Texas TRS Alternative Benefits Study

August 2022

Segal

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Executive Summary

During the 87th Regular Session (2021), the Texas Legislature enacted the 2022-23 General Appropriations Act. In TRS budget rider 21, the Legislature directed the Teacher Retirement System of Texas (TRS) to engage a third-party vendor to examine alternative methods to deliver the current benefits supplied under TRS-ActiveCare. TRS selected Segal to develop this report. Segal provides benefits and actuarial consulting services to over 2,700 clients, of which 500 are public sector clients. Additionally, Segal provides comprehensive health care consulting to 24 state level health plans. We are employee owned and independent and have been providing unbiased actuarial and consulting services to a wide range of public sector entities for 80 years. The report has multiple detailed sections that will address specific topics, with this executive summary highlighting a few of the main points.

Currently, Texas provides coverage to school district employees and their dependents through TRS-ActiveCare, a State Level Education Health Plan administered by the Teacher Retirement System. **Note that we use school district and public education employer interchangeably throughout this report with both public school districts and charter schools included in the programs we describe.** TRS-ActiveCare provides benefits to actively employed public teachers and school district employees of employers in Texas that choose to participate in the plan. It is separate from the state employee health plan provided through the Employee Retirement System (ERS), which covers individuals employed by the state and other agencies, retirees, and their dependents.

TRS-ActiveCare was created in 2001 when TRS was given the responsibility of administering a new statewide health care program for eligible public school employees and dependents. TRS-ActiveCare was designed to provide comparable coverage to all eligible employees, and statute required TRS to make a benefit plan similar to the Uniform Group Insurance Program (UGIP) for state employees in the Employees Retirement System of Texas (ERS). Funding for TRS-ActiveCare was originally set with a minimum employer contribution of $225 per month, and participating school districts were allowed to fund this through a mix of state and local funding sources. The $225 minimum contribution is made up through the school finance formula requiring a state contribution of $75 per employee per month and a $150 minimum contribution from the public education employer.

Prior to the enactment of Senate Bill 1444 (87R) in 2021, employers were not allowed to opt out after joining TRS-ActiveCare. Additionally, school districts and other risk pools with 500 or fewer employees were required to participate in TRS-ActiveCare. With enactment of this new legislation, participation in TRS-ActiveCare will be voluntary at the district level and school districts may choose to leave TRS-ActiveCare by notifying TRS by December 31st of the year before the plan year they intend to leave the plan (i.e., notify by 12/31/2021 to leave 9/1/2022). All school districts in Texas now have the option to join TRS-ActiveCare or administer their own health plan. After a school district makes the decision to leave TRS-ActiveCare, they can only re-join after a period of five plan years. Employers that are not currently participating in TRS-ActiveCare and elect to join must remain in TRS-ActiveCare for at least five years. These five-year entry-exit provisions are employed to manage selection risk and maintain stability for the program.

As of today, the TRS monthly minimum employer contribution remains at the original 2001 contribution of $225, with many Participating Districts contributing more than the minimum. In 2021, TRS districts' contributions towards health coverage varied significantly across the state. Overall, the weighted average district contribution is approximately $330. The state contribution of $75 has remained in effect since 2001 as well as the required public employer minimum contribution of $150, neither which has been increased in the last 20 years. Meanwhile, the Kaiser Family Foundation (KFF)[1], has been providing surveys dating back to 1999 and shows that the cost of healthcare over the past 20 years, at a minimum, has more than doubled.

The current program administered by TRS is primarily a self-insured model, which includes four plan design options (Primary, Primary+, HD, and AC2 [closed]). For these plans, TRS contracts with third party to administer the benefits and pay claims.

"Benchmark analysis showed that TRS-ActiveCare total premiums are lower than peer states and national state averages"

Plan and Cost Benchmarking

TRS is one of seven states that provides optional coverage through a state level education health plan and is the largest of this type with 287,000 individual employees covered as of May 2022, and 448,000 total members including dependents. The most widely used option by states to provide benefits to school districts is to require school districts to be covered under the state health plan.

TRS requested Segal to benchmark the TRS-ActiveCare program last year to gain a broader understanding of how the program compares to other states in terms of health plan features and costs. Segal's benchmark analysis showed that TRS-ActiveCare total premiums are lower than peer states and national state averages. However, employer funding for TRS-ActiveCare is significantly lower than benchmark states and national state averages, which then requires employee contributions to be higher and more burdensome on employees than with the benchmark states. In addition to employee contributions, members also pay out-of-pocket costs (deductible, coinsurance, copays) based on plan designs. Primarily due to lower overall funding levels, the TRS plans require higher out-of-pocket costs when compared to the benchmark states. If we combine all costs including employer funding, employee contributions and member out-of-pocket costs, TRS-ActiveCare plan total costs are lower on average than the benchmark states. This demonstrates that TRS is operating efficiently and is more cost effective than the comparative groups.

"This demonstrates that TRS is operating efficiently and is more cost effective than the comparative groups."

[1] Kaiser Family Foundation (KFF) is a non-profit foundation that does research, journalism, and communications programs. It focuses on major health care issues in the United States. Its goal is to be an unbiased source of facts, information, analysis, and journalism for the general public, as well as for policy makers, the media, and the health care community

Using a 2020 study and survey by the Medical Expenditure Panel Survey (MEPS), the Insurance Component collected data on employer-sponsored health insurance offerings in the U.S. The calculated monthly average of employer contribution is $817 in Texas and $849 for the U.S. overall. At the $330 average employer contribution, TRS is only receiving 40% of the Texas average.

With limited growth in employer funding over the last 20 years, the majority of program costs falls to public education employees. This has led to a program with significant cost sharing that has outpaced other state employees in Texas, as well as the peer states.

The employer funding has a direct impact on the entire program. If TRS-ActiveCare funding amounts were similar to other states, the program could provide enhanced benefit plan designs. Funding similar to other peers would allow for expanded benefit offerings, reduced member cost sharing, and lower family premiums, among enhancements. Compared to peers, TRS-ActiveCare premiums reflect TRS is managing the overall cost of the program well.

Underwriting

TRS-ActiveCare is primarily a self-insured health plan sponsor, responsible for paying all claims as well as any administrative expenses. Plan sponsors that self-insure are responsible for all risks, including month to month claims fluctuations and shock claims (i.e., large individual claims). From the public education employer perspective, they are effectively participating in a fully insured program through TRS-ActiveCare, where they are insulated from the potential volatility of high-cost claims and can rely on predictable monthly expenses; however, they receive the benefits of self-insurance from a cost reduction perspective.

Prior to the 2022-23 plan year, TRS-ActiveCare plans were rated on a statewide basis while pooling the experience for all school districts that participate with the TRS program. With the newly provided legislation, SB 1444 (87R), the TRS-ActiveCare program adjusted rating methodology from statewide rating to regional rating to reflect costs in local areas and provide regionally competitive rates to remain a competitive and viable option across the entire state. The key objective is to limit anti-selection in an environment where districts are able to receive and compare premiums at a local level.

In future years, other underwriting options may be considered with approaches that account for the specific risks and claims experience of each district, while retaining the benefits of the large risk pool and efficiencies that it creates. There are several possibilities available to TRS to move in this direction, including:

- Rating by district – a more granular approach to regional rating would be to rate each district individually. Note that rating all 1,000 districts individually would be administratively burdensome and would also not be feasible from a risk standpoint for small districts.
- Self-insuring each district - the most aggressive approach would be to allow each district to self-insure their claims with TRS. While this approach could potentially benefit some larger districts, it is unlikely to be a suitable approach for the majority of the TRS system.
- Minimum premium – a hybrid approach to district level funding would be a plan where TRS and districts agree that the individual district will be responsible for paying all claims up to an agreed upon level, with TRS responsible for the excess

Any approach would need to be cost-neutral to TRS which would result in both winners and losers among districts. The overall goal should be to reflect some level of risk for districts while maintaining overall risk management for the plan.

Plan Design Options

Under the current TRS-ActiveCare platform, participants are offered a choice of three plans (four for certain participants who participate in a plan no longer open to enrollment), along with fully insured regional Health Maintenance Organization (HMO) options in certain areas. These plans consist of a High Deductible Health Plan (HD), and two copay-based primary care driven Exclusive Provider Organization (EPO) plans (Primary, Primary+). An HMO is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO, generally won't cover out-of-network care (except in an emergency) and may require you to live or work in its service area. An HD is a plan with a higher deductible than a traditional insurance plan, monthly premium is usually lower but usually pay more health care costs yourself before the insurance company starts to pay. An EPO plan is a managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

Some alternative options available to TRS related to the Plan Design Offerings that can be considered, including:

- Account-Based Plans

  Three main types of account-based plans are often paired with health plans: Health Savings Accounts (HSA), Health Reimbursement Arrangements (HRA), and Flexible Spending Accounts (FSA). These plans have different features and tax requirements. Very few public education employers offer HSAs to their employees but all have the ability to do so. The benefit of these accounts is that they can provide first dollar coverage for lower-income participants that are participating in high-deductible health plans, since higher deductibles can be a burden, particularly to those with lower incomes. Further, HSAs can be set up as true investment vehicles for certain participants (typically higher earners), to save for medical expenses in retirement. Note that unless directly funded by the State, any monies that would be added to these accounts from an employer perspective would either need to be funded by the districts or built into the premiums offered through TRS-ActiveCare.

- Incentives for certain behaviors

  While the above discusses the general nature of account-based plans, some plan sponsors choose to provide these funds as incentives, based on meeting certain plan requirements. This approach can build in some health-related requirements and/or health behaviors that could potentially reduce overall long-term trends as a prerequisite for earning dollars.

  TRS-ActiveCare currently provides an incentive program where members earn dollars when they call to shop for commonly known health care services. This program provides personalized education and navigation to help members use their benefits more effectively to get a better value. Participants can save money depending on where they go for care.

- Creation of a Flex Type Design for the districts

  Another consideration for TRS-ActiveCare would be to implement a Flexible Benefits Design, which is an approach that could be implemented in several ways, including Flexible Plan Design – where districts would have choice in the designs that get offered to their participants from a pre-selected list and/or a Flexible Carrier Approach – where multiple carriers can be offered.

A detailed list of advantages and challenges associated with these various approaches is included later in this report. TRS-ActiveCare would need to perform additional analysis to determine the viability and fit for the program.

Pharmacy Benefit Management (PBM)

Prescription drugs are the most highly utilized benefit within health insurance. TRS currently provides self-insured pharmacy benefits through a contracted large national PBM. This relationship was procured through an RFP, and through review of hundreds of pharmacy contracts and contract terms annually, we consider this to be best in class. It includes many of the best practices, based on Segal's industry knowledge, described in the pharmacy section, including:

- Comprehensive and competitive contract clearly defining annual terms including minimum financial guarantees on discounts and rebates by distribution channel with 100% pass through to the plan. This allows for maximum payments with no limits on upside while putting downside risk on the PBM who has negotiating power with the manufacturers and networks.
- List price trend guarantees – this also shifts risk to the PBM
- Inflation protection guarantees – this shifts risk to the manufacturers
- Transparency regarding pharmacy reimbursements, manufacturer rebates and audit requirements
- Utilization management and clinical rules including prior authorizations, step therapies and quantity limits
- Annual market checks to ensure best pricing
- A plan design that incentivizes lowest cost drugs through member cost sharing (copays and coinsurance) while maximizing manufacturer rebates

Additionally, TRS is implementing Manufacturer Copay Assistance programs for FY 2023 for all eligible plans. These programs are in place with a number of large state plans.

TRS and the PBM need to continuously focus on pharmacy management to aggressively:

- Manage the Pharmacy Pipeline – when/if to put on formulary
- Implement Utilization Management and Prior Authorizations
- Review Specialty Drugs – pricing, limited distribution drugs, etc.
- Isolate Medical Specialty Costs

Clinical Opportunities

The clinical section provides a review of opportunities. We have focused our review on four main areas – addressing current needs of the population and opportunities for long term success:

- Oncology Second Opinion
- Clinic Options – via Telemedicine, onsite/near site clinics, and hybrid virtual clinics—platforms providing on-demand in-person care.
- Digital Therapeutics - TRS has had good initial success in their digital diabetes pilot. We recommend TRS consider expanding the pilot to a broader subset of the population.
- Concierge Care/Health Advocacy - We would recommend that TRS reviews options available through its current vendors and vendors in the marketplace.

The clinical recommendations would provide enhancement to the benefit structure and improve the care for TRS's membership.

Network Options

TRS-ActiveCare is an extremely large self-insured plan sponsor who contracts with a health plan to provide statewide networks along with favorable pricing and administration of their plans. TRS requires good access for all types of providers in the entire state, but there are also other contractual agreements for many services beyond network access provided by the health plan. TRS chooses a health plan through a formal procurement process with analysis balancing all of the services required along with pricing. Developing a network is a massively complex and continuous job for a health plan, and not one for a large plan sponsor. However, TRS management understands that healthcare varies by locality, and they continue to look for opportunities to curate a more custom network to include even better access to quality care specific to local needs.

Given the diverse workforce and geographic dispersion across the state, we believe the opportunities do not lie in a customized statewide contracting effort, but rather in potentially leveraging other existing statewide or local arrangements to support this approach.

A tiered network has some traction in other states, where members who utilize a "Tier 1" narrow network provider would get enhanced benefits, with "Tier 2" resorting back to the current PPO broad network. This is in development in Texas, with some vendors currently offering the product.

The health care industry as a whole is trying to move away from payments based on fee-for-service (FFS), where providers are paid for each procedure they perform, to some type of value-based care. Value-based care comes in many forms, but the premise is that providers are paid based on efficient care and/or quality outcomes rather than FFS. Most value-based arrangements include some type of risk sharing or gain sharing with the provider.

Types of value-based alternative payment models include:

- Bundled payments or case rates
- Reference based pricing
- Pay for Performance

- Shared savings
- Capitation

Types of value-based alternative service models include:

- Patient Centered Medical Homes (PCMH)
- Accountable Care Organizations (ACO)

Blue Cross Blue Shield has some of these value-based models in the current network that TRS-ActiveCare is currently using. TRS has an opportunity to lead the way to influence more of these arrangements and curate more value-based models.

In Summary

The largest issue with the TRS-ActiveCare program is a lack of funding. Health care costs have risen on average 5% per year over the past 20 years, and funding from state and local sources for TRS-ActiveCare is largely the same as was legislated 20 years ago.

Although the program is highly efficient, much of the benchmarking points to low state and employer funding leading to members contributing more premium than their peers and higher out-of-pocket costs. These results are across all benchmarks including other state peer groups, Texas employers, and national employers.

With the resources and staff available, TRS has been successful in managing the program while staying current with market opportunities. Segal's review identified opportunities to further enhance the TRS-ActiveCare program. These opportunities include clinical programs, network strategies, pharmacy management, plan options and underwriting. However, some programs require up-front investment before the plan is able to realize a return on investment (ROI). This is difficult with the lack of funding in the current system and eliminates options that do not provide an immediate ROI.

TRS partnered with state leadership over the past year to share information about funding issues and identify claims eligible for federal reimbursement. As a result of additional funding from The Coronavirus Aid, Relief, and Economic Security (CARES) Act and American Rescue Plan Act (ARPA) this year, the employers will receive rates that are below market for at least two rate cycles. If additional funds are not available to TRS, rate increases for public education employees will be significantly higher than trend in near-term future years.

With a change to the funding policy, the benefits may be enhanced significantly.

State Comparison

This section of the study is intended to provide a high-level benchmarking comparison of state program structures, eligibility rules and other provisions included in public education employee health benefit plans.

Segal captured data using internal research and benchmarks along with published data from Georgetown University Health Policy Institute study. Segal's research included a review of the public information available on state health plan websites, state level education department websites, state retirement administration websites, state educators' certification websites, and state and local government legislation (administrative codes). This allowed us to compare eligibility and program participation rules across all states.

When collecting data from various sources, there are always some discrepancies. As we put the exhibits together, we used the latest information available, supplemented by our client experiences. Segal has not audited the information provided, but believe in totality, it is reasonable benchmark for this study.

From the data, we developed two main summary tables:

- Summary - School District Structure: This table summarizes data specific to the health plan coverage for school districts.
- Summary - Program Eligibility: This table lists the participation eligibility for each State Employee Health Plan.

These exhibits provide the foundation for the observations included in this section.

Teacher Retirement System of Texas

Currently, Texas provides coverage to school district employees and their dependents through TRS-ActiveCare, a State Level Education Health Plan administered by the Teacher Retirement System. **Note that we use school district and public education employer interchangeably throughout this report with both public school districts and charter schools included in the programs we describe.** TRS-ActiveCare provides benefits to actively employed public teachers and school district employees of employers in Texas that choose to participate in the plan. It is separate from the state employee health plan provided through the Employees Retirement System (ERS), which covers individuals employed by the state and other agencies, retirees, and their dependents.

Prior to the enactment of Senate Bill 1444 (87R) in 2021, employers were not allowed to opt out after joining TRS-ActiveCare. Additionally, school districts and other risk pools with 500 or fewer employees were required to participate in TRS-ActiveCare. With enactment of this new legislation, participation in TRS-ActiveCare will be voluntary at the district level and school districts may choose to leave TRS-ActiveCare by notifying TRS by December 31st of the year before the plan year they intend to leave the plan (e.g.., notify by 12/31/2021 to leave 9/1/2022). After a school district makes the decision to leave TRS-ActiveCare, they can only re-join after a period of five plan years. Employers that are not currently participating in TRS-ActiveCare and elect to join must remain in TRS-ActiveCare for at least five years. These five-year entry-exit provisions are employed to manage selection risk and maintain stability for the program.

Program Structure and Participation Eligibility by State

Program structures vary significantly from state to state. Overall, we found five basic structures for providing benefits to school districts as noted below:

Option 1 – Combined with State Health Plan (Required): in this scenario, school districts are required to be part of the overall state health plan, which is defined as the health plan that covers all employees of the state. This option provides a standard set of benefit options for state employees and school district employees, which reduces the flexibility and autonomy that school districts have to control benefits. School districts may want the ability to control benefits in order to influence recruiting and retention. Alternatively, in some states, the state health plan options may provide a higher level of benefits than school districts or local governments would provide on their own. *In this scenario, public education health benefits would be provided by the Employee Retirement System of Texas (ERS).*

Option 2 – Combined with State Health Plan (Voluntary): in this scenario, school districts have the option to join the state health plan or to join another plan and/or administer their own plan. The state health plan must continue to adequately manage risk for the stability of the program and often does this through entry-exit rules that require plans to join for a certain number of years before exiting (or remain out of the plan for a certain number of years after exiting before re-entering).

Option 3 – State Level Education Health Plan (Required): in this scenario, all school districts in the state are required to join a state-wide education health plan that is separate from the state health plan. This is similar to option 1, except that all school districts are in a plan that is distinct from the plan that covers other state employees.

Option 4 – State Level Education Health Plan (Voluntary): in this scenario, all school districts in the state have the option to join a state-wide education health plan that is separate from the state health plan or to join another plan and/or administer their own health plan. This is similar to option 2, except that all school districts have the option to join a state-wide plan that is distinct from the plan that covers other state employees. *TRS falls under this category.*

Option 5 – School District Level Health Plan: in this scenario, school districts do not have the option to join the state health plan or a state level education health plan and must administer their own health plan (or potentially join a separate coalition). This option provides flexibility and autonomy to each school district, but also provides the least amount of overall protection from a risk perspective.

