ALTERNATIVE DELIVERY METHODS

Employees Retirement System of Texas Group Benefits Program

A Report for the 87th Texas Legislature, Senate Bill 1, Rider 17

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Introduction

The Texas Employees Group Benefits Program (Group Benefits Program), administered by the Employees Retirement System of Texas (ERS) since 1976, is a key component of the compensation package for Texas state agency and higher education institution employees, contributing to the financial security and overall well-being of over a half a million employees, retirees and their families. In 2021, the 87th Legislature required that ERS engage a third party vendor to examine alternative methods to deliver the benefits currently supplied under the Group Benefits Program (GBP). This report, prepared by Willis Towers Watson (WTW), is intended to fulfill this requirement. WTW began working with ERS as a consultant on its health and welfare plans in 2022 and was not involved in the design of the current benefit plans.

The scope of this report considers group benefits only and does not extend to other options that may be available to covered members through individual or other insurance markets. Consistent with the Legislature's requirement, this report considers the current benefits covered by the Group Benefits Program only. This report does not identify or recommend benefits to be added to or deleted from the current benefits program, since that would be beyond the scope of the requirement.

The primary focus of this report is on the HealthSelect health plans covering active employees, retirees and their families. The GBP includes other types of benefit plans, including dental, vision, optional life and accidental death and dismemberment (AD&D) insurance, disability insurance, and flexible spending accounts. Optional benefit programs are funded by participating members, and the State of Texas does not provide funding for these benefits. Thus, the discussion of benefits and alternative delivery methods in this report centers on the health plans where the State funds most of the cost.

87th Legislature, Senate

Bill 1, Rider 17

Alternative Delivery Methods for Group Benefits Program. It is the intent of the legislature that the Employees Retirement System (ERS) engage a third party vendor to examine alternative methods to deliver the current benefits supplied under the Group Benefits Program and that ERS provide a report to the chairs of the Senate Finance and Health and Human Services committees, the chairs of the House Appropriations and Insurance committees, and the Governor on the findings of the third party vendor no later than August 31, 2022.

Health Care Market

This examination of methods for benefits delivery is conducted within the context of the broader health care and group benefits market and considers alternative delivery methods that are currently available and relevant to the GBP plans in the present environment.

U.S. spending on health care increased to $4.3 trillion in 2021 (source: https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00113) according to the Centers for Medicare & Medicaid Services, and yet the U.S. health care system overall remains somewhat fragmented and inefficient. There are elements of growth in the health care sector that are directly related to innovation that delivers high value while many drivers of the increase in spending deliver no value or even negatively impact population health. For the group benefits market, much of the focus in recent years has been on the creation and deployment of interventions to manage costs while increasing access to and driving use of high value services, treatments and providers.

Over the past few years, the health care industry has been materially impacted by the COVID- 19 pandemic. COVID-19 caused a dramatic shift in the delivery of health care services beginning in March 2020 and impacted health plan cost trends for group health plans. With stay-at-home orders in place across the country and fears about virus transmission, the use of virtual care increased dramatically, both through existing telemedicine channels and by traditional brick-and-mortar physicians and providers using technology to communicate with patients rather than providing in-person treatment.

The health care market has continued to experience industry consolidation by direct providers of care as they focus on integrating services and building scale. Start-up niche vendors and larger companies from other industries entering or expanding in the health care space have created a dynamic market that impacts consumer behaviors and pricing. Market expectations are that cost increases may accelerate over the next few years for a variety of reasons including, but not limited to, those listed in the table below.

Prospective Future Cost Drivers

Future medical trend uncertainty due to COVID-19 and recent legislation

Increases costs....	Decreases cost....	Other factors....
• Downstream impact on health of "COVID survivors", long-haulers • Return of deferred care • Long-term impact of missed cancer screenings and immunizations • Provider consolidation • Treatment and testing • Pandemic vaccination and treatment costs no longer paid for by federal government • Overall rising inflation	• Sustained increased use of telehealth services • Sustained decrease in avoidable emergency room visits	• Exacerbation of already urgent behavioral health needs • Potential provider consolidation and its impact on unit costs • Plan sponsor/health plan transparency requirements • Energy sector shocks from war in Ukraine and other unknowns

Figure 1. WTW Active Health Care Trend Setting Considerations, spring 2022

With all of this uncertainty surrounding the future of health care, we have identified and analyzed several alternatives for ERS to consider as it looks forward. The remainder of this document describes the primary alternatives available in the market today and identifies those which could be relevant for the GBP programs. As a foundation, we begin with an overview of the current GBP health plans and the goals and objectives they were designed to achieve.

Current ERS Plans

The GBP for State employees and retirees began operation in 1976 as the Uniform Group Insurance Program (UGIP) under Article 3.50-2, Texas Insurance Code. The GBP replaced the UGIP in 2001 and was later codified in 2003 as Chapter 1551 of the Texas Insurance Code [Texas Employees Group Benefits Act (the Act)].

The purposes of the GBP as specified in the Act under Section 1551.002 are as follows:

1. provide uniformity in life, accident, and health benefit coverages for all state officers and employees and their dependents,
2. enable the state to attract and retain competent and able employees by providing employees and their dependents with life, accident, and health benefit coverages at least equal to those commonly provided in private industry,
3. foster, promote, and encourage employment by and service to the state as a career profession for individuals of high standards of competence and ability,
4. recognize and protect the state's investment in each permanent employee by promoting and preserving economic security and good health among employees and their dependents,
5. foster and develop high standards of employer-employee relationships between the state and its employees,
6. recognize the long and faithful service and dedication of state officers and employees and encourage them to remain in state service until eligible for retirement by providing health benefits for them and their dependents, and
7. recognize the service to the state by employees and retired employees of community supervision and corrections departments by extending to them and their dependents the same life, accident, and health benefit coverages as those provided under this chapter to state employees, retired state employees, and their dependents.

Many of the parameters applicable to the GBP plans, including eligibility and participation provisions, are established by the Act. The Act also defines the authority of the ERS Board of Trustees (Board) and its powers, outlining objectives for the program which include:

- develop health benefit plans that permit access to high-quality, cost-effective health care;
- design, implement, and monitor health benefit plan features intended to discourage excessive utilization, promote efficiency, and contain costs;
- develop and refine, on an ongoing basis, a health benefit strategy consistent with evolving benefit delivery systems; and
- develop a funding strategy that efficiently uses employer contributions to achieve the purposes of this chapter and that is reasonable and ensures participants a fair choice among health benefit plans.

In recognition of the dynamic nature of health care, ERS maintains a written Texas Employees Group Benefits Program Policy and Guidelines document (Policy and Guidelines) that provides a framework for management of the GBP. ERS uses this document to assist in the determination of funding requests and plan design, guide operational decision making, and educate stakeholders about the plans. To meet the stated GBP policy goals of offering competitive benefits at a reasonable cost, and preserving the sustainability and financial integrity of the GBP health plans, the Policy and Guidelines document includes a number of guidelines and policy statements. This report will reference some of these guidelines and statements when they are relevant to the discussion of alternative delivery system methods.

The benefits provided through the GBP are part of the total compensation package that State agencies and higher education institutions use to attract and retain employees as they compete for talent in the marketplace, offsetting potential lower salaries in many cases. As of the time of this report, a time which many have called the Great Resignation due to the higher-than-usual number of employees voluntarily leaving their jobs, the U.S. job market remains extremely competitive, making benefit plans all the more important as employees consider their options.

Active Employee Coverage

Health coverage for active employees and their families is currently provided through the self- funded HealthSelect plans. If the employee does not opt-out or waive coverage, employees have a choice of two plan options for medical benefits:

- HealthSelect of Texas: A point-of-service plan requiring the designation of a primary care provider (PCP) for those who live or work in Texas. The vast majority of active employees are enrolled in this plan.
- Consumer Directed HealthSelect[1]: Consumer Directed qualified high deductible health plan (CDHP), an account-based health plan with a tax-advantaged Health Savings Account (HSA). To help offset the deductible ($2,100 individual; $4,200 family), the State makes contributions to an eligible member's HSA (currently $540 per year for an individual and $1,080 for a family).

	HealthSelect of Texas (point-of-service plan)	**Consumer Directed HealthSelect** (high deductible health plan with health savings account)
Administrator/Insurance Carrier	Blue Cross and Blue Shield of Texas (BCBSTX)	
In-network Deductibles	$50 prescription drug deductible	$2,100 individual / $4,200 family
Copays / Coinsurances?	Yes/Yes	No/Yes
PCP Designation Required?	Yes	No
Referrals Needed for Specialty Care?	Yes	No
Out-of-network benefits available?	Yes	No

Source: ERS Texas Employees Group Benefits Program Annual Report, FY21

The CDHP was added as an option effective September 1, 2016 and while enrollment has steadily grown, it remains low compared to the point-of-service plan.

Both medical plans offer statewide coverage. For those who live or work outside of Texas, each has a HealthSelect Out-of-State plan variation which offers a PPO network.

Participants in both plans receive comprehensive prescription drug coverage under the HealthSelect of Texas Prescription Drug Program.

Blue Cross and Blue Shield of Texas (BCBSTX) currently administers the HealthSelect medical plans for active employees and their families, while prescription drugs are currently administered by OptumRx, a division of UnitedHealthcare.

Figure 1. **Enrollment by Plan, FY21**

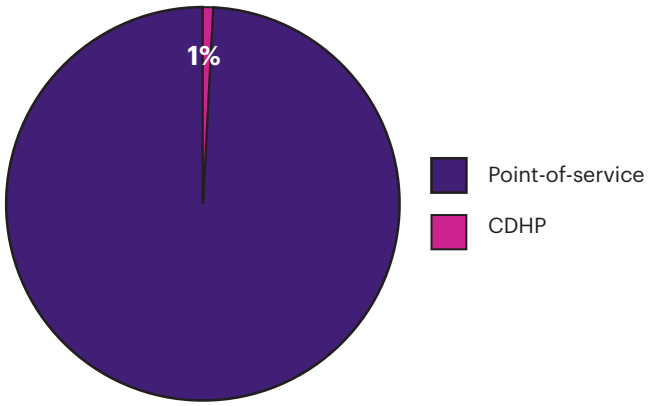
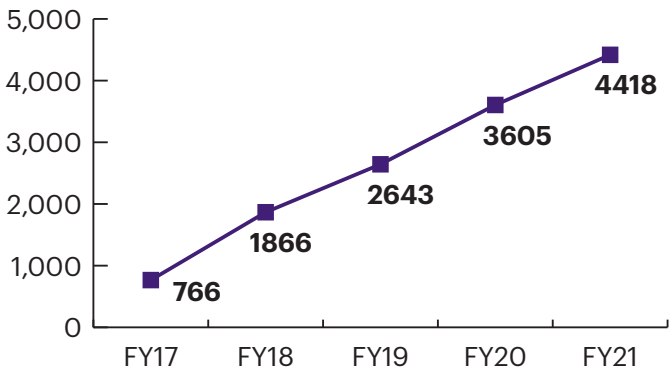


Figure 2. **CDHP Enrollment is steadily increasing**



Source: ERS Texas Employees Group Benefits Program Annual Report, FY21

1 Note that throughout this report, we use the terms account-based health plan (ABHP) and consumer-driven health plan (CDHP) interchangeably. The GBP refers to its account-based plan with the term CDHP.

In the past, fully-insured regional HMOs were offered to GBP members as health plan options. A more stringent selection process, as well as changes in the HMO market in general, resulted in a decrease in the number of HMOs in the GBP, with only two remaining as of Fiscal Year (FY) 2021. A Rider in the ERS bill pattern of the General Appropriations Act (GAA) requires that an alternate health plan, such as an HMO, cannot be offered if it exceeds the cost of HealthSelect on an actuarially adjusted basis.

