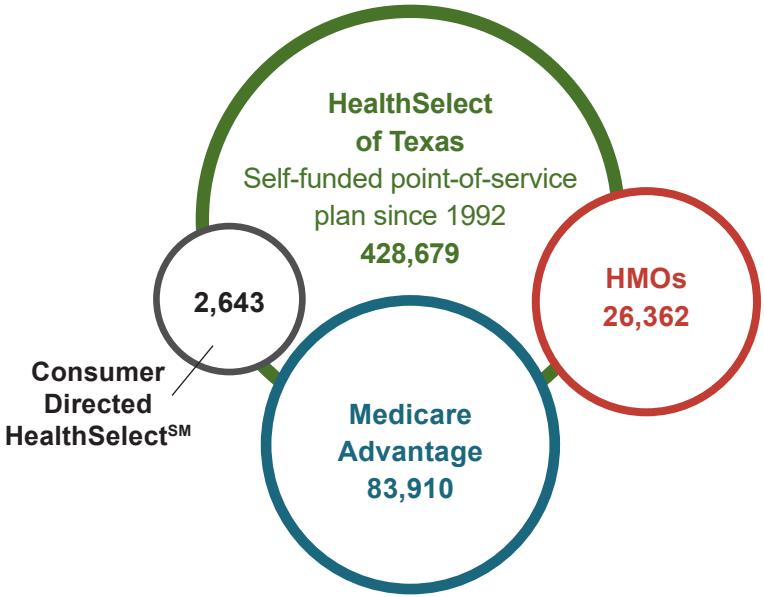
ERS has administered insurance benefits for state agency employees and retirees since 1976.

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

All newly hired state agency employees eligible for health coverage are enrolled in HealthSelect of Texas after a 60-day waiting period, but may opt out or switch to another plan. Important deadlines apply.

79% of all participants enroll in HealthSelect of Texas

August 31, 2019



GBP benefits available in FY19

Health Benefits	Health Benefits for Retirees Enrolled in Medicare	Optional Add-on Benefits
HealthSelect	**HealthSelect**	**Dental Plans**
• Point-of-service plan • Consumer directed health plan • Out-of-state plan • Prescription drug program	• Medicare Advantage preferred provider organization (PPO) • Secondary plan • Employer Group Waiver prescription drug plan (EGWP)	• Dental PPO • Dental HMO • Dental Discount Plan
Health Maintenance Organizations (HMOs)	**HMOs**	**Vision Insurance**
• 3 Regional HMOs in Houston, San Antonio, and central Texas areas	• 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

GBP health insurance choices – FY19 benefit highlights

	HealthSelect of Texas (point-of-service plan)	**Consumer Directed HealthSelect** (HDHP with HSA)	**Regional HMOs**	**HealthSelect Medicare Advantage (MA) PPO**	**Medicare Advantage (MA) HMO**
Administrator/ Insurance Carrier	Blue Cross and Blue Shield of Texas		Community First; Scott & White; KelseyCare powered by Community Health Choice*	Humana Insurance Company	KelseyCare Advantage MA
In-network Deductibles	$50 prescription drug deductible	$2,100 individual; $4,200 family	$50 prescription drug deductible	$50 prescription drug deductible	
Copays/Coinsurance?	Yes/Yes	No/Yes	Yes/Yes	No/Yes	
PCP designation required?	Yes	No	Only for Community First Health Plans	No	No
Referrals Needed for Specialty Care?	Yes	No	Subject to HMO rules	No	Only for non-Kelsey-affiliated specialists
Out-of-network benefits available?	Yes	Yes	No, except for emergency care	Yes	No, except for emergency or urgently needed care

* KelseyCare powered by Community Health Choice HMO withdrew from the GBP on August 31, 2019

Consumer Directed HealthSelect

Beginning September 1, 2016, GBP members could 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.

CONSUMER DIRECTED HealthSelect℠

2019 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, but funds used for something other than payment for eligible medical expenses are subject to income tax.

HSA contributions and maximums for CY19

	Individual Coverage	Family Coverage
Annual Maximum Contribution	$3,500	$7,000
Annual State Contribution	$540 ($45 monthly)	$1,080 ($90 monthly)
Annual Maximum Participant Contribution, add $1,000 "catch-up" contribution for age 55 and older	$2,960	$5,920

HSA Activity (January 1 – August 31, 2019)	
Number of Accounts Active	1,605
Average Account Balance	$1,347
Average Employee Monthly Contribution	$214

Regional health maintenance organizations (HMOs) in FY19

In the San Antonio area

COMMUNITY FIRST HEALTH PLANS
Keeping Our Commitment to You

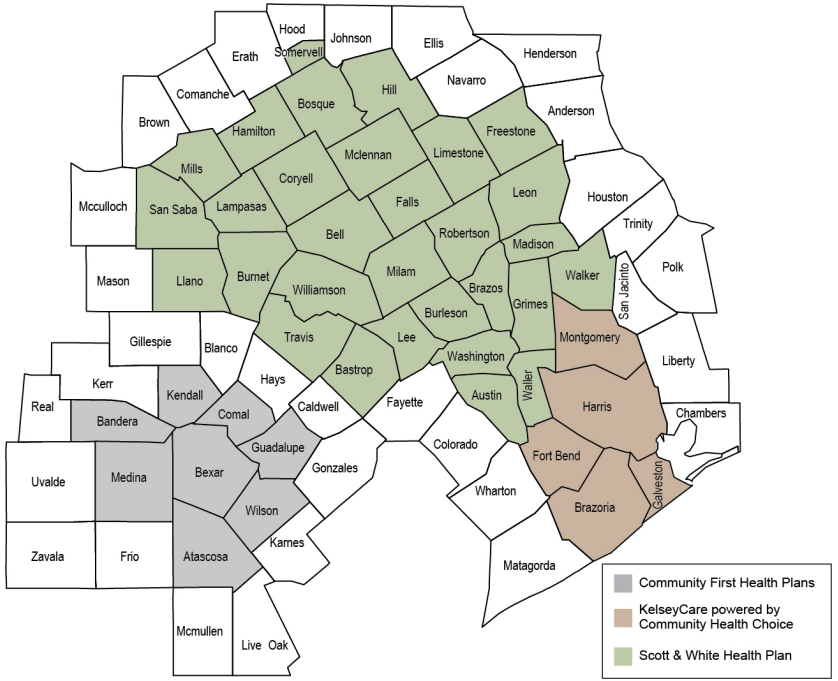
In the Houston area

(withdrawn in FY20)

KelseyCare powered by COMMUNITY HEALTH CHOICE

In central Texas

Scott&White HEALTH PLAN



Health insurance is also available to eligible retirees

In addition to the HealthSelect and HMO plans, the GBP offers eligible retirees two Medicare Advantage (MA) options with lower dependent premiums and no deductible:

- **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 Medicare-enrolled retiree with dependent coverage will pay lower premiums with no deductible.

HealthSelect of Texas Medicare Advantage Plan

KelseyCare Advantage

76% of eligible Medicare retirees and their eligible spouses enrolled in the MA plans, while the rest remained in HealthSelect of Texas or an HMO.

All enrolled health plan participants have prescription drug coverage

HealthSelect℠ 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 OptumRx.

HealthSelect Medicare Rx is a self-funded employer group waiver program with a wraparound feature (EGWP + Wrap) 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 UnitedHealthcare Services, Inc. HealthSelect Medicare Rx also applies to GBP Medicare Advantage participants.

HealthSelect of Texas Prescription Drug Program | HealthSelect of Texas Medicare Rx

Health Select of Texas 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
*not applicable to Consumer Directed HealthSelect

The GBP includes a range of optional add-on (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**	**FY19 TPA/Insurer**	**FY19 Enrollment**
Dental	PPO	Self-funded	HumanaDental Insurance Co.	332,327
	HMO	Fully insured	DentiCare, Inc. (subsidiary of Humana)	115,605
Vision	Vision insurance	Self-funded	Superior Vision Services	224,154
Optional Life	Group term insurance	Fully insured	Minnesota Life Insurance Co.	216,741
Dependent Life				105,938
Voluntary AD&D	Group term insurance	Fully insured	Minnesota Life Insurance Co.	129,383
Texas Income Protection Plan (Disability Insurance)	Short-term	Self-funded	ReedGroup	112,519
	Long-term	Self-funded		85,937
State of Texas Dental Discount Plan℠ (not available in FY20)	Discount (non-insurance) program	NA	Careington International	8,970
TexFlex	Flexible spending accounts	NA	WageWorks	48,568

Dental and vision

The GBP offered three optional dental benefit programs and vision coverage in FY19:

- **State of Texas Dental Choice Plan**[SM] 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**[SM], a non-insurance discount program offering discounts on dental treatment and services at participating providers (not available through the GBP in FY20)
- **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

FY19 flexible spending accounts (FSAs)

TexFlex℠

ERS offers four tax-advantaged savings options

Health Care FSA	Limited Purpose Health Care FSA	Dependent Care FSA	Commuter Reimbursement
§ 125 Reimbursement Plan	§ 125 Reimbursement Plan	§ 125 Reimbursement Plan	§ 132(f) Reimbursement Plan
Maximum contribution: $2,650 per member per fiscal year	Maximum contribution: $2,650 per member per fiscal year	Maximum contribution: $5,000 per household per fiscal year	Qualified parking benefit: $255 monthly Qualified transit benefit: $255 monthly
Eligible expenses include: • Copays & coinsurance • Dental expenses • Eyeglasses/Lasik/contacts • Medical supplies • Some over-the-counter products	Available to Consumer Directed HealthSelect participants for eligible: • Vision expenses • Dental expenses	Eligible expenses: • Day-care expenses for eligible dependent children or adults	Eligible expenses, parking: • Parking* Eligible expenses, transit: • Mass transit* • Vanpool*
$500 allowable carryover	$500 allowable carryover	Eligible for grace period	Not subject to forfeiture during employment
Subject to forfeiture	Subject to forfeiture	Subject to forfeiture	
Accounts: 44,620	Accounts: 86	Accounts: 3,572	Accounts: 290

*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 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 Term Life Insurance at no cost to the retiree.

When hired, an employee may elect **Optional 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. An employee's Optional Term Life election provides an equal amount of additional AD&D coverage. The amount of life insurance may not exceed $400,000 with a corresponding amount of AD&D coverage.

This 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 Term Life and AD&D insurance.

securian FINANCIAL™

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 Plan[SM] 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 income, when the employee is determined by a doctor to be totally disabled.

Summary of insurance benefit changes from FY19 to FY20

Health insurance premium changes

As of September 1, 2019:

- HealthSelect plans - no increase
- Community First Health Plans HMO - no increase
- Scott & White Health Plan HMO - 3.3% decrease
- KelseyCare powered by Community Health Choice HMO – withdrew from the GBP on August 31, 2019

As of January 1, 2020:

- HealthSelect Medicare Advantage, a Medicare Advantage PPO
  - No increase in member-only rate
  - 1.0% increase for member and spouse coverage
  - 1.1% increase for member and child coverage
  - 1.4% increase for member and family coverage
- KelseyCare Advantage, a Medicare Advantage HMO - 3.9% increase

GBP Plan Changes (Fiscal Year 2019 – present)

Fiscal Year 2019	All HealthSelect plans	Added mental health virtual visits at the same benefit level as an in-network mental health office visit.
	HealthSelect of Texas, HealthSelect Out-of-State, and Consumer Directed HealthSelect	Through partnership with The University of Texas MD Anderson Cancer Center, launched the mobile mammography initiative, bringing onsite mobile mammogram screenings to eligible participants in the Houston area, at no cost to participants or the plan.
	Consumer Directed HealthSelect	Removed out-of-network total out-of-pocket maximum to align with all the other non-Medicare Advantage plans, which do not apply any maximums to out-of-network services.
	All non-Medicare Advantage health plans	Removed $1,000 benefit limit for hearing aids for eligible minors age 18 and under, who may, if eligible, also receive coverage for one cochlear implant per ear with internal replacement as medically necessary.
		Increased the total out-of-pocket maximums to $6,650 per individual and $13,300 per family for the non-Medicare Advantage plans to align with IRS maximums.