The table below shows the number of states within each basic structure based on the descriptions above:

	Number of States
Combined with State Health Plan (Required)	21
Combined with State Health Plan (Voluntary)	9
State Level Education Health Plan (Required)	2
State Level Education Health Plan (Voluntary)	7 (*including TRS*)
School District Level Health Plan	11

As noted in the table, the most widely used option by states is to require school districts to be covered under the state health plan. TRS is one of seven states that provides optional coverage through a state level education health plan and is the largest of this type with 283,000 individual employees currently covered and 433,000 total members including spouses and dependents.

Entry-Exit Rules for Voluntary Coverage

As noted in the descriptions for Option 2 and Option 4 above, coverage through these state health plans, or separate state level education health plans, is voluntary. This can potentially negatively affect the state-wide health plan, since employees from school districts that enter or exit will potentially change the risk pool. If school districts with low claims experience all begin to leave the state plan, then rates in the plan will increase, potentially creating a scenario where more districts decide to leave because of the rate increases. The state-wide plan must remain sustainable and manage risk for the stability of the program. One way to combat this is through the use of entry-exit rules. Information on participation rules can be difficult to obtain since it is not often publicly available. Of the 16 entities with voluntary state-wide coverage, we were able to find the following participation rules:

- Four states identified a certain timeframe required once joining the plan and upon leaving the plan. The timeframe typically varies from 3 to 5 years.
- One state requires districts to remain in the plan for 3 years upon joining or pay a penalty if they leave in the first 2 years.
- Some states develop rates and/or surcharges based on the entering/joining school districts' loss experience for the first few years and then convert to the published state level plan rates.

Another way for larger states to provide a sustainable program, especially when there is significant variation in costs from region to region, is to provide regional rating. We identified one state (California) that provides regional adjustments to rates for school districts and local governments.

Cost Benchmarking

TRS requested Segal to benchmark the TRS-ActiveCare program last year to gain a broader understanding of how the program compares to other states in terms of health plan features and costs. TRS-ActiveCare plans were compared against a targeted comparison group of peer state plans and national averages from all states. The targeted benchmark states included Alabama, Georgia, Illinois, North Carolina, Tennessee & Wisconsin. The national state averages came from Segal's 2018 State Employee Health Benefits Study.

TRS-ActiveCare currently provides four benefit design options. Three of these plans, ActiveCare Primary, ActiveCare Primary+ and ActiveCare2, were used to compare against other PPO plans (costs are weighted by enrollment where one number is shown), while ActiveCare HD was used to compare against other high deductible health plans (HDHP).

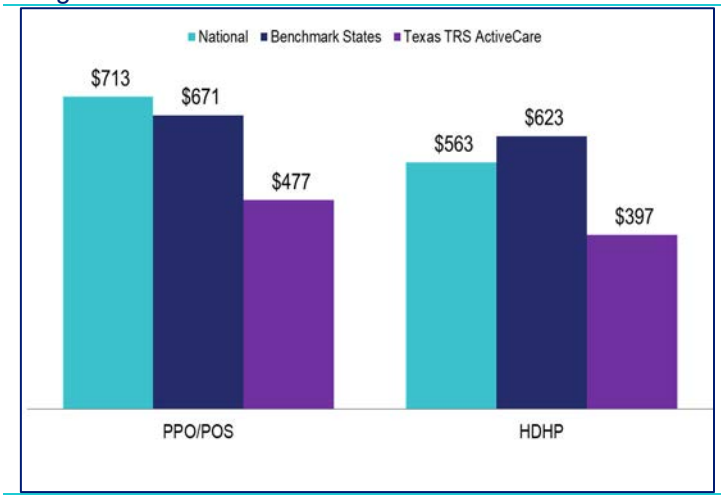
Multiple items were examined during the benchmarking study; however, for purposes of this report we will highlight the key components starting with: Total Premium, State Contributions, Employer Contributions and Employee Contributions. The Total Premium represents the amount of total funding the plan needs to administer the benefits of ActiveCare, including funding from both the state/ employers and employees. The charts on the following page illustrate the benchmarking of these key components.

Overall, TRS-ActiveCare total premiums (the combined State, Employer, and Employee contributions) are lower than benchmark states and national state averages. However, Employer funding for TRS-ActiveCare is significantly lower than benchmark states and national state averages, which then requires employee contributions to be higher and more burdensome on employees than with the benchmark states. The problem is further exacerbated for employees with family coverage.

"TRS-ActiveCare total premiums (the combined State, Employer, and Employee contributions) are lower than benchmark states and national state averages."

Total Premium = State/Employer Contribution + Employee Contribution

Single



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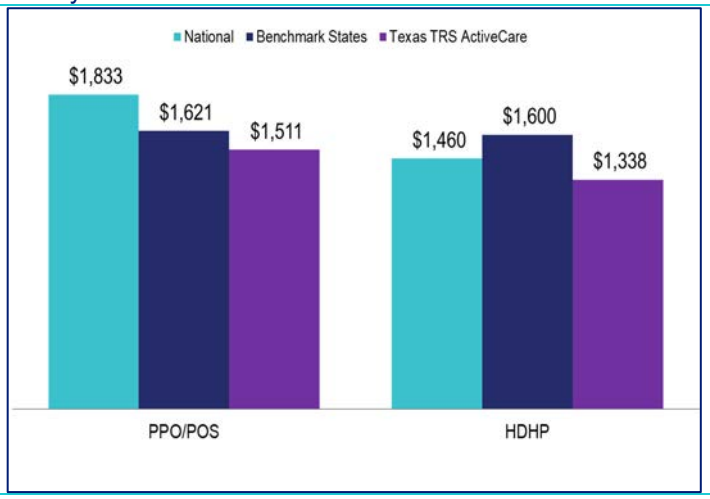
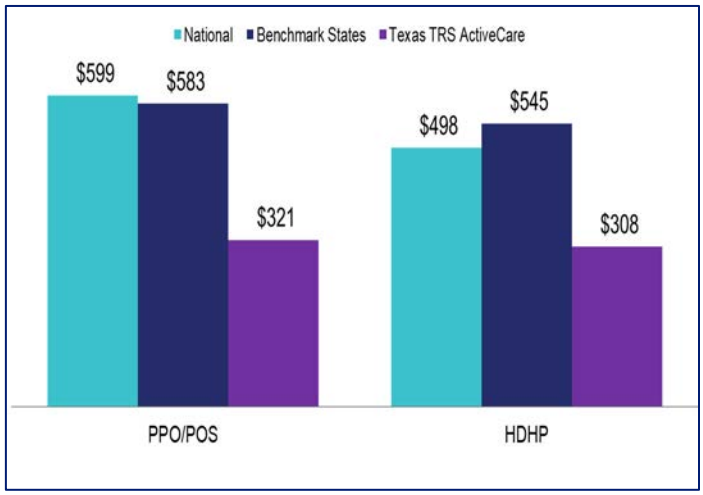


State/Employer Contribution = Employer Funding

Single



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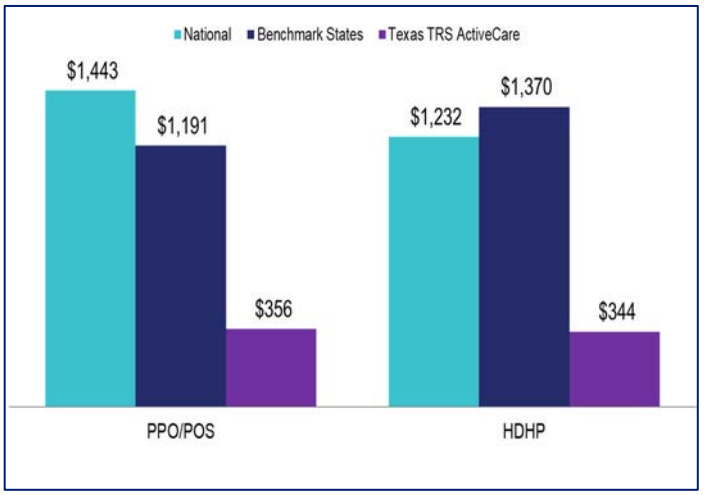
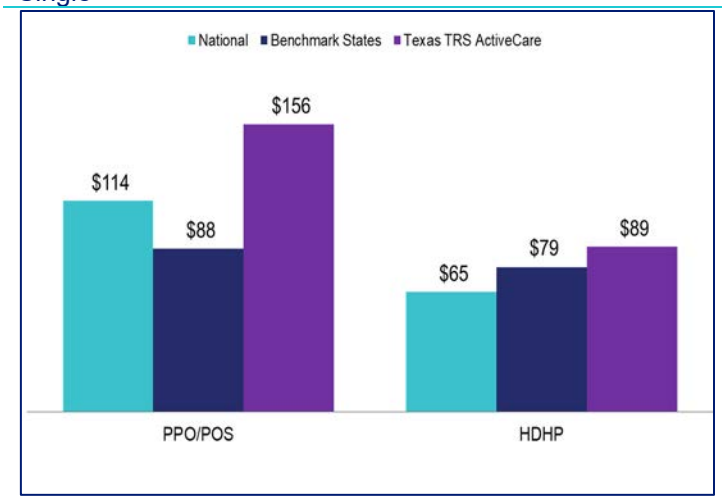


Employee Contribution

Single



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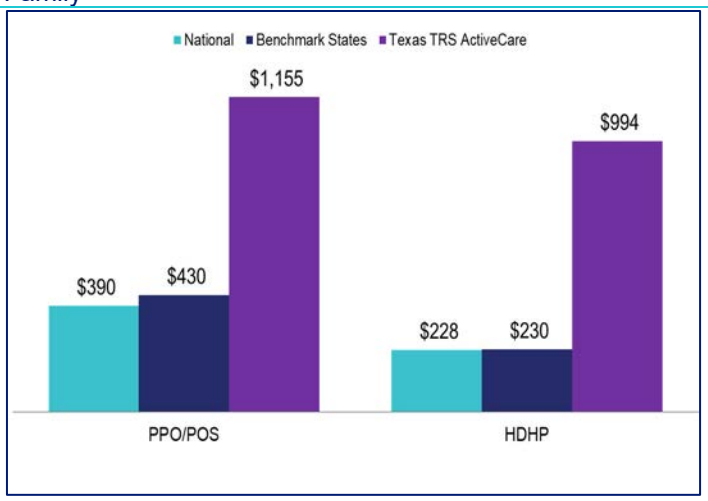
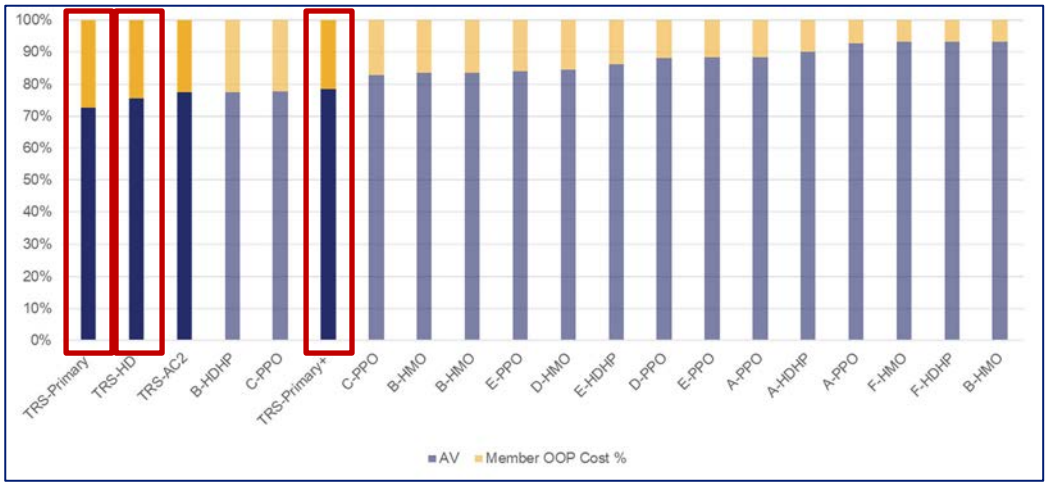


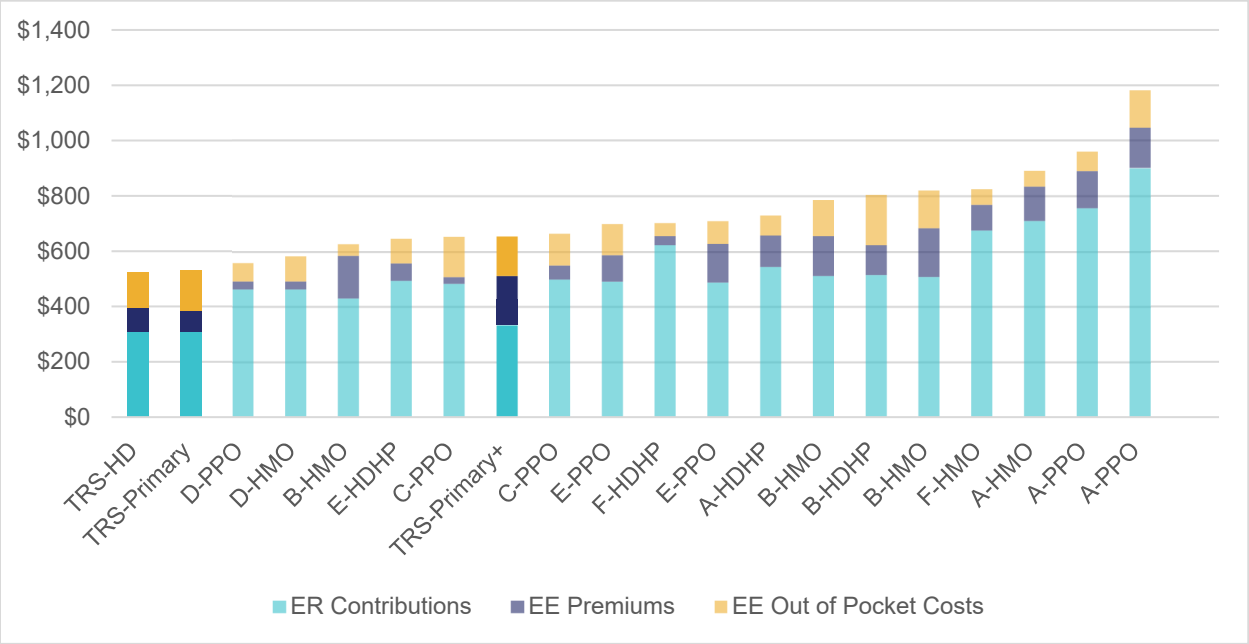
In addition to the premium rate shown above, members also pay out-of-pocket costs (deductible, coinsurance, copays) based on plan designs. Another benchmark known as Actuarial Value (AV) was used to compare plan design differentials. Actuarial Value provides measurement of overall plan value based on the average member out-of-pocket costs. The higher the actuarial value, the lower the member cost sharing. Below is a ranking of the actuarial values for the plans in the benchmark states with TRS-ActiveCare plans highlighted with red boxes.

Actuarial Value = Percentage of benefits paid by the plan



Primarily due to lower overall funding levels, the TRS plans are some of the lower actuarial value plans when compared to the benchmark states, listed above in the chart as B-HDHP, etc. *(Note that these results are blinded, with letters identifying the various state comparators, along with the type of plan offering)*. This means that in addition to the higher employee contributions noted earlier, members have higher cost sharing through higher-than-average deductibles, coinsurance, copays, and maximum out of pocket amounts. For example, for TRS-Primary, the plan pays 73% of the total cost, while the member will pay 27% of the total cost in out-of-pocket costs on average. The 73% remaining is the total premium cost and is then funded through the employer premiums and employee contributions, represented in the top graph shown in the chart on the prior page.

If we add the employee out-of-pocket costs to the total premium costs (split by state/employer premiums and employee contributions), we get the total cost of the plans. The graph below ranks the total costs for the single plans in the benchmark states with TRS-ActiveCare plans currently available for enrollment highlighted in bold bars. State/Employer contributions "ER" are shown in light blue, employee contributions "EE" in dark blue and employee out-of-pocket costs in yellow "EE".



Even with the lower AVs and higher employee out-of-pocket costs included, the total costs for TRS-ActiveCare plans are lower on average than the benchmark states including two of the lowest cost plans. This demonstrates that TRS is operating efficiently and is more cost effective than the comparative groups.

The State/Employer Premium/Funding has a tremendous impact on the entire program. With the impact of rising costs in healthcare nationally year over year and given current funding levels, TRS management has performed extremely well managing the overall cost of the program while balancing the impact of benefit reductions and employee premium increases. If TRS received higher Employer contribution amounts, similar to other states, the program could be enhanced potentially allowing TRS to have higher actuarial values. The additional funding would allow TRS to expand benefit offerings, reduce member cost sharing, lower family premiums, etc.

"TRS is operating efficiently and is more cost effective than the comparative groups."

Sources:

"UNLEASHING THE GIANT: Opportunities for State Employee Health Plans to Drive Improvements in Affordability" June 2021; by Sabrina Corlette, Maanasa Kona, and Megan Houston, Georgetown University Health Policy Institute, Center on Health Insurance Reforms.

Texas Market

This section focuses on the Texas Market and a broad view of various factors that impact healthcare decisions.

In Texas, employers provide 48% of health insurance coverage for the total population, consistent with the U.S. average of 49%. Texas is also the state with the highest number and highest percentage of uninsured in the nation[2]. A highly uninsured population affects the overall economy, putting stress on the healthcare industry with excessive use, uncompensated care and leaving those with insurance paying higher costs. This highlights the significance that employers play in healthcare. Affordable healthcare not only enables employers to attract, motivate, and retain highly skilled and talented employees, but paired with healthier employees who contribute towards increased productivity, impact the economy overall.

Many of the private health plan enrollments through employers and individual plans in Texas have managed care plans sold by HMOs and other health insurers. Even the government plans including Medicare and Medicaid are growing share in managed care plans[3]. HMOs are managed care plans providing services through networks of doctors, hospitals, and healthcare providers with a primary care physician selected to oversee care and specialist referrals. Based on 2019 data, there are 42 or so companies licensed as HMOs in Texas with UnitedHealthcare being the largest. Other healthcare systems operating HMOs in Texas include Memorial Hermann, Superior Healthcare (government sponsored healthcare programs), Community Choice (Harris County), and Scott and White Health Plan. Texas HMOs offer Commercial, Medicare, Medicaid, Marketplace, and Self-Insured (Others) product lines. Commercial lines include members enrolled through employer group or individual policies[4]. HMO enrollment in employer group plans has declined dating back to 2000, where HMO enrollment in individual plans has increased as of 2014. Employer groups moved to PPO plans both in the Texas Market and on a national level. Blue Cross Blue Shield of Texas, which is contracted by TRS-ActiveCare, is one of the largest insurers in Texas with both HMO and PPO plans, along with Aetna, CIGNA, and UnitedHealthCare[2].

TRS has HMOs and PPO based programs, consistent with the marketplace. Enrollment in each varies depending on the region, where HMO offerings may be more or less prevalent.

Provider Landscape

Healthcare systems in Texas are reaching larger geographic area and operating their own health insurance companies by forming partnerships. Their larger footprint provides significant negotiation leverage when these provider groups negotiate with insurance companies, resulting in upward pressure on pricing.