After considering the actuarially adjusted cost of the remaining two HMOs, the impact on the self-funded risk pool and the potential disruption to covered members, ERS made the determination that the HMO options no longer met the cost requirements set forth in the GAA. This resulted in the discontinuation of the HMOs' participation in the GBP effective September 1, 2021. The majority of providers in the most recently offered HMO networks also participate in the HealthSelect network, allowing network access for covered members to the same providers under the larger self-funded risk pool.

Retiree Health Coverage

Retiree health benefits through the GBP are available to most State of Texas retirees and their eligible dependents. Retirees covered under the GBP include eligible ERS retirees as well as certain Teacher Retirement System of Texas (TRS) retirees. Health plan options for eligible retirees are based on Medicare eligibility and enrollment, and where the retiree lives.

Eligible non-Medicare-primary retirees have access to the same health plans as active employees. These plans are currently administered by BCBSTX for medical benefits, while prescription drugs are currently administered by OptumRx, just as for the active employee plans.

For Medicare-primary retirees, there are two plan options available:

- For medical coverage, the retiree can choose from the following plans:
  - HealthSelect Medicare Advantage Plan, a preferred provider organization (MA PPO): The MA PPO is specifically designed for the Medicare-primary population and, as a Medicare Part C program, it replaces and provides more comprehensive benefits than original Medicare and allows the GBP to access significant Federal subsidies. The majority of ERS' eligible Medicare-primary retirees and spouses (78% in 2021) enroll in this plan, which is currently fully-insured with UnitedHealthcare.
  - HealthSelect of Texas Secondary, under which Medicare is the primary payor with the plan paying secondary on a coordination of benefits (COB) basis: while HealthSelect Secondary provides generous benefits, it requires higher monthly contributions for dependents and potentially higher out-of-pocket costs than the Medicare Advantage plan. The HealthSelect Secondary plan is currently administered by BCBSTX.
    - Note: a Medicare-primary retiree cannot make contributions to an HSA due to IRS regulations. Medicare-primary retirees can use any accumulated HSA funds to cover eligible out-of-pocket costs.
- For prescription drug (Rx) coverage, all Medicare-primary retirees and their dependents are enrolled in HealthSelect Medicare Rx, a self-funded stand-alone Employer Group Waiver Plan (EGWP) prescription drug plan currently administered by UnitedHealthcare.

Opt-Outs

Approximately 19,000 employees and retirees, representing 3.4% of the eligible membership, have opted-out or waived health coverage through the GBP. While this opt-out rate is very low, it is important to acknowledge that there could be unintended financial consequences to the extent that any of the alternatives contained in this report would incent those who have previously opted-out or waived coverage to come back into the plan, increasing program costs.

Funding

The State of Texas makes contributions towards State employees' health care contributions based on available funding provided by the Texas Legislature. Currently the State pays 100% of health plan contributions for eligible full-time employees and 50% of health plan contributions for their eligible dependents. For eligible part-time employees, the State pays 50% for employees and 25% for their eligible dependents. Employees pay the reminder of the contribution by paycheck deduction before taxes are withheld.

For retirees, the State currently contributes a portion of the health care premium. The amount of the contribution varies based on the retiree's length of service at retirement, type of employment (full- or part-time), and the health plan selection.

Historical Plan and Cost Management

From a cost perspective, ERS' current plans have historically performed well compared to the market.

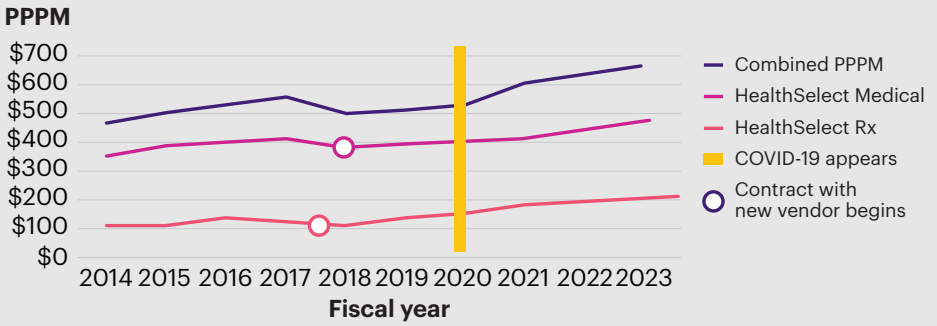
The GBP currently employs a number of strategic and cost management techniques, including the following key elements:

Single large risk pool: the use of a single self-funded risk pool covering nearly half a million participants spreads risk, avoids adverse selection and helps to keep costs affordable. This single pool also eliminates the need to purchase stop loss insurance. The GBP self-funded risk pool is both large and demographically diverse in age.

Broad network with favorable discounts: the GBP uses a broad network of over 110,000 providers and facilities, with network access available to members throughout the State, reducing the need for higher-cost out-of-network services. Because the network requires PCP designation, the negotiated network rates are deeper than those available to other plans without the PCP requirement. BCBSTX has large market share and more leverage than some competing health plans to accomplish substantial discounts.

Emphasis on primary care relationships: the required PCP designation in the HealthSelect of Texas point-of-service plan promotes stronger relationships between covered participants and their primary care providers, since the PCPs must direct care to other more complex, and typically more expensive, types of services.

Figure 3. **Actual and projected plan costs** (per participant per month – PPPM)



Costs presented do not include the impact of pharmacy rebates.
Source: ERS Texas Employees Group Benefits Program Annual Report, FY21

Inclusion of integrated delivery systems: the provider networks utilized for the HealthSelect plans include integrated provider delivery systems such as patient-centered medical homes (PCMHs). There are 8 different major provider groups that function as PCMHs in several cities across the State providing care for over 65,000 ERS participants in 2021. These PCMHs focus on primary care as well as managing chronically ill and high-risk patients through coordinated care.

Utilization of value-based contracting arrangements: current provider contractual arrangements that promote and reward quality measures include episodes of care and bundled payments. Episodes of care is a condition-focused payment model that groups related healthcare services, such as hip or knee replacements, and reimburses providers based on achieving certain positive outcomes. The underlying provider contracts have payment arrangements based on episodes of care for certain services in three major locations. Bundled payments, which involves an all-inclusive flat fee, is in place for certain services in Austin.

Care management and utilization management programs: the HealthSelect plans include appropriate clinical programs focused on management of high-risk patients and chronic conditions, and targeting effective and efficient use of high-cost services. Prior authorization is required for many high-cost services.

Incentives for members to select cost-effective providers: the HealthSelect plans incent smart shopping for in-network medical services and procedures through the HealthSelectShoppERS program. This shared-savings program implemented in 2020 encourages HealthSelect active employees and their non-Medicare-primary dependents to shop for in-network, lower cost, high-quality healthcare services by sharing the savings with participants. Employees can earn up to $500 each plan year credited to a flexible spending account when they compare prices on certain provider-recommended medical procedures and select a rewards-eligible location for the procedure. During 2021, which was the first full year the program was in place, the program exceeded expectations, with 31% of eligible participants activating the program either electronically or telephonically. The program generated savings of over $500,000 and paid out just over $100,000 in incentives (source: ERS Texas Employees Group Benefits Program Annual Report, FY21).

Telemedicine and virtual care: telemedicine services (available pre-pandemic and on an ongoing basis) are covered by the HealthSelect plans for traditional brick-and-mortar physicians at the same level as in-person visits. Additionally, two telemedicine/virtual visit providers, Doctor on Demand and MDLive, offer services 24/7 at no out-of-pocket cost to covered HealthSelect of Texas participants and at low cost to CDHP participants.

Wellness initiatives: wellness resources available and promoted through the HealthSelect plans include telephonic support for chronic condition management, maternity resources, fitness programs, tobacco cessation, weight management programs, discounts on health and wellness services, a health risk assessment, and a portal with tools to track participation and progress. ERS engages State employers on wellness initiatives and shares and promotes wellness content through a network of State agency wellness coordinators.

Other cost saving initiatives include fraud and abuse prevention programs, prepayment claims edits, coordination of benefits policies, regular claims audits, and performance monitoring against contractual guarantees to ensure carrier and vendor partners perform as expected.

The HealthSelect provider network with BCBSTX is a custom network designed specifically for ERS with over 110,000 health care providers and facilities. It is important to note that the reimbursement levels achieved with this network are predicated on the designation of a primary care physician as a gatekeeper to many other medical services, and these reimbursement rates are not available in the market to other employer groups or health plans. The achieved network discount level is substantial, saving $7.7 billion for the HealthSelect plans through negotiated discount savings off of total billed charges of $13.8 billion (source: ERS, FY2021 GPB Annual Report). This level of network discount, 56% overall, represents a very favorable overall result based on WTW experience with large self-funded health plans.

Members participating in HealthSelect choose a primary care physician (PCP) who is responsible for coordinating care and managing any referrals needed to specialists or for more intensive healthcare services. For certain services, including OB/GYN visits, mental health and substance abuse, chiropractic and vision services, participants can access providers directly without a PCP referral.

Regarding mental health and substance abuse services, the GBP has taken several steps to intentionally increase and simplify members' access to providers. The mental health and substance abuse network is part of the broader BCBSTX network, and members can access services directly, either in person or via telemedicine visits, without PCP direction. Additionally, behavioral health services are available through the two telemedicine/virtual care providers, Doctor on Demand and MD Live, at no cost or low-cost, depending on plan enrollment.

Prescription drug benefits are provided through a Pharmacy Benefit Manager (PBM) which is a nearly universal approach for large group health plans. The current PBM, OptumRx, manages the pharmacy network, mail order operations and the formulary of covered drugs. The prescription drug program includes a Free Glucose Meter Program with no-cost test strips and related diabetic supplies. Note that a competitive bid process for the prescription drug contract is underway at the

time of this report, and thus limited information is provided on alternative options due to the bidding process.

As part of ERS requirements and pursuant to Texas Government Code, vendor contracts, including those with the medical plan administrator and pharmacy benefit manager (PBM), are generally competitively bid every 6 years to ensure competitive terms and pricing. During such a bid, costs, network access and current network provider match, customer service, and administrative capabilities are all considered. ERS also holds Solution Sessions to consider new ideas emerging in the market and whether products and services meet the needs of the plan.

For FY 2021, effective management techniques utilized by the GBP reduced HealthSelect costs by $10.9 billion overall, from a total potential cost based on billed charges of $13.8 billion down to $2.9 billion in actual net payment of benefits, a reduction of 79% (source: ERS, FY2021 GPB Annual Report). This level of discount from total billed charges exceeds the results typically achieved by large health plans in the market based on our experience.

Almost two-thirds of survey participants agreed health insurance is a major factor in their decision to continue working for the State.