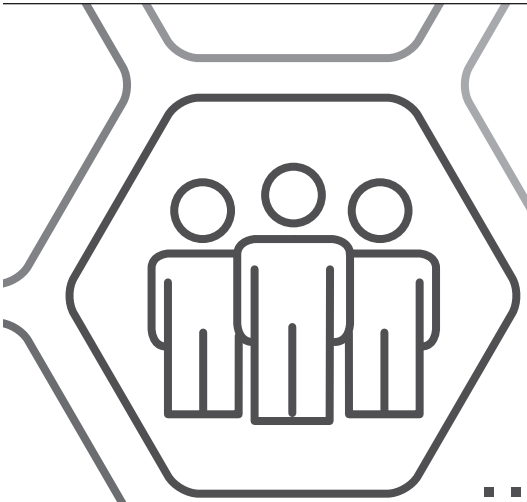
GBP Plan Changes (Fiscal Year 2019 – present) continued

Fiscal Year 2019	State of Texas Dental Choice PPO	• Increased individual annual benefit maximum to $2,000 (from $1,500) for basic and restorative services. • Removed age limit for orthodontic services. • Removed exclusion and benefit limitations related to missing tooth replacement. • Removed 40% expanded benefit coverage for out-of-network services once the benefit maximum is met. • Removed the requirement to have a tooth extracted while insured with ERS for obtaining an implant, denture, bridge or partial.
	State of Texas Vision	• The Opt-Out Credit available to participants who decline GBP health coverage may now be applied to the State of Texas Vision plan. • Reduced annual eye exam copay from $25 per visit to $15 per visit. • Modified the frequency for vision benefits from 12 months from date of service to once each plan year.

GBP Plan Changes (Fiscal Year 2019 – present) continued

Fiscal Year 2020 (September 1, 2019 - January 1, 2020)	All HealthSelect plans, excluding HealthSelect MA	Changed allowable amount for out-of-network emergency services received on or after January 1, 2020 from 100% of billed charges to 100% of the BCBSTX average contracted rate for PPO network hospitals and providers.
	All non-Medicare Advantage plans	Increased the total out-of-pocket maximums (for medical plans) to align with IRS maximums.
	KelseyCare powered by Community Health Choice HMO	Houston-area HMO voluntarily withdrew from the GBP on August 31, 2019.
	State of Texas Dental Discount Plan	No longer available under the GBP. Dental discount plans may be accessed through the Discount Purchase Program™, administered by Beneplace, Inc.
	TexFlex	Implemented a 60-day waiting period for new employees that coincides with health plan enrollment.

Whom We Serve



...about our members

Who can enroll in the GBP?

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

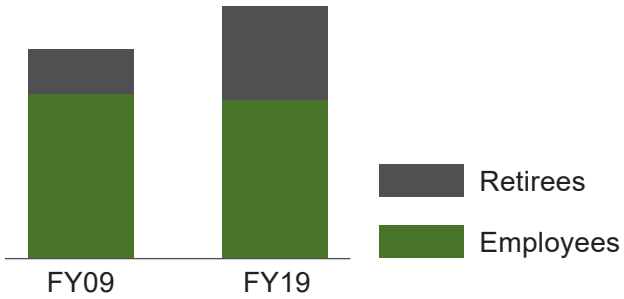
Of those enrolled in health insurance plans:

- The average age of a GBP member is 54.
- About one-third work in higher education.
- The retiree population has grown 53% over 10 years.

GBP health insurance enrollment

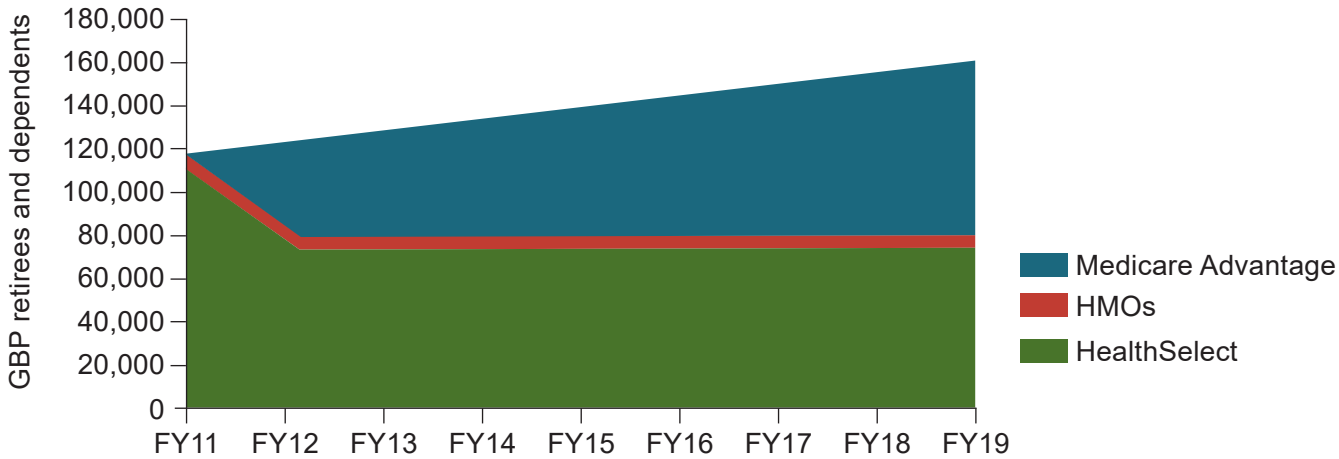
(not including dependents)

	FY09	FY19	% Change
Employees	214,139	213,518	-0.3%
Retirees	76,770	117,784	53.4%
Total	297,632	331,302	13.9%



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

Participation in retiree plans steadily shifted to Medicare Advantage since its introduction in FY12



Retirees choosing MA plans saved $61.5 million in dependent premiums in FY19.

The GBP health plan member demographics in FY19

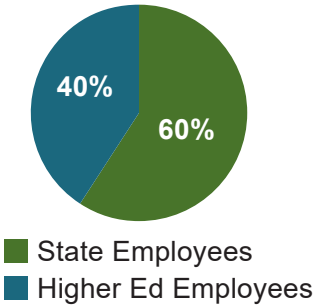
	Active Employees	Pre-65 Retirees	65+ Retirees	All Members*
Total Number	213,518	34,555	83,229	331,302
Average Member Age	45 years	59 years	74 years	54 years
Average Dependent Age	22 years	38 years	68 years	29 years
% Who Enroll Dependents	37%	29%	25%	33%
Gender	58% female 42% male	54% female 46% male	54% female 46% male	57% female 43% male
Tenure	9 years	25 years	21 years	14 years
Place of Employment	67% agency 33% higher ed	86% agency 14% higher ed	71% agency 29% higher ed	70% agency 30% higher ed

*Members include active employees and retirees only. It does not include dependents, survivors, COBRA or other miscellaneous groups.

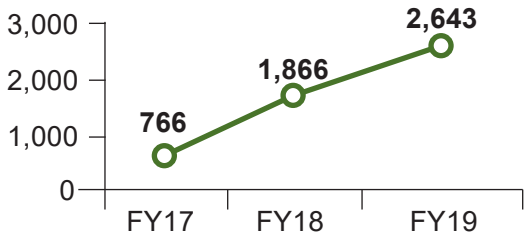
FY19 Characteristics of Consumer Directed HealthSelect enrollees

- 2,643 participants, as of August 31, 2019
- Average member age of 42 years old, compared to 50 years in other plans, excluding Medicare Advantage plans

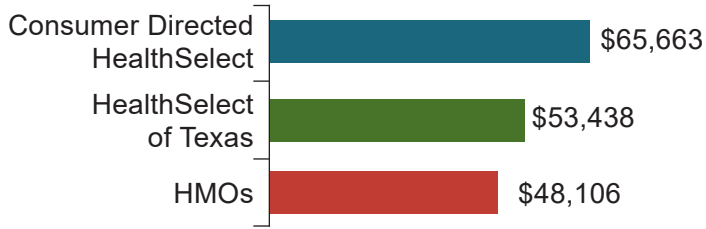
40% of employees enrolled in Consumer Directed HealthSelect are higher education employees, compared to 30% in other GBP health plans



Enrollment in Consumer Directed HealthSelect has more than tripled in three years



Employees enrolled in Consumer Directed HealthSelect typically earned $12,225, on average, per 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.

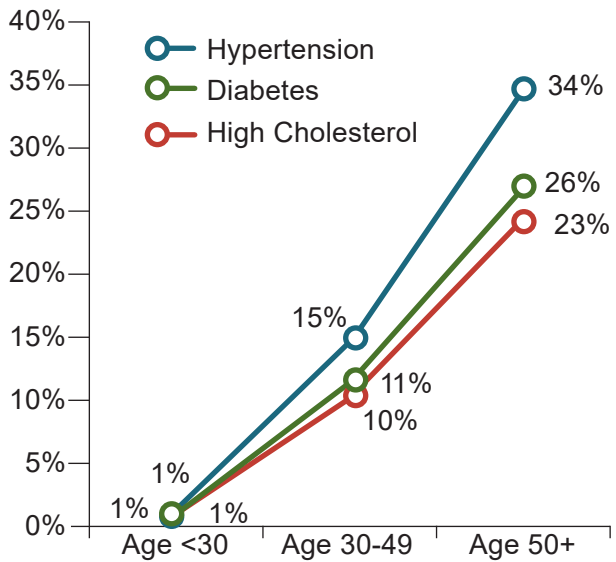
The average age of a GBP member (both employees and retirees) is 54.

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

Source: BCBSTX Healthcare Economics Team

Percentage of FY19 HealthSelect population living with chronic conditions

(Medicare population not included)

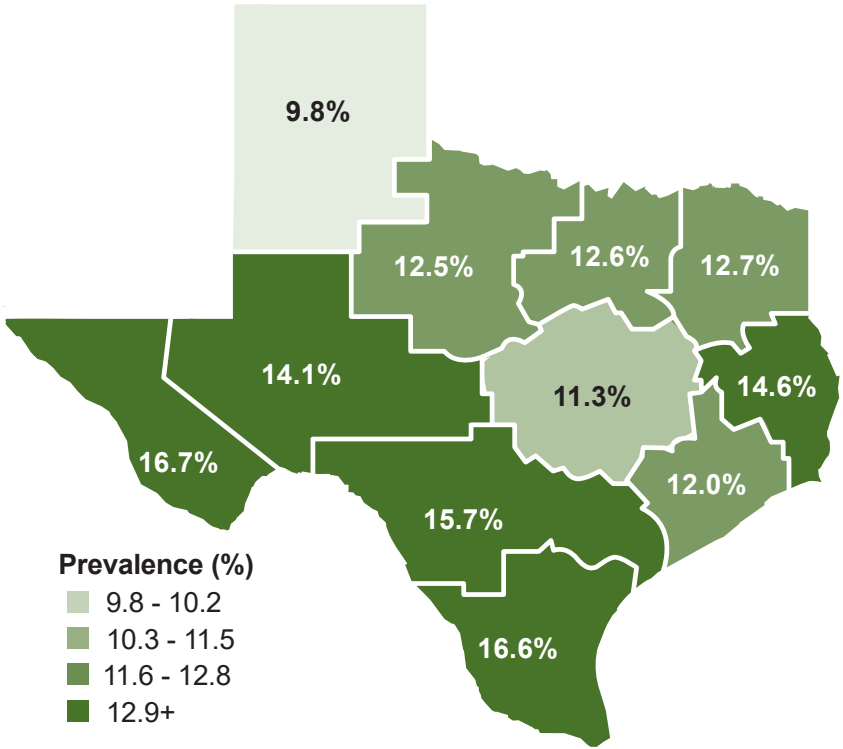


Certain regions have higher rates of diabetes, which continue to grow

Diabetes prevalence among the top 10 agencies is highest among employees at the Health and Human Services Commission (14.1%) and the Texas Department of Criminal Justice (12.0%).