Based on 2019 data, HCA Healthcare is the largest healthcare system, having over 50 hospitals in the four largest Texas metropolitan areas. HCA has a number of joint ventures, including ones with St. David Hospital, Methodist Hospital, and others.

[2] Kaiser Family Foundation, Health Insurance Coverage of the Total Population; https://www.kff.org/other/state-indicator/total-population/?dataView=0&currentTimeframe=0&selectedDistributions=uninsured&sortModel=%7B%22colId%22:%22Uninsured%22,%22sort%22:%22desc%22%7D

[3] Texas Health Market Review; By Allan Baumgarten; December 2020

[4] Office of Public Insurance Counsel, 2020-2021 Guide to Texas HMO Quality; https://www.opic.texas.gov/hmo-report-card/

The University of Texas hospitals is the second largest system. It includes M.D. Anderson Cancer Center, University of Texas Southwestern in Dallas, and the University of Texas Medical Branch in Galveston. There are many partnerships in place, including ones with Ardent Health, the University of Texas Northeast Health System, and seven hospitals in the Tyler area.

The third largest healthcare system, Baylor Scott and White, was formed by a merger in 2013 and was in merger talks with Memorial Herman system that were cancelled in 2019. However, that same year, Baylor Scott and White acquired SHA, LLC, doing business as First Care and Southwest Health Alliance from Covenant Health System and Hendrick Health System.

For Medicaid, Centene acquired WellCare in 2020, becoming the largest Medicaid managed care company in the U.S.

TRS Creation and Funding History

In 2001, TRS was given the responsibility of administering a new statewide health care program for eligible public school employees and dependents called TRS-ActiveCare. It is our understanding that prior to the creation of TRS-ActiveCare, comparability studies conducted by TRS, on behalf of the Texas Legislature, indicated that many Texas public school employees did not have affordable health coverage that was comparable to the coverage offered to state employees. Seventeen school districts offered no health insurance to their employees and 46 percent did not offer comparable coverage. With this in mind, TRS-ActiveCare was designed to provide comparable and additional coverage choices to all eligible employees of participating school districts.

Consistent with this goal, statute required TRS to make a benefit plan similar to the Uniform Group Insurance Program (UGIP) for state employees, administered by ERS, available to public education employees. As originally enacted, TRS was required to offer a basic plan as well as a more comprehensive plan similar to the UGIP. The basic plan was funded at an amount within $25 per member per month of the UGIP. Public education employees also received a $1,000 per month raise so that they could afford the more comprehensive plan, elect coverage outside of TRS, or use the funding for other purposes. Funding for TRS-ActiveCare was originally set with a minimum employer contribution of $225 per month, and participating school districts were allowed to fund this through a mix of state and local funding sources. The $225 minimum contribution is made up through the school finance formula requiring a state contribution of $75 per employee per month and a $150 minimum contribution from the public education employer. The minimum contribution required by the state and participating districts has never been increased. Because funding per member subsequently lagged behind funding for the UGIP, the TRS option comparable to UGIP became unaffordable to many TRS members. The requirement was eliminated in 2013,HB 3357(83R).

As of today, the TRS monthly minimum State/Employer contribution is still $225 with many Participating Districts contributing more than the minimum. In 2021, TRS districts' contributions towards health coverage varied significantly across the state:

2021 Average District Contribution	Number of Districts	Number of Employees	% of Employees
$0- $225	185	20,242	7.10%
$226- $249	18	3,897	1.40%
$250 - $275	172	50,377	17.60%
$276 - $299	43	11,780	4.10%
$300 - $325	239	72,241	25.20%
$326 - $351	67	35,074	12.20%
$352 - $377	29	8,811	3.10%
$378 - $403	74	23,631	8.20%
$404 - $429	128	38,035	13.30%
$430 and up	75	22,402	7.80%

Overall, the weighted average district contribution is approximately $330.

The calculated monthly average of employer contribution is $817 in Texas and $849 for the U.S. overall.

This contribution is lagging other employers on a national basis as well as employers in Texas. Using a 2020 study and survey by the Medical Expenditure Panel Survey (MEPS), the Insurance Component collected data on employer-sponsored health insurance offerings in the U.S. The calculated monthly average of employer contribution is $817 in Texas and $849 for the U.S. overall.

2020 Average Monthly Employer Sponsored Premiums	U.S.	Texas
Employee Contribution	$321	$353
Employer Contribution	**$849**	**$817**
Total Premium	$1,169	$1,170

KAISER FAMILY FOUNDATION (KFF) State Health Facts - National Avg Premiums; Sources: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey (MEPS)- Insurance Component, 2013-2020.
Notes: The Medical Expenditure Panel Survey (MEPS) Insurance Component is an annual survey of establishments that collects information about employer-sponsored health insurance offerings in the United States. Figures may not sum to totals due to rounding.

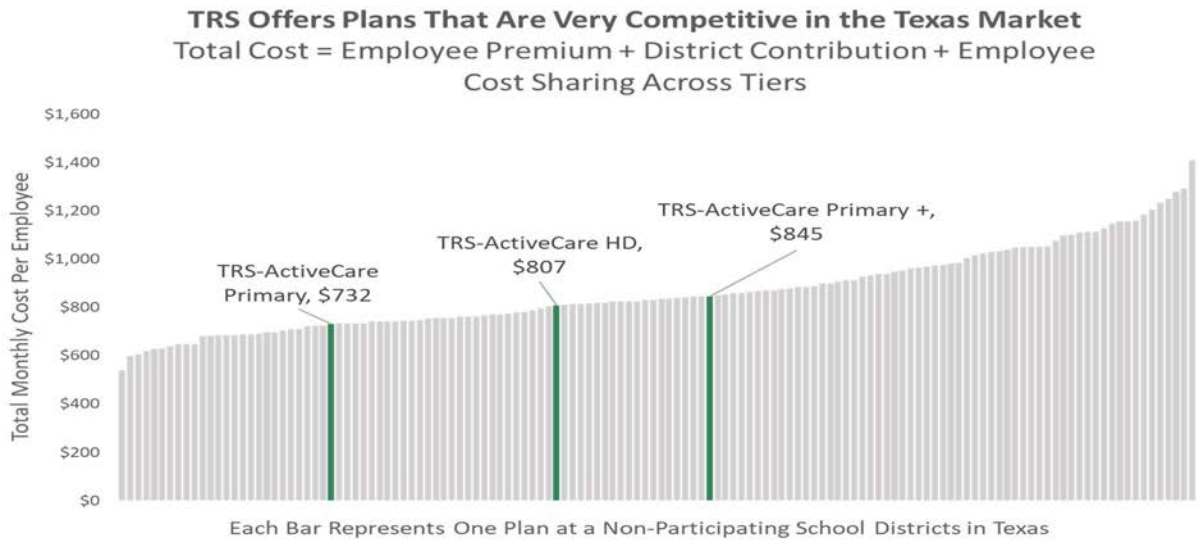
At the $330 average district contribution, TRS is only receiving 40% of the Texas average.

Non-Participating Districts

TRS performed a 2021 Non-Participating District Benchmark Study. Based on the analysis, it was determined that the level of benefits provided by non-participating districts are comparable but generally provided at a higher overall cost.

As part of this study, State/Employer contributions and overall premiums were also collected for 39 districts and 141 total plans representing 82% of employees in non-participating districts. From a State/Employer contribution perspective, 53.8% of the 39 districts (21) provide a subsidy of over $430 per month. This compares to only 7.8% of members in TRS. In addition, only 3 non-participating districts, or 7.7% of the studied population, provided less than $326, whereas 55.4% of TRS members receive less than this amount. So collectively, it appears that non-participating districts contribute significantly more than participating districts.

If we compare total cost for the plans, including State/Employer contribution, employee premium and employee cost share, TRS plans are more competitive for the majority of non-participating districts. The chart below shows TRS plans vs. other plans being offered:



Other Market Competitors

There have been several competitor programs that have drawn membership from the TRS population over time. Prior to the enactment of SB 1444 (87R), some districts worked with brokers who provided “competing coverage” alongside TRS offerings. Historically, this coverage has been less expensive, but much leaner than what is provided through TRS. This resulted in attracting some of the healthier individuals, leaving TRS population with the sicker population. SB 1444 clarified that competing coverage is not permitted when participating in TRS, but some districts may choose to opt out of TRS and offer their own benefits in their market.

The passage of SB 1444 may lead to additional areas of competition for membership within the State. Additional coverage is also available through partnerships like the Texas Association of School Boards (TASB). TASB is a statewide voluntary not-for-profit association that supports the local Texas school boards. TASB membership is voluntary with products and services provided to members as part of their annual membership fees. Further competitors may arise as districts continue to make decisions relating to participation in TRS-ActiveCare.

Public Exchange Offerings & Evolution

Along with group-based coverage, there is also a growing individual market coverage landscape as a result of the Affordable Care Act (ACA). The overall U.S. healthcare system was historically changed by ACA and brought the marketplace exchanges that deal with many of the same challenges employer health plans experience. In 2014, ACA qualified individuals who made less than 400% of the federal poverty level qualified for a subsidy on coverage purchased through the health insurance marketplace exchanges. Premiums were allocated on a sliding scale determined by income. Small business tax credits were also put in place. The ACA required all Americans to get health insurance available through employer health plans, individual plans, marketplace exchange, or pay a fine.

A major change took place in 2017 causing uncertainty to the exchanges and premiums in 2018 and 2019. The presidential administration decided to cease reimbursements to insurers for cost-sharing reductions (for those with incomes below 250% of the federal poverty level). This resulted in marketplace premiums to increase, exceeding 29% on average, especially on the silver plans. Along with premium adjustments, some insurers also left the exchanges or opted to only offer the more economical HMOs and EPO plans[5]. As additional talks to repeal and replace the ACA were being discussed, uncertainty in the marketplace continued with increase in premiums causing a drop in enrollment from 2017 through 2019. The Texas Market mirrored this decrease in enrollments. Although "Repeal and Replace" legislation did not pass, legislation was passed eliminating the individual mandate penalties, beginning in 2019. Insurers began adjusting premiums accordingly averaging a 0.4% to 3.5% premium reduction within a year.[6] The Texas Market was a little slower to see increasing enrollment but picked up considerably from 2020 to 2022.

Exchange Enrollments	2019	2020	2021	2022
U.S. Enrollments	11.4M	11.4M	12.0M	14.5M
Percentage change	-3%	0%	5%	21%
Texas Enrollments	**1.1M**	**1.1M**	**1.3M**	**1.8M**
Percentage change	**-4%**	**3%**	**16%**	**42%**

Exchange Structure

As of 2022, there are 18 state-based exchanges, three (3) state-based, federally supported exchanges, and 30 federally facilitated exchanges (exchanges and marketplace are used interchangeably). Some states have changed their models over the years. Kentucky, Maine, and New Mexico moved to state-based exchanges for 2022. As of 2020 there were 12 state-based exchanges, five (5) state-based federally supported exchanges, 28 federally facilitated exchanges, and six (6) state-partnership exchanges.[7] A state-partnership exchange is a hybrid model where states may assume primary responsibility for many of the functions of the Federally-

[5] Healthinsurance.org, Texas Health Insurance Marketplace: History and News of the State's Exchange; by Louise Norris, February 15, 2022; https://www.healthinsurance.org/health-insurance-marketplaces/texas/

[6] U.S. Health Reform—Monitoring and Impact, Marketplace Premiums and Insurer Participation: 2017 – 2020; January 2020 By John Holahan, Erik Wengle, and Caroline Elmendorf; https://www.urban.org/sites/default/files/publication/101499/moni_premiumchanges_final.pdf

[7] KFF: State Health Insurance Marketplace Types, 2022
https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Facilitated Exchange permanently or as they work towards running a State-based Exchange.[8] The Texas exchange operates as a Federally Facilitated exchange.

Premiums and Metal Categories

The plans in the marketplace exchanges fall into the four metal categories based on how the plan splits the costs and amount paid by insurance. The silver metal category is frequently used as a baseline for several benchmarking data, election is required to receive the subsidy for those eligible for the cost-sharing reduction, and even several Medicaid insurers frequently offer the lowest silver premiums in the marketplace.

Plan Category	Insurance Pays (Actuarial Value)	Member Pays
Bronze	56% - 62%	38% - 46%
Expanded Bronze	56% - 65%	35% - 46%
Silver	65% - 72%%	28% - 35%
Gold	76% - 82%	18% - 24%
Platinum	86% – 92%	8% - 14%

Based on these values, the TRS-ActiveCare plans would all fall into the Gold range for coverage. Current premiums and actuarial values for these plans are detailed below.

TX TRS Plan	2021 -2022Total Monthly Rate	Actuarial Value
TRS-ActiveCare Primary	$417	76%
TRS-ActiveCare HD	$429	77%
TRS-ActiveCare Primary+	$542	81%

In the individual marketplace, rates vary widely by metallic level as well as by region and age. When comparing the TRS premium rates to Gold plans in the market, the TRS rates are generally more competitive. Using the rates for a 40-year-old, which is similar to the TRS population's average age, and weighting by the location of where TRS participants reside, the weighted average lowest cost Gold rate is $418, while the weighted average "average" rate by region is $546. The lowest cost TRS plan (Primary, $417) is approximately the same cost as the average lowest cost gold plan in the market ($418), while all plans are less expensive than the average Gold plan rate ($546). These rates are more competitive than the market, even with the much broader provider networks that are offered through the TRS program.

[8] DHHS, Affordable Insurance Exchanges Guidance, Guidance on the State Partnership Exchange; January 3, 2013, By Center for Consumer Information and Insurance Oversight

Market Design Comparison and General Market Data

According to "My Texas Public School District" website, there are 1,026 public school districts that are independent, consolidated, or municipal school districts. All but one is separate from any municipality, county, or the state. Aside of the high-level State Comparison earlier in this report, Segal also gathered 2021 health and welfare benefit program data through an internal benchmark of several Texas political subdivisions (public sector municipalities) as well as publicly available survey data listed below.

- Austin Independent School District
- Bexar County, TX
- City of Arlington, TX
- City of Austin, TX
- City of Dallas, TX
- City of El Paso, TX
- City of Fort Worth, TX
- City of Garland, TX
- City of Georgetown, TX
- City of Houston, TX
- City of Plano, TX
- City of Round Rock, TX
- City of San Antonio, TX
- San Antonio Independent School District
- Texas ERS
- Travis County
- University of Texas at Austin

National data source material: (1) 2019 Mercer National Survey of Employer-Sponsored Health Plans and (2) 2020 Kaiser Family Foundation Employee Health Benefits Survey.

In comparing the TRS-ActiveCare health plans to these public entities in Texas, the TRS-ActiveCare plan designs were within the deductible, coinsurance, copay, and maximum out-of-pocket ranges for medical and prescription benefits. However, the majority of TRS medical and pharmacy benefits were toward the higher end of the ranges (i.e., less competitive).

2021 CDHP/HDHP	2021-2022 TRS-ActiveCare HD	Local Data	National Data Industry: Government Region: South
Deductible	$3,000 Ind $6,000 Fam	$500 – $5,000 Ind $1,250 – $10,000 Fam	$1,750 – $3,000 Ind $3,500 – $6,500 Fam
HSA/HRA ER Credit/Deposit	$0 HSA	$125 – $1,000 (HSA) $250 – $700 (HRA)	$550 - $600 Ind; $1,000 Fam
Coinsurance (after deductible)	30% In-Network 50% OON	0% – 40% In-Network; 40% – 50% OON	20% In-Network; 40% OON
Out-of-Pocket Max	$7,000 Ind $14,000 Fam	$3,000 – $8,150 Ind $6,000 – $16,300 Fam	$4,000 – $8,150 Ind $6,850 – $16,300 Fam
Rx (retail) after deductible	20% Generics 25% Formulary	0% – 20% after Ded (Generic)	Subject to Deductible & Coinsurance
	50% Non-Formulary	10% – 20% after Ded (Brand)	

2021 PPO/POS/OAP	2021-2022 TRS-ActiveCare Primary	2021-2022 TRS-ActiveCare Primary+	Local Data		National Data Industry: Government Region: South
Deductible	$2,500 Ind $5,000 Fam	$1,200 Ind $3,600 Fam	$350 – $3,000 Ind $1,000 – $6,000 Fam		$750 – $1,000 Ind $1,250 – $2,500 Fam
Coinsurance (after deductible)	30% In-Network No OON Cvg	20% In-Network No OON Cvg	0% – 30% In-Network 30% – 50% OON		20% In-Network; 40% OON
Out-of-Pocket Max	$8,150 Ind $16,300 Fam	$6,900 Ind $13,800 Fam	$1,800 – $8,150 Ind $3,400 – $16,300 Fam		$3,000 – $4,000 Ind $6,600 – $8,000 Fam
Office Visit Copays	$30 PCP $70 Spec	$30 PCP $70 Spec	Tier 1: $0-$35 PCP $25-$75 Spec.	Network: $25-$45 PCP $25-$65 Spec.	$25 PCP $45 Specialist
Rx (retail): Generic Brand Formulary Brand Non-Formulary	$15 Copay 30% after Ded 50% after Ded	$15 Copay 25% after Ded 50% after Ded	$0 – $30 Generic $25 – $100 Formulary $45 – $150 Non-Formulary		$11 Generic $33 Formulary $57 Non-Formulary
Rx Deductible	integrated with medical	$200 per person for brand	$50 – $100 per person $125 – $300 Fam		Not surveyed

2021 HMO/EPO	2021-2022 TRS-ActiveCare (HMO) Regional Network	Local Data: Traditional HMO		Local Data: EPO		National Data Industry: Government Region: South
Deductible	$500-$1,150 Ind $1,000-3,450 Fam	$0–$1,500 Ind $0–$3,000 Fam		$600-$4,200 Ind $1,700-$8,400 Fam		$500 – $1,000 Ind $1,500 – $2,500 Fam
Coinsurance (after deductible)	20% - 25%	0% – 20%		0% – 40%		0% – 40%
MOOP	$4,500-$7,450 Ind $9,000-$14,900 Fam	$2,500 – $8,150 Ind $5,000 – $16,300 Fam		$4,500 - $8,150 Ind $9,000 – $16,300 Fam		$2,500 – $8,150 Ind
Office Visit Copay	$20 - $25 PCP $60 - $70 Spec	Tier 1: $0-$30 PCP $30 Spec	Network: $25-$35 PCP $35-$65 Spec	Tier 1: $0-$40 PCP $45-$65 Spec	Network: $25-$40 PCP $40-$80 Spec	$20-$25 PCP $35 - $40 Specialist (No difference for Tiers)
Rx (retail): Generic Brand Formulary Brand Non-Formulary	$5 - $10 Copay 30% / $40 Copay 50% / $65 Copay	$0 – $15 $30 – $100 $50 – $150		$10 – $15 $25 – $100 $50 – $150		$11 $33 $57
Rx Deductible	$100 - $200 per person	$50 - $150 Ind $150 - $450 Fam		$50 - $100 Ind $100 - $125 Fam		Not surveyed

A high-level review of the benchmarking indicates the TRS benefits have higher member cost sharing compared to the local and national plans. Much of the disparity is due to the limited funding received by TRS. If TRS received the benchmark funding levels discussed earlier, they would likely have the highest value benefit program and much lower employee contributions.

Summary

Overall, the TRS plans align with the offerings in the Texas Market from an actuarial value / benefit level, and generally provide coverage on a more cost-effective basis than other plans. Conversely, State/Employer contributions lag the market by a considerable amount. This results in higher-than-average employee contributions, with significant costs for participants that are covering dependents on the plans.