ERS 2019 Retirement and Benefits Survey

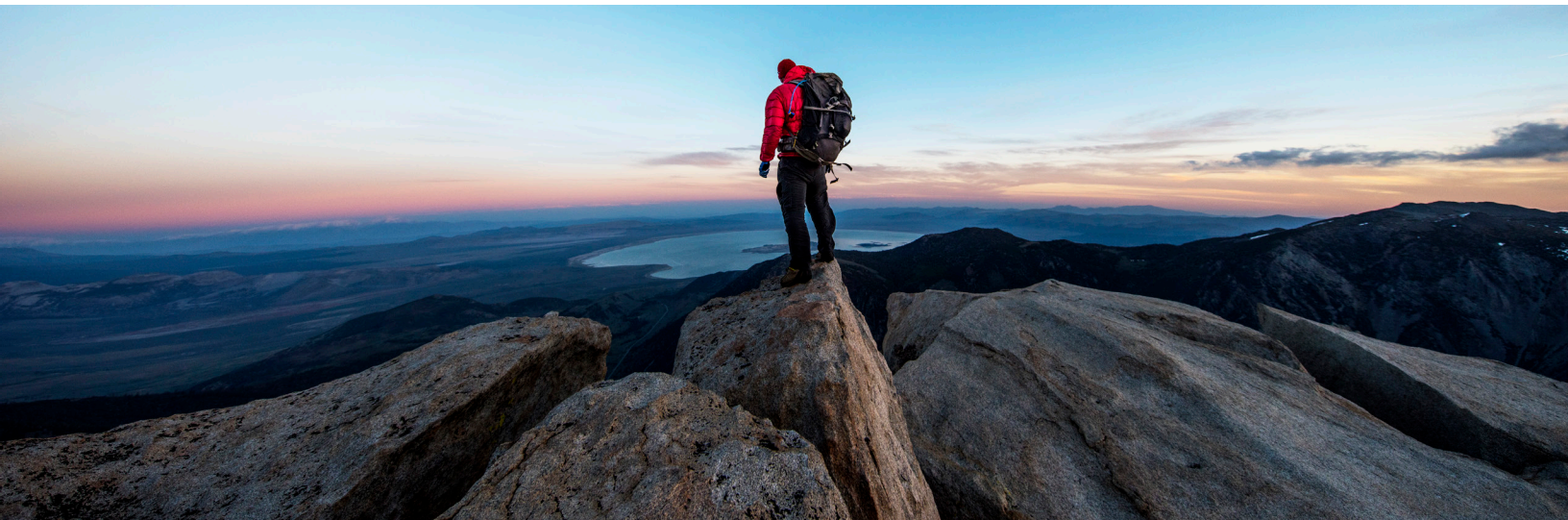
Member Experience

An important aspect of the current GBP plans is whether the plans meet the needs of its members and are thus satisfying the purpose and objectives for the plans.

ERS periodically surveys its members to gauge the perceived value of the benefit offerings and to identify new ways to meet the needs of the covered population. The most recent surveys, conducted in late 2019, found that:

- Roughly 85% of respondents viewed health insurance and related benefits as a valuable part of their compensation package;
- Almost two-thirds (2/3) of survey participants agreed health insurance is a major factor in their decision to continue working for the state. In fact, the longer employees have been with the state, the more positive their perceptions are regarding the GBP; and
- 60% agree the GBP is a competitive benefits package when compared to those offered by private employers.

The ERS results exceed those of a recent WTW survey in which 60% of employees reported that the health care program was an important reason why the employees remained with their employer (WTW 2022 Global Benefits Attitude Survey, U.S. results), emphasizing the importance of the health insurance plans for State participants. An evaluation of alternative delivery methods, then, needs to consider not only the cost impact of any potential change, but also the impact of the change on employees and the member experience, to ensure the program continues to be perceived as a valuable part of the compensation package.



Alternative methods for delivering benefits

This report examines alternative methods for delivering the benefits currently provided through the GBP health plans. For ease of reference, we have separated the types of alternative methods into two categories: plan design alternatives and delivery system alternatives. Plan design alternatives include the range of plans currently available and prevalent in the market today for *group* health plans. While there is a marketplace for individual health plans, individual plans would not satisfy the purpose of providing uniformity in benefits that is specified in the Act, and as such, a discussion of that market is not included in this report.

Delivery system alternatives include methods that can be employed to deliver care and benefits to employees independent of the underlying plan design. These methods include alternative network and vendor contracting strategies such as the use of Centers of Excellence for certain clinical conditions, as well as delivery through alternative means such as virtual care and telemedicine. In most cases these alternative strategies can be used to deliver benefits through or alongside a variety of plan design options, although in certain cases there are limitations which must be considered (for example, telemedicine benefits must be designed to satisfy restrictions on providing first dollar pre-deductible coverage through an HSA-eligible high-deductible health plan.)

For the relevant plan design and delivery system alternatives identified for the GBP plans, this report considers the potential impact on costs, the member experience, and plan administration. Medicare-eligible retiree health plan alternatives are considered separately, since the options for that population differ materially due to the existence of Medicare benefits.

The plan design strategies, delivery alternatives and retiree options included in this report represent the most prevalent alternatives evaluated and utilized by large health plans in the market today, based on WTW experience. While other delivery alternatives may exist, it would be critical to have sufficient experience and results from those options before they could be considered as relevant alternatives for a health plan of the GBP's size and scale.

Plan Design Alternatives

There are a range of plan designs available in the market through which current benefits could be delivered. These designs vary based on the level of management in the program and covered members' access to providers of health care services. Until the 1980s, benefits were typically delivered through Indemnity or Managed Indemnity plans (also called conventional plans). Members sought care from any provider and the health plan reimbursed the cost of the service based on a fee schedule derived from usual and customary rates. In this type of fee-for-service environment, there were few controls over the utilization of services, and an inherent incentive for providers to perform additional and more expensive services to increase compensation levels.

In an attempt to manage costs paid by the benefit plan, Managed Indemnity plans began to address some of the issues by adding medical management controls, such as pre-authorization or pre-certification around high-cost services like inpatient hospital stays and some imaging services. While the requirements may vary by health plan, these types of utilization management programs are almost universally present in large group health plans, including the GBP plans. In the current market, Managed Indemnity plans are typically in place only for health plans providing benefits in very rural areas where provider networks are limited or where no networks exist (e.g., out-of-area plans and expatriate plans) or for Medicare-primary individuals.

Today the most prevalent type of health plan design in the market is the Preferred Provider Organization (PPO). In this type of health plan design, health plans negotiate with physicians and facilities to obtain discounted fee-for-service prices for health care services. In return, providers gain access to a health plan network that will help steer a large number of potential patients. Covered plan participants have the ability to use in-network providers and receive a higher level of reimbursement, with cost limits in place due to the underlying provider contracts, but can also see out-of-network providers with higher cost sharing, and can often be subject to balance billing.

These PPO networks are also usually the basis for two other types of health plan delivery. Point-of-Service (POS) plans build upon the typical PPO design by using a Primary Care Physician (PCP) as gatekeeper

to manage access to more costly specialty services within the network. Account-based health plans (ABHPs), also called consumer-driven health plans (CDHPs), including qualified high-deductible health plans with Health Savings Accounts (HSAs), are typically set up using PPO networks.

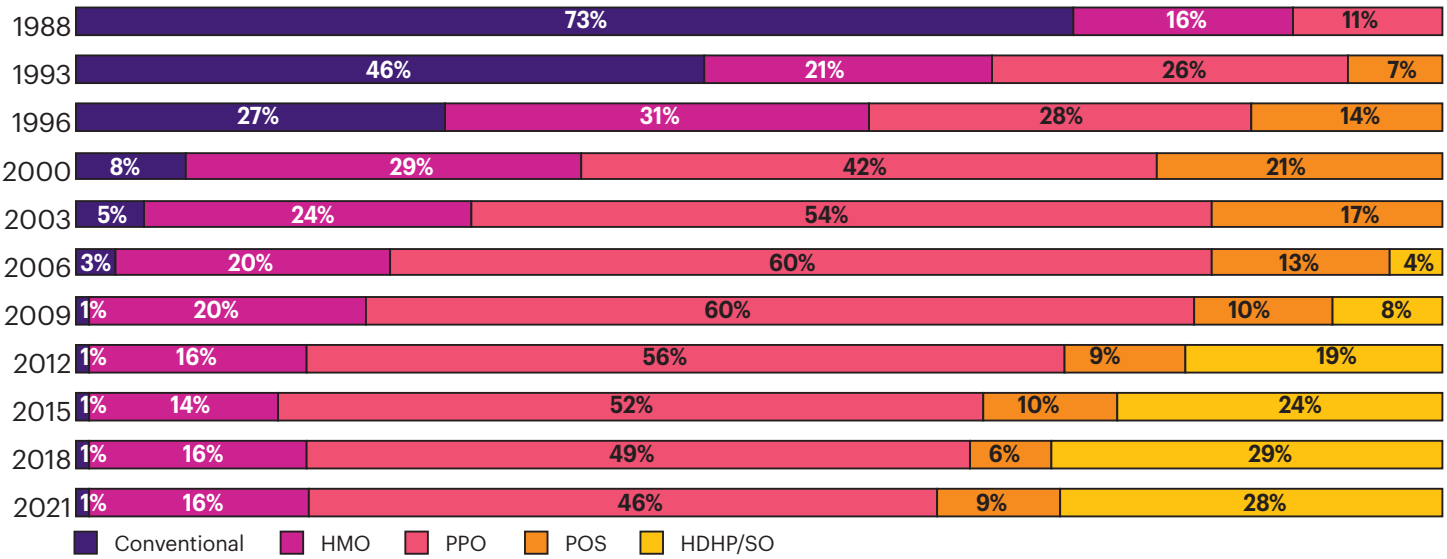
Finally, Health Maintenance Organization (HMO) and Exclusive Provider Organization (EPO) designs are typically distinguished by the lack of available benefits out-of-network, except in the event of an emergency. HMOs are typically the most tightly managed models designed around integrated provider delivery systems. HMO models in the market range from staff models, where the physicians are employed by the HMO, to models with broader networks and multiple integrated delivery systems. HMOs tend to be concentrated in metropolitan areas because of the need for sufficient local integrated provider resources, whether owned or coordinated, as well as for a threshold number of members to be financially viable and satisfy capital and regulatory requirements. Access to HMOs is sporadic across the State of Texas, with different HMOs leading the market in different areas, and few options available in more rural areas. A designated geographical service area must be filed with the Texas Department of Insurance, and a participant must live or work within the service area to be eligible for enrollment in the HMO plan.

A summary of these health plan design and network arrangements is shown below:

Type of Plan Design	Provider Network	Benefit Design	Controls on Member Access	Most Common Uses
Indemnity / Managed Indemnity	No	Same level of benefit applies to any provider	Pre-authorization and medical management around certain higher-cost services	Out-of-area plans, expatriate plans, plans for Medicare-primary populations
PPO	Yes	Benefit plan design incents use of in-network providers with reduced benefit and higher out-of-pocket costs out-of-network	Pre-authorization and medical management around certain higher-cost services	Most prevalent design in US today
POS	Yes	Benefit plan design incents use of in-network providers with reduced benefit and higher out-of-pocket costs out-of-network	In addition to controls above, Primary Care Physician (PCP) serves as gatekeeper, controlling access to higher cost specialty services	Although not as commonly used today as PPOs, can achieve significant savings when there is a high percentage of designated PCPs
HMO / EPO	Yes	Benefits available only for in-network use with no benefit payable out-of-network except in the event of an emergency	HMOs are based on integrated provider delivery systems and typically require a PCP. EPOs may or may not have a gatekeeper	HMOs provide delivery of benefits for an integrated provider delivery system, often available only in urban areas. EPOs may be available more broadly.
ABHP / CDHP	Yes	Typically uses PPO network. Frequently paired with either a Health Reimbursement Arrangement (HRA) or more commonly a Health Savings Account (HSA). A high-deductible health plan must meet IRS requirements for minimum deductibles and out-of-pocket levels for members to be eligible for tax-advantaged HSA	Pre-authorization and medical management around certain higher-cost services	Designed to encourage members to be more cost-conscious consumers since they must cover most costs other than preventive care up front. Also intended to promote savings to cover future health care expenses. Academic studies have demonstrated delayed access to high value care for those enrolled in HDHPs

The following chart from the Kaiser Family Foundation shows the change in the types of plan designs offered in recent years:

Figure 4. **Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988–2021**



Source: 2021 Kaiser Family Foundation (KFF) Employer Health Benefits Survey, November 2021. "HDHP/SO" means High Deductible Health Plan with Savings Option (https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/)