*FY19 Medicare-primary population excluded

Source: BCBSTX Healthcare Economics Team



How to be a smart health care consumer

…get the most out of the HealthSelect of Texas plan and avoid unexpected costs

The HealthSelect of Texas point-of-service plan

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

A primary care provider (PCP) ensures that HealthSelect participants receive appropriate care and avoid unnecessary services.

- HealthSelect members are required to select a PCP for in-network benefits.
- The PCP manages a patient's care by providing appropriate referrals to in-network specialists.
- Patients must have a referral for specialists to receive in-network benefits.

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 Members.

Stay in the Network

The HealthSelect network includes more than 50,000 health care providers across Texas. You'll pay less if you see an in-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 provider (PCP) manage your care, referrals, prior authorizations, medications and more.*

Get Preventive Care

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

Talk to Your PCP

Before you see a specialist, talk to your 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.

*HealthSelect℠ Secondary, Consumer Directed HealthSelect and and HealthSelect Out-of-State participants are not required to get a referral before getting care. Call a BCBSTX Personal Health Assistant to find out if your plan requires a referral or prior authorization.

Essential Tools

BCBSTX, the administrator for the non-Medicare Advantage HealthSelect plans, 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.

- **BCBSTX HealthSelect Provider Finder*** is an online directory of in-network providers. Visit **www.healthselectoftexas.com** and select the box that applies to your coverage and select your zip code

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

*To download the mobile app, text BCBSTXAPP to 33633

How a BCBSTX Personal Health Assistant can help you:

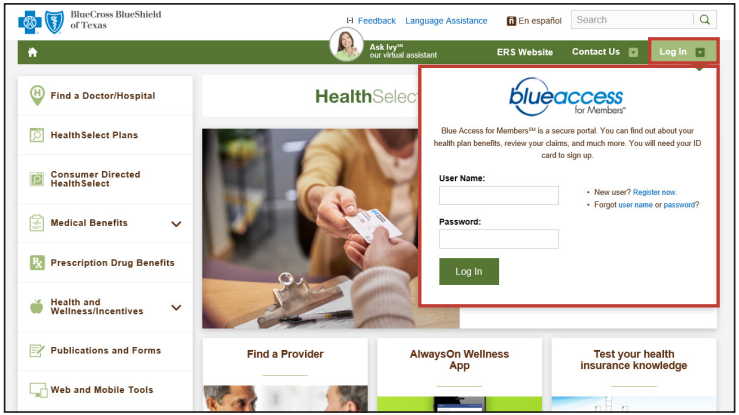
- Answer questions about benefits
  - Assist with prior authorizations and referrals
  - Provide information about HealthSelect programs and benefits
- Explain health care costs and options for care
  - Locate in-network options
  - Schedule or cancel appointments
- Connect you to other resources
  -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

Call toll-free (800) 252-8039, Monday-Friday 7 a.m. – 7 p.m., and Saturday 7 a.m. – 3 p.m.

Blue Access for Members (BAM) Participant Portal

BAM Portal Features:

- View your claims, download EOBs
- Find in-network doctors, hospitals and providers
- Select or change a primary care provider
- Check estimated costs of providers and services
- Download a temporary ID card
- Confirm prior authorizations and referrals are in place



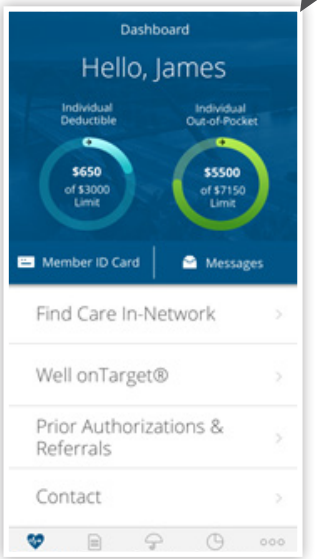
To register you will need your ID number on the front of your ID card OR you can call a BCBSTX Personal Health Assistant

www.healthselectoftexas.com
To download the mobile app, text BCBSTXAPP to 33633.

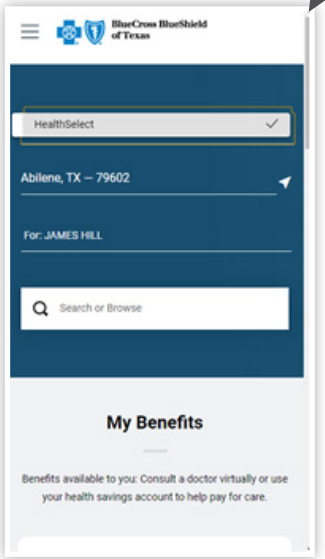
Mobile access

BCBSTX Mobile App – Text BCBSTXAPP to 33633 for a link to download

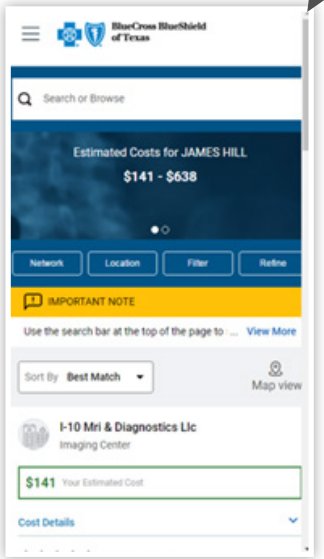
Dashboard



Provider Finder



Cost Estimator



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 BCBSTX before you visit an in-network HealthSelect 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 retail health 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 your provider sends the collected sample 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 an out-of-network center, 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 in-network 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 in-network 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 asking the provider, calling a BCBSTX Personal Health Assistant, logging into your BAM account and using the Cost Estimator, or asking your provider.

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 HealthSelect of Texas participant scheduled to visit an orthopedic surgeon recommended by her PCP. She called a BCBSTX Personal Health Assistant (PHA) to find out how much the visit will cost. The PHA told Yolanda she will have a $40 copay to this in-network specialist as long as she has a referral on file from her PCP. Without the referral, she would be responsible for more of the specialist's $120 charge, even though the specialist is in network, because the visit would be considered out of network without a referral.

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	$120	$120	
Deductible	N/A	$500	
Copay	$40	N/A	
Coinsurance	N/A	$48 (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: Call a BCBSTX Personal Health Assistant at (800) 252-8039 or log onto your Blue Access for Members account to confirm that BCBSTX has approved your PCP's referral (or that it has not expired) before your office visit with a specialist. If it's not on file, contact your PCP immediately.

David visits an orthopedic surgeon and did not check network status

David is a HealthSelect of Texas participant who visited an out-of-network orthopedic surgeon. David did not check the surgeon'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

Smart Consumer Tip: Ask your PCP for a referral to an in-network specialist or call a BCBSTX Personal Health Assistant at (800) 252-8039 for help. You may also search the BCBSTX Provider Finder on your mobile device or computer.

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 decided to visit a nearby acupuncturist, expecting to receive out-of-network benefits. Feeling 100% 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 health care flexible spending 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.

Primary Care Provider (PCP) 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 PCP 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 Primary Care Provider'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.

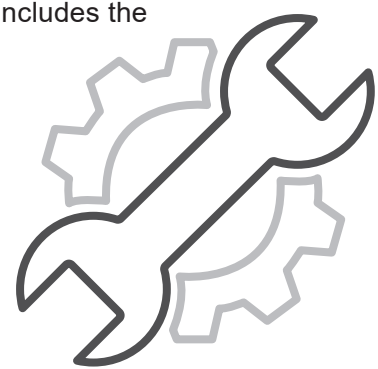
Freestanding Emergency Rooms —$$$$$$ (Average Out-of-Pocket Cost)

Most freestanding emergency room facilities and providers are out of network, so your share of the bill could be 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

In addition to the essential tools listed on page 41, here are helpful tools to help you find the care you need while avoiding surprise medical bills and unnecessary delays.

- **Nurseline** is available 24/7 to answer questions about where to go for care or medical concerns. (800) 581-0368
- **HealthSelect Mental Health Support Line** is available 24/7 for mental health care crises and support. (800) 442-4093
- **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

The appeals process

ERS publishes 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 TPA's or insurer's website.

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

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

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

Important deadlines apply in 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
- Consumer Directed HealthSelect
- State of Texas Dental Choice
- State of Texas Vision
- Life Insurance, including Basic Term Life, Optional Term Life, Dependent Term Life
- Accidental Death & Dismemberment, including Basic AD&D, Voluntary AD&D, Dependent AD&D
- Texas Income Protection Plan (short- and long-term disability insurance)

ERS does not consider appeals for the HealthSelect Prescription Drug Program, Medicare Advantage PPO Plan or any HMO plans, including Medicare Advantage HMO Plan and the dental HMO plan. Participants in the HealthSelect Prescription Drug Program appeal to OptumRx. Participants in the Medicare Advantage plans and any HMO plan 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 2019 plan year, for instance, roughly 5.8 million HealthSelect medical claims were paid on behalf of participants.

Second Internal Appeals to ERS									
Fiscal Year	Number of Grievances by Insurance Type								
	HealthSelect	EOI*	Disability	Life	Dental	TexFlex	Other**	Total	% Change
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%
FY19	145	0	38	3	11	5	0	202	-39%

*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 Trends

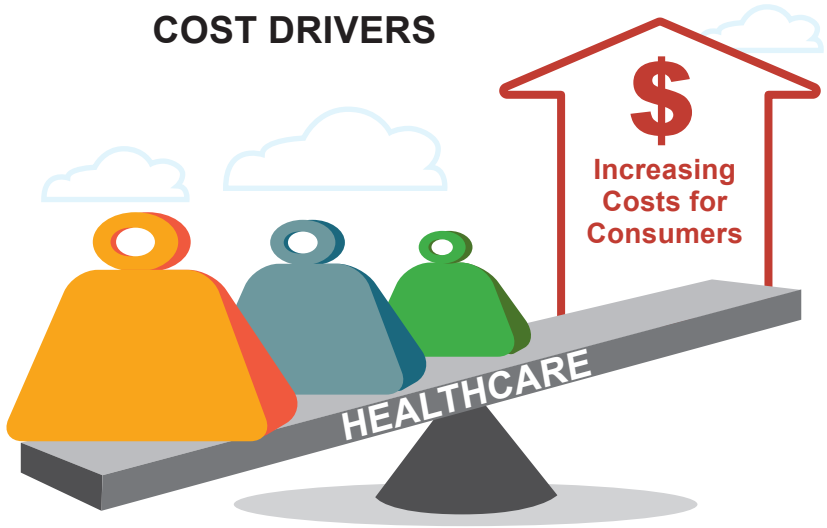
...about the marketplace

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.