When comparing to the individual market, the TRS program premiums are on the richer end, more cost effective than what can be accessed in the individual market, and include a much broader network than what can be found in the Texas Individual Marketplace.

Even with lower State/Employer contribution and higher employee out-of-pocket costs included, the total overall costs for TRS plans are within the average or lower than the benchmark states, municipalities, and other districts / programs within the State of Texas.

State Funding Options

As described in earlier sections, TRS funding was originally established through legislation in 2001. The initial amount set a minimum required contribution from participating entities at $225 per employee per month. The $225 minimum contribution is made up through the school finance formula requiring a state contribution of $75 per employee per month and a $150 minimum contribution from the public education employer. This amount has not changed in 20 years.

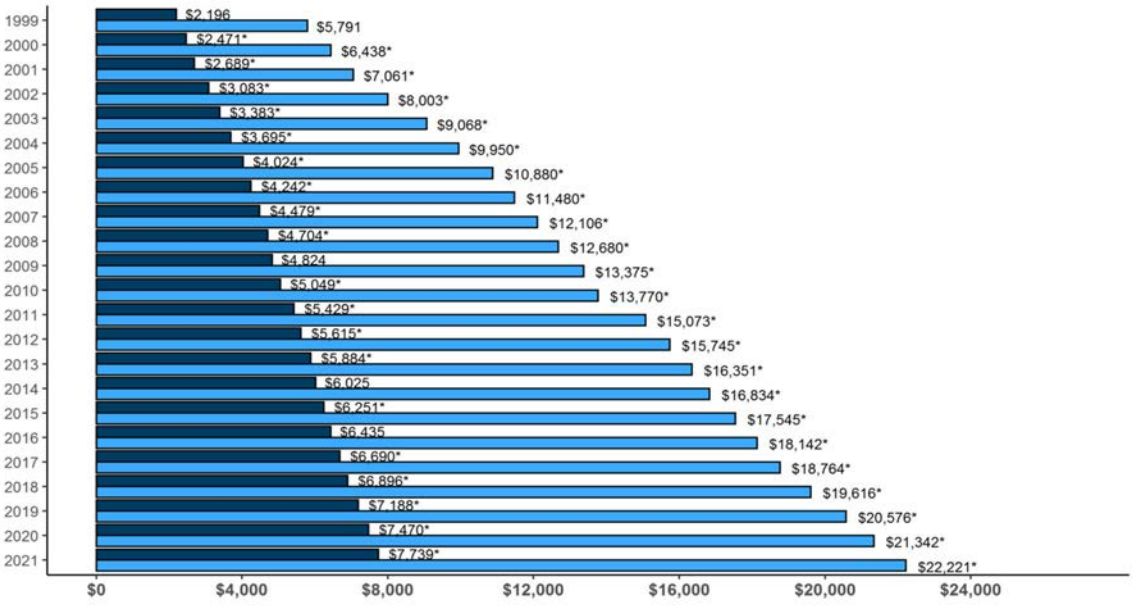
Over the past 20 years, TRS has been extremely effective in managing the total cost of the program. This was highlighted earlier in this report under “Benchmarking”. The limited growth in contributions has led to several benefit and contribution reductions, placing additional cost on Texas public school employees.

In this section we will briefly summarize overall healthcare spending increases over the last 20 years, how other states manage and budget for increased costs, and provide long-term recommendations for the program. Note that there is tremendous variation on how states fund these programs.

Historical Costs Increases

Over the past 20 years the cost of healthcare, at a minimum, has more than doubled. The Kaiser Family Foundation (KFF) is one of the most well-known benchmarks and has been providing surveys dating back to 1999. Below is their most recent study, showing the average annual premiums (employer + employee cost) for single and family coverage:

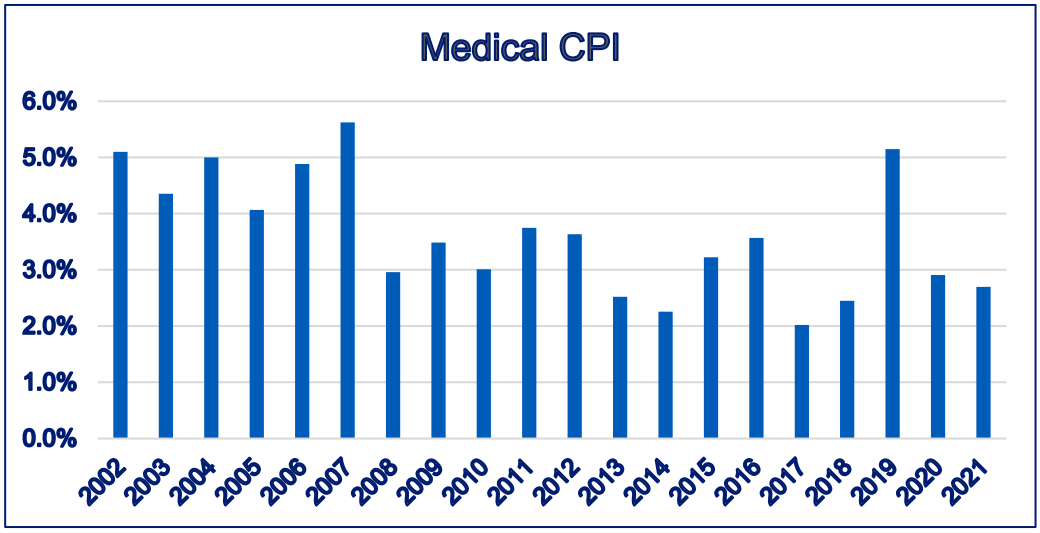
Figure 1.12
Average Annual Premiums for Single and Family Coverage, 1999-2021



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Since 2002, Single Coverage premiums have risen from $3,083 to $7,739 (251%) and Family Coverage from $8,003 to $22,221 (278%). This equates to an increase of approximately 5% per year. These increases are consistent with our Segal study, as well as those provided by Mercer, Aon, PWC and others.

Additionally, if you simply look at the increase in Consumer Price Index (CPI) for Medical over that same period, it varies from a low of 2% to a high of 5.6%.



Over the 20-year period, the average increase was 3.6%, doubling over the period. In addition to pricing inflation, additional costs include new technologies and more expensive treatments as well as disease prevalence that continues to grow. For a well-managed plan to simply keep up with this, they would need to have funding increases similar to the increases shown in the KFF study.

State Funding Policies

The vast majority of states increase their plan funding in conjunction with their budget cycle – annually or bi-annually. Each state reviews expected cost increases, population changes, pending legislation, etc., and prepares a funding request that best meets their financial needs. It is a delicate balance of providing additional funding within the state budget projections while trying to maintain competitive benefits for their state employees. In general, it is expected that states fund based on CPI changes within their market, of course noting that fiscal pressures and state revenue ultimately influence the available funds.

Included With State Employees – One Allocated Amount

The most stable programs fund state employees and public school employees so that each group receives equivalent per employee state and local revenue contributions supported by a larger risk pool with all state employees treated equitably. The State of North Carolina is a good example of this, where every employee is funded at the same per employee rate. The rate is reviewed during their biennium budget cycle, with recommendation from the plan and their actuaries. The legislature initially targets and budgets for a 4% annual increase – prior to the plan's formal request.

Separate Plan for All Public School Employees

Several of the states that Segal works with have a statewide plan for Public School Employees only. They are typically funded through a larger allocation, with a specific allotment for healthcare built in. Funding will either be on a per student, per teacher or per enrolled or eligible member basis. Regardless of the allocation method, the intent is to fund the statewide program at a required level. An example of this would be the State of Alabama – where the public school employees receive an annual allocation. Their board reviews the level needed to support the program, and when necessary, request additional funding from the legislature. There will be years when there is no funding request due to plan management activities. Note that the per employee funding level is much higher than that found in Texas.

Other states with separate plans have a more convoluted funding method. It may have considerations for federal matching funds, one-time dollar allocations, other funds, district contributions, etc. The State of Arkansas is a good example of this, where money to fund the program comes from various sources, some with no direct connection to public school employees or healthcare. They are currently developing legislation to alter the funding mechanisms to be more transparent and deliberate, while linking future funding increases to medical inflation.

Separate Plan for Public School Employees on a Voluntary Basis

Finally, several states, like Texas, have a program that allows individual school districts to elect coverage through the statewide program. This is the most difficult way to rate and fund a program, since there are many factors to consider (e.g., who participates, district funding provided), creating significant anti-selection potential. In general, these programs operate like an insurance company, where districts come in at a pre-determined premium rate, with some minimum required contribution level.

"With no increases in the minimum required contribution in the last 20 years, TRS has been extremely successful holding down program costs."

For these programs there is typically some contribution from the state that is built into the school district funding levels. It is very difficult to uncover all the funding elements for each state and it is very typical for these programs to struggle financially. The smaller the enrollment, the harder it is to manage the risk in the program.

Given these challenges, the way TRS has been able to manage the program and provide benefits to public school employees throughout the state over the years is exceptional.

Recommendation

With no increases in the minimum required contribution in the last 20 years, TRS has been extremely successful holding down program costs. They have had low premium increases in most years and continue to use and implement the most cost-effective vendors and management strategies.

Unfortunately, with limited growth in State/Employer funding, TRS has had to shift some program costs to public education employees over the years. This has led to a program with significant cost sharing, much more than the other state employees in Texas. It has also required the educator, from the bus driver, teacher to school administrator, to pick up the additional inflationary costs for which they have limited to no responsibility for creating.

To keep up with inflation, we recommend that the TRS-ActiveCare program funding be increased on an annual basis, with the increase in funding linked to some sort of healthcare index or expected average annual increase. This would allow the gradual increase to be split equitably between the state and the public school employees, while providing a manageable increase expectation for plan management.

If additional funding was allocated to make up the 20-year gap, the total state and employer contribution would be approximately $600 per employee per month, with the split between the state and public school employers needing to be decided by the legislature. With this amount of funding, contributions and plan designs could potentially be changed to allow them to be more consistent with the 2001 intent of the TRS-ActiveCare program.

Underwriting

Insurance Options

Plan sponsors have the option to secure coverage on either a fully insured basis, self-insured basis, or some combination of the two (hybrid). These options can be described, as follows:

Fully Insured Coverage

An entity that is fully insured purchases insurance coverage from an insurance company, paying a fixed monthly premium for each covered member. This premium is developed prospectively to cover the overall claims and administration costs of the insurance coverage provided. As a fully insured entity, the plan sponsor is shielded from any claims fluctuation including adverse claims experience within the year and is only required to pay the agreed upon monthly premium set at the beginning of the year. This allows the insured to budget for month-to-month costs, without consideration of actual claims experience. In order to take on this risk, the insurance company includes profit and risk charges, reserve requirements and administrative costs in the calculated premium. In addition, fully insured entities are generally required to pay state premium taxes, which are also included in the premiums.

Additionally, the majority of health insurers will incorporate group underwriting requirements within group coverage to prevent increased risk. Some of these requirements may include minimum participation levels or minimum employer contributions. The more the employer contributes to the cost of coverage, the lower the cost for employees and therefore the more likely employees are to enroll. When the majority of employees enroll, the risk is more evenly spread among healthy and less healthy members, reducing the average cost per member. If the cost of coverage is too high, higher risk individuals will be most likely to take coverage because they will need more services. This is known as adverse selection.

At the end of each plan year, the insurance company will review prior year claims experience and provide renewal terms (i.e., premium increase requirements), based on any changes to claims, demographic and/or risk profile of the group and estimated utilization and cost trends. The insured has the opportunity to accept these terms, consider potential plan changes to reduce increases, or, depending on contract terms, potentially shop the market for an alternative insurance carrier.

Self-Insured Coverage

Alternatively, a self-insured entity is one that is responsible for paying all claims as well as administrative expenses. Plan sponsors that self-insure are responsible for all risks, including month to month claims fluctuations and shock claims (i.e., large individual claims), effectively taking on the role of insurer as described in the fully insured model. Large plan sponsors generally self-insure the risk and costs for medical and pharmacy benefits once they reach a size that allows them to reasonably predict cash flows on a monthly and annual basis. In doing so, the plan sponsor is afforded the following benefits:

- Elimination of premium tax
- Reduced administrative costs

- Removal of insurance carrier profit margin and risk charges
- Cash flow benefits

The reduction in costs can be as much as 10% or more as compared to fully insured premiums. In addition to the financial benefits, self-insured plan sponsors can achieve additional control over the program, including plan design, data collection and management, and provider networks.

As a self-insured entity, plan sponsors are required to hold reserves to protect against adverse claims risk, as well as cover incurred but not reported claims. Actuaries develop self-funded rates each year to cover estimates of future costs. However, projected rates are not a guarantee of future results as actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, changes in group demographics, overall inflation rates and claims volatility. In the last couple of years, program costs and utilization patterns changed substantially with a global pandemic that was unpredictable. Adequate reserves are especially important to cover these types of situations, and are also important to smooth out premium increases year over year, cover budget shortfalls that may develop and potentially allow some flexibility to invest in cost saving programs.

Partially Insured – Incorporating Stop Loss Insurance

Stop loss insurance coverage creates a ceiling for how much a self-insured plan sponsor has to pay for high claims, and aggregate and specific are two forms of this coverage. TRS is one of the largest state programs in the country and has the ability to absorb high-cost claimant volatility for unique situations without the expense of stop loss coverage.

Aggregate stop loss puts a cap on the amount that a self-insured employer must pay across an entire plan year. Having an aggregate stop loss policy helps the employer budget for its healthcare costs with some accuracy, since this policy lets the employer put a dollar figure on its maximum potential liability for the plan year. This type of policy will set an aggregate deductible that's based on its total expected monthly claims and its risk tolerance. That number is multiplied by a percentage (commonly 125 percent) to determine the plan's aggregate attachment point. The plan sponsor pays for its claims, and at the end of the policy period, it's reimbursed for any claims that exceeded the aggregate attachment point.

While aggregate stop loss coverage protects a self-funded employer against higher-than-expected costs across its entire plan, specific stop loss puts a cap on the amount that the employer will pay for any one individual claim. Specific stop loss insurance is protection for self-insured plan sponsors against the volatility of large losses on individual claimants whose cost exceeds a pre-defined claim dollar threshold (deductible). Typically, stop loss insurance is acquired by plan sponsors with low enrollment (less than 20,000) to stabilize variability in monthly claims cost when individual high dollar claims have the ability to drive the majority of a plan's claims variation. As the plan gets larger, the individual claims do not cause significant variability in monthly claims cost based on pure statistics.

For example, for TRS-ActiveCare which has approximately 433,000 members with $2B in annual claims, a $1M claim would only increase monthly spend by 0.6% for the month the claim was paid. However, if a plan had 20,000 members with the same average cost per member, a $1M claim would increase monthly spend by 13% for that month. If a plan had 5,000 members with the same average cost per member, a $1M claim would increase monthly spend by 52% for that month. Furthermore, TRS is so large, the law of large numbers makes this risk predictable by plan

actuaries. Over the last 5 years, claimants exceeding the $100,000 threshold have consistently been 0.5% to 0.6% of the self-insured population, varying by only 0.1%. This variability is extremely small and requires no transfer of risk by TRS through stop loss insurance.

Based on the risk shown in the example above, smaller plan sponsors who choose to self-insure typically purchase stop loss insurance. This could be considered a combination of fully insured and self-insured coverages, as some of the risk is transferred to the stop loss carrier. But this transfer of risk comes with a cost. Reinsurance companies build in profit, and over the long term the cost of stop loss premiums is expected to be significantly more than the reimbursements received from the plan sponsor. Stop loss carriers typically set premiums with target loss ratios of 60%–80%, meaning 20% to 40% of the premium is used to pay for risk, administration and profit.

Stop loss is medically underwritten annually and the reinsurer may exclude certain claimants, coverages or load rates in the following year when they become aware of potentially large, catastrophic conditions. Additionally, rates will increase when the prior year profits are not achieved. Therefore, while stop loss provides protection against higher-than-expected costs within a given year, the cost may be higher than expected in subsequent years with some portions of the risk no longer covered. The stop loss insurance market has been extremely volatile with rates escalating upwards of 40% in past years.

Looking at both coverage options, specific stop loss is typically used and is more expensive. Aggregate is less necessary and fairly inexpensive since missing a claims target by 25% is highly unlikely when high dollar claims are capped with specific. Small self-insured employers who want to manage risk may opt to use both types of coverage to achieve maximum protection. As the size of a group gets larger, the threshold for specific stop loss increases as the program is able to bear more risk. Eventually the threshold goes away, typically at around 20,000 members. With TRS membership twenty times that size, there is no reason to reinsure this program. Purchasing stop loss coverage would simply add unnecessary cost to the program. We estimate the cost to TRS to purchase reinsurance with a $250,000 specific threshold would cost approximately $29M annually. We estimate the cost to purchase reinsurance with a $500,000 specific threshold would cost TRS approximately $8M annually.

Current TRS Structure

The current program administered by TRS is primarily a self-insured model, which includes four plan design options (Primary, Primary +, HD, and AC2 [closed]). For these plans, TRS contracts with Blue Cross Blue Shield of Texas to administer and pay the medical claims, and CVS to administer and pay the prescription drug claims. TRS is billed, retrospectively, on a weekly or bi-weekly basis for the claims that are incurred for the prior period. Claims are pooled based on individual group experience for all school districts that participate within the TRS program. As plan sponsor, TRS underwrites the program, and generates premiums for participating districts. In certain areas, there are also small fully insured HMO plans that are offered alongside the self-insured TRS plans.

From the public education employer perspective, they are effectively participating in a fully insured program from a claims risk perspective where they are insulated from the potential volatility of high-cost claims and can rely on predictable monthly expenses; however, they receive the benefits of self-insurance from a cost reduction perspective. As part of the larger TRS program, districts are able to benefit from the size and scale of the entire state in the following ways:

- Not required to purchase separate stop loss coverage, as this risk is retained by TRS
- TRS is able to negotiate lower administrative costs than individual districts
- Full insurance is provided without the need to pay potential premium taxes as well as profit and risk charges that would otherwise be required
- Claims risks are retained by the larger group
- Complex legal, compliance, actuarial and administrative support is provided by the TRS program

Over the past few years, some districts used an interpretation from the Districts of Innovation (DOI) designation in the Education Code to offer competing coverage alongside TRS-ActiveCare. Some of the competing plans offered coverage that is less expensive than TRS-ActiveCare but also does not provide the comprehensive coverage that TRS-ActiveCare provides. This created a situation where employees who thought they would not need the comprehensive coverage may have opted for the less expensive coverage. This caused gaps in care for some members, and in some cases, members found out they did need the coverages not provided by the other plans. This caused additional adverse selection for members opting into TRS.

During the 87th Regular Session (2021), the Texas Legislature enacted SB 1444 which closed the interpretation loophole for DOI and also changed the structure of TRS-ActiveCare to allow districts to leave the program for the first time. This allows plans to choose coverage through TRS-ActiveCare or shop for coverage on their own. As described previously, entry-exit rules dictate that if districts choose to leave, they are not allowed to return for 5 years. Likewise, if plans choose to join for the first time, they are not allowed to leave for 5 years. All of the rules in the new legislation are designed to provide choice for the districts as well as stability for the TRS-ActiveCare program.