Account Based Health Plans

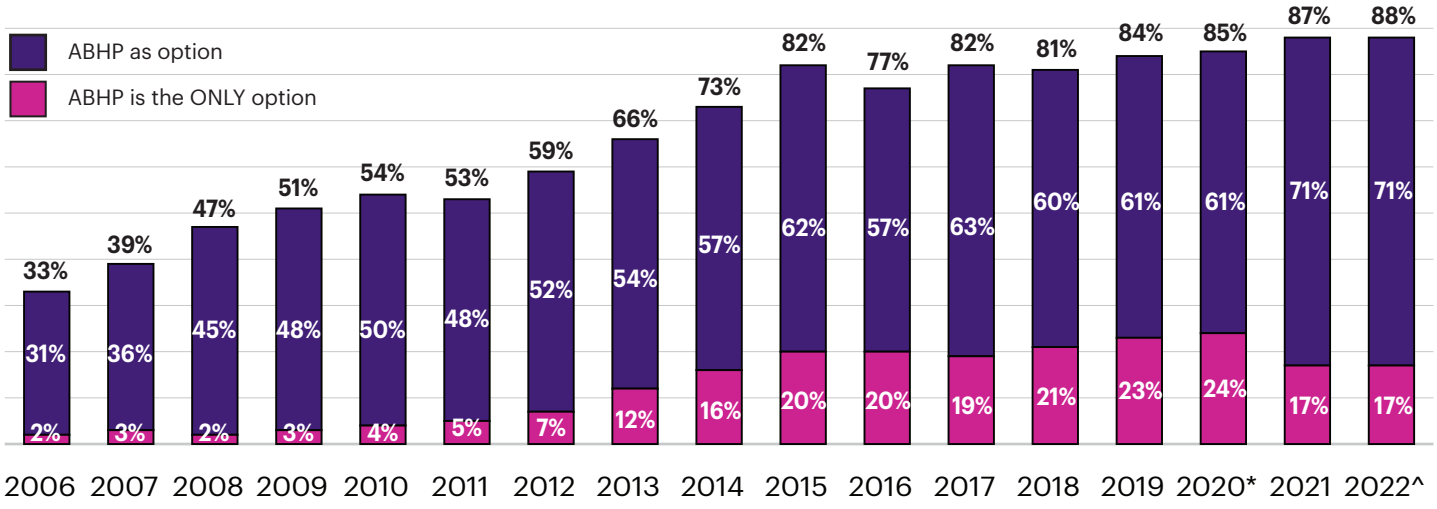
ABHPs are health plans paired with an account which can be funded either by the employer, the employee, or by both depending on the type of account. Typically, the underlying health plan has a lower cost than more traditional plans due to higher deductible and out-of-pocket requirements, so members have higher out-of-pocket expenses when care is needed. Plans with higher out-of-pocket costs and lower premiums also attract younger members with fewer medical conditions, and thus also have lower costs due to the health of the population.

ABHPs may be paired with a health savings account (HSA) or a health reimbursement arrangement (HRA), and regulatory requirements exist around both types of accounts. The intent of ABHPs is to increase members' involvement in the way health plan funds are spent by giving them ownership in the funds, resulting in better choices and more efficient use of health care spend.

A health savings account (HSA) is a tax-favored trust or custodial account that can be established and contributed to by, or on behalf of, an eligible individual covered by a qualifying high-deductible health plan (HDHP). A qualifying HDHP must meet statutory requirements for annual deductibles and out-of-pocket maximums and provide significant benefits. HSAs offer meaningful tax protection, allowing account holders to pay for qualified medical expenses (as defined in IRC § 213(d)), as well as the medical expenses of a spouse and tax dependents, on a tax-free basis. Because HSAs belong to the covered individual, they are portable (i.e., the account remains with the individual even after employment or health coverage changes) and can serve as a savings vehicle to cover future medical expenses.

A health reimbursement arrangement (HRA) is an arrangement sponsored by an employer to reimburse employees, on a tax-preferred basis, for certain medical care expenses incurred by employees (including former employees) and their spouses and tax dependents. HRAs are typically notional (i.e., unfunded) accounts and must be paid solely by the employer. As with HSAs, employees are not taxed on the value of HRA coverage made available to them or the reimbursements they receive for qualified medical expenses from the HRA. HRAs generally cannot be offered to active employees on a stand-alone basis unless they qualify as excepted benefits under the Affordable Care Act (e.g., retiree-only HRA) or reimburse expenses that qualify as excepted benefits (e.g., limited scope dental and vision expenses). HRAs are also not portable, and an individual's access to receive reimbursements through an HRA will end when employment or health plan coverage ends, if not earlier (in many plans, HRA coverage ends at the end of the plan year, and balances do not roll over to the following plan year.)

Figure 5. **Prevalence of ABHPs / CDHPs among Large Employer Health Plans, 2006 – Current**



Source: 2021 Willis Towers Watson Best Practices in Health Care Employer Survey. Based on companies and health plans that cover at least 1,000 employees with or without an ABHP.

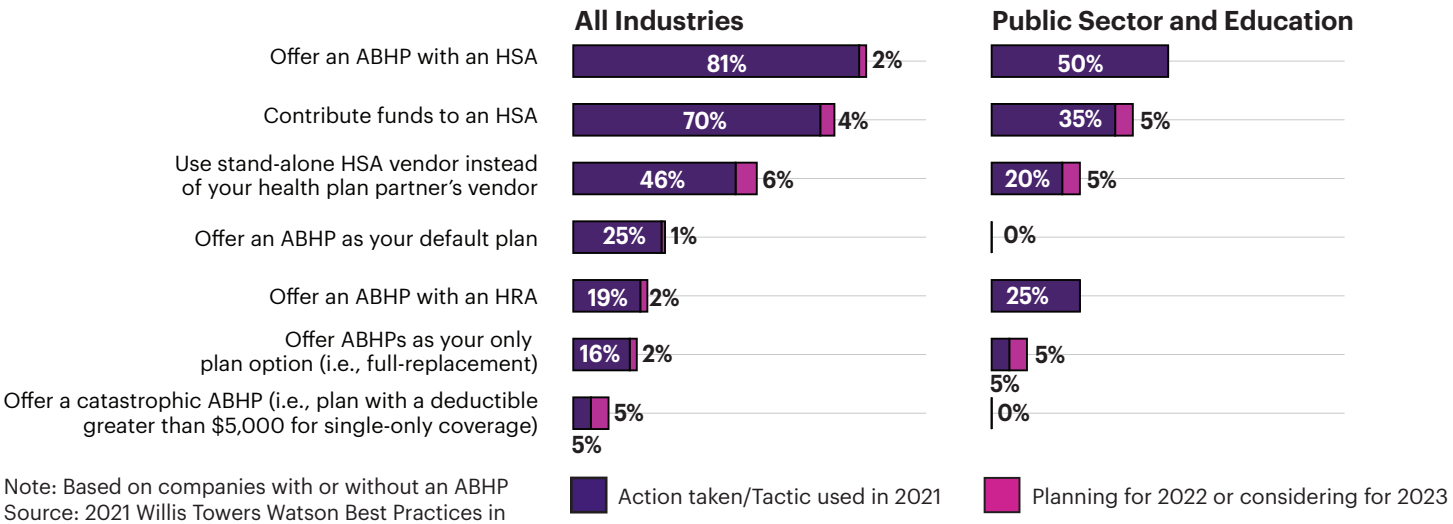
*Includes companies indicating "Planned for 2020". ^ Includes companies indicating "Planned for 2021".

After the regulatory establishment of HSAs in 2004, the prevalence of ABHPs with HSAs grew steadily as employers and health plans sought to encourage members to become better consumers of health care services. Prevalence varies by industry, and is higher in retail and manufacturing, but lower in health care systems, public sector health plans and in academia.

While many private sector organizations moved to a full-replacement strategy offering only ABHPs, the percentage of full-replacement plans has plateaued in recent years due to concerns over affordability of care for members, with a number of employers reintroducing lower deductible plan options. Today, only one in five private sector companies has a full-replacement strategy with regard to ABHPs. Uptake of HDHPs is low in the public sector in general.

For those organizations that do offer ABHPs, the use of HSAs as the "account" portion of the design is the most prevalent in the market today:

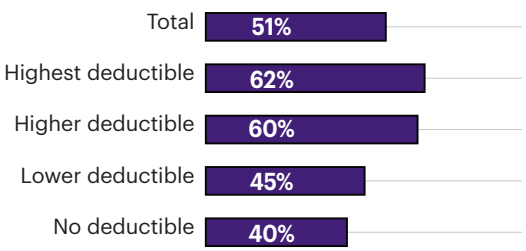
Figure 6. **ABHP / CDHP Common Design Features for Large Health Plans**



Note: Based on companies with or without an ABHP
Source: 2021 Willis Towers Watson Best Practices in Health Care Employer Survey

In recent years, concerns over the affordability of care and deferred care, which was exacerbated by the COVID-19 pandemic, have caused many employers and health plan sponsors to reconsider the plan designs and deductibles offered. Deductibles have increased much more than the amounts made available in ABHP accounts, impacting affordability of care in particular for lower-paid employees and those with chronic conditions. Surveys have shown that those enrolled in the higher deductible plans are more likely to skip or delay both low value and high value care due to financial constraints.

Figure 7. **Percent who say they or a family member have skipped or postponed getting health care or prescription drugs in the past 12 months because of the cost:**



Source: http://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance

Recent studies on the clinical impact of ABHPs suggest that HDHPs are associated with lower health care costs as a result of a reduction in the use of health services – but that reduction in services includes high value services such as preventive care (Agarwal, 2017[2]) and chronic disease medications (Huckfeldt, 2018).[3] Other clinical studies have raised concerns over delay in treatment of diabetic retinopathy (Wharam, 2018)[4] and diagnosis and treatment of breast cancer (Wharam, 2018).[5]These and other studies raise concerns about the resulting unfavorable clinical outcomes for covered members if care and treatment is delayed, but also on the potential for increased costs under the health plan overall due to higher downstream costs.

Emerging plan design alternatives

In addition to the more traditional approaches to plan designs, there have been emerging plan design alternatives that are not widely deployed in the market yet. These ideas are being considered and evaluated primarily by private-sector employers looking to control costs or even exit the healthcare space altogether, as well as by some health insurance carriers looking to design and offer less costly plan options. Emerging alternatives include the use of reimbursement accounts to subsidize employees or spouses for coverage in other plans, and the use of technology to personalize plan designs and direct members to care.

Individual Coverage Health Reimbursement Arrangement (ICHRA)

ICHRAs became available beginning January 1, 2020 following Executive Order 13813 issued by the Trump administration in June 2019 which called for expansion of HRAs. ICHRAs allow employers to provide tax-advantaged funds to all or to specific groups of employees while discontinuing employer-sponsored group health insurance. Employees can use ICHRA funds to reimburse or reduce coverage costs for policies purchased in the individual market, including through state exchanges. This allows greater choice for employees and reduces the cost volatility for employers over time, since an employer or health plan sponsor can fix their contribution. Through an ICHRA strategy, an employer can provide a defined amount (a "defined contribution" approach) that satisfies its Affordable Care Act (ACA) requirements (the employer mandate to offer affordable coverage) as an employer, while detaching itself from the risk of managing group health plan coverage.

However, ICHRAs may result in coverage which is much less favorable than that provided through employer sponsored group coverage depending on employee demographics and the plans employees select. The value of the available health plans differs from market to market due to the reliance on the underlying ACA individual health insurance marketplace.