Projected annual health FY20-21 plan cost trend is 7.3%

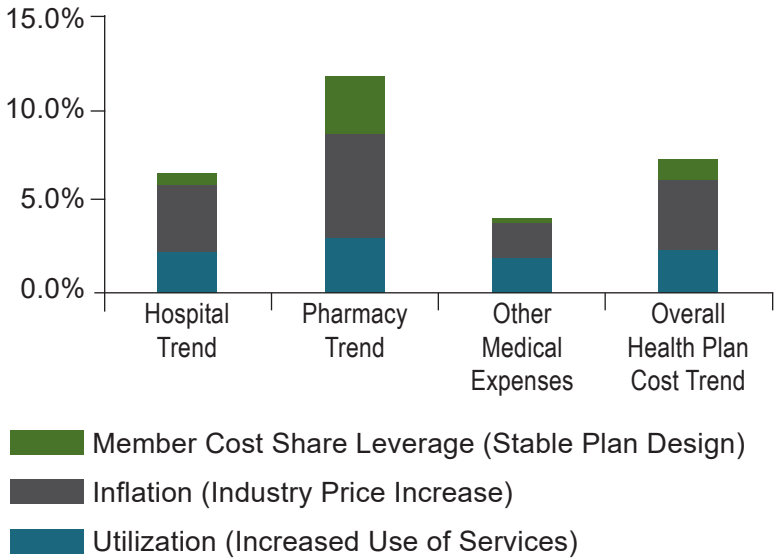
The major components of the benefit cost trend are increases in:

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

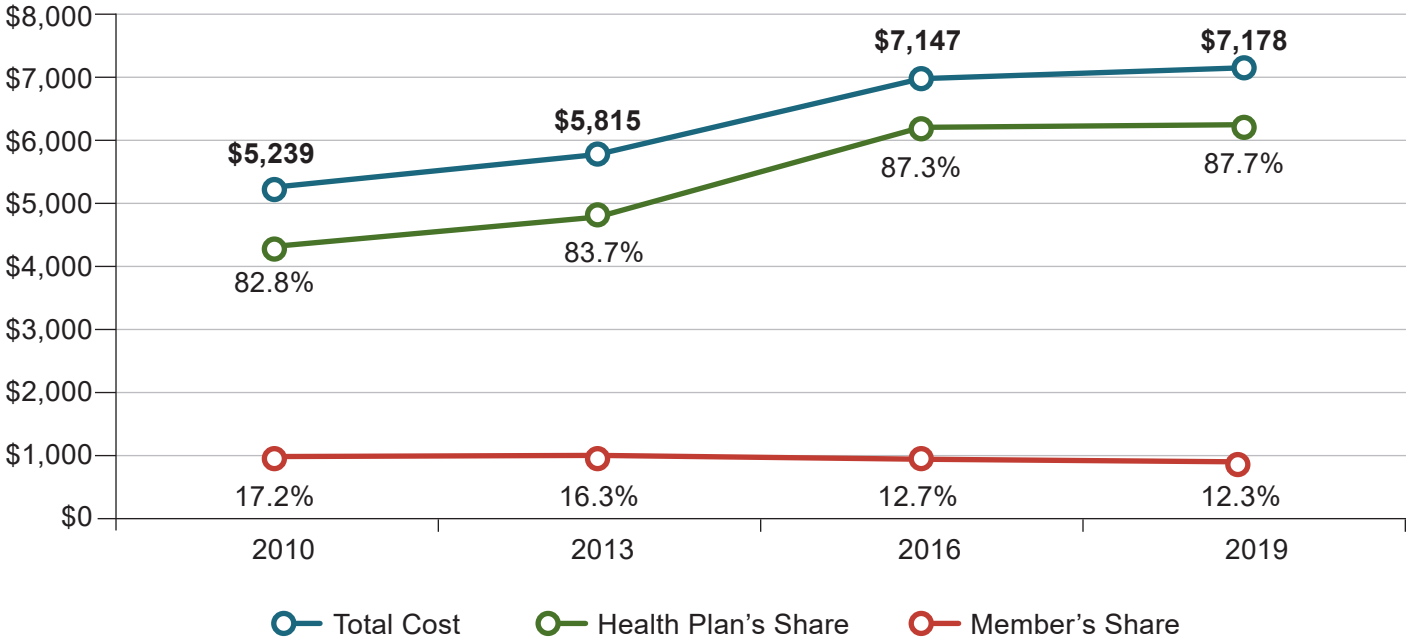
These cost drivers are common to all plans, not just HealthSelect.

Industry price increases continue to be the primary cost driver

(projected HealthSelect benefit cost trends, FY20-21)



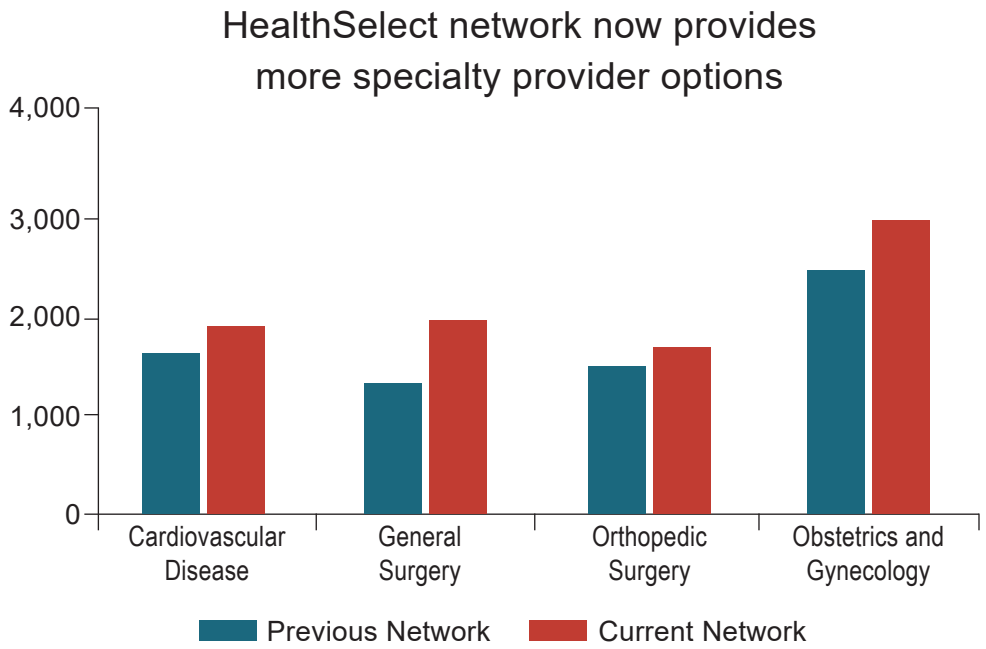
The state has paid for increases in plan cost



Access to high quality providers continues to grow

The creation of the broad HealthSelect-specific provider network offers more choices to HealthSelect participants. The network includes more PCPs and high-volume specialists than before.

The number of PCPs in the current network is 14,979, a 20% increase compared to 12,414 in the previous network at the time of TPA transition.



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 requirement by the 85th Legislature, ERS took several steps to reduce FSER cost.

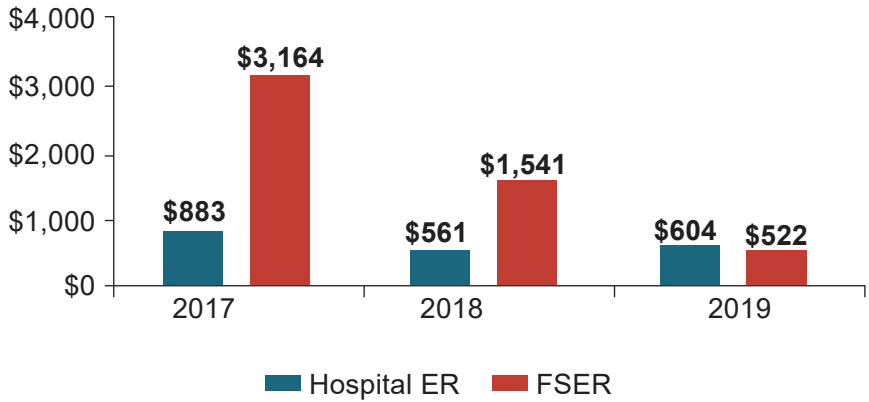
- Beginning January 1, 2018, HealthSelect plans stopped paying billed charges to out-of-network FSERs. HealthSelect plans now pay an allowed amount to these facilities, similar to using a contracted allowable rate for payment to a hospital-based emergency department.
- On September 1, 2017, ERS imposed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

In FY19, a HealthSelect participant who received a balance bill from any out-of-network FSER exceeding $500 could request mediation from the Texas Department of Insurance. Beginning January 1, 2020, with the enactment of Senate Bill 1264, out-of-network facilities and providers cannot balance bill insurance plan participants for emergency services.

FY18 changes to out-of-network FSER reimbursement reduced costs by $38.6M in FY19

ERS achieved the biennial savings required in the FY18-19 General Appropriations Act Rider 15 ($26.1 million in GR and $42.2 million in All Funds), passed by the 85th Legislature.

The average amount HealthSelect paid per visit to freestanding ERs decreased significantly

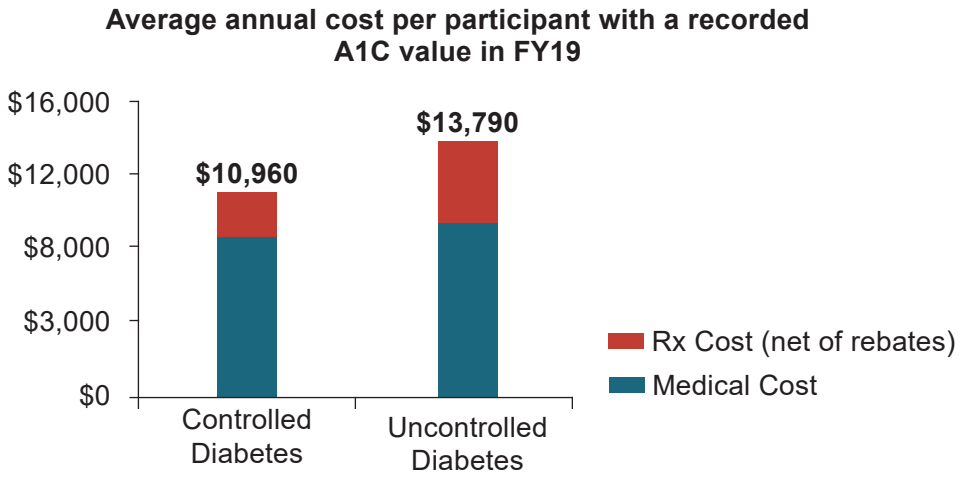


Controlling diabetes with medication benefits both the participant and the plan

Uncontrolled diabetes drives costs when it leads to ER visits and hospitalization.