Regional Rating

Competing Plans and the Need for Regional Rating

Prior to the 2022-23 plan year, TRS-ActiveCare plans were rated on a statewide basis while pooling the experience for all school districts that participate within the TRS program. As described in the previous section of this report, during the 87th Regular Session (2021), the Texas Legislature enacted SB 1444 which changed the structure of TRS-ActiveCare to allow districts to leave the program for the first time. This allows plans to choose coverage through TRS-ActiveCare or shop for coverage outside of TRS-ActiveCare.

Like many other services and products, the cost of health care varies in different areas of the state, based on provider contracts, referral patterns and utilization of services. Variation in health care costs also exist based on population risk profiles and demographics within different areas of the state. Districts that are shopping for coverage will compare TRS-ActiveCare to other options available that reflect the local cost of care and demographic/risk of the group seeking coverage.

With the newly provided legislation, the TRS-ActiveCare program adjusted rating methodology from statewide rating to regional rating to reflect costs in local areas and provide regionally competitive rates to remain a competitive and viable option across the entire state.

Financial Viability and Underwriting Considerations

As noted above, the key objective of regional rating is to ensure the financial viability of the TRS-ActiveCare program by limiting anti-selection in an environment where districts are able to receive and compare premiums at a local level. To illustrate the issue of this underwriting strategy in the new environment, consider the following illustrative example. Note the figures in the below chart do not reflect actual estimates and is intended to provide an illustration of the expected dynamics using artificial data:

Region	Cost Per Member	Statewide TRS Premium	Non-TRS Bid
Region A	$100	$90	$102
Region B	$95	$90	$97
Region C	$90	$90	$92
Region D	$85	$90	$87
Region E	$80	$90	$82
Average	*$90*	*$90*	*$92*

Under the model used until September 1, 2022, TRS provided one set of statewide rates based on the average cost of care (shown as cost per member) for all regions. Here, the average for illustration is $90 and is the statewide rate for all regions. However, the cost of care varies by each region as shown in the first column for Regions A through E. If the TRS rate remained at the statewide average, the lower cost districts would presumably be able to find lower cost coverage, as shown in the last column, and leave the program to secure coverage on their own (Regions D and E above). As a result, the statewide average would be recalculated and increase from $90 to $97 for all remaining districts across the state. The pattern would continue annually, driving out the lower cost regions each year while increasing the remaining statewide average each year, until only the highest cost regions remain.

To address this issue, Segal worked with TRS after passage of SB 1444 to develop a regional rating model to ensure TRS would remain viable. The process utilized to develop the regional rating model is described below.

Underwriting Process and Considerations

Population Stratification

To regionally rate, the first consideration was to determine the most appropriate regional breakouts for the population. Regions need to be developed in a way that reflects the cost differentials of the regions but are also both appropriate for this population and logical and easy to administer and communicate. It was also important to look at the size of the population in each region when considering the regional breakouts to ensure each group was large enough to produce credible profiles and consistent costs to ensure stability in rates from year to year. In the case of TRS, we reviewed multiple options and narrowed it down to two main options to choose from, Affordable Care Act (ACA) regions based on areas defined for the public exchange in Texas and Education Service Center (ESC) regions. Medicaid regions were eliminated as an option based on the fact that Medicaid provider reimbursements are fixed through formula and these region breakouts do not reflect the cost differentials that exist in the commercial market. Further, one Medicaid region spans nearly one-half of the state, while another region is non-contiguous. As described previously, the regional breakouts were determined to allow pricing to reflect the cost of care within an area that would be competitive with other carriers in the market. All pricing was evaluated utilizing both groupings, to determine the variation and sensitivity of factors within and between both regional breakouts. The ESC groupings were ultimately selected. Below are some of the factors that helped determine which regional structure to employ.

Region Grouping	Pros	Cons
ACA	• Currently priced for in individual market, with readily available pricing factors	• Regional breakouts do not align well with TRS distribution. Many regions would have less than 1,000 lives • The rural ACA Region 26 spans the entire state of Texas • Six additional pricing districts would result in more complex communication

ESC	• Well-known and understood by TRS districts • All ESCs have large enough populations to be underwritten on their own • Six fewer regions than the ACA structure, resulting in simpler pricing / administration and communications	• More complicated to develop regional pricing factors, as they need to be created from Metropolitan Statistical Area (MSA) discount mapping

Global Underwriting

Step 1 of the underwriting process is to develop a baseline rate for the statewide TRS population. This part of the process is no different than the process utilized to develop statewide rates in previous years. Standard actuarial underwriting practices are employed to develop the baseline rate, which can then be used to develop pricing for all regions and plans. Underwriting considers plan actuarial values and relativities, network pricing, market trends, incurred claims and enrollment by plan, pharmacy rebates, and required reserves.

Regional Adjustment

Each district is grouped according to their ESC region. Based on these groupings, the following adjustment factors are developed:

Manual Rating Factors

- Regional / Network Adjustments – The cost of healthcare varies by location, which is a large driver for the need to price regionally. To capture this in the pricing, Blue Cross Blue Shield provided regional factors that account for both the cost of care and the strength of their network discounts for each Metropolitan Statistical Area (MSA). These discount factors were mapped to each district and rolled up to regions to develop a regional pricing factor. Factors are developed for each underlying network, as network discounts vary by region for each network separately. Network and regional factors only apply to medical claims since the cost of pharmacy claims do not have this type of network variation by region.
- Demographic Factors – A demographic factor is developed for each region, based on the age and gender profile of the respective population. This factor is then compared against the overall demographic factor of the TRS population to determine the demographic adjustment for each region.
- Risk Factors – A prospective risk score is developed for each region based on risk modeling software that considers medical and pharmacy claims utilization, illness burden, and demographics of the respective populations within the region. Risk scores are produced separately to be applied to medical and pharmacy projections. Risk scores are then compared against the overall TRS population risk scores to develop medical and pharmacy risk adjustments for each region.

Experience Rating Factors

- Experience Factors – For each region, an experience rate is also developed based on historical cost, normalized for plan choice, networks and enrollment. Individual large claimants above $150,000 are pooled across all employers statewide. A global pooling rate is then added to each experience rate, effectively providing no cost stop-loss insurance or reinsurance to every employer and region. These total individual experience rates are compared to the overall group experience to develop an experience rate factor for each region.

These factors are combined to develop an overall regional adjustment for each region. Regional network adjustments, demographic factors and risk factors are weighted to develop an overall manual rating factor. This factor is then blended with the regional experience factor to develop an overall regional rating factor.

Regional Rate Development

After developing the global underwriting and regional rating factors, the model develops a standardized rate for each region, by multiplying the respective regional rating factor, separately for medical and Rx, against the global standardized rate. Rates for each of the plans are developed by applying actuarial value relativities as well as regional network relativities for plans on another network. Medical and Rx rates are added together to develop the overall regional rates for each plan on an Employee Only basis. Administrative costs are added and rates for other tiers are developed by applying the appropriate tier factors in effect for each plan.

Risk Mitigation

Anti-Selection Risk

By developing these regional rates, the overall risk of anti-selection is significantly reduced. Revisiting the illustrative example from above, if regions are rated based on their own experience and demographics, the costs would apply, as follows:

Region	Cost Per Member	Regional TRS Premium	Non-TRS Bid
Region A	$100	$98	$102
Region B	$95	$93	$97
Region C	$90	$90	$92
Region D	$85	$87	$87
Region E	$80	$82	$82
Average	*$90*	*$90*	*$92*

Under a regional rating approach, rates are competitive with what would be available to the districts on their own, while allowing them to continue to achieve the benefits of being part of the larger TRS program. Risk still exists within regions, as the lowest cost districts within each region still have the potential to leave TRS-ActiveCare if their costs are below the average for the region.

Globally, however, the risk of adverse selection has been significantly reduced due to the stratification of the population.

Credibility Considerations

While TRS is taking the first step in regional rating as described above for the 2022-2023 plan year, TRS has other options for further stratification available to consider in future years. One of the main tenets of the TRS program is the size and scale of the combination of the districts as a combined group, estimated to cover almost 400,000 lives in 2022-2023. This provides the group stability in rates across years, due to the law of large numbers. This stability benefits the districts, insulating them against the volatility within their own district and spreading it across the entire TRS program. A group of this size can absorb and spread costs of large claims, which would be challenging for any individual district. This is achieved through the pooling measures that have been incorporated into the underwriting process, which allows the program to use the size and scale of the entire group to insulate individual districts against adverse experience, while still considering some of the unique cost drivers in the specific regions.

When developing the regions, TRS ensured that all districts had large enough populations to be credible on their own. This will ensure that there is stability for the districts from year to year.

Options to Consider

In future years, other underwriting options may be considered with approaches that account for the specific risks and claims experience of each district, while retaining the benefits of the large risk pool and the efficiencies that it creates. There are several possibilities available to TRS to move in this direction, including:

- Rating by district – a more granular approach to regional rating would be to rate each district individually. Groups could be rated based on their specific experience, credibility blended with a manual rate from the larger group based on size of the district. This approach allows the larger districts to be more impacted by their individual experience and the cost of care in their area. The most likely scenario would be to rate districts over a certain size individually and rate the others regionally. This could be accomplished under this option by pegging 100% manual credibility to the desired group size. Note that rating all 1,000 districts individually would be administratively burdensome and would also not be feasible from a risk standpoint for small districts.
- Self-insuring each district - the most aggressive approach would be to allow each district to self-insure their claims with TRS. The districts would have the opportunity to benefit from the negotiating power of the larger TRS program for administrative fees but would retain all other risks associated with self-insurance. While this approach could potentially benefit some larger districts, it is unlikely to be a suitable approach for the majority of the TRS system.
- Minimum premium – a hybrid approach to district level funding would be a plan where TRS and districts agree that the individual district will be responsible for paying all claims up to an agreed upon level, with TRS responsible for the excess. TRS would also be responsible for processing claims and administrative services. In general, the district is exposed to this maximum aggregate level, effectively having overall aggregate stop loss insurance.

Communications

Whichever method is chosen, it is imperative to communicate the calculation and methodology to the district decisionmakers. Underwriting can be very complicated and TRS is beginning to make more information available to the districts. However, healthcare is complicated and the lack of understanding of the information provided can cause the decisionmakers to misinterpret the information and result in poor decisions. We have seen Brokers providing districts misinformation, which could ultimately lead to districts deciding to leave TRS based on an incorrect understanding. TRS has a communication strategy designed to help the districts understand their options and considerations that should result in districts understanding the value that TRS brings to them. Districts should receive a suitable rate to cover their risks, understanding that most (96%) of the premium dollars received by TRS-ActiveCare are spent on claims. The remaining 4% pays for expenses to administer the plan and includes no profit.

Plan Design Options

Current Environment

Under the current TRS-ActiveCare platform, participants are offered a choice of three plans (four for certain participants who participate in a plan no longer open to enrollment), along with fully insured regional Health Maintenance Organization (HMO) options in certain areas. These plans consist of a High Deductible Health Plan (HD), and two copay-based primary care driven Exclusive Provider Organization (EPO) plans (Primary, Primary+). An HMO is type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO, generally won't cover out-of-network care (except in an emergency) and may require you to live or work in its service area. An HD is a plan with a higher deductible than a traditional insurance plan, monthly premium is usually lower but usually pay more health care costs yourself before the insurance company starts to pay. An EPO plan is a managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

There are no additional benefits, beyond medical and prescription drugs covered by these plans, offered or administered through the TRS-ActiveCare program. There are some options available to TRS related to the Plan Design Offerings that can be considered, including Account Based Plans, Incentives for certain behaviors, or the creation of a Flex Type Design for the districts. This section will explore these options, including ways in which they could be incorporated into the TRS-ActiveCare program.

Account-Based Plans

There are three main types of account-based plans that are often paired with health plans: Health Savings Accounts (HSA), Health Reimbursement Arrangements (HRA), and Flexible Spending Accounts (FSA). These plans have different features and tax requirements, some of which are summarized in the table below.

Plan Feature	Flexible Spending Accounts (FSAs)	Health Reimbursement Arrangements (HRAs)[9]	Health Savings Accounts (HSAs)[10]
Account creator	Employer / Plan Sponsor	Employer / Plan Sponsor	Employer / Plan Sponsor or Individual
Permissible contributors	Employer / Plan Sponsor and employee	Employer / Plan Sponsor only	Employer / Plan Sponsor and employee (but no contributions for those enrolled in Medicare)

[9] Approved in Notice 2002-45 and Revenue Ruling 2002-41.

[10] Created by Section 223 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Tax status of employer contributions	Contributions are excludable from the employee's income. Employer contributions are not subject to FICA or FUTA.	Same	Same
Pre-tax salary reduction	Permitted subject to maximums	Not permitted — HRAs are exclusively employer-funded	Permitted subject to maximums
Tax Free Earnings?	No	No	Yes
Vesting	No requirements	No requirements	Fully vested
Funding	Not required by IRC (could be required under ERISA)	Not required	Funding and trust are both required and subject to specific requirements.
Portability	None	None	Individual money is portable and may be rolled over into another HSA no more frequently than once in a 12-month period.
Maximum contribution level	For 2022, maximum salary reduction is $2,850.[11]	Set by employer	For 2022, maximum contribution is $3,650 (single)/$7,300 (family)[12]
Catch-up contributions	Not allowed	Not allowed	$1,000 catch-up contribution allowed if age 55 or older and not enrolled in Medicare
High-deductible health plan (HDHP)	Not required	Not required	Required. For 2022, the minimum deductible is $1,400 (single)/$2,800 (family).[13]

[11] Announced in Revenue Procedure 2021-45.

[12] Announced in Revenue Procedure 2021-25.

[13] For all coverage tiers other than single coverage, the minimum family deductible specified in the chart must be met before the HDHP pays for care for any family member. As noted elsewhere in the chart, the HDHP may pay for preventive care and other types of permitted coverage before the deductible is met.

Out-of-pocket maximum for HDHP	NA	NA	For 2022, $7,050 (single)/$14,100 (family). Special rules for network plans.
Reimbursable medical expenses	Medical expenses under IRC §213(d); prescription required to reimburse over-the-counter medications (but not insulin)	Same	Same

While FSAs are common, they are not generally provided within the plan designs that are offered by group plan sponsors. HRAs and HSAs, by contrast, are generally offered and provided as funds to offset out-of-pocket expenses within the medical plans. As an example, a plan sponsor could provide a PPO plan, with a seed of HRA or HSA dollars (assuming plan rules are met). FSAs are more often offered to cover non-medical plan expenses (e.g., dental, vision benefits), where an employee can set aside tax-free dollars to fund these projected costs. Within the TRS-ActiveCare program, the plan could consider incorporating employer seed money to offset some of the costs of deductibles, copayments, and coinsurance. Since HD is the only qualified HDHP plan offered, an HSA can only be paired with this plan, but TRS could offer a seed into an HRA for both the Primary and Primary+ plans. This would require additional funding to the program to fund these accounts, with HSA seeds being true dollars out the door, as the monies are employee funds, while HRA seed would represent a portion of the seeded funds, since the accounts are notional, and do not transfer to the employee upon termination.

The benefit of these accounts is that they can provide first dollar coverage for lower-income participants that are participating in high-deductible health plans, which can be a burden at times. Further, HSAs can be set up as true investment vehicles for certain participants (typically higher earners), to save for medical expenses in retirement.

While these account-based plans have their benefits, it is important to note that unless directly funded by the State, any monies that would be added to these accounts from an employer perspective would either need to be funded by the districts or built into the premiums offered through TRS-ActiveCare. Currently a few school districts offer their employees an account-based plan, but with additional funding TRS could consider offering a statewide option.

Incentives

While the above discusses the general nature of account-based plans, some plan sponsors choose to provide these funds as incentives, based on meeting certain plan requirements. This approach can build in some health-related requirements and/or health behaviors that could potentially reduce overall long-term trends as a prerequisite for earning dollars. Common incentives include visiting a PCP for a preventive care visit, completion of smoking cessation programs, or meeting certain health metrics (e.g., closing care gaps for members with chronic disease). Full wellness programs can be developed around incentives, with various levels of funds provided to accounts based on different metrics. These programs can be static in nature, or progressive, with additional requirements needed to be met in order to secure funds as the program evolves. More complicated wellness style programs are often paired with a dedicated wellness vendor, which would require additional expenses and likely an RFP.

TRS-ActiveCare currently provides an incentive program where members earn dollars when they call to shop for commonly known health care services. This program provides personalized education and navigation to help members use their benefits more effectively to get a better value. Participants can save money depending on where they go for care.

Flexible Benefits Program Options

Another consideration for TRS-ActiveCare would be to implement a Flexible Benefits Design, which is an approach that could be implemented in several ways, including:

- Flexible Plan Design – where districts would have choice in the designs that get offered to their participants from a pre-selected list
- Flexible Carrier Approach – where multiple carriers can be offered
- Combined – where both carrier and plan design would be flexible.

Flexible Plan Design:

To develop a flexible model TRS could offer multiple plan design options at various benefit levels. This could be developed in several ways, often with parameters to simplify both administration and communication of the program. An approach that could be adapted to TRS could mirror some of the Private Exchange models that have been created in the corporate market. Typically, in these models there are a pre-set group of plan design options to choose from, with certain plan levels that are required to be offered. A flexible design approach can be created with multiple plans offered at different levels of richness (i.e., Actuarial Value levels). In the market, these levels of richness tend to be referred to in metallic levels – Bronze, Silver, Gold, and Platinum, with Bronze being the least rich plan offerings, and Platinum being the richest. As an example, TRS-ActiveCare could design three Bronze plans, three Silver plans, three Gold plans, and three Platinum plans, where a Gold and Silver plan option must be offered, and only one plan can be selected from each metallic level. These parameters are generally implemented to simplify pricing, as well as control for overall risk and adverse selection in the program. Pricing for each plan could vary based on the relative differences in actuarial values of the plans offered, as well as the projected risk mix between the plans offered (e.g., Gold may be priced differently if Platinum is offered due to higher risk members choosing Platinum over Gold). Plans within metallic levels can vary in design types (e.g., PPO style, HMO style, HDHP qualified) to meet the needs of the varying contingencies more broadly in the member population. While this type of approach adds additional flexibility to the districts, both from a cost basis and level of choice, it would add significantly to the overall administrative structure required to price premiums, communicate benefits, and control costs.

Other flexible design options exist where members can “build their own plan”. In this type of approach, members can vary deductibles, out-of-pocket costs, coinsurance levels, and/or copayments. While this approach exists, it is complicated from an administrative level and not particularly common.

Flexible Carriers:

In a flexible carrier approach, there are two main ways to vary the carrier lineup. The first would be to create a network of carriers, on a regional basis, that would only offer one carrier per region, based on the lowest discounts in that area. Currently Blue Cross Blue Shield is the only carrier that is offered through the TRS-ActiveCare program (Baylor Scott & White HMO and Blue Cross Blue Shield HMO are also offered regionally), which provides the best overall discount on a Texas-wide basis. This approach would diversify the number of carriers offered, taking advantage of the network strength of various carriers regionally. For example, if Aetna is more cost effective in Region A, they might replace Blue Cross Blue Shield in that region, while CIGNA may be more cost effective than Blue Cross Blue Shield in region B, making them the carrier offered. This network would incorporate multiple carriers, but only offer one per region. TRS-ActiveCare could decide how granular the regional structure would be created, potentially selecting a carrier by MSA, ESC, or broader geography. While the approach would be more cost effective on a discount basis, TRS would need to consider member disruption, as well as the impact on ASO fees and benefits administration costs associated with a multi-carrier environment.