Figure 8. **How ICHRAs Work**

Source: WTW Final Rule for Individual Coverage Health Reimbursement Arrangements, October 2019

2 Sources: Agarwal, 2017: https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0610
3 Huckfeldt, 2018: https://www.nber.org/papers/w20927
4 Wharam, 2018 diabetic retinopathy: https://www.acpjournals.org/doi/10.7326/M17-3365
5 Wharam, 2018 breast cancer: https://ascopubs.org/doi/10.1200/JCO.2017.75.2501

Due to complex rules and administrative requirements and the lead time needed to implement these programs, uncertainty about the state insurance exchanges, and the COVID-19 pandemic, we have not seen significant adoption of ICHRAs in the market to date. ICHRAs are most likely to be considered as a meaningful health plan design alternative for employers seeking to exit offering traditional group health plan coverage for either certain classes of employees or for all employees. Organizations best suited for an ICHRA would be those with a philosophy that views health benefits as more of a burdensome and costly requirement rather than as a core part of the employee value proposition. Early adopters of ICHRAs are expected to be smaller to mid-size organizations with certain workforce characteristics, in industries with relatively lean health care benefits, shorter tenures, higher turnover, and large part-time and seasonal populations. If early adopters begin to implement these plans and demonstrate success with them, in time ICHRAs may become more appealing for other employers looking for emerging market alternatives and cost control techniques.

Spousal Incentive Health Reimbursement Arrangement (SIHRA)

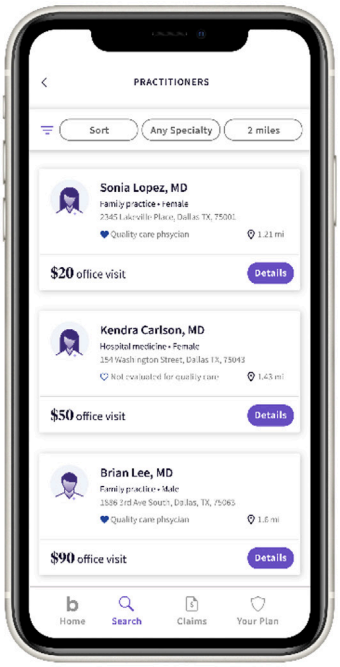
A Spousal Incentive Health Reimbursement Arrangement (SIHRA) is a somewhat complex approach that encourages spouses to obtain insurance benefits from their own employers. The plan sponsor sets up HRAs for spouses, and they are encouraged to seek coverage from their own employers, as opposed to being on the employee's coverage through a family plan.

SIHRAs allow spouses to submit for HRA reimbursement claims that their own plan did not cover for reimbursement.

Note that there are limitations to this approach that an organization would have to address if a SIHRA is implemented. First, a spouse with a spousal incentive HRA would be disqualified from having a tax-advantaged HSA if enrolled in a high-deductible health plan, as the HRA funds would constitute "additional coverage". Given the prevalence of HSA plans in the market today, this could represent a challenge for many dual-income families. Secondly, the administrative costs of these HRAs can be significant relative to the proposed savings they provide. Finally, there is debate related to plan compliance as to whether organizations offering SIHRAs must offer such accounts to all spouses, including those who previously waived coverage. Ironically in some instances, spousal incentive HRAs could increase total medical spending.

Plan Designs Using Technology For Personalization and Steerage

One of the key challenges for health plans in the current market is engaging employees to be more involved in making choices related to their own care. Choosing higher quality physicians and facilities leads to better outcomes and ultimately, lower costs for health plans. Educating employees and getting them to make better choices, however, continues to be a challenge in a market where the cost of services is not readily available nor easily understood. Implementation of multiple recent transparency regulations, including those under the Consolidated Appropriations Act of 2021, is in process as regulators attempt to improve the amount of price and quality information available in the health care system.



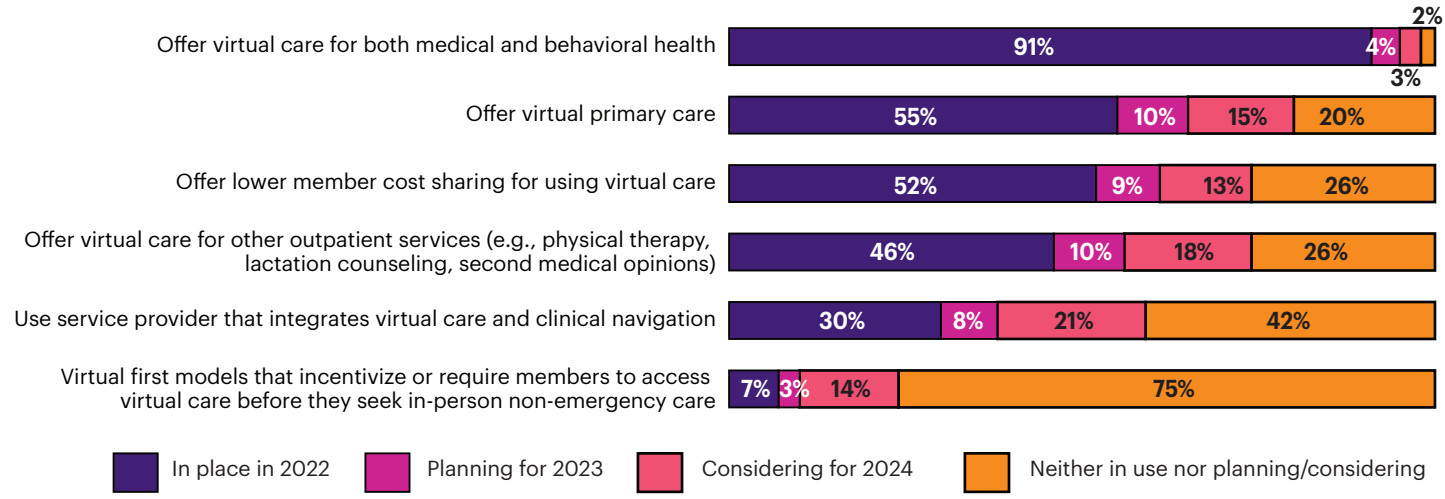
There are new health plans that have attempted to disrupt the current health care market by promising to allow employees to choose insurance plans better tailored to their individual needs, which may deliver lower premiums and lower cost. For instance, one new health plan design offers copayments instead of deductible and coinsurance and requires a buy up for certain elective surgeries, which can be paid over several months. Generally, these plans are likely to be less expensive than conventional health plans and will attract younger and healthier employees. These employees would have lower medical costs regardless of which health plan they enrolled.

One company included a requirement for employees to buy up for coverage for a few dozen highly discretionary interventions. Health plan sponsors implementing this type of program will face significant ongoing administration requirements and must understand and communicate the tax implications of any buy up done outside of the open enrollment period. The legal, tax and administrative challenges which this type of a plan design offering has presented has led this carrier to begin offering a more traditional design with less member customization.

New plan designs and carriers are emerging that use a combination of a plan design that incents consumer behavior coupled with a technology platform that steers members to high-quality, lower-cost providers. An example are the plans offered by one carrier whose technology employs a "shopping experience" that is similar to what is seen on several consumer-friendly sites. When a member searches for care, the highest-quality physicians and facilities show up first in the search, and thus increase the likelihood that a "better" provider will be chosen. This steerage happens in the background, but also allows members to see the quality scores of the facilities and physicians, as well as the cost to them and the plan. While providing tools to educate members on provider cost and quality is not a new concept, these plans differentiate the member's out-of-pocket cost based on the provider selected. For example, in one plan option, a member's copay for an office visit may vary anywhere from $10 to $190 depending on the provider chosen.

As the adoption of virtual care and health care technology platforms becomes more widespread, some carriers are beginning to design plans using these tools as a gatekeeper feature. Members can seek care virtually for primary care, urgent care, and behavioral services. A care navigation technology is implemented in conjunction with the virtual care to connect members to high-quality, in-person providers when it is deemed necessary. This results in a cohesive care experience for the member and provides care delivered in cost-efficient manner. There are a handful of carriers that have recently introduced plan designs using technology as a gatekeeper, although these offerings tend to be concentrated in certain geographic locations. To date, these plans are not widely available and tend to be used by smaller geographically-concentrated employers seeking less costly plan design alternatives. As shown in the chart below, while virtual care options are currently in place for a majority of large health plans, very few use virtual care today as a gatekeeper to broader medical care services.

Figure 9. **Virtual Care: Large Employer Health Plan Emerging Strategies**



Note: Percentages may not add up to 100% due to rounding.
Source: 2022 Emerging Trends in Healthcare Survey, United States

The emerging plan design alternatives described above overall are not yet widely available and utilized, nor tested on covered populations of the size and scale of the GBP covered membership.

Plan Design Options for the GBP Plans

As we consider whether the plan design alternatives discussed above would represent relevant alternatives for delivering benefits under the GBP, there are a few key points that warrant highlighting about the current GBP plan designs. The HealthSelect plan which covers the majority of the active employee population is a Point-of-Service plan requiring selection of a PCP to manage care. GBP Consulting Actuaries have estimated the savings from having a PCP gatekeeper to be 2% annually. Importantly, HealthSelect is able to achieve its favorable discounts in part because this type of managed network is in place. Plan designs which remove the gatekeeper would be expected to result in material cost increases to the plans overall.

ERS also reports that 88% of HealthSelect of Texas participants have designated a PCP for coordination of medical care (Source: Texas Employees GBP Annual Report, FY2021). While the PCP assignment and referrals required under this plan to access specialists may be inconvenient for some employees, and this design is less prevalent in the market today than designs without a gatekeeper, this design provides both meaningful cost savings and promotes the integrated care delivery that should improve overall quality for members over the long term.

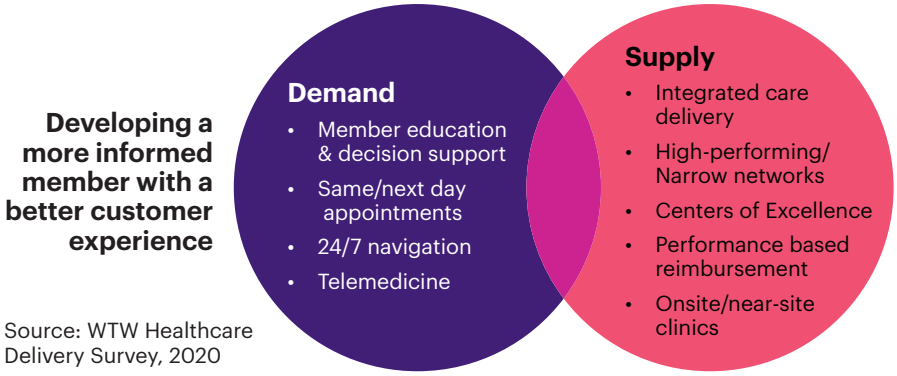
Considering the population currently covered by the GBP health plans, the following chart summarizes the impact of various plan design alternative strategies on the plan cost, on the member experience, and on ERS administration (with red indicating negative impact, green indicating positive impact and gray indicating the result could be either). Note that POS and ABHP plan designs are not shown on the chart since they are already in place.

Alternative Method	Description	Cost Impact	Member Experience Impact	Administrative Impact	Comments
Indemnity/ Managed Indemnity	Remove the network requirement				While members would have the freedom to access any provider with no difference in design, the financial benefits and protection of the provider network would be lost. Cost prohibitive from a plan perspective. This plan design is VERY uncommon.
PPO	Remove the gatekeeper				Members would have direct access to any provider without a referral, but without the emphasis on the PCP relationship, preventive care screenings, care coordination and other quality metrics could decrease. This plan design is very common but would increase costs.
HMO/EPO	Offer an HMO as an alternative to existing plans				HMOs would not be available to all ERS membership. HMOs were removed as alternative options in 2021. If insured, this action would split the risk pool, increasing financial risk to the plan. If offered, these plans also increase ERS administrative and communication requirements.
HMO/EPO	Offer a new plan design option with no out-of-network benefit				Adding a plan option with no out-of- network benefit could provide a less costly plan option but by design limits member choice of providers. This would need to be offered on a self-insured basis to avoid splitting the risk pool.