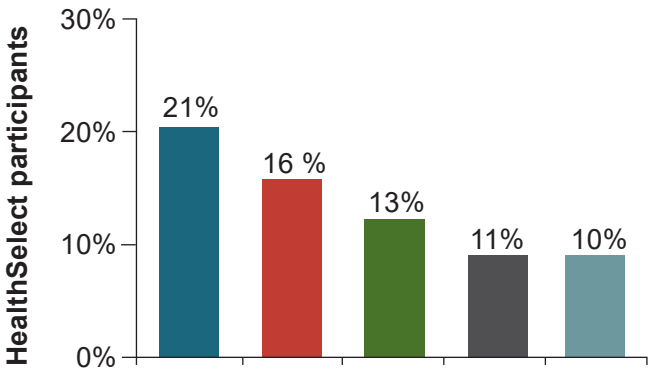
In FY19, participants with uncontrolled diabetes had 25% more emergency room visits and 25% more inpatient admissions than those with controlled diabetes.

Average costs are 26% higher for a participant with uncontrolled diabetes, compared to a participant with controlled diabetes

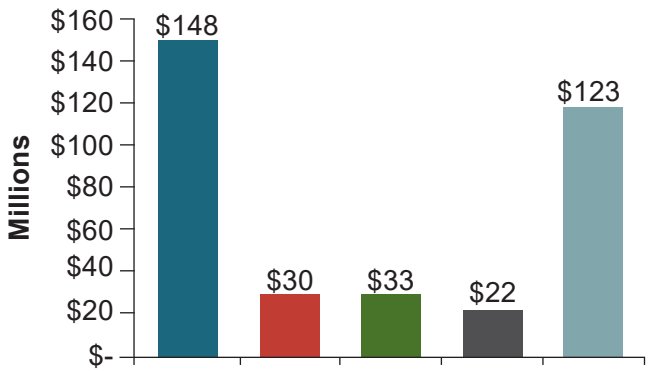


In FY19, back and joint pain was the most expensive chronic medical condition in the HealthSelect plans

Prevalence of top 5 chronic medical conditions within HealthSelect population



Medical costs for top 5 chronic conditions*



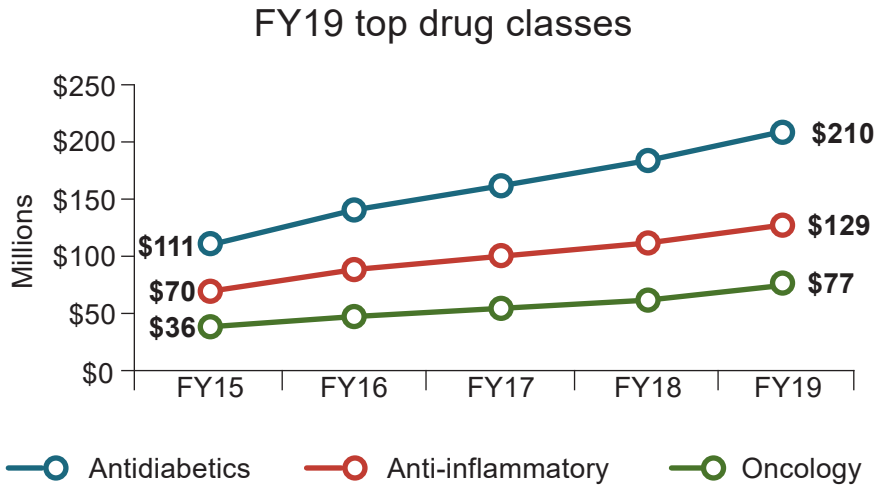
Back Pain/ Joint Pain | Hypertension | Diabetes | Mental Health/ Substance Abuse | Heart Disease

*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 3 highest-cost drug therapy classes

The diabetic therapy class is the fastest growing drug class, with five of the top 10 highest-cost prescription drugs.

Factors driving increases include drug prices and utilization.



Note: Amounts are gross, not net of rebates.

Hepatitis C drugs

In FY15, drugs treating Hepatitis C were among the costliest drug classes at $41.3 million.

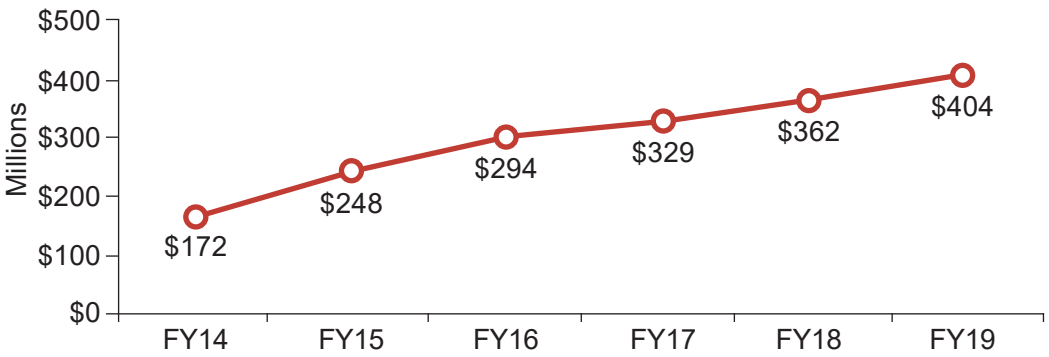
Since then, gross cost has fallen to $6.5 million in FY19.

More than half of this amount is offset by manufacturer rebates.

Specialty drugs represented 1% of all prescriptions filled but 38% of prescription drug costs in FY19

The plan paid $404 million, before applying rebates, for approximately 89,000 specialty claims.

Specialty drug costs have increased 135% in 5 years



Amounts are gross amounts, not net of rebates.

Top Five Specialty Conditions

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

Best Practices

...successes and new programs

Changing the Script: addressing the opioid epidemic

Changing the Script was created by ERS in 2017 as a unique, collaborative approach to address the opioid epidemic through a comprehensive health plan strategy.

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

Changing the Script is an ongoing 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)

Compliance with recent Centers for Disease Control (CDC) guidelines continues to reduce the number of opioid utilizers. The program shows meaningful potential to help curb the opioid epidemic.

Reduction in Utilizers From CY17 to CY18

	Short-acting Opioids (SAO)	Long-acting Opioids (LAO)
Total Utilizers	-35.0%	-69.8%
Treatment-Experienced*	-56.5%	-67.9%
New-to-Therapy**	-36.4%	-91.3%

* 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

Changing the Script (continued)

Compliance with recent CDC guidelines and the Changing the Script program continued to drive down the number of utilizers. The table below illustrates continued success with this program.

Reduction in Utilizers From CY18 to CY19

	Short-acting Opioids (SAO)	Longacting Opioids (LAO)
Total Utilizers	-9.0%	-27.6%
Treatment-Experienced*	-28.7%	-27.8%
New-to-Therapy**	-6.9%	-14.9%

* 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

Medicare Advantage plans are designed for a senior population

Medicare Advantage plans are a type of Medicare health plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits, and additional value-added features typically not covered by Medicare.

ERS makes two Medicare Advantage plans available to retirees. Premiums are lower in the Medicare Advantage plans for Medicare-enrolled dependents and retirees whose premiums aren't fully paid by the state.

HealthSelect of Texas
Medicare Advantage Plan

A Medicare Advantage PPO plan

- Available nationwide – participants may see any physician who accepts Medicare
- When compared to original Medicare, no deductible and no (or low) out-of-pocket costs
- Prescription drug coverage by HealthSelect Medicare Rx administered by UnitedHealthcare

Medicare Advantage plans (continued)

A Medicare Advantage HMO plan in the Houston area

- Select a PCP to manage your care with referrals to participating providers from the KelseyCare Advantage Medicare HMO network
- No out-of-network coverage (except in an emergency)
- When compared to original Medicare, no deductible and no (or low) out-of-pocket costs
- Prescription drug coverage by HealthSelect Medicare Rx administered by UnitedHealthcare

80% of eligible retirees and their eligible spouses choose a Medicare Advantage plan for the benefits and lower out-of-pocket costs

Medicare Advantage plan participants also enjoy a plan design and programs targeted for the senior population, including benefits that are not a part of original Medicare. By enrolling in the statewide HealthSelect Medicare Advantage Plan or Houston-area KelseyCare Advantage plan, more than 66,500 Medicare-enrolled retirees and 17,400 Medicare-enrolled spouses enjoy savings and enhanced benefits through:

- A lower premium for Medicare-enrolled dependents than HealthSelect Secondary
- Hearing aid and vision benefits
- Silver Sneakers, a popular health and fitness program

$61.5M amount retirees saved in dependent premiums in FY19 by choosing MA plans

Medicare Advantage plans continue to add new benefits. Participants should check their benefits regularly.

Patient-centered medical homes (PCMHs) benefit participants and the plan

PCMHs are groups of doctors, hospitals and other health care providers that focus on:

- ongoing relationships between patients and their primary care providers and
- coordinated care across the entire spectrum of health care.

Value-based PCMH strategies include:

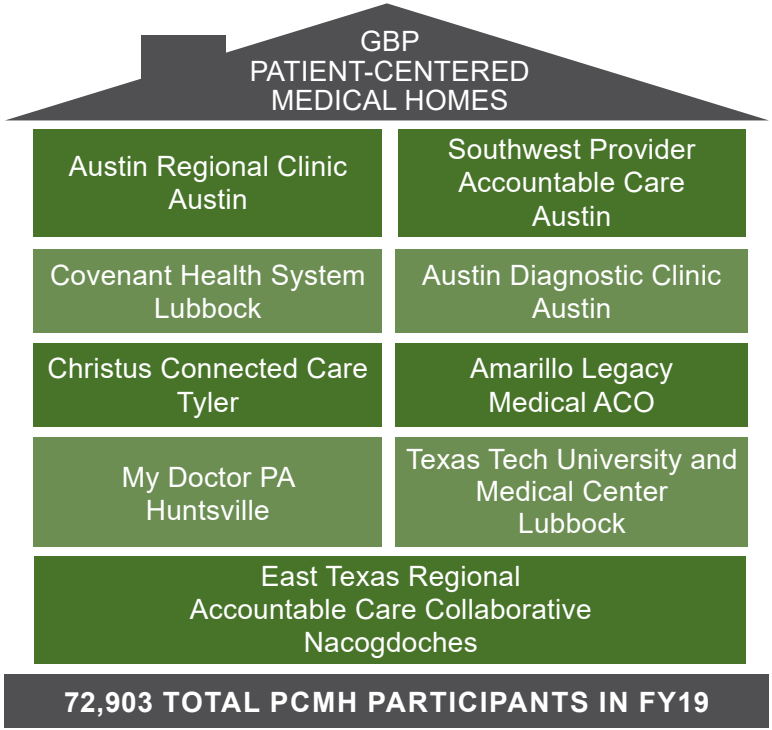
- emphasizing preventive care, such as cancer screenings, to improve long term outcomes for patients;
- offering extended hours and walk-in appointments for urgent care visits;
- using electronic medical records to better coordinate care across the group;
- using care coordinators to better assist chronically ill patients; and
- identifying high-risk patients and proactively managing their care.

HealthSelect has nine PCMH partners with 72,903 participants

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

The ERS value-based PCMH strategies result in cost savings to the patient and the plan. The PCMH partners focus on a primary care model, also meeting patients' urgent care needs and effectively managing chronically ill and high-risk patients.

From FY11 to FY18, PCMH practices saved the plan $88.4 million and practices received $21.5 million in shared-savings payments, in addition to their contracted reimbursements for medical care. Savings for FY19 have not yet been finalized.