An alternative approach would be one that would build off the above but is more like the Marketplace structure in the ACA market, where all carriers would be offered on a regional basis, but the carrier with the most cost-effective pricing would be assigned the lowest overall premiums. This approach would limit provider disruption issues by incorporating multiple carrier networks, while still taking advantage of regional pricing advantages between carriers. The downside would be the additional administration (and corresponding administrative costs) required around managing a multi-carrier environment and would also require buy-in from the carriers to participate in a multi-carrier environment. This approach would also require a more complicated communication strategy, and add to adverse selection pricing risks, as there would be multiple rates for each plan (one for each carrier in each region). Further, in either flexible carrier approach, TRS-ActiveCare would need to consider the loss of leverage that the program would have over specific carriers, as the membership would become fragmented between multiple carriers.

Combined:

The most complicated approach in a flexible benefits approach would be to combine some of the options above – allowing plan design choice as well as varying carriers – either prescribed by region or a multi-carrier regional approach. While this would allow for the most flexibility in the program, TRS would need to decide whether the administrative and communications challenges would be worth the potential savings associated with these approaches.

For any of these flexible approaches, TRS-ActiveCare would need to perform additional analysis the viability and fit for the program. While flexibility is a net positive for these approaches, it adds a level of complexity to the program that would make the program difficult to communicate, and potentially create some inconsistencies across districts. While we have seen some savings associated with a multiple carrier model for more national programs, it remains to be seen whether the savings will be significant enough on a more local level to justify the additional risks and administrative costs that would be introduced.

Pharmacy Program

Prescription drugs are the most highly utilized benefit within health insurance. Employers and plan sponsors offering health insurance have seen the cost of prescription drugs grow from approximately 10% of their total healthcare spend 10 years ago to upwards of 30% in recent years. Prescription drug benefits are typically managed by Pharmacy Benefit Managers (PBMs) or medical insurers which partner with PBMs. PBMs interface with drug manufacturers, wholesalers, retail pharmacy chains, independent pharmacies, medical centers, and others to consolidate the prescription drug benefit into a more manageable process for their plan sponsor clients.

TRS Pharmacy Benefits

TRS currently provides self-insured pharmacy benefits through a contracted large national PBM. This relationship was procured through an RFP, and through review of hundreds of pharmacy contracts and contract terms annually, we consider this to be best in class. It includes many of the components described in this section including:

- Comprehensive and competitive contract clearly defining annual terms including minimum financial guarantees on discounts and rebates by distribution channel with 100% pass through to the plan. This allows for maximum payments with no limits on upside while putting downside risk on the PBM who has negotiating power with the manufacturers and networks.
- List price trend guarantees – shifts risk to the PBM
- Inflation protection guarantees – shifts risk to the manufacturers
- Transparency regarding pharmacy reimbursements, manufacturer rebates and audit requirements
- Utilization management and clinical rules including prior authorizations, step therapies and quantity limits
- Annual market checks to ensure best pricing
- Plan design that incentivizes lowest cost drugs through member cost sharing (copays and coinsurance) while maximizing manufacturer rebates

Additionally, TRS is implementing Manufacturer Copay Assistance programs for FY 2023 for all eligible plans.

Pipeline Management

On average, the FDA approves almost 40 new drugs each year. Additionally, each year, several high-cost brand drugs go off patent and make room for an available generic alternative. Of the new drugs, the vast majority are a specific subset called specialty drugs. These new specialty drugs aim to treat complex or rare conditions or improve upon the efficacy of existing treatments. In recent years some notable new medications have been approved for the treatment of Alzheimer's, Spinal Muscular Atrophy, Psoriasis, and Rheumatoid Arthritis.

These drugs can also have complex routes of administration such as through infusion or the need for a physician to administer the medication. Because of the extensive research, handling requirements, development costs, clinical trials, and safety and monitoring required to produce these new drugs, the costs of specialty drugs can be substantial.

For therapeutic conditions with limited competition, these new drugs can be costly and there are few mechanisms in place to help control the costs for the plan sponsor. While many of the new drugs can add significant clinical value, there are some new drugs that are determined to only be marginally better than their predecessors.

PBMs help to determine whether new drugs would add clinical or financial value to their plan sponsor clients. They maintain extensive lists of drugs they recommend covering on lists called formularies. PBMs, Health Plans, and Insurers have therapeutics teams which update these formularies frequently. As new drugs come out, the therapeutics teams individually assess their value and determine whether to cover the drug as well as where it should be placed on a formulary to incentivize use of lowest cost drugs through member cost sharing.

The review process is complex and compares the cost and efficacy data to all other comparable products already covered on their formulary. PBM formularies often contain tens of thousands of prescription drug products in varying strengths and dosage sizes. Without a managed formulary, there would be no safeguards in place to ensure the most effective treatment is being prescribed as well as helping to ensure the most expensive product isn't always dispensed when cheaper alternatives are available.

No-Waste Formulary

Formularies are developed by PBMs to maximize the clinical options available to patients and prescribers and balance financial impacts through rebates. PBMs negotiate with manufacturers to obtain strong rebates in return for placement on the PBMs formulary. In some cases, manufacturers will require that PBMs include their entire basket of available drugs on the formulary to maximize rebates on any of the manufacturer's drugs. If all the manufacturer's drugs are included, there may be competing products in the market from other manufacturers that have lower cost alternatives or better clinical options available. These types of products are called high-cost low-value drugs.

A 'no-waste formulary' is a concept that aims to eliminate the high-cost and low-value drugs that are sometimes found within standard PBM formularies. PBMs will allow plan sponsors to individually select medications to add or remove from their standard formularies. Once this option has been initiated by a plan sponsor, they have taken the first step towards creating a custom formulary. By removing these drugs from the formulary, PBMs can reduce the rebate levels that were contracted with the plan sponsors. Depending on the plan sponsor's specific drug utilization, it can be financially beneficial to the plan sponsor by removing these high-cost low-value drugs even after the reduction in rebates. However, actual plan utilization and PBM rebate guarantees should be evaluated prior to adjusting any formulary.

Utilization Management

Implicit within PBM formularies are additional clinical and cost control mechanisms referred to as utilization management (UM). UM is typically split into three primary categories:

- Prior Authorizations
- Step Therapies
- Quantity Limits

Prior Authorizations (PAs) are meant to ensure that the drug which the patient was prescribed is an appropriate clinical fit based on the members other prescriptions or medical conditions. PAs work by the PBM communicating with the prescribing physician to ensure the indicated drug is the best fit based on the patient. These are an important tool used by PBMs to ensure that the right drug is being prescribed for the right patient for the right indication. If found that the prescribed drug would have a negative clinical impact, the prescription is denied, and alternatives are suggested for the patient.

Step Therapies (STs) are roadmaps which outline which medications must be tried before a patient can move to a higher cost medication. These are common for therapeutic categories which have multiple medication options. The standard approach is for patients to try lower cost drugs within a category as the first option. If those medications do not meet the patient's needs, they are allowed to try other medications within that category as outlined by the ST criteria. STs can help reduce plan costs since the program encourages lower cost medications over higher cost options.

Quantity Limits (QLs) are criteria for specific medications or categories of medications to prevent stockpiling, abuse, or ineffective treatments. A QL would indicate that a patient could only receive, for example, four pills per month of a high-cost or high-risk medication. QLs control plan costs and reduce patient exposure to potential abuse.

UM criteria are carefully reviewed by PBMs therapeutics teams to optimize cost control, clinical outcomes, and patient safety. PBMs maintain various levels of UM within their formularies to meet the needs of plan sponsors.

New Texas legislation allows physicians with 90% approval of prior authorizations within 6 months to no longer be required to receive prior authorization for services. Assuming this applies to pharmacy prescription drugs, this may eliminate some of the utilization management available to TRS.

Specialty Drugs

While new specialty drugs are frequently becoming available in the market, the conditions these drugs treat are rare. Specialty drugs are utilized by roughly 1% of a plan sponsor's population, but the cost of these drugs can account for up to 50% of the plan's entire prescription drug spend. The cost of Specialty Drugs can average between $8,000 - $10,000 per prescription before any sort of PBM discounts or rebates. For reference, the cost of a traditional brand drug can average between $300-$500 and a traditional generic drug can average around $100 before any PBM discounts. Notably, for many districts that offered competing coverage, the competing coverage plans did not cover specialty drugs.

Because of the complexity involved in the development of specialty drugs, there are not as many generic alternatives as in traditional medications. Therefore, the solutions for plan sponsors in this space cannot just exclude all brand drugs in hopes of relying on lower cost generics.

PBM pricing relies on negotiation of reimbursement rates between the PBM and the dispensing pharmacy, wholesaler, or manufacturer. Because specialty drugs are new to the market with limited competition, they have higher list prices with lower discounts available to PBMs. However, rebates negotiated and received through PBMs are much higher than for non-specialty drugs. Rebates are used by manufacturers to increase market share based on formulary placement by the PBM.

Although most PBMs and plan sponsors can agree upon a broad definition for specialty drugs, the specific drugs in which they consider specialty can vary widely by PBM. PBMs maintain unique lists of drugs based on their own definitions. These lists are updated and may be adjusted by the PBM multiple times throughout the year. These updates are also not always communicated to plan sponsors and therefore must be followed closely by the plan sponsor.

Limited Distribution Drugs

Limited Distribution Drugs or LDDs, are a subset of specialty drugs that have been garnering attention in the PBM space in recent years. These drugs treat extremely rare conditions and the manufacturers of these drugs have limited the supply of the medications to specific pharmacies with unique handling or storage requirements. The cost of LDDs can average between $20,000 - $40,000 per prescription before any negotiated discounts.

In the case that a PBM has restricted or limited access to a medication, the opportunity for pricing negotiation decreases. As such, PBMs have typically carved LDDs out from their pricing guarantees and shifted the risk of the cost of these drugs onto the plan sponsor.

Similar to specialty drugs, there is no consistent definition of an LDD and they vary widely by PBM. The LDD status of a drug changes frequently at the PBMs discretion. As these drugs gain traction, plan sponsors will be taking on more risk if left unchecked.

Manufacturer Copay Assistance

Due to the high cost of many specialty drugs, patients weigh the affordability of the drug when deciding whether to continue therapy. As a result, manufacturers of these high-cost medications have offered to provide cost sharing assistance to patients who face this dilemma of cost versus treatment. Manufacturers of certain drugs have offered to fund the entire portion of the patient cost sharing for their medication to help patients continue to adhere to therapy.

Whether the patient has a $10 copay or a $1,000 copay, the manufacturer will cover that portion of the cost of the drug, up to a defined annual maximum benefit. The cost assistance offered varies by manufacturer and requires the member to pursue assistance and register with the manufacturer. PBMs and third-party vendors have developed programs which work to take advantage of and maximize the manufacturer assistance for many of these high-cost specialty drugs.

These programs typically work by adjusting the plan sponsor's benefit design and significantly raising the copay or cost sharing on eligible specialty drugs in order to capture the maximum amount of the copay assistance. The PBM or third-party vendor will then work to enroll all active specialty drug utilizing patients in the program. Each subsequent prescription for those members will be subject to high-cost sharing, such as 20% or 30% of the drug's cost. The manufacturer assistance will come in to fund the entire cost sharing for the patient. The patient responsibility will therefore be $0, and the plan sponsor will benefit from the incremental savings between the provided manufacturer assistance and the prior cost sharing before the program was implemented.

These programs are administered by the PBM or a third-party partner of the PBM on behalf of the plan sponsor. The PBM requires that patients fill their prescriptions at the PBMs owned/partnered specialty pharmacies so that they can appropriately account for the manufacturer assistance coupons. This is to say that if a member tried to fill their specialty medication at their local retail pharmacy, they would be re-routed to the PBM-owned specialty pharmacy and would have their prescription provided via mail order.

PBMs have also developed infrastructure for plan sponsors to decide whether the coupons should apply towards a patient's true out of pocket (OOP) costs. This infrastructure takes place at the PBM-owned specialty pharmacies. Their adjudication platforms can distinguish between dollars that came directly from the patient or dollars that came from manufacturer assistance. Monitoring the OOP costs is important such that members are not artificially meeting their deductibles and OOP maximums through manufacturer assistance dollars. The reason for this is to eliminate increased plan sponsor costs that would occur by paying for the expensive drug in place of the copay assistance available. This distinction is not able to be made at retail or independent pharmacies at this time, hence why a criterion for these programs is to allow an exclusive specialty arrangement with the PBM-owned specialty pharmacy.

These programs can offer significant savings to both plan sponsors and their members with no up-front fees charged by the vendors. Vendors who offer these programs are compensated by retaining a portion of the savings that are realized by the plan sponsor. These plans require substantial plan design edits, so it's critical to ensure all members utilizing specialty drugs are enrolled. If members refuse to enroll in the vendor's program, the members will be responsible to pay the full 20-30% coinsurance for their specialty drugs. Because the program will ultimately reduce the member's cost sharing to essentially $0, there is rarely push-back from members to enroll.

Specialty vs Retail Pharmacies

In pharmacy benefits there is a distinction between several types of pharmacies. A retail pharmacy is one which a patient can physically walk in and pick up their prescription. Common examples of retail pharmacies are CVS stores, Walgreens, Rite-Aid, HEB, and other independent pharmacies. These pharmacies actively stock and dispense common prescriptions for patients such as antibiotics, chronic condition meds, inhalers, etc.

A specialty pharmacy is typically a closed-door pharmacy which dispenses medications for complex or costly conditions. These pharmacies usually mail the medications overnight directly to the patient. Some of these medications require special handling such as cryogenic freezers or are administered via IV infusion and the packaging can be fragile.

Some of the specialty medications can cost upwards of $100,000 per treatment. Many retail pharmacies may not want to stock these medications on their shelves due to the shelf-life and the risk of not having a patient who needs it. However, retail pharmacies do sometimes stock less costly or more common specialty medications if they know which medications their patient-base will be requiring.

The pharmacists at each of these types of facilities are knowledgeable and attentive to the medications which they dispense. However, the pharmacists at the specialty pharmacies are typically more familiar than a retail pharmacist with the rare diseases and conditions that specialty medications treat. Conversely, the retail pharmacists can be more familiar at common non-specialty drug interactions and focus on a broader knowledge of prescriptions.

Specialty pharmacies also employ concierge-type programs which provide continual follow-up to patients with complex conditions and ensure their medications are working as intended and are not experiencing severe side-effects.

It is common for PBMs to own specialty pharmacies and provide stronger pricing to plan sponsors that enroll in an exclusive specialty arrangement. These arrangements ensure that when a patient requires a specialty medication, it will be dispensed only through the PBM-owned specialty pharmacy. If a member tries to fill a specialty prescription at a retail pharmacy, it will be re-routed to the PBM-owned specialty pharmacy. This gives the PBM more line-of-sight into the specialty patients' conditions and how their health status is improving over time. This also allows the PBM and specialty pharmacist to employ any requested clinical programs which might help the patients better manage their conditions.

In the non-Medicare space, some States are proposing any-willing-provider laws which aim to remove the distinction between a retail and specialty pharmacy. If passed, these laws would allow patients to receive their medication from any pharmacy, assuming the requested pharmacy has the medication in stock. By removing the volume of prescriptions flowing through the PBM-owned pharmacy, the PBM would be less incentivized to provide stronger pricing to the plan sponsor. Also, at this time the plan sponsor would not be able to take advantage of the revenue available through the manufacturer copay assistance program described above.

Specialty Carve-Out

In addition to manufacturer copay assistance, there are charitable organizations, government grants, and other non-profit foundations that work to help patients cover the cost of their high-cost medications. These organizations cover the highest-cost specialty medications for patients with and without insurance. Unlike the manufacturer copay assistance, these organizations cover the entire cost of the medication.

There are a handful of third-party vendors that have developed programs to help plan sponsors enroll their members in these programs. These programs are robust and work to essentially eliminate the entire specialty drug benefit. Third-party vendors that sponsor these programs retain a fee of roughly 20-30% of the savings realized. This means that the savings available to plan sponsors can be up to 70-80% of their entire specialty drug costs.

Some of these organizations require substantial member documentation before financial assistance is provided. Documentation can include proof of insurance, income statements, tax return documents, medical records, and more. Once documentation has been approved and enrollment by the patient has been completed, the member will receive their medications either direct from the manufacturer or provided by a specific pharmacy.

Plan sponsors that have carved-out their specialty benefit to these third-party vendors have seen their specialty drug costs reduced significantly and, in some cases, eliminated aside from the shared savings fees. The plan sponsor's existing PBM will be exempt from all specialty related pricing guarantees (point-of-sale discounts and rebates) if these programs are implemented. If the drug required by the member is not covered by any funding, it will revert back to the original non-specialty PBM and the plan sponsor will be responsible for the full cost of the medication.

Some of the larger PBMs partner directly with vendors who offer specialty copay assistance programs. However, they do not always partner directly with these specialty carve-out vendors, or their contracts are structured such that specialty is not allowed to be carved out. In these cases, plan sponsors might have to solicit an entire new non-specialty PBM if they want to partner with a specialty carve-out vendor. Soliciting a new non-specialty PBM can have significant cost impacts to the plan sponsors non-specialty drug costs in the case the new vendor's non-specialty pricing terms are not as competitive as their current vendor.

There are no financial guarantees or pricing metrics associated with these programs. These programs are subject to the longevity of the organizations providing funding. If funding is depleted, the costs will shift back directly to the plan sponsor.

Non-Specialty Drugs

Specialty drugs often account for up to 50% or more of a plan sponsor's total prescription drug spend. However, this implies that there is still up to 50% being spent on traditional medications. Plan sponsors and PBMs have several options of areas they can focus on to control non-specialty costs.

PBMs maintain several standard formularies that vary by degree of drug inclusion. Broad formularies cover the largest number of drugs which typically coincides with weaker financial terms. Narrow formularies cover fewer drugs but typically yield stronger pricing. Plan sponsors can decide which formulary best aligns with their financial and member satisfaction goals. Additionally, some plan sponsors create custom formularies or adjust current formularies based on their independent reviews with pharmacy experts. However, custom formularies or adjustments sometimes have financial implications when they do not align with the standard formularies provided by their PBM.

Careful review of PBM formularies can help plan sponsors identify many high-cost / low-value drugs which often have alternatives with lower cost or better clinical alternatives. These high-cost / low-value drugs are sometimes maintained on formularies to help add total rebate value to the PBMs book of business. Depending on the plan sponsor's utilization, removing some specific high-cost / low-value drugs could produce net cost savings to the plan.

Many PBMs and insurers have point-solution programs which aim to promote medication adherence and lifestyle adjustments in patients with costly chronic conditions. These programs can aim to improve health status for many conditions such as: diabetes, rheumatoid arthritis, asthma/COPD, and several others. The primary goals of these programs are to improve patient health status and reduce the potential for future costly medical events. These cost-avoidance techniques can be helpful in reducing future trends in healthcare cost for a plan sponsor.

Another common problem within pharmacy benefits is the concept of prescription waste or abuse of medications. Opioids have become an ongoing concern across the nation. These drugs are relatively low-cost relative to other prescriptions but patient dependence and complications from over-use can lead to costly medical encounters. PBMs have been developing solutions which helps to pinpoint these drugs that typically don't show up on high-cost reports. PBMs are able to pinpoint specific members, prescribers, and pharmacies which have an unusual number of opioids or other schedule II drugs. These intervention programs can individually lock out members from pharmacy-hopping or investigate prescribers with unusual prescribing patterns.