As of today, we do not believe the emerging plan design models represent viable options for the GBP plans. The first purpose for the GBP health plans as outlined in the Act is to provide uniformity in benefits to employees and their dependents, and the emerging models are not yet at a point where the benefit offerings or outcomes would be uniform. The use of technology may be an emerging model which the GBP may want to continue to explore as a way to supplement or enhance, rather than replace, delivery of benefits going forward, as it has already by implementing program options such as the HealthSelectShoppERS program.

Delivery System Alternatives

Figure 10. **The emerging role of supply and demand in health benefit strategies**



Source: WTW Healthcare Delivery Survey, 2020

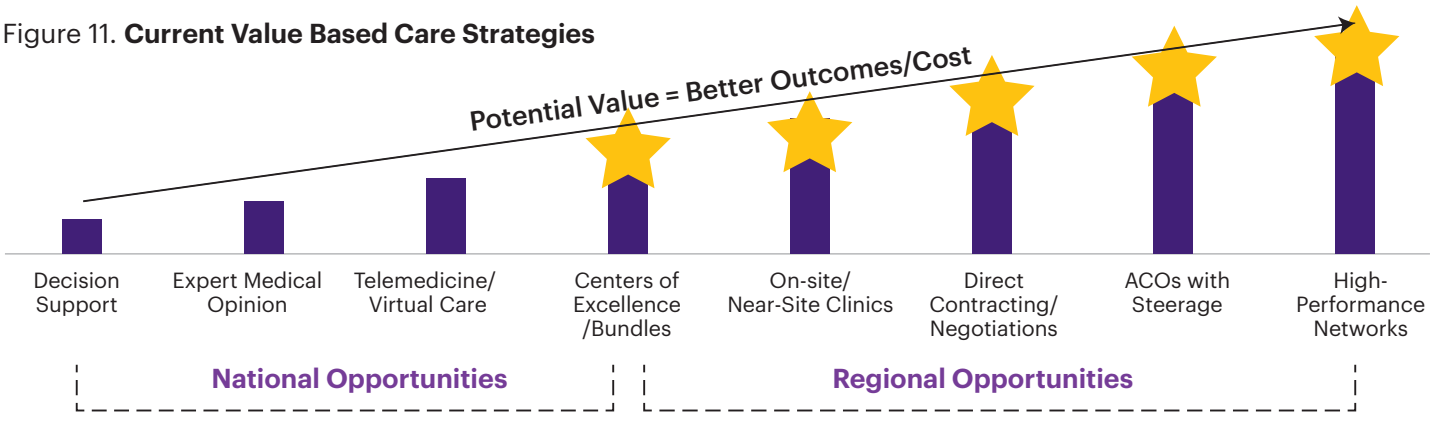
Health care delivery models emphasize supply — which is reshaping how we think about the roles of the member and the delivery system

To deliver the benefits currently provided under the HealthSelect plans, there are care delivery alternatives which can be considered. While many of the plan design features and technology tools in the market focus on the demand side, supply side strategies focus on how the care delivery system can be more accountable to provide high-quality services efficiently. As the health care market evolves, alternative health care delivery strategies can be used to complement the services of existing health plan designs and vendors and provide more targeted solutions to certain populations or for clinical conditions.

Value-based care is a broadly defined term focused on improving quality and outcomes for patients while delivering care in an efficient manner. This generally means increasing utilization of high value services, and decreasing utilization of low value services. The chart below shows many of the value-based care strategies we see large health plans considering and implementing in today's market. As shown, some of these opportunities can be deployed statewide, while others are available only in certain locations. The strategies on the left side of the chart tend to be simpler to implement, while those on the right side represent more major interventions requiring higher administrative effort and with larger execution risk.

Value-based programs aim to provide better care for individuals and better health for populations at a lower cost. When provider contracting is considered, value-based contracts are a form of provider reimbursement that ties payments for care delivery to the quality of care provided. This contracting strategy attempts to reward providers for both efficiency and effectiveness.

Figure 11. **Current Value Based Care Strategies**



Decision Support Tools

Decision support tools are used within benefit plans for navigation and for steerage to higher-quality, lower-cost providers. These tools can help guide members toward higher value services in general. Self-service consumer tools may provide information on providers and the cost of services and assist employees in making decisions pertaining to health care. The challenge has been engaging employees in this process, since the employee must generally initiate use of the tools and take an active role.

A variety of models and vendors have emerged in recent years attempting to address the challenge of how to direct members to the best providers and most appropriate sites of care. Navigation vendors provide guidance to individuals to drive program engagement and improve health care outcomes and experiences. There are vendors that can replace or augment member service departments, and use inbound calls, data analytics, and claims review to identify members who will most benefit from their assistance. Some of these vendors promote highly personalized, concierge-level patient advocacy services, which can be significantly more expensive on a per member fee basis, and while they may promise returns on investment, the evaluation methodology warrants close scrutiny. This category of solutions continues to develop rapidly, offering flexibility in the types of services offered, targeted use of data, and direct integration with care delivery channels such as virtual care.

The GBP recently implemented HealthSelectShoppERS program, which uses Blue Cross Blue Shield of Texas tools to identify and steer to more efficient providers within the network. The HealthSelectShoppERS program is currently featured prominently on the plan's website with an attention-grabbing headline "it pays to shop around" drawing employees to the tools. As previously referenced, both usage and cost savings have exceeded expectations for this program, and in its first year it generated a positive return on the investment made in incentives.

Expert Medical Opinion

Expert medical opinions are another intervention to address higher-cost services and conditions while improving care for members. These programs obtain reviews of a patient's diagnosis and proposed treatment plan from nationally selected expert physicians. Expert medical opinion vendors and services can address a broad range of surgeries and conditions or may be focused on a single condition such as cancer. These programs supplement existing delivery systems; they are not an alternative delivery strategy that replaces the existing system.

Expert medical opinion programs can result in a change in diagnosis or treatment plan. Independent research on one commercial vendor found that out of nearly 6,800 cases, 37% resulted in changes to treatment and one-third of these changes had a moderate/major clinical impact[6]. For health plans, there can be potential cost savings from less morbidity from unnecessary treatments and provider visits, as well as from patients choosing more conservative therapies as an alternative to surgery. Patient satisfaction among users of expert medical opinion services is high.

Over the past several years, ERS has heard presentations from several organizations offering expert medical opinion programs as part of its Solution Sessions, so we are aware that this type of program has been reviewed for the GBP. There are up-front and ongoing fees associated with these programs. Programs with variable fees (i.e., fees calculated as a percentage of savings) present a challenge in particular, since determining savings based on avoided care is difficult to validate. We recommend fixed per member or case rate fee schedules for these programs, with return on investment (ROI) guarantees if possible, to provide transparency into fees paid for these services. Integration with the existing benefit program and provider and vendor relationships is also an important consideration for a program to be effective.

Telemedicine and Virtual Care

Virtual care is a term used to encompass services that deliver medical care through various technology solutions. Virtual care solutions may include telemedicine, patient triage, or remote patient monitoring, which may be accessed through health portals and ideally integrated with electronic medical records for use by treating physicians.

Telemedicine and virtual care solutions have been in existence for some time but usage surged beginning in 2020 with the COVID-19 pandemic. The shift was caused both by stay-at-home orders and concerns over reducing exposure during the pandemic, as well as regulatory actions under the Coronavirus Aid, Relief, and Economic Security Act (CARES) that expanded access to and allowed for reduced out-of-pocket costs for telemedicine services. Virtual visit vendors experienced triple-digit increases in usage while more traditional brick-and-mortar providers moved visits from in-person to virtual technology platforms. This shift was more pronounced in certain health care specialties such as behavioral health care and for chronic conditions needing ongoing monitoring such as diabetes.

The virtual care market has been rapidly evolving. Traditional telemedicine offerings have broadened to include triage, primary care, chronic condition management and other services. Multiple virtual care carve-out vendors have emerged in specific condition areas, while others have expanded to address multiple conditions. Virtual visits should be lower cost and have fewer associated ancillary costs, but can raise aggregate costs if they are incremental rather than substituting for in-person visits.

For many years the GBP plans have included benefits for virtual visits through two vendor options, MD Live and Doctor on Demand. The GBP plans also cover telemedicine visits to traditional brick-and-mortar physicians at the same level as any other office visit, a practice that also pre-dated the pandemic. Additionally, the GBP plans cover mental health virtual visits at the same benefit level as in-network mental health visits, enhancing access for covered members. Virtual care will be an area to continue to watch given the rapid changes that continue to happen in the market.

Centers of Excellence / Bundles

Centers of Excellence (COEs) have evolved from identifying the highest-quality institutions for providing transplant care to more broadly available uses including heart and bariatric surgery, joint replacements, infertility, general surgery, designated ambulatory centers and non-surgical cancer treatment. COE alternatives in the market today include programs available through the major health carriers as well as carve-out vendor solutions typically focused on quality with bundled case rate pricing. The carriers are now moving towards limiting their COE networks to the highest value providers at their designated facilities.

6 Source: Meyer, Singh, Graber. 2015. http://www.amjmed.com/article/S0002-9343(15)00369-1/fulltext

In general, COEs provide members better outcomes at a lower cost than at most other facilities. Health plan savings are achieved via discounted pricing, and improved quality means fewer preventable readmissions and other adverse events. COE strategies are most applicable when costs and cost trends are high for a clinical condition, or when there is high market variability in cost and quality in a given geographic area. Navigation into a COE program and integration of COE benefits with the health plan is extremely important for these programs to be effective. Finding ways to steer members to the COE early in the treatment process is key to the success of a program.

The GBP HealthSelect plans currently include COEs with bundled payment arrangements for several conditions in Austin. In the Houston, Dallas/ Fort Worth, Austin and San Antonio areas, episode of care arrangements are available for certain orthopedic conditions. These types of payment programs continue to expand as part of the GBP program.

There may be opportunities for the GBP to evaluate COEs in other clinical areas. The GBP can consider carrier-provided COEs as well as programs from carve-out vendors with necessary integration with the health plan. The GBP must consider both clinical and administrative costs of such programs. As part of its Solution Sessions, ERS has reviewed several COE options.

On-site / Near-site Clinics

In an effort to attract and retain talent in a competitive labor market, larger employers have expanded their use of health clinics both on-site and near-site. Such clinics make it convenient for employees to get care, which can range from help managing acute or chronic conditions to preventive screenings, without having to take extensive time off from work. These clinics benefit employers by giving them greater control over costs and helping avoid unnecessary and costly emergency room visits. On-site centers can also allow selective referral to higher-value specialists. The majority of organizations make targeted use of on-site and near-site clinics, employing a market-specific strategy in selected locations.

The General Appropriations Act, FY 2022-2023, Rider 14 grants authority for the Board to operate or contract with a person to operate an on-site or near-site health clinic at a State agency or institution of higher education. The Board must determine that three conditions are met:

1. The clinic can be operated on a cost-neutral or cost-positive basis to the health plan;
2. There is sufficient health plan participation in the area where the proposed clinic will operate; and
3. No funds will be spent by the Board for the cost of acquiring or building the clinic, capital expenses, or acquiring equipment.

A feasibility study would be needed to assess whether the first requirement could be met in a given location where there is sufficient health plan participation, per the second requirement. Given the size of the covered population, there are multiple geographic locations which could be evaluated and prioritized. Many on-site vendors expect their clients to pay initial capital costs, so the third requirement could limit vendor selection. Some agencies currently do have on-site clinics for their employees, and the cost of those programs is covered by the employing State agency.