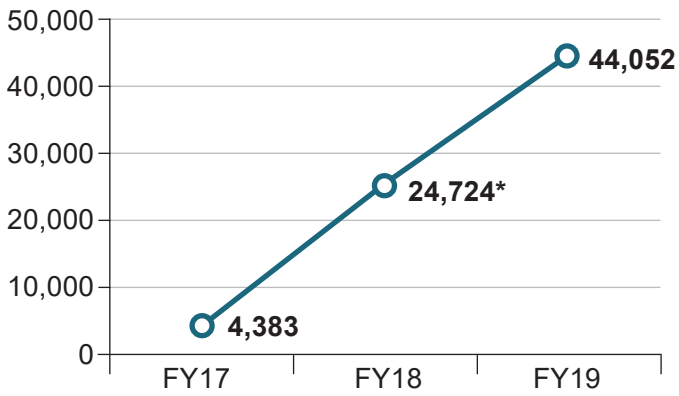


Virtual visits grew 78% in FY19

Virtual visits connect participants with a licensed physician directly through their mobile devices or computers. For medical virtual visits, HealthSelect of Texas participants do not pay a copay when using Doctor on Demand or MDLive. Virtual visits result in lower plan cost.

- In FY19, ERS added scheduled mental health virtual visits at the same benefit level as an in-network mental health office visit ($25 copay for HealthSelect of Texas participants)
- In FY19, participants used a virtual visit provider for 2,716 mental health visits
- The satisfaction rating remains high
  - Doctor on Demand: 4.9 on a 5-point scale
  - MDLive: 95% positive

Virtual visits grew steadily since FY17



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

*The FY18 virtual visit count is corrected from the number published in last year's report.

Group Benefits Advisory Committee (GBAC) brings stakeholder perspectives to the GBP

Formed in 2018 per statute, the GBAC advises the ERS Board of Trustees on the planning and development of employee and retiree benefits under the GBP. The Committee provides the Board with input from ERS participants, benefit experts and professionals to ensure that state benefits provide value to participants and employers, and remain competitive at a reasonable cost to the state, employees, retirees and their dependents.

The Board may appoint up to 11 members to the Committee, which includes employees and retirees from GBP-participating state agencies and institutions of higher education of different sizes and areas of the state.

As a result of findings and discussions over four meetings in 2018 and 2019, as well as committee member involvement in publication and policy reviews outside of the meetings, the GBAC put forth several recommendations in 2019 for staff to consider:

- changes to make enrollment guides, new employee guides and the appeals guide more user-friendly;
- ways to promote, encourage and/or incent participation in wellness programs; and
- expansion of the ERS tobacco policy to include e-cigarette products and methods for communicating the change to plan participants.

ERS holds regular Solution Sessions to consider new ideas

ERS is reviewing the products and services presented as part of these Solution Sessions against current needs, market conditions, industry best practices and cost considerations.

Entity	Presentation Date	Description of Product/Service
Advanced Medical Pricing Solutions	January 8, 2019	Conducts technology-driven, physician-led medical bill reviews of hospital, facility and physician claims to identify health claims with errors, waste or abuse and to ensure only valid claims are paid
Prescription Care Management	February 6, 2019	Engages physicians to switch pharmacy participants from high-cost prescription drugs to low-cost prescription drugs
Covera Health	May 15, 2019	Partners with doctors to better define, measure and deliver quality care through its Radiology Centers of Excellence program
Thomson Reuters	July 17, 2019	Offers CLEAR, a research platform that delivers a vast collection of public and proprietary records for a streamlined, efficient search

The Episodes of Care Program: a value-based, hip and knee replacement program available in Houston

In FY19, ERS created a program to generate savings to the plan and improve health outcomes by incenting orthopedic doctors for superior care to patients receiving hip and knee replacements.

Incentive payments to providers are based on performance in a combination of areas:

- potentially avoidable complications,
- hospital re-admissions,
- surgeon-controlled complications expense, and/or
- a positive patient experience.

ERS has partnered with a Houston-based clinic focused on orthopedic surgery. The clinic uses innovative, advanced and efficient surgical programs that take advantage of the latest medical technologies and best practices to create superior outcomes.

Spotlight: Wellness

...making Texas the healthiest state work-force in the country

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.

AMP wellness campaign

Through three areas of engagement, ERS is working to decrease the prevalence of major chronic conditions, improve participants' general quality of life, and reduce long-term health costs for the plan. ERS engages state employers – both leadership and wellness coordinators – to share:

- insights on the health challenges and engagement levels of the workforce,
- wellness resources of the GBP health plans and
- potential barriers or tools for sustaining a culture of wellness and support for employees.

Goals are for participants to:

Assess: complete an online health assessment to identify participant health needs

Manage: enroll in available weight management programs (Naturally Slim and Real Appeal), if applicable

Prevent: complete an annual preventive screening (annual check-up)

AMP wellness campaign (continued)

Assess:

M

P

Completing an online health assessment with a GBP health plan is a common strategy for learning more about personal health status, and the resources the plan offers to help address personal health goals, such as improving cholesterol levels, physical fitness and managing diabetes.

In FY18, 1.78% of ERS participants completed an online health assessment. ERS has set a statewide goal of reaching 20% annually.

AMP wellness campaign (continued)

A

Manage:

P

For HealthSelect participants (except HealthSelect Medicare Advantage participants) with a BMI greater than 23, two weight management programs – Naturally Slim and Real Appeal – offer a way to take control of their health and change behaviors related to nutrition, movement, rest, exercise and activity levels. These programs are available at no cost to eligible participants. Those who completed a program in FY19 lost an average of 3%-4% of their total body weight.

In FY18, 0.99% of participants enrolled in available weight management programs. ERS has set a statewide goal of reaching 5% annually.

AMP wellness campaign (continued)

A

M

Prevent:

In addition to more quickly identifying medical needs before they become severe, preventive screenings allow participants to maintain a productive relationship with their primary care providers, which can improve overall health outcomes.

In FY18, 45.88% of plan participants completed an annual preventive screening visit. ERS has set a statewide goal of reaching 70% annually.

More than half of females enrolled in HealthSelect received screenings, while only 35% of males received screenings.

FY19 Accomplishments

- Established baseline data for AMP measures.
- Began working directly with leadership of the 16 largest state agencies and eligible higher education institutions to increase communication and education efforts regarding available wellness programs and coverages. These communications, supported by employer organizations' leadership, aim to increase participant engagement and encourage healthy behaviors.
- Launched redesigned website to share information and tools for participants and wellness coordinators to use in improving health and promoting workplace wellness. Features wellness benefits specific to each health plan, wellness articles, educational seminars and upcoming events. Visit **https://ers.texas.gov/Wellness-Resources-en**
- Launched regional wellness initiatives for GBP participants in areas that present opportunities for measurable short-term wellness metric improvements.

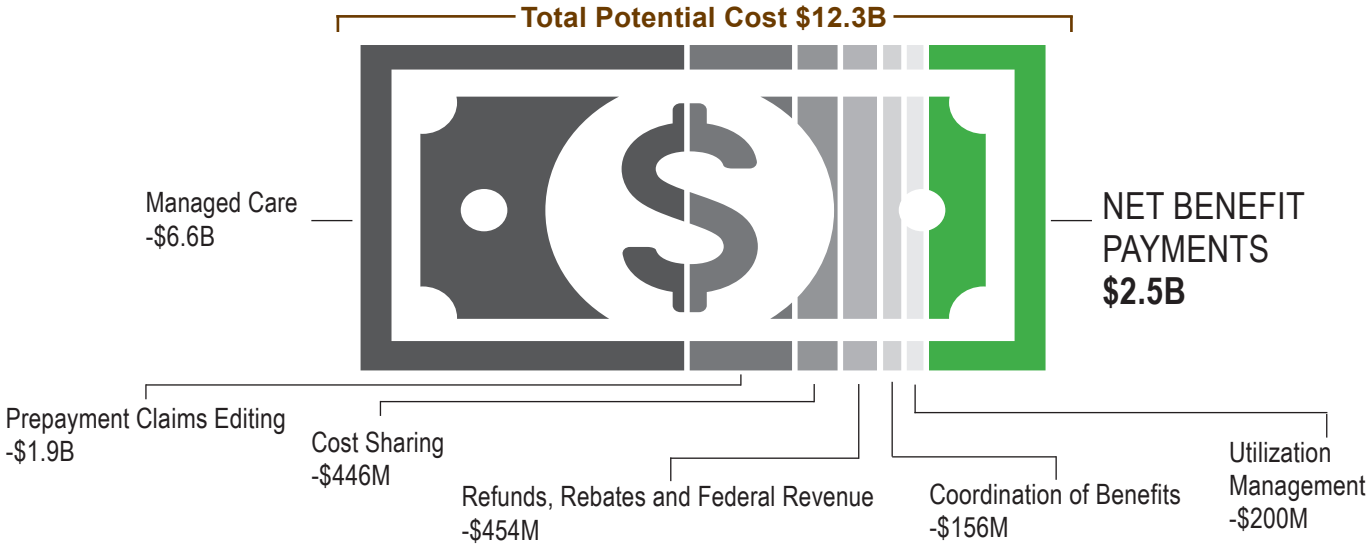
Cost Management and Fraud Prevention

...about our strategies

HealthSelect reduced plan cost by $9.8 billion in FY19

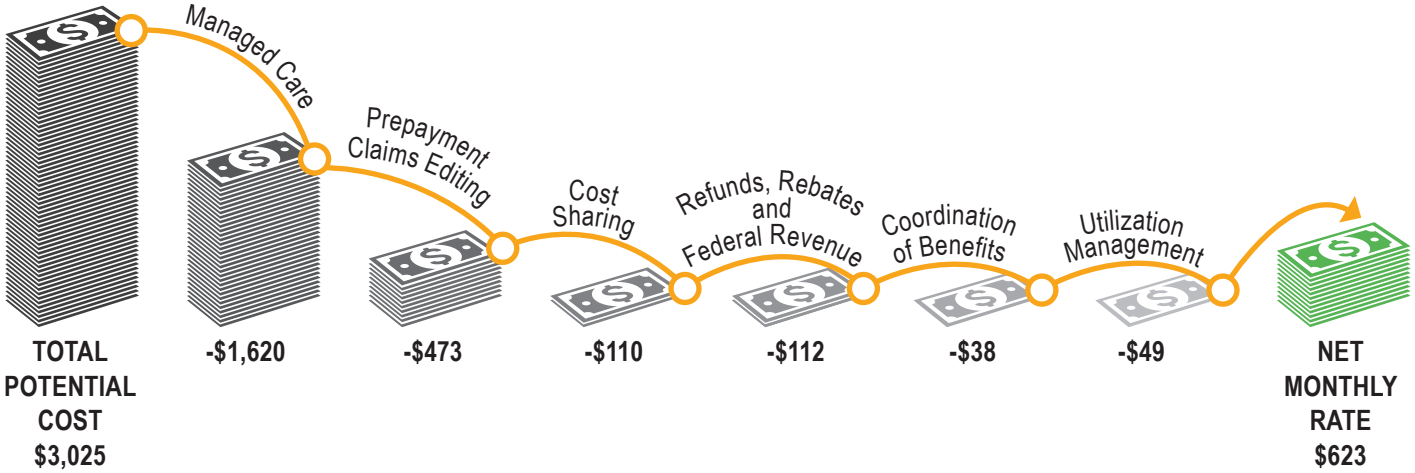
Employee health insurance costs the State of Texas more than $2 billion a year – so it's important to get the most out of every dollar.

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 FY19, the member-only contribution rate was $623 per month. Without cost management programs, the member-only rate would have been $3,025 per month.