Prescription drug pricing changes rapidly and plan sponsors should engage their PBM or their consultants regularly to ensure that their pricing terms are competitive. Common analyses to ensure pricing competitiveness are Request for Proposals (RFPs) and market checks. PBM RFPs solicit new pricing contracts from potential PBM vendors which compete to offer the best partnership with the plan sponsor. RFPs incorporate all mechanisms (formulary management, utilization management, specialty drug management, etc.) to ensure a best-in-class pharmacy benefit program. Market checks are utilized during the course of a contract to compare recent pricing terms that were reviewed or negotiated by a consultant on behalf of a plan sponsor. These de-identified data points help plan sponsors assess the relevance and competitiveness of their contract pricing terms to determine if they should be re-negotiated. Audits are also helpful to ensure that the pharmacy benefit was administered correctly, and the pricing committed to by the PBM was achieved.

Medical Specialty Drugs

All pharmacy programs described to this point have referred to patient-administered outpatient prescription drugs. Some specialty drugs are administered through IV infusion or have complicated dosing requirements and need to be administered by a medical professional. If this is done on an inpatient basis, at an outpatient facility, at a physician's office or through home health, the patient and plan sponsor will be billed through the medical benefit. These medical-plan processed prescription drugs are also rising and can account for more than 10% of the medical spend in some cases.

Plan sponsors aim to increase the visibility and transparency of their health benefit costs. A new process has been developed by PBMs which works to dispense the physician administered drugs through their PBM-owned specialty pharmacies and bill the patient and plan sponsor through the pharmacy benefit. PBMs can often offer more transparent pricing as well as guaranteed pricing terms on these drugs. This option helps to reduce the large variability in prices that can be charged under the medical benefit. This area has become more common as drug prices continue to rise and more complicated drugs are approved which require physician administration.

When covered under the medical benefit, these drugs are purchased by the administering physician and then billed back to the medical carrier based on the carrier's negotiated reimbursement rates. These reimbursement rates are not subject to any financial guarantees held by the medical carrier. When covered under the pharmacy benefit, the PBM will price the medication based on a guaranteed discount off AWP. Additionally, the PBM will contract with manufacturers to obtain rebates on select medications and pass those rebates through to the plan sponsor with an associated financial guarantee. Rebates are not typically disclosed or directly passed through to plan sponsors when these drugs are covered under the medical benefit. Some medical carriers use the rebates to buy-down the plan sponsor's medical admin fees. In some cases, the plan sponsor can structure the contract with their medical vendor to require actual pass-through of all rebates.

The drawback to this approach is that the administration becomes more fragmented. Physicians and medical centers will have to coordinate with the PBM to have the drug dispensed and mailed from the specialty pharmacy to arrive at the facility which will administer the drug. If the patient is due to receive treatment before the PBM can intervene, that member will receive the medication at their primary facility and handled under the medical benefit. All subsequent doses are handled by the PBM and billed under the pharmacy benefit. It's important that these programs focus on clinical treatment and that the coordination of vendors does not delay care for the patient.

Because of the transparency and the drug purchasing power offered by the PBMs, these programs have typically yielded significant savings to plan sponsors. In addition to the strong pricing and rebates offered by PBMs, by carving out these drugs plan sponsors are also able to coordinate with their specialty copay assistance vendor to obtain manufacturer assistance on these medications. Some medical carriers do not currently offer full-service manufacturer assistance programs on these medications.

Similar to any-willing-provider laws, some states are proposing specific legislation that prevent PBMs from re-routing medications to less-costly sites of service. While patients can still apply for exceptions, most medications transferred through these programs are billed to the plan sponsor at much lower costs than when handled through the medical benefit.

Clinical Options

TRS monitors clinical innovations that arise and implement programs they believe are beneficial to their members. This is very challenging, as new multichannel healthcare delivery models continue to emerge. Technological innovation is making information and decision-making tools easily accessible to consumers, in some cases enabling them to access care without going to a traditional provider's office. As a result of these trends, a variety of non-traditional care models – such as expanded telemedicine (both between doctors and direct to patients), digital therapeutic resources, retail health clinics, onsite health centers and hybrid clinics – have emerged to meet demand (from both members and plan sponsors) for increased access and affordability.

It is a crowded marketplace with health tech investment in products and vendors. Not all healthcare solutions enabled by technological innovation yield the same results, even with similar products, nor are all equal when it comes to member disruption. The goal is to choose solutions that improve population health, accessibility and convenience, while containing costs with least member disruption.

We have focused our review on four main areas – addressing current needs of the population and opportunities for long term success:

- Oncology Second Opinion
- Clinic Options – via Telemedicine, onsite/near site clinics, and hybrid virtual clinics—platforms providing on-demand in-person care
- Digital Therapeutics
- Concierge Care/Health Advocacy

We will briefly discuss each area, how it could be beneficial to TRS, recommendations and next steps.

Oncology Second Opinion

Cancer is considered a disease of uncontrolled cell growth that spreads to other parts of the body. Rather than seeing cancer as a single designation, it is now a category of well over 100 different disease types. Selecting a treatment plan is very complex and the treating provider must take into consideration multiple factors such as age, genetics, quality of life, individual preferences, latest advancement in treatment options, and potential complications. In addition, pathology has a high variability in accuracy and will impact diagnosis and ultimately the treatment pathway that is selected. Inaccurate diagnosis can lead to over or under treatment, inferior outcomes, increased cost and significant risk to members.

Nationally, there are a significant number of cancer treatments that are deemed to be misdiagnosed and/or treated via an incorrect pathway. While the cost of treatment varies, it is typically over $100,000 per person. With mortality rates of over 30% after diagnosis, one can understand the importance of having the appropriate diagnosis and treatment. A diagnosis of cancer changes lives for a patient, their family and friends. Costs of cancer include treatment such as surgeries, post-operative care, chemotherapies, radiation and multiple scans and follow-up for years. Besides the costs of treatment, other costs are incurred by the patient including travel expenses for care, lost wages, home care and others.

The National Cancer Institute (NCI) has created a program designation. NCI Cancer Centers are recognized for the development and translation of scientific research devoted to the treatment of cancer patients. It is difficult for treating providers to maintain a robust knowledge base due to the swift advancement of the science in cancer treatment. Due to the advanced specialization, NCI Cancer Centers are not accessible to the entire population unless they have means to travel.

For these reasons, the National Comprehensive Cancer Care Network (NCCN) supports and recommends a second opinion. The challenge is in leaving a second opinion in the hands of a patient, who can find it confusing and overwhelming. With the advancements in telemedicine and technology, an opportunity exists to connect NCI level cancer care to local patients and providers without disrupting the physician relationship and support network. In essence, in can be designed so your members will automatically receive a 2nd option from an NCI level center, partnering with their current provider.

Current Treatment Plan Management

The role of the current carrier cancer care management programs is to manage the member through the acute phase of care, focusing engagement on the high stage malignancies. These programs identify members based on requests for prior authorization for surgical procedures, emergency admissions, high-cost medication, and/or accumulation of high-cost claims tied to a cancer diagnosis. Unfortunately, this is well after the member has received a diagnosis and determined a course of treatment. There are no 2nd opinion processes in place, unless the member initiates on their own, with significant additional expense.

Opportunities/Recommendations

Layering on a second opinion option that targets engagement with members before a treatment plan is decided can reduce the rate of diagnostic errors, increase access to latest technologies, provide proper genetic counseling, and ensure members are receiving the highest standards of care. Many second opinion services are offered virtually or directly engage with the treating provider. This allows for ease of engagement, reduces the stress on the member, and can potentially close access, racial, and gender inequities that has been documented in cancer care.

Clinic Options

Pre-covid, many public sector health plans were researching the potential of onsite clinics as a way to provide a true Patient-Centered Medical Home to their members. These clinics can provide preventive/primary services, disease management, health risk assessments and onsite pharmacy. Clinics can help the plan gain better control of primary care, direct care to quality providers within their network for specialty services and can work very well as a wellness hub. In addition, clinics are highly customizable and are meant to be member centric. Primarily, the vast majority of public sector on-site clinics were implemented by cities and counties, with only a few state-level plans. This was primarily due to the requirement that success typically requires membership be concentrated in a single location, offsetting fixed costs of the program. This model has been problematic for state plans, where members are scattered over a large geographic area.

Much of the thought process around clinics evolved with the emergence of Covid-19. The Covid-19 pandemic was a collective trauma, drastically changing the approach to accessing clinical care. For example, where telemedicine was used by a minimal percentage of the population prior to Covid-19, it exploded after the beginning of the pandemic when the Centers for Disease Control (CDC) recommended that health care providers offer clinical services through virtual means. Developing a system to enable easier access to care, safely, became of paramount importance. With these changes, there have also been drastic changes in the flexibility and capabilities of

what was termed an “on-site” clinic. There is no longer a requirement of “brick and mortar”, making it possible to extend the concept across the entire state. Certain specialties, such as behavioral health and physical therapy, have been integrated into the overall program designs.

Benefits of Clinic Solutions

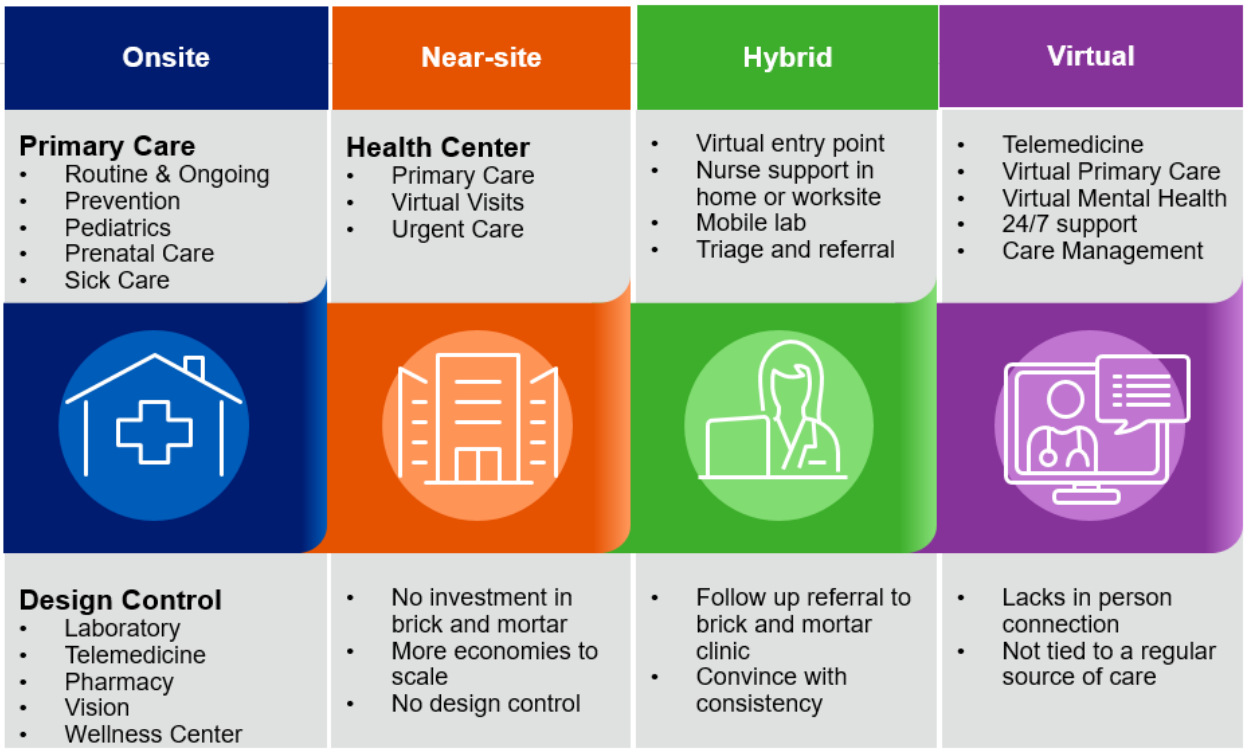
Clinics provide an environment that allows for increased patient participation and compliance with treatment. If planned right, the proximity of the clinic reduces the barrier of traveling to visit a doctor when needed. Removing this travel barrier can be instrumental in closing social determinants of health gaps. The barrier of not being able to secure an appointment with the doctor’s office is also eliminated as the clinic can accommodate walk-in patients. Further, closing a key barrier to care in medically underserved communities. Clinics can be designed to be open on weekends, and before or after workhours, making clinics more available than most doctors’ offices. Onsite or hybrid on-demand clinics can be utilized during breaks in working hours increasing the convenience to obtaining needed care in a timely fashion. The ability to visit a clinic during a wider range timeframe may incentivize members to visit a clinic instead of an emergency room in some non-emergent situations, thereby eliminating some emergency room visits with a much higher cost of treatment.

Additional benefits are realized from the clinic staff knowing the benefit plan of the patients, giving them personal attention, and getting them to engage in wellness and disease management programs. Also, proximity and a well-thought-out clinic design that provides all the necessary services under one (nearby) roof makes it more likely that patients will comply with the treatment regimens. Especially for chronic conditions, increased patient participation and compliance leads to, over time, decreased specialist referrals and visits, emergency room visits, and inpatient hospitalizations. Members can also be directed to more efficient service providers and facilities, so the cost per unit of service is less. Additionally, clinics can be designed to restrict service to treatments that research has proven ineffective.

Newer clinic models are combining virtual access to care while utilizing acuity-specific staffing, further optimizing access to the most appropriate level of care. Consideration can be given to “clinic-like” models that forgo brick-and- mortar and rely on a telemedicine platform with in-home support and evaluation.

Finally, consideration should be given to including pharmacy service in the clinic. Significant savings can be generated by dispensing generic drugs, obtaining a lower price than is available from retail providers, and better monitoring drug utilization and compliance.

Models to Consider



While onsite clinics are not suitable for all regions, there are different versions of near-site and shared clinics that we recommend including in the evaluation.

As the clinic market evolves, there is increased capability of designing a strategy that is regionalized and custom to the unique needs of the population while also potentially filling gaps in the local provider network. This approach is part of a long-term strategy and often the ROI takes 3 – 5 years to be realized. Proper planning and analysis must occur to maximize these results.

Feasibility Study

It is critical to conduct a pre-clinic feasibility study to determine the cost and/or savings estimates of implementing one of these models utilizing claims data and geographic utilization patterns. It is important to separate true need from manufactured demand within the current healthcare infrastructure.

If an onsite brick and mortar clinic is targeted in certain locations, a membership population of at least 1,000 (or 2,500 including dependents) will need to be concentrated within a 20-mile driving distance of the clinic location. While onsite clinics are not suitable for all regions, States are looking at Hybrid models to meet their diverse needs.

In evaluating the feasibility of a clinic, the following topics should be given significant consideration:

- Who is eligible to use the clinic, for example, members, dependents, retirees, etc.?
- What costs are currently targeted through the use of an onsite clinic?
- Are the services at the clinic free to the user or is there a charge? Should there be a charge and, if so, how much should the charge be?

- How should the clinic pricing be positioned, compared to the cost of obtaining medical services through the existing health benefit plan?
- Is the geographic location saturated with healthcare services and will the clinic be duplicative?
- Will the population respond and engage with a clinic model?
- Given the healthcare services provided at the clinic, what staffing is appropriate?
- What are the desired benefits of the clinic and how should these be measured?
- Does it make sense to contract with a nearby existing retail clinic or a virtual hybrid or a combination of multi-clinic modalities?
- Does it make sense to invite other group health plans in the vicinity to participate in the clinic, and hence share the costs?
- Should the clinic be 100% virtual? How can it be customized for the unique schedules of public school employees?
- How can the clinic be integrated into the entire member experience?

There are a number of other elements that should be factored into the study to make sure the best solution is implemented and can be successful in the near and long-term.

Performance Measurement

Performance metrics and benchmarks are recommended to track success and can be utilized to negotiate performance guarantees.

The list may include the following:

- Specialist referrals and visits
- Discretionary ER visits
- Inpatient hospitalizations
- Pharmacy costs
- Medication compliance
- Compliance with preventive screenings
- Compliance with evidence-based medicine
- Participation in disease management programs
- Participation in wellness programs, health promotion programs, and health coaching programs
- Absenteeism rate

Opportunities/Recommendations

There are multiple ways to contract and construct a clinic model. Pricing structures vary greatly in the market. Once a regional strategy to enhance benefits and member experience is determined by TRS, a Request for Proposal (RFP) or Request for Information (RFI) should be developed based on TRS specifications and issued to determine and compare structures and strategies available in the market. Prior to releasing an RFP or RFI, we recommend TRS consider touring a clinic, meeting with potential providers and gauging interest of districts and members.

The final design must be flexible and meet the diverse needs of your population. We believe the market is now matured and could be molded to TRS.

Digital Therapeutics

Historically, disease management's core concept was meant to reduce healthcare costs while improving quality of life for individuals with chronic conditions. Many large health plans, pharmacy benefit managers (PBMs) and plan sponsors have structured disease management programs and wellness initiatives aimed at improving lifestyle choices. In the past, few of these have been successful in demonstrating sustainable change while reducing both overall disease burden and medical trend. Traditional programs have focused on a behavior driven telephonic coaching model and individual goal setting, but due to the costly nature of staffing, a high variability in the ROI modeling, and minimal engagement, many programs have been abandoned. Unfortunately, the diabetes epidemic and the rate of diagnosed chronic illness has not slowed down.

With the emergence of the COVID-19 pandemic, the world shifted to a virtual environment and members became comfortable accessing clinical services in a new way. As a result of this market shift, numerous digital therapeutic point solution vendors have emerged and created multiple channel partnerships with both PBMs and health plans alike.

Digital Therapeutic point solution vendors offer enhanced virtual capabilities utilizing cognitive behavioral therapy (CBT) through self-driven mobile applications, and some include digital tools to manage and improve chronic illness. However, not all vendors are the same. Many fail to offer evidenced-based clinical benchmarks. Some have fallen short to show how their virtual self-driven engagement results in true attainable and sustainable lifestyle modification. The landscape becomes more confusing and continues to shift through mergers and acquisitions. Additionally, each vendor offers an array of variable pricing models, yet only a few provide clinical performance guarantees.

These solutions often represent one piece of a total strategy to address a specific condition or disease state. In this section we will discuss the major disease categories that have benefited from the digital environment, and possible opportunities for TRS.

Diabetes: Approximately 13% of TRS' current gross pharmacy spend is for diabetic-specific medications. Besides the cost of medications, diabetics have significant medical costs for inpatient admissions, emergency room visits, physician visits, supplies, etc. This is not unique to the TRS population as the prevalence of type 2 diabetes continues to grow throughout the country.

Through Blue Cross Blue Shield, TRS piloted a diabetes program with Virta Health that launched 3/15/2021. Virta Health is a virtual diabetes clinic that focuses on medical nutritional therapy to reverse diabetes and deprescribes insulin and other diabetic-specific medications using real-time biometric feedback. Virta has some of the strongest ROI models, putting a large portion of their fees at risk for reductions to pharmacy spend. The Virta pilot is coming close to year one completion showing favorable results and high engagement.