Direct Contracting / Negotiations

Some of the largest employers with very large concentrations of employees in a geographic area have begun directly negotiating and contracting with a subset of high-value providers. Typically direct contracting takes place between the employer and a clinically integrated network, often a hospital system with employed and community-based physicians tied by joint contracting and integrated care management. A key component to this process is determining who will function as the claims administrator for this contract. The objectives for these contracts are to lower costs and shift risk from the self-funded health plan to the clinically integrated network.

We are not aware of many direct contracting arrangements in the public sector due to procurement requirements around transparency and equal opportunity for any entity meeting requirements that wishes to do business. Texas would be able to provide such an option to only a small portion of its membership unless it did contracts with multiple different systems, as the Texas market is diverse and no provider can offer access throughout the state. For private sector companies engaged in direct contracting, the intent is to deliberately narrow the contracting parties to achieve the maximum possible result. As such, we do not believe this strategy is relevant to the GBP plans.

For ERS, a primary responsibility of its health plan administrators like Blue Cross Blue Shield of Texas is to develop, negotiate and manage provider contracts on its behalf.

Accountable Care Organizations (ACOs) with Steerage

ACOs and clinically integrated networks typically include hospitals and professional providers within a single system that agree to share financial responsibility for the total cost and the quality of care for a defined population. In some locations, ACOs may represent 30% to 50% of the provider community in the market. Generally, the aim is to align financial incentives to decrease overutilization, improve safety and quality, and promote coordination across providers.

ACOs often contract as part of a carrier's network offering, although others have begun to organize and market themselves as health plans.

The networks utilized by the HealthSelect plans currently include ACOs in a number of markets across the State. For example, the Amarillo Legacy Medical ACO in the Texas Panhandle is part of the Blue Cross Blue Shield network. Other ACOs are part of the network in the Austin, Dallas/Fort Worth, and Houston areas. While certain ACOs have formed and are marketing their ACO as a health plan, these options are only available in limited markets. Having ACO arrangements through BCBSTX allows ERS to offer this option where it adds value without expending the administrative resources to contract directly with ACOs.

High-Performance Networks

High Performance Networks (HPNs), sometimes referred to as "narrow networks", are local network solutions that generally include 35% to 85% of the provider community in an area. Often carrier-based, these networks seek to include cost-effective providers with proven track records of favorable health outcomes. The HPN may include providers from multiple ACOs and health care systems within a community.

As carriers continue to develop and expand these HPNs, employers have considered them as a way to lower plan costs while maintaining high quality.

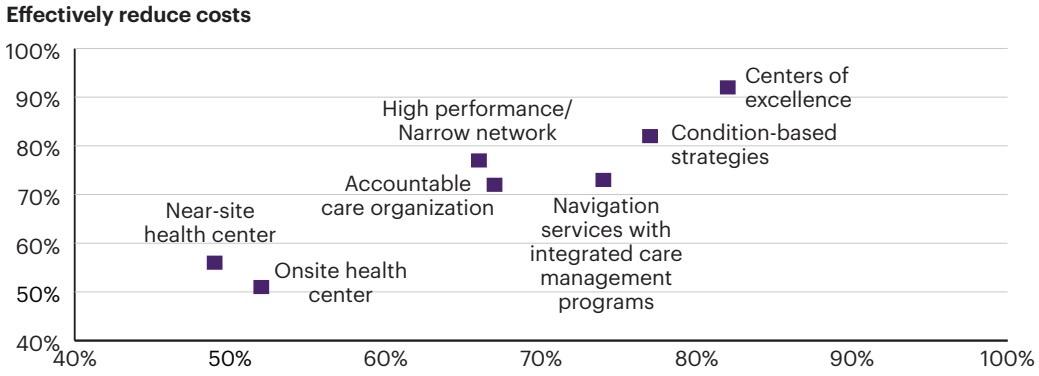
Many employers consider a plan with an HPN as a lower-cost per paycheck option offered alongside other plan options, increasing choices for employees. A challenge with HPNs, as with ACOs, is that they are locally based, so access is limited to certain geographic areas.

For an HPN to provide value, network providers need to care for the people who use health care services the most. Care needs to be confined to the HPN as much as possible, which typically means eliminating out-of-network coverage as much as possible.

For the GBP, consideration of an HPN would likely need to come as part of alternative plan design option. GBP could not offer consistent and uniform access for employees throughout the state since there are no statewide HPNs currently available. We would not suggest replacing the currently broad provider network with an HPN due to disruption of provider relationships and the negative impact on member satisfaction. A narrow network could be offered alongside a broad network plan, although ERS would need to evaluate risk selection, as healthier people tend to be more likely to choose narrow networks.

The shift to value-based care aims to improve the quality of care delivered while lowering overall costs to the member and organization. While not every value-based approach will work for all organizations, WTW recent research shows that the sponsors of large health plans believe that these strategies have the potential to deliver positive results:

Figure 12. **Employers believe a variety of Health Care Delivery options will effectively reduce costs and improve quality**



Note: Percentages indicate from "To a moderate extent" to "To a very great extent"
Source: 2020 Health Care Delivery Survey, United States

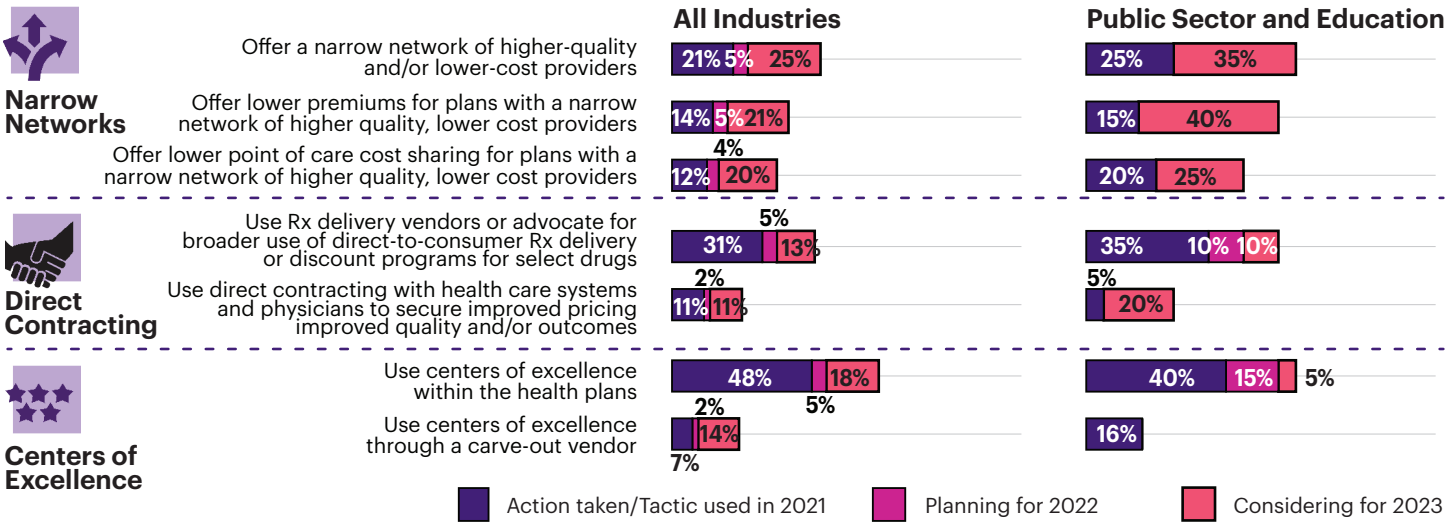
Q1: To what extent do you believe the following network and provider management strategies will **effectively reduce annual health care costs per employee?**

Q2: To what extent do you believe the following network and provider management strategies will **effectively improve the quality of care provided to employees?**

WTW recent surveys found that the percentage of health plan sponsors that have adopted different types of healthcare delivery models will increase over the next three years. Some of those health plan sponsors will be considering different delivery solutions in different markets based on availability and workforce needs.

On the demand side, as health plan sponsors grapple with rising health care costs, research shows they are considering a variety of plan design changes in conjunction with alternate delivery system models to steer employees to higher value care:

Figure 13. **Employers are considering a variety of plan designs to steer employees to higher value care:**



Source: 2021 Willis Towers Watson Best Practices in Health Care Employer Survey

A summary of alternative delivery system methods and the potential impact on ERS is shown below:

Alternative Method	Description	Cost Impact	Member Experience Impact	Administrative impact	Comments
Decision support tools	Tools for plan selection or for steerage to providers				Tools for provider steerage are already in place, and HealthSelectShoppERS participation and savings has exceeded expectations
Expert medical opinion	Service to provide expertise and review				While there is an up-front cost for the service, there is an opportunity for quality improvement and cost savings, subject to acceptable pricing arrangements and integration with existing vendors
Telemedicine / virtual care	Expansion of options for members to receive care through virtual means				While virtual care is generally cost effective compared to in-person care, if it results in redundant services it can increase costs in certain cases
Centers of excellence	Incent or require use of a COE or specialized network for specific clinical				Should result in delivery of higher quality care but has additional administrative requirements and can limit member choice. Currently in place for limited services
On-site / near-site clinics	Delivery of care on-site				Feasibility assessment and evaluation of locations would be needed. Coverage of initial capital costs is an open issue.
Direct contracting/ negotiations	ERS undertakes direct negotiation with major health care systems	n/a	n/a	n/a	Not suitable for public sector contracting
Implement ACOs	Limited networks within the broader network				Only available in certain urban markets, and currently in place in certain markets. Can provide some cost savings but limits member choice.
High-performing / narrow networks	Offered as another plan option				Enrollment system must be able to determine plans available based on member zip code

Retiree Alternatives

As the number of retirees surges and costs of providing retiree health care benefits continue to increase, both private and public sector organizations are reevaluating how retiree health care benefits are delivered, including looking for opportunities to reduce spend and achieve savings. In the face of looming costs and budgetary restrictions, some organizations have taken more drastic actions such as tightening eligibility requirements, reducing premium subsidies, and even discontinuing retiree health coverage altogether; however, the latter has been more prevalent within the private sector. Given the relatively low levels of pay in the public sector, retiree medical coverage remains a key component of the overall compensation package and is critical to ensuring financial stability during retirement for enrollees.

Medicare-Primary Retirees

Benefits for Medicare-primary retirees and their dependents were historically administered through a Medicare Supplement plan, offering benefits intended to wrap around and supplement traditional Medicare. The retiree drug subsidy (RDS) available under Medicare enabled employers to continue assisting their Medicare eligible retirees in obtaining more generous drug coverage. However, over the last decade, plan sponsors of traditional retiree group health coverage increasingly turned to Employer Group Waiver Plans (EGWP) for pharmacy and group Medicare Advantage programs for medical care. These plans offer additional advantages and

opportunities for savings. At the far end of the continuum is the individual marketplace, sometimes called an exchange, which has provided organizations the ability to exit sponsorship of a retiree group plan. Plan options and prices vary based on the retiree's age and zip code, and responsibility for choosing an appropriate plan then falls to the retiree.

The chart below shows the changes in the available options for Medicare plan sponsorship over time and key highlights that we will discuss in greater detail on the pages that follow:

Medicare Supplement with RDS

- Medicare supplement plan pays part of cost not paid by Medicare
- No CMS subsidy for medical
- Employer-sponsored group Rx plan qualifies for RDS subsidy
- Administration remains with the plan sponsor

Medicare Supplement with EGWP

- Medicare supplement plan pays part of cost not paid by Medicare
- No CMS subsidy for medical
- Group Medicare Part D plan with third-party provides savings
- EGWP typically self insured
- Employer sets plan design
- Administration remains with the plan sponsor

Group Medicare Advantage with EGWP

- Insured group Medicare Advantage plan with cost largely paid by CMS
- Employer sets plan design
- Future rates reflect employer claim experience and CMS funding levels
- Typically combined with an EGWP although can be structured as MA-PD plan with MA and Rx provided through the same insurer
- Administration remains with the plan sponsor

Currently these programs are most commonly used by public sector health plans.