HealthSelect cost management and cost containment detail

1. Considered Charges Plus Estimated Cost Avoided		$	12,313,704,918
2. Estimated Cost Avoided			(200,148,640)
3. Considered Charges			12,113,556,278
4. Less Ineligible Charges (Prepayment Claims Editing)			(1,926,150,890)
5. Eligible Charges			10,187,405,388
6. Less Reductions to Eligible Charges			
a. Prescription drug program (PDP) Charge Reductions	$ 1,349,455,493		
b. Provider Discounts and Reductions	5,246,886,191		
c. Medical Copayments and Deductibles	113,343,399		
d. Medical Coinsurance	199,698,921		
e. PDP Cost Sharing	133,106,110		
f. Coordination of Benefits - Medical - Regular	7,374,423		
g. Coordination of Benefits - Medical - Medicare	147,822,572		
h. Miscellaneous Medical Reductions	799,344		(7,198,486,453)

7. Gross Benefit Payments			$	2,988,918,935
8. Refunds, Rebates and Federal Revenue				
a. PDP Rebates	$	365,054,709		
b. Federal Revenues - Medicare Part D		89,389,367		(454,444,076)
9. Net Benefit Payments			$	2,534,474,859

*Data sources:

(1) Annual Experience Accounting reports prepared by BCBSTX

(2) Annual Experience Accounting prepared by PBMs,

(3) HealthSelect Prescription Drug Program data

(4) ERS FY19 Comprehensive Annual Financial Report (Federal Revenues)

Utilization and care management, consumerism, virtual visits and other programs avoided more than $200 million in plan costs

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

1. Considered charges plus estimated cost avoided	**$12,313,704,918**
2. Estimated cost avoided due to utilization and care management	**($200,148,640)**
3. Considered charges	**$12,113,556,278**

In FY19, BCBSTX utilization management reduced inpatient stays, reducing cost by an estimated $69 million.

Prepayment claims editing prevented $1.9 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	**$12,113,556,278**
4. Less charges eliminated through prepayment claims editing	**($1,926,150,890)**
5. Eligible charges	**$10,187,405,388**

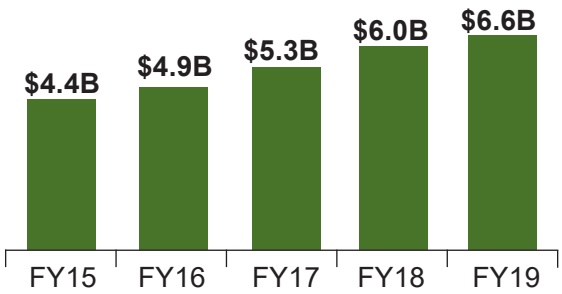
Negotiated provider discounts lowered the plan's costs by $6.6 billion

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	($1,349,455,493)
6b. Medical provider discounts and reductions	($5,246,886,191)
Subtotal	**($6,596,341,684)**

Managed care discounts lowered the state's cost by $27 billion over five years



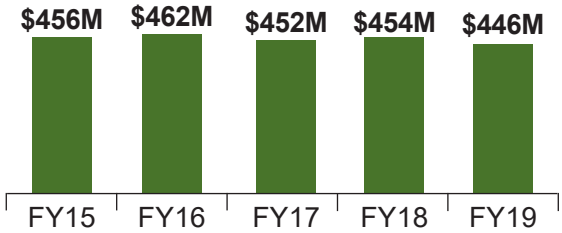
Participants paid $446 million in deductibles, copays and coinsurance

Lines 6c-6e: Participant cost sharing

Cost sharing encourages participants to more actively engage in their own heath care. HealthSelect pays 100% of eligible preventive care services.

Participant cost-sharing savings	
6c. Medical copayments and deductibles	($113,343,399)
6d. Medical coinsurance	($199,698,921)
6e. PDP cost-sharing	($133,106,110)
Subtotal	**($446,148,430)**

Despite rising healthcare costs, member out-of-pocket cost remains steady



The plan saved $156 million by coordinating benefits

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.
  Note: Different rules apply to Medicare Advantage plans.

Coordination of benefits savings	
6f. Coordination of benefits - medical – regular	($7,374,423)
6g. Coordination of benefits - medical – Medicare	($147,822,572)
6h. Miscellaneous Medical Reductions	($799,344)
Subtotal	**($155,996,339)**

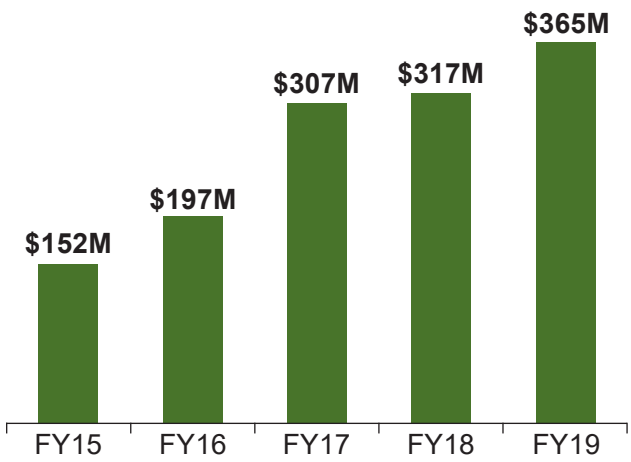
HealthSelect lowered cost by $365 million through drug rebates

Line 8a: Prescription drug program rebates

- FY19 drug rebates continue to grow.
- Through arrangements with drug manufacturers, the HealthSelect pharmacy benefit manager (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	($365,054,709)
Subtotal	**($365,054,709)**

PDP rebate savings

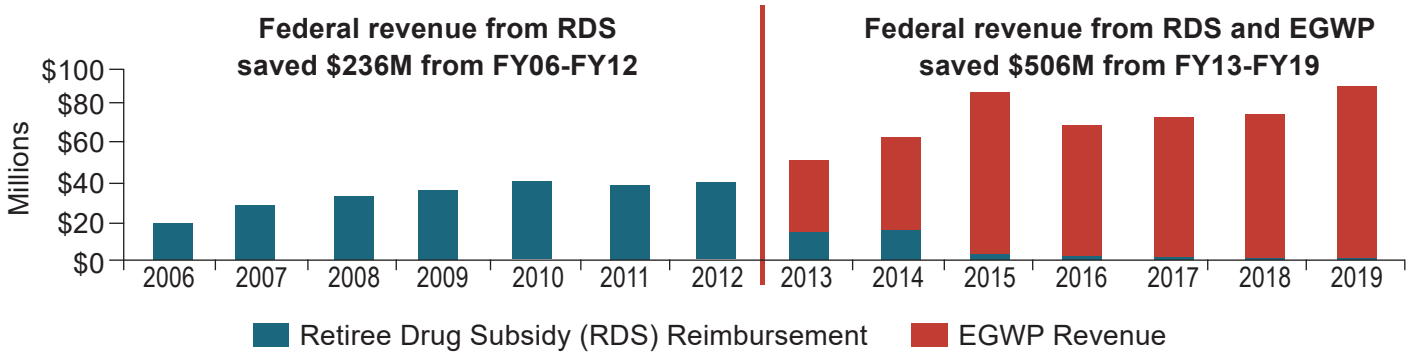


PDP rebates include payments under Medicare Part D Coverage Gap Discount Program of $246M from 2013-19.

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	($89,389,367
Subtotal	**($89,389,367)**



Under Medicare Part D, the plan collected $742 million in total federal revenue since 2006.
Medicare participants have a 'wraparound' plan that provides benefits that are similar to those provided to other HealthSelect participants.

Fraud investigations are a focus for all HealthSelect plans

ERS' Actuarial and Reporting Services (ARS) team regularly monitors the financial performance of plans and identifies underlying causes if actual experience differs from expected results. The ARS team reviews claims details to find outliers and anomalies that may identify savings opportunities. This typically occurs with pharmacy data review. If issues are discovered, the ARS team works with Group Benefits Division leadership and the PBMs to take action, including formulary modification if appropriate.

The BCBSTX Special Investigations Department (SID) 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 streamlines BCBSTX's approach to reducing health care fraud.

Advanced data analysis used to identify potential fraud includes artificial intelligence and predictive modeling, which can help identify unusual billing patterns and abuse of certain service (CPT) codes.

Fraud investigations are a focus for all HealthSelect plans (continued)

Examples of identified fraudulent activity include billing for medically unnecessary or improperly documented services, experimental/investigational/unproven procedures, inflated hours, services not rendered and services for family members.

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

- contract requirements,
- the TPAs internal standards,
- industry standards and
- previous year audit results (if applicable).

Performance Monitoring

...about our program oversight

Participant satisfaction with the GBP plans

GBP Name	TPA/insurer	Plan Year	Satisfaction Rating
HealthSelect of Texas medical plans	BCBSTX	2019	83.6%
HMO	KelseyCare powered by Community Health Choice	2019	100.0%
HMO	Scott and White Health Plan	2019	94.8%
HealthSelect MA PPO	Humana Insurance	2018	97.0%
MA HMO	KelseyCare Medicare Advantage HMO	2018	92.4%
HealthSelect Prescription Drug Program (PDP)	UnitedHealthcare / OptumRx	2019	95.0%
HealthSelect Medicare Rx (EGWP)	UnitedHealthcare	2018	97.0%
State of Texas Dental Choice PPO	HumanaDental	2019	98.0%
Dental HMO	DentiCare/HumanaDental	2019	99.2%
State of Texas Vision	Superior Vision	2019	88.0%
TexFlex	WageWorks	2019	pending
Texas Income Protection Plan	ReedGroup LLC	2018	86.0%

Note: Ratings are rounded to the first decimal.

All GBP contracts have performance guarantees

A performance guarantee (PG) assessment and/or liquidated damages are triggered when a TPA/insurer 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.	• 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, FY19

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

Severity Level	PG Category	Performance Results	PG Assessments	PG Requirement	PG Actual
1	Emergency PGs	1 Emergency PG missed	**System Availability Rate** 1 PG assessed (1 of 4 quarters)	99.5% per quarter	99.33%
		1 Emergency PG under review	**System Availability Rate** 1 PG assessment pending (1 of 4 quarters)		99.27%
2	Critical PGs	1 Critical PG under review	**Identification Card Mail Out Rate, Initial** 1 PG assessment pending (1 of 12 months)	100% per month	98.97%
3	Moderate PGs	1 Moderate PG missed	**Financial Accuracy Rate of Claims** 1 PG assessed (1 of 12 months)	99% per month	98.69%
4	Minor PGs	2 Minor PGs under review	**Identification Card Mail Out Rate, Reissues** 1 PG assessment pending (1 of 12 months)	100% per month	99.07%
			Participant Satisfaction Survey 1 PG assessment pending (FY2019)	85% per fiscal year	83.56%

Performance reporting, FY19

Community First Health Plans

Severity Level	PG Category	Performance Results	PG Assessments	PG Requirement	PG Actual
1	Emergency PGs	1 Emergency PG missed	**Maintenance Eligibility File Processing** 1 PG assessed (1 of 12 months)	100% per occurrence	80%
2	Critical PGs	2 Critical PGs missed	**Identification Card Mail Out Rate, Initial** 2 PGs assessed (2 of 12 months)	100% per month	82.55% - 97.82%
3	Moderate PGs	No Moderate PGs missed	N/A	N/A	N/A
4	Minor PGs	1 Minor PG missed	**Identification Card Mail Out Rate, Reissues** 1 PG assessed (1 of 12 months)	100% per month	97.34%