Individual Market

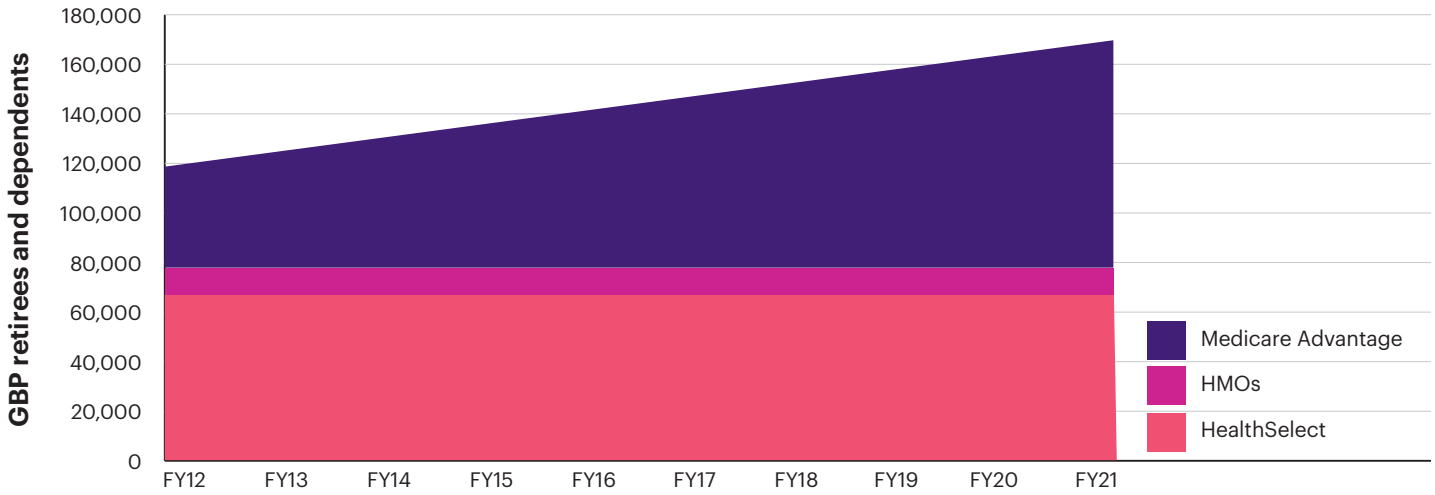
- Employer ceases group plan sponsorship; reduces administration effort
- Employer can continue subsidy throguh tax-free HRA to help retirees pay for coverage
- Retiree selects plan from range of carriers and designs available
- Marketplace vendor provides enrollment support and HRA administration

For ERS, Medicare-primary retirees make up the majority of the retiree population (approximately 72%[7]). In the GBP, there is a default election for Medicare-primary retirees into the MA plan with Part D prescription drug plan through an EGWP. Medicare-primary retirees who do not wish to participate in the MA plan can opt out and elect the HealthSelect Secondary plan which has higher contribution requirements and potentially higher out-of-pocket costs than the MA plan.

7 Source: Texas Employees Group Benefits Program - Annual Report FY21

Participation of Medicare-primary retirees and dependents in the MA plan has increased since it was introduced in FY 2012, as shown in the graph below:

Figure 14. **Participation of Medicare-primary retirees and dependents in the MA plan since FY12**



Source: ERS Texas Employees Group Benefits Program Annual Report, FY21

By offering a Medicare Advantage plan and EGWP, the State benefits from additional federal subsidies available on those products, reducing the cost of coverage. Allowing retirees the choice between the Medicare Advantage and HealthSelect Secondary plan also improves the retiree experience. There are other organizations that have taken the approach of offering Medicare-primary retirees only a Medicare Advantage plan. However, that could create two problems. First, those over age 65 are not required to enroll in Medicare and pay for Part B; however, Part B is required for those who enroll in a Medicare Advantage plan. Second, for those whose provider does not accept Medicare, the participant would either have to change providers or pay higher out-of-pocket costs. Requiring enrollment in a Medicare Advantage plan can create unanticipated challenges for retirees and their family members.

Another newer alternative that has gained traction among private employers is an individual exchange or Medicare Marketplace[8]. These can provide access to a wide range of individual Medicare plans to retirees including Medigap, Medicare Advantage and Part D plans[9]. The number and range of available options will vary based on the geographic location of the retiree, so the retiree experience may differ.

Most employers who do this either discontinue plan subsidization or offer a flat subsidy regardless of retiree plan choice.

The Medicare marketplace supports retirees with communications, online tools, and guidance from licensed, objective benefit advisors who help them understand their options and enroll in a plan that best fits their medical and financial needs. While retirees can make more customized decisions, the decision-making process can be a stressful and time-consuming experience for many Medicare-primary retirees, especially those with less experience and sophistication with technology.

8 Disclosure: Willis Towers Watson offers a private Medicare Marketplace; however, there are other vendors which also provide these services, such as Alight, AmWins, Conduent, Labor First, and Mercer.
9 Medicare Advantage is a program through which private health insurers offer comprehensive health insurance benefits in place of Original Medicare. Medicare Part D is Medicare's prescription drug benefit; it is administered by private plans and subsidized by Medicare. Medigap – also known as Medicare Supplemental coverage – is coverage the pays secondary to Medicare, filling in the gaps left by the deductibles and coinsurances that are part of original Medicare.

Plan sponsors can subsidize their retirees' purchase of individual Medicare plans by contributing to a health reimbursement arrangement (HRA) — a notional, tax-advantaged account used to reimburse eligible beneficiaries for qualified expenses. Plan sponsors can set the parameters of an HRA to allow retirees to use their funding to defray the cost of Medicare premiums and eligible out- of-pocket medical costs if the sponsor chooses.

A Medicare marketplace can offer a number of advantages for both plan sponsors and retirees:

- Plan sponsors:
  - Lowers administrative burden, since support services are provided by the Marketplace rather than the plan sponsor
  - Reduces or eliminates risk associated with sponsoring a self-funded group health plan
- Retiree advantages:
  - Can provide a wider range of choices, including different plan designs and carrier choices, to fit individual needs
  - Delivers lifetime support and advocacy

On the other hand, a Medicare marketplace may not be a viable strategy in certain instances:

- Plan sponsors:
  - Organizations where legislative restrictions require retiree benefits to exactly match benefits offered to active employees
  - Organizations that perceive moving to a marketplace would result in a loss of control due to the termination of the existing group plan
  - Instances where Medicare and non-Medicare retirees are pooled to create indirect subsidies to help reduce the cost of non-Medicare retirees
  - Plans where participation rates in a group plan are low and offering a defined contribution approach would attract the waived population back
- Retiree disadvantages:
  - Retirees with very comprehensive plan coverage, like that provided by the GBP plans today, may not be able to find comparable coverage or cost
  - In certain locations with many available options, the amount of choice and decision-making process may be difficult for some retirees

Medicare-primary retirees participating in the GBP currently have access to very comprehensive medical and pharmacy benefit coverage with an extremely broad choice of providers through both the Medicare Advantage and HealthSelect Secondary plans. Most have no out-of-pocket premium cost for retiree coverage and low out-of-pocket premium cost for their dependents. Enrollment in GBP health coverage requires little effort on the part of the Medicare-primary retiree and assistance with plan understanding, communications, enrollment and claims issues is readily available from ERS and its plan administrators.

As compared to current GBP health coverage, individual plans available through a Medicare marketplace would likely create disruption for this population in terms of available providers and benefit reduction with likely higher out-of-pocket premium cost for GBP Medicare-primary retirees. In summary, a change to a marketplace plan approach would likely result in confusion for Medicare-primary retirees accustomed to the level of support and customer service they receive today through the resources provided by ERS and its plan administrators.

Non-Medicare Retirees

Non-Medicare or pre-65 retirees represent a smaller portion of the GBP retiree population (approximately 28%). The average member age is 59 years old with an average of 25 years of service. A vast majority (85%) come from State agencies, with the remaining percentage coming from higher education institutions. The split by gender is 54% female and 46% male.

These non-Medicare retirees are currently offered the same benefits as those offered to the active population, which is a very common approach for public payers. Changes made to the active employee plans, also apply for non-Medicare retirees.

Because of the advanced age and health status of these retirees, coupled with the fact that Medicare does not offset any portion of the costs, these retirees are typically significantly more costly than both active employees and Medicare retirees. It is important to note that the cost drops at age 65 when Medicare eligibility begins.

COVID-19 Pandemic

This report was prepared during the COVID-19 pandemic, which has had a significant impact on health care costs and required plan sponsors to alter the delivery of certain benefits. While some of those changes were temporary, others such as the increased utilization of telemedicine and tele-behavioral health will likely remain. Examining the impact on the COVID-19 pandemic on alternative delivery methods is beyond the scope of this report; however, where appropriate we have included additional information regarding the impact of the pandemic on delivery alternatives.

Conclusion

This report has examined methods of delivering current GBP plan benefits through alternative plan design approaches and through alternative delivery systems. After considering the purposes for the GBP as outlined in the Act and the objectives for the health plans, we find that the delivery methods currently in place are highly effective approaches. Changes in delivery alternatives may adversely impact plan cost, the member experience and the administrative efforts required by ERS.

The HealthSelect Point-of-Service plan design, while less common in the commercial market today, emphasizes primary care and the coordination of care by the PCP, which is an effective strategy for promoting the provider-patient relationship and improving population health. Because this structure is in place, the plan benefits from decreased specialist utilization and lower provider reimbursement rates not available for less managed plan designs. Changing the plan design by removing key elements such as the PCP gatekeeper would increase health care costs for the plan.

The HealthSelect Consumer Directed Health Plan is an option for employees, and plan enrollment is growing but remains a small portion of the overall Texas ERS population. This result appears aligned with the first purpose of the Act, which is to provide uniformity in benefits to employees, spouses and dependents.

The private health care market has seen significant growth in ABHPs like the Consumer Directed HealthSelect, but expansion has plateaued in recent years due to concerns over affordability for employees and delayed services and treatment. Thus, we do not suggest a targeted effort to push for higher ABHP enrollment. The Consumer Directed HealthSelect does provide the opportunity for employees to save medical funds for the future through the use of the HSA. This is may be valuable for some higher wage-earners who obtain greater tax savings because they are subject to higher federal income tax rates.

Regarding delivery system alternatives, the GBP plans currently utilize a variety of value-based care and contracting strategies, including ACOs within the network and episodes of care and bundled payments for certain services. Other value based options, such as high-performing or narrow networks, exist in the market but would not be available on a consistent basis to the covered membership throughout the State. Some of these options, like high-performing networks, are typically offered through separate plan design options that minimize out-of-network coverage. While there is the potential to achieve cost savings, these types of alternatives would also impact the member experience and overall plan administration.

The GBP has a number of elements promoting high-quality, cost-effective care within the plan. The HealthSelectShoppERS program, for example, which incents members to shop for and select higher quality in-network providers has exceeded cost savings projections and has benefitted members as well. The GBP has also expanded the use of virtual care and telemedicine to improve access to care under the plans, in particular for behavioral health services.

As the health care market continues to evolve, ERS may want to monitor emerging approaches and strategies to continue improving the employee experience and plan efficiency. Identification of programs and services available through the health plan administrator would be a preferred approach to simplify administration and ensure coordination of services for participants. Alternative delivery system methods which may warrant additional consideration going forward include expert medical opinion programs and expanded Centers of Excellence to address additional high-cost or chronic clinical conditions in the covered population. Many of the leading programs and vendors have already been reviewed during the Solution Sessions which ERS regularly holds. Navigation of employees into these programs and integration with the health plan is extremely important for these programs to be effective.

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