Performance reporting, FY19

KelseyCare powered by Community Health Choice

Severity Level	PG Category	Performance Results	PG Assessments	PG Requirement	PG Actual
1	Emergency PGs	1 Emergency PG missed	**Maintenance Eligibility File Processing** 1 PG assessed (1 of 12 months)	100% per occurrence	85%
2	Critical PGs	No Critical PGs missed	N/A	N/A	N/A
3	Moderate PGs	1 Moderate PGs missed	**Written Correspondence Rate** 1 PG assessed (1 of 4 quarters)	100% per quarter	98%
4	Minor PGs	1 Minor PG under review	**Reporting Requirements** 1 PG assessment pending (1 of 12 months)	100% per month	0%

Performance reporting, FY19

Scott and White Health Plan

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

Severity Level	PG Category	Performance Results	PG Assessments	PG Requirement	PG Actual
4	Minor PGs	1 Minor PG missed	**Identification Card Mail Out Rate, Reissues** 1 PG assessed (1 of 12 months)	100% per month	95.59%

Performance reporting, CY18

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

- 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	Performance Results	PG Assessments	PG Requirement	PG Actual
4	Minor PGs	1 Minor PG missed	**Reporting Requirements** 1 PG assessed (1 of 12 months)	100% per month	89%

Performance reporting, CY18

KelseyCare Advantage, a Medicare HMO plan

- 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	Performance Results	PG Assessments	PG Requirement	PG Actual
4	Minor PGs	1 Minor PG missed	**Reporting Requirements** 1 PG assessed (1 of 12 months)	100% per month	<100% timely delivery

Performance reporting

HealthSelect Prescription Drug Program (PDP) and HealthSelect Medicare Rx (EGWP + Wrap), *administered by UnitedHealthcare Services Inc. / OptumRx*

- **For Fiscal Year 2019:**
  UnitedHealthcare Services, Inc. performance guarantees were met for all performance standards and assessments did not apply for the HealthSelect Prescription Drug Program.

- **For Calendar Year 2018:**
  UnitedHealthcare Services, Inc. performance guarantees were met for all performance standards and assessments did not apply for the HealthSelect Medicare Rx Plan (EGWP + Wrap).

Performance reporting, FY19

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 Choice℠ plan.
- DentiCare, Inc. (an affiliate of HumanaDental) performance guarantees were met for all performance standards. Assessments did not apply for HumanaDental DHMO.

Performance reporting, FY19

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	Performance Results	PG Assessments	PG Requirement	PG Actual
3	Moderate PG	3 Moderate PGs Missed	**Adjudication Rate of Clean Claims** 3 PGs assessed (3 of 12 months)	100% per month	Range from 99.81% to 99.99%
4	Minor PGs	9 Minor PGs Missed	**Reporting Requirements** 9 PGs assessed (9 of 12 months)	100% per month	Range from 66.67% to 99.96%

Performance reporting, FY19

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

- Minnesota Life Insurance Company (Securian) performance guarantees were met for all performance standards and assessments did not apply to the life insurance and AD&D plans.

Performance reporting, FY19

TexFlex, *administered by WageWorks*

- 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); assessments did apply.

Severity Level	PG Category	Performance Results	PG Assessments	PG Requirement	PG Actual
4	Minor PGs	2 Minor PGs Missed	**Communication Materials** 2 PGs assessed (1 of 12 months)	100% per month	<100%

Performance Reporting, FY19

Texas Income Protection Program, *administered by ReedGroup LLC*

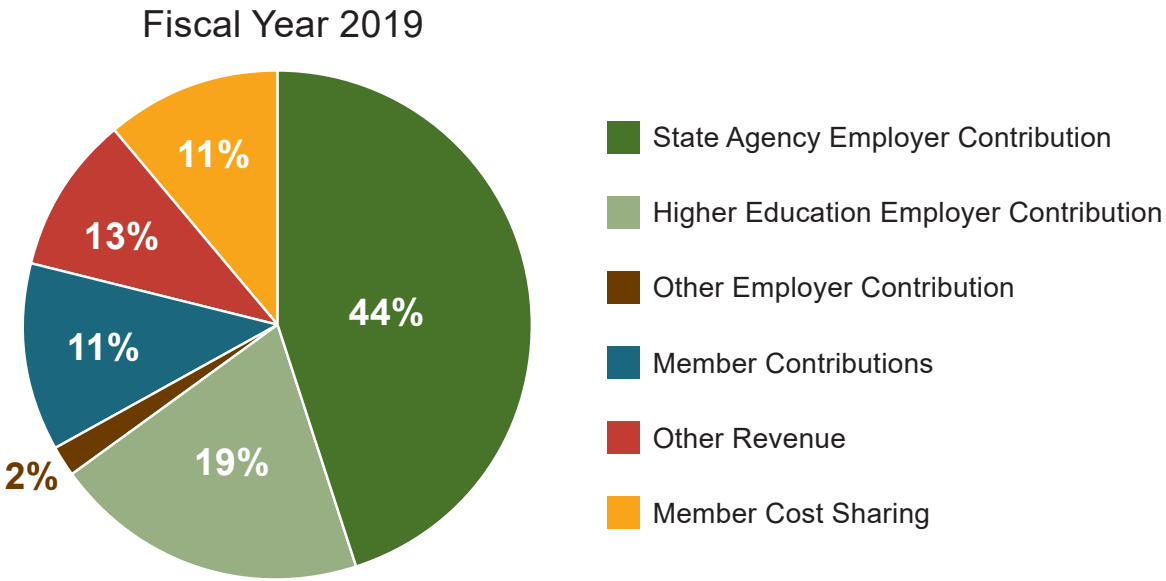
- Performance guarantees were met for Emergency (severity level 1), Critical (severity level 2), and Moderate (severity level 3) categories; assessments did not apply.
- Performance guarantees were not met for Minor (severity level 4); assessments did apply.

Severity Level	PG Category	Performance Results	PG Assessments	PG Requirement	PG Actual
4	Minor PGs	1 Minor PGs Missed	**Reporting Requirements** 1 PG assessed (1 of 12 months)	100% per month	<100%

Appendix

Financial Tables
Legislative Update
Looking ahead to FY20

Who pays for GBP health care benefits?



GBP cost by program, FY19 (net of rebates and subsidies)

	Medical Cost	Pharmacy Cost	Administrative Cost	Total
HealthSelect	$1,966,395,931	$459,603,765	$50,477,511	**$2,476,477,207**
Scott and White Health Plan	$82,923,059	$16,721,812	$7,830,901	**$107,475,772**
KelseyCare powered by Community Health Choice	$21,558,160	$4,083,900	$3,685,750	**$29,327,810**
Community First Health Plans	$15,442,047	$3,686,646	$2,966,704	**$22,095,397**
Medicare Advantage HMO – KelseyCare	$1,875,561	$1,628,859	$377,550	**$3,881,970**
Medicare Advantage PPO – Humana	$134,377,491	$106,941,958	$19,747,127	**$261,066,576**
Total	**$2,222,572,249**	**$592,666,940**	**$85,085,543**	**$2,900,324,732**

For HealthSelect, MA HMO and MA PPO plans, the pharmacy cost is reduced to account for revenue returned through drug rebates and Medicare Part D subsidies.

GBP cost by program, FY19 (continued)

Optional Program	FY19 Administrative Costs
TexFlex	$1,191,273
State of Texas Dental Choice	$3,439,495
State of Texas Dental Discount Plan℠	$234,598
HumanaDental DHMO	$2,259,212
State of Texas Vision	$739,908
Life Insurance Plans (all)	$3,462,559
Texas Income Protection Plan (disability insurance)	$5,888,449

Projected health care cost trend for FY20-21

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%	2.0%	0.2%	4.1%
Gross Pharmacy	3.0%	5.7%	3.0%	11.7%
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 Plans Financial Status

Summary of Actual and Projected* Health Plan Experience *(through September 2019)* $Millions									
	FY18	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26****
			Projected						
Revenue									
State Contributions	$2,895.2	$2,947.9	$2,974.9	$3,031.8	$3,089.7	$3,148.7	$3,208.8	$3,270.1	$3,332.6
Member Contributions	509.2	505.0	507.5	517.1	527.0	537.1	547.3	557.8	568.5
Other Revenue	423.2	591.7	599.5	675.0	728.5	755.8	804.0	849.7	892.5
Total Revenue	**$3,827.6**	**$4,044.6**	**$4,081.9**	**$4,223.9**	**$4,345.2**	**$4,441.6**	**$4,560.1**	**$4,677.6**	**$4,793.6**
Health Care Expenditures	**$3,184.2**	**$3,392.4**	**$3,697.2**	**$4,061.5**	**$4,455.1**	**$4,891.9**	**$5,386.0**	**$5,929.8**	**$6,534.7**
Net Gain (Loss)	**$643.4**	**$652.2**	**$384.7**	**$162.4**	**($109.9)**	**($450.3)**	**($825.9)**	**($1,252.2)**	**($1,741.1)**
Fund Balance	**$1,441.1**	**$2,093.3**	**$2,478.0**	**$2,640.4**	**$2,530.5**	**$2,080.2**	**$1,254.3**	**$2.1**	**($1,739.0)**
Other Expenses Incurred Outside of the GBP Fund									
Member Cost Sharing	**$481.2**	**$485.2**	**$492.1**	**$499.1**	**$506.2**	**$513.4**	**$520.8**	**$528.2**	**$535.7**

* Assuming per capita funding remains at the FY20 level through FY26
**Under this scenario, the GBP's invested assets would be fully depleted shortly after the beginning of FY26. At that time, the GBP would be unable to pay expenses and would cease to operate. Therefore, the ending Fund Balance for FY26 is shown for illustrative purposes only.

Updates from the 86th legislative session

- **Data-sharing with other state agencies** – ERS continues to work with the Health and Human Services Commission, the Texas Department of State Health Services, Teacher Retirement System of Texas and Texas Department of Criminal Justice to evaluate a system for data-sharing among state-funded health care programs. The updated rider (G.A.A. Art. IX 10.06) included a $5 million appropriation via HHSC to partner with the Center for Healthcare Data at The University of Texas Health Science Center at Houston (UT Data Center) for data analysis services. The agencies will submit a joint report on the analysis in 2020.
- **Incenting ERS health plan participants to shop** – The 86th Legislature included budget rider language for FY20-21 indicating its intent that ERS implement a shared-savings program that encourages HealthSelect active employees and their non-Medicare dependents to shop for lower cost, in-network healthcare services by sharing the savings with participants. ERS is working with the HealthSelect third-party administrator to implement a program and monitor the utilization and success of the concept.
- **House Bill 170** – This legislation requires health plans to cover diagnostic mammography at the same benefit level as screening mammography.

Updates from the 86th legislative session (continued)

- **House Bill 392** – Under previous law, ERS had been permitted to procure and offer only group long-term care insurance, but with significant changes in that insurance market, it was no longer possible to offer group long-term care insurance at an affordable rate for ERS members. HB 392 allows ERS to explore the option of offering individual long-term care insurance if an affordable option can be offered.

- **Senate Bill 1264** – The 86th Legislature passed legislation to prevent patient surprise balance billing in certain situations for state-regulated health plans and other state-funded plans including the ERS HealthSelect and HMO plans. SB 1264 applies to medical services received on or after January 1, 2020 and provides mediation or arbitration options that allow the providers and health plans to resolve billing issues in emergencies and in cases in which the consumer had no choice of providers, rather than the patient being surprise billed for services.

The ERS Board of Trustees and staff will monitor the implementation of these and other health care-related legislation to identify potential recommendations for future statutory changes that allow ERS to efficiently administer the GBP health plans.