Additional Options to Consider:

Weight Management/Diabetes Prevention Program: Pre-diabetes is a condition in which an individual's blood sugar is higher than normal but has not hit the threshold to be considered a diabetic. Unfortunately, many do not know they have pre-diabetes and claims analysis often will not show the true prevalence within the population. Typically claims will represent 1% of the total population as having a diagnosis of pre-diabetes. The National Institute of Diabetes and Digestive and Kidney Disease (NIH) estimated that more than 37% of the population has pre-diabetes and around 20% are unaware.

Recognizing the concern of a growing public health crisis, in 2018, the Center for Disease Control (CDC) gave approval for the National Diabetes Prevention Program (DPP) to be considered a preventive care service. Focusing interventions on lifestyle modification to prevent or delay the onset of type 2 diabetes. Offering this type of solution through a virtual partner can provide access and support to members struggling to maintain or lose weight to improve health outcomes.

Musculoskeletal: Musculoskeletal (MSK) conditions remain a top cost driver for TRS. A journey through a member experience MSK pain can be complex. One option a member may consider is physical therapy. Physical therapy (PT) involves treatment focused on the prevention and management of injuries. This can help relieve pain and prevent overuse of opioid medications. The goals of PT are to promote healing and restore function and movement. In-person physical therapy typically has lower adherence rates and often requires time away from work and family. Increasing out-of-pocket cost can deter members from attending all sessions and achieving the desired results. Sustained coaching and adherence to the recommended treatment is required to return to a normal level of function.

To break down barriers to treatment, new technology exists where members can access PT in the comfort of their home. Through sensor technology, members can achieve the same results as those from in-person therapy. Many of these programs are achieving higher engagement rates by breaking down barriers to access. Considering an omnichannel approach combining in person and virtual physical therapy can reduce barriers and improve clinical outcomes.

TRS is launching pilot programs with 2 MSK providers for the 2022-2023 plan year. These pilots are with Airrosti which features in-clinic or virtual treatment and Hinge Health which is a digital clinic with sensor technology and computer vision.

Behavioral Health: Historically, behavioral health benefits have focused on episodic and reactionary treatment of a mental health diagnosis. While coverage exists for preventive and progressive therapy, many members find it difficult to navigate the system. Also, there is a lack of qualified providers to provide the recommended treatment, leading many to forgo supportive therapy. To assist in the promotion of help-seeking and self-care many virtual options can be considered in conjunction with existing behavioral health services. Some occur within the community, as public domain, and other options can be enhanced to provide the tools to aide in this process. Tele-health, including text-based therapy and coaching, have proven safe and effective.

Like healthcare workers, public school employees were among those that were responsible for the physical and mental safety of large segments of the population as part of the collective trauma of Covid–19. They were required to flex with many unknowns to continue teaching and are still required to do so today. To support this population, we recommend TRS consider expanding beyond telehealth and communicating early access to self-driven and text-based care options for members experiencing both episodical and long-term mental health concerns.

Total well-being: Employers continue to focus on strategies that keep people healthy and engaged. Increasingly, employers are recognizing that being truly healthy extends beyond physical activity and optimal nutrition. Some employers are taking a broader view of wellness to encompass total well-being, including support of challenges, such as stress relief, family caregiver and mental health challenges. A localized approach to well-being can increase the sense of community support and well-being.

Opportunities/Recommendations

TRS has had good initial success in their digital diabetes pilot. The pilot was structured to target the highest risk diabetics. We recommend TRS consider expanding the pilot to a broader subset of the population.

We also recommend continuing to explore the other digital therapeutics options discussed in this section. A pilot may be appropriate in certain programs and regions as a starting point to determine the cost/benefits of each as TRS is doing with the MSK programs. When appropriate, roll out a more comprehensive package, keeping in mind the marginal cost/benefits of each.

Concierge Care/Health Advocacy

As consideration is given to enhancing the strategic benefit design, the end user experience can become complex and vary. Members may not understand their health care options or fully take advantage of the benefits they have to support their health and well-being. For members with chronic conditions, delays in accessing appropriate care management can lead to increased treatment costs and hospitalizations. Member advocacy programs are gaining momentum in the marketplace. As expense keep increasing and the experience becomes more complicated, members are looking for simple support to making these critical healthcare decisions.

An advocate can play a critical role in improving the quality, affordability, and accessibility of healthcare for participants and dependents. An advocate can help organizations better manage healthcare utilization and costs, vendor relationships, and wellness initiatives. The advocate can also monitor specific clinical programs, review high-cost claims, identify claims for external review where appropriate, and coordinate patient education programs. The role is deep and varied drawing on a strong professional background and communication, critical thinking, and creative problem-solving skills.

Advocacy programs assist health plan participants navigate the health care system and optimize the use of their health care benefits. Assistance can be provided in the following areas:

- Resolve inaccurate provider billing or erroneous claim payments resulting in unnecessary out of pocket costs
- Help find the right provider
- Explain complex conditions and medical terms
- Prepare for upcoming provider visits
- Coordinate care for second opinions including transfer of records
- Clarify and explain benefits, guide to other solutions
- Facilitate mental health support
- Negotiate payment arrangements, Facilitate pre-authorizations
- Concierge services (make appointments, etc.) and provide travel assistance for those with Center of Excellence / bundled payment programs with travel benefits
- Avoid wasted care resources

Such advocacy products are available directly through health plan sponsors/carriers or through integrated vendors.

Opportunities/Recommendations

TRS has benefit advocates locally within the districts that work with Blue Cross Blue Shield's account team to resolve member service issues. Blue Cross Blue Shield offers medical management and well-being advocacy through their core suite of clinical programs. As TRS continues to build flexible benefit offerings and partners externally with unique clinical solutions regional advocacy services may be necessary to provide concierge support to members navigating customized benefit options.

We would recommend that TRS reviews options available through its current vendors and vendors in the marketplace. It would then be practical to do a cost/benefit analysis of the approach for each.

Networks

TRS currently covers employees and dependents of approximately 1100 school districts dispersed across all areas of the state, from urban areas to extremely remote. Employees eligible for coverage include everyone employed by the district, such as superintendents, teachers, administrators, coaches, cafeteria workers, bus drivers, and custodians. This requires TRS management to be cognoscente of a broad range of socioeconomic concerns. As of May 2022, TRS-ActiveCare currently covers 287,000 employees and another 161,000 dependents (spouse and/or children), making a total of 448,000 Texans.

Additionally, given the expansive geographic distribution of this population, TRS requires a broad network that provides access to providers throughout the state, while balancing cost efficiencies. Pharmacy networks are typically very broad and provided through a contract with a Pharmacy Benefit Manager (PBM), which was discussed earlier. Here we will focus on the medical provider network and potential strategies for TRS.

Medical Provider Networks

A medical network is comprised of many types of providers. A network must include all kinds of professionals: primary care physicians (PCP), specialty care physicians (SCP), hospital-based physicians, mental health providers, physical therapists, and many other types of specialized professionals. Contracts for these providers may be at the individual level, medical group level, integrated delivery system level, or with other specialized groups. Additionally, a network has to include providers for ancillary services: such as diagnostic labs, imaging and testing, therapeutic rehabilitation, ambulance and other medical transportation services. Poor network contracting in any of these categories can not only be costly but could result in significant gaps in needed care.

Although there are less providers to contract with on the facility side, the task is extremely difficult. A network must have adequate and broad hospital coverage, and contract terms are negotiated separately for each hospital or entity within each health system. Some hospitals are required for certain specialties and may be designated as a “center of excellence” for meeting certain criteria, while others are considered “critical access” and may be in very rural areas without another hospital within many miles, and all other types of hospitals in between. A network must include other facilities that are less expensive than a hospital, such as urgent care centers, ambulatory surgical centers, infusion centers, diagnostic imaging centers, and many more.

One anomaly in Texas is the abundance of Freestanding Emergency Rooms. These are often funded through Private Equity and are typically more expensive than hospital ERs because they will often not contract with the networks for a discounted rate. They advertise to the community where people go when they believe a situation is emergent. However, there is a significant number of people who go there for non-emergent care.

With new state and federal legislation, such as SB 1264 (86R) enacted in 2019 and the No Surprises Act more recently, contracting has become even more challenging for plans. New laws such as these and others require a lot of effort and expertise to organize and construct the contracts and infrastructure required to achieve and maintain compliance.

Health plans, including HMO's and other insurers, are required to provide sufficient coverage for a service area to be licensed in the state. To provide good access, health plans typically contract with more than the minimum required. Access standards are typically defined by distance and number of providers, including accounting for practices open to new patients. Parameters differ by type of provider and are typically different for urban, suburban and rural areas to account for the differences in distance and demand.

Health plans contract with providers to get the provider to provide services, but there are many other components included in the agreement such as acquiring favorable pricing terms or discounts off full charges, requiring the provider to cooperate with the plan's utilization and quality management programs, and allowing clinical and billing audit rights for care provided to plan members. A plan may have thousands of provider contracts with management continuing at all times to identify network gaps, recruit and negotiate renewals. Contracting also involves other processes such as provider credentialing, on-site evaluations, orientations, etc.

The above was a brief summary of the complexities involved in contracting. It is a major undertaking by health plans and requires a very specific skill set to administer.

TRS Current Network

TRS-ActiveCare is an extremely large self-insured plan sponsor who contracts with a health plan to provide statewide networks along with favorable pricing and administration of their plans. TRS requires good access for the entire state, but there are also other contractual agreements for many services beyond network access including administration of claims, district support, customer service, quality of care programs including wellness and care management, utilization management and large or catastrophic case management, administration of appeals, out-of-network negotiations, and analytics reporting. They choose a health plan through a formal procurement process with analysis balancing all of these items along with pricing.

From a pricing standpoint, vendors in the last procurement, statewide PPO vendors, were analyzed on a regional basis to determine if better pricing could be achieved in certain regions with different networks. The results of the analysis showed that no additional savings were available by splitting up the regions for different PPO vendors across the state. There are state level plans that contract with multiple vendors; however, this is highly dependent on the state and has not been shown to significantly lower costs over time.

There are many HMOs and other managed care organizations/insurers in Texas that are local; however, most of these are regional and do not cover the entire state. Blue Cross Blue Shield of Texas is the only local insurer that has a broad network to cover TRS' population. There are several other national insurers that also have networks in Texas that can cover TRS' population, including Aetna, Cigna, Humana and United Healthcare. TRS-ActiveCare is currently contracted with Blue Cross Blue Shield to provide their networks, including 2 broad statewide networks to cover the 4 plans offered.

In addition to the four Blue Cross Blue Shield (4) self-insured network plans, TRS currently offers regional fully insured HMOs in some areas of the state. These are provided through Blue Cross Blue Shield and Baylor, Scott and White (BSW). TRS continues to explore other regional options, including a potential narrow network with Blue Cross Blue Shield, with lower rates paid to providers in exchange for directed care volume, as well as other options within the state.

While TRS management understands that healthcare varies by locality, they continue to look for opportunities to curate a more custom network to include even better access to quality care specific to local needs.

Options

Based on the efforts required to build a network as described above, we do not believe a full custom network is an option for TRS-ActiveCare. Direct contracting the entire network for the number of contracts involved would require massive expertise and effort, and TRS does not have staff to accomplish this. We have seen another large state try to build a custom network with a reference-based pricing model. The goal of this model was to create transparency and overall plan savings with contracted pricing pegged as a percentage of Medicare pricing. After months of planning, analysis and communications with help from outside expertise, the state had no hospitals willing to contract and only a handful of preferred physicians. Therefore, we believe the opportunities do not lie in a statewide contracting effort, but rather in potential other statewide or local arrangements.

A tiered network has some traction in other states, where members who utilize a “Tier 1” narrow network provider would get enhanced benefits, with “Tier 2” resorting back to the current PPO broad network. This is in development in Texas, with some vendors (United HealthCare) currently offering the product. Blue Cross Blue Shield may be able to build a similar product in the near future.

The health care industry as a whole is trying to move away from payments based on fee-for-service (FFS), where providers are paid for each procedure they perform, to some type of value-based care. Value-based care comes in many forms, but the premise is that providers are paid based on efficient care and/or quality outcomes rather than FFS. Most value-based arrangements include some type of risk sharing or gain sharing with the provider.

Types of value-based alternative payment models include:

- Bundled payments or case rates – This type of arrangement pays a set rate for an episode rather than each visit or procedure and incentivizes efficiency and outcomes because the provider is paid one rate regardless of the number of procedures.

- Reference based pricing – While this may not be achievable at the entire network level, it may be available in certain types of services or in certain areas. This is useful to decrease variability in pricing for the plan. It would incent members to use the lower cost providers but would require information be available for members to shop. If the members used providers that were above the reference price, the additional cost would be shifted to the member.

- Pay for Performance – This type of arrangement provides bonuses to providers for quality improving activities and/or outcome metrics.

- Shared savings – This provides additional payments to a provider for savings achieved based on beating a target cost over a period of time.

- Capitation – This sets a prospective amount that is paid each month for a certain set of services on a periodic basis, typically for a year.

Types of value-based alternative service models include:

- Patient Centered Medical Homes (PCMH) - This service model is focused on patient-centered comprehensive and coordinated care within a team of providers.

- Accountable Care Organizations (ACO) – This is another coordinated care service model and is based on an organizational infrastructure that is capable of receiving and distributing share savings at the organizational level.

All these value-based models have existed in different scenarios, and types available for contracting are organization specific based on the amount of risk a provider is able and willing to take. Results have been mixed with both successes and failures, and we tend to see these types of models recirculate in different forms and applications. Development of the contract terms and pricing or targets is critical to the success of one of these programs. Clinicians and actuaries need to be involved to understand the components that are included and develop solid clinical and financial targets that are understood by all parties.

Blue Cross Blue Shield has some of these value-based models in the current network; however, TRS has not been involved in the development of the arrangements. As time goes on, TRS has an opportunity to lead the way to influence more of these arrangements and curate more value-based models on their own. Custom network development is not a new concept but has historically been met with many challenges. The key to development is to provide services around local systems to specifically target local members.

Primary Care Risk Models

There are many studies that suggest having a primary care physician can lead to better overall health of your members. With healthcare being localized, there are certain regions in Texas where partnership opportunities with larger physician practices could exist. These physician groups typically have great reputations in the community, are affiliated with the local hospital and have preferred referral patterns. Building the infrastructure needed makes it difficult for these physician groups to practice medicine effectively and manage the entire spectrum of a member's health. Fortunately, there are new emerging companies, who are well funded, and can support their needs and fill the gaps needed. They seem to be emerging and looking for good solid partners.

In some of Segal's current state clients, there appears to be a resurgence in developing these regional integrated systems, when the risk in borne by a partner. The partner will work with the integrated system, providing the physicians the infrastructure and tools needed. They work diligently to get members to select primary care physician who are in the medical group, get the membership engaged and put into motion all the care management needed to curb the long-term trend. They will use the plan's current data to come up with a fair rate and lock into that for typically a 3-year period. To be successful, the region needs to be clearly defined and have a dominant primary care practice. The agreement would include TRS, the Partner and the Physician Practice with all three having a stake in the risk.

Segal met with multiple vendors who could be interested in partnering with TRS to develop local opportunities. Some of these vendors also provide additional services that were not available previously including virtual opportunities to engage. This type of contracting could provide better care, but also additional flexibilities and convenience. Similar to our discussion on virtual clinics, care must be taken to ensure coordination with the current vendor and services through analysis and development.

ACA Review

ACA Overview – Coverage Requirements

Under the Affordable Care Act, the employer shared responsibility penalty (IRC Section 4980H) imposes a penalty on large employers with at least 50 full-time equivalent employees (FTEs) under certain conditions. Most school districts in the TRS program meet the 50 FTE criteria. The penalty applies only if at least one full-time employee receives subsidized coverage in an ACA State Exchange or the federal ACA Marketplace (offered at healthcare.gov). The amount of the penalty will be based on whether the employer offers health coverage to full-time employees. Employers would pay the 4980(a) penalty of $2,000 (indexed to $2,750 in 2022) times the total number of full-time employees if coverage is not offered; and would pay the 4980(b) penalty of $3,000 (indexed to $4,120 in 2022) times the number of individuals who receive subsidized coverage in an Exchange if the coverage is not minimal value and affordable. Note that these penalties would apply to the individual districts, rather than TRS, since they are the employers.
A large employer will be treated as having offered coverage to its full-time employees for a calendar month if, for that month, it offers coverage to 95% of its full-time employees and their dependents through the end of the month in which they turn age 26. Treasury and IRS rules implementing the penalty only require coverage to be offered to the employee and dependent children, not the spouses.

Market Subsidies Overview

Individuals who enroll in individual health insurance coverage through the federal Marketplace may be eligible for premium assistance tax credits ("subsidies") to help pay for coverage. These subsidies are available to individuals without access to minimum value coverage or with coverage deemed "unaffordable" based on their income levels. Coverage is deemed unaffordable if the premium for employee only coverage exceeds 9.61% of household income in 2022 (adjusted annually). In the case of spouses and dependents, affordability is based on the employee only premium, meaning that as long as coverage is affordable for employees, the spouses or dependents would not be eligible for subsidies, even if not "affordable" for these individuals. This is known as the "Family Glitch." On April 7, 2022, the Administration proposed rules that would eliminate the "family glitch" and provide that affordability would be based on whether employee's share of the premium for *family* coverage exceeds 9.61% of household income.[14] This would provide access to individual market subsidies to some spouses and dependents that would otherwise not be available. Note that employer penalties related to affordability for employee only coverage would not apply.

Subsidies are based on a sliding scale, initially set for those between 100% and 400% of the Federal Poverty Level.[15] As part of COVID-19 Relief under the American Rescue Plan Act (ARPA), subsidies were increased and expanded beyond 400% of the FPL, as follows:

[14] 87 Fed. Reg. 20354 (April 7, 2022). Comments are due on the proposal by June 6, 2022 and a public hearing is scheduled for June 13, 2022.

[15] Additional cost-sharing subsidies are available to those who are eligible for premium subsidies and whose income is between 100 and 250 percent of the FPL. These cost-sharing subsidies require enrollment in certain silver plans in the Marketplace.

	Maximum Percentage of Household Income to be Spent on Health Premiums	
Income (% of poverty)	**Affordable Care Act (before legislative change)**	**COVID-19 Relief (current law 2021-2022)**
Under 100%	Not eligible for subsidies	Not eligible for subsidies
100% – 138%	2.07%	0.0%
138% – 150%	3.10% – 4.14%	0.0%
150% – 200%	4.14% – 6.52%	0.0% – 2.0%
200% – 250%	6.52% – 8.33%	2.0% – 4.0%
250% – 300%	8.33% – 9.83%	4.0% – 6.0%
300% – 400%	9.83%	6.0% – 8.5%
Over 400%	Not eligible for subsidies	8.5%

The Inflation Reduction Act of 2022, signed into law August 16, 2022, extends these additional subsidies through 2025.

Subsidy Considerations, Impact on Spouses

Based on the individual market rules detailed above, since coverage is offered to spouses, and in most cases would be deemed affordable for employees, spouses would not be eligible for subsidies in the individual market. Currently, flat subsidy structure (through State/Employer contributions) in the TRS-ActiveCare program, enrolling in coverage for spouses is expensive. As noted in the benchmarking section earlier in this report, spouse generally pay the full differential in premium between the employee plus spouse and employee only tier, since State/Employer contributions are flat across all tiers. Coverage costs range from $759 - $792 per month for the three Core plans (AC2 costs $1,389 but is closed to most participants). Based on these costs, it is likely that there are individual market options that are more affordable for spouses in the TRS program, if they were to qualify for a subsidy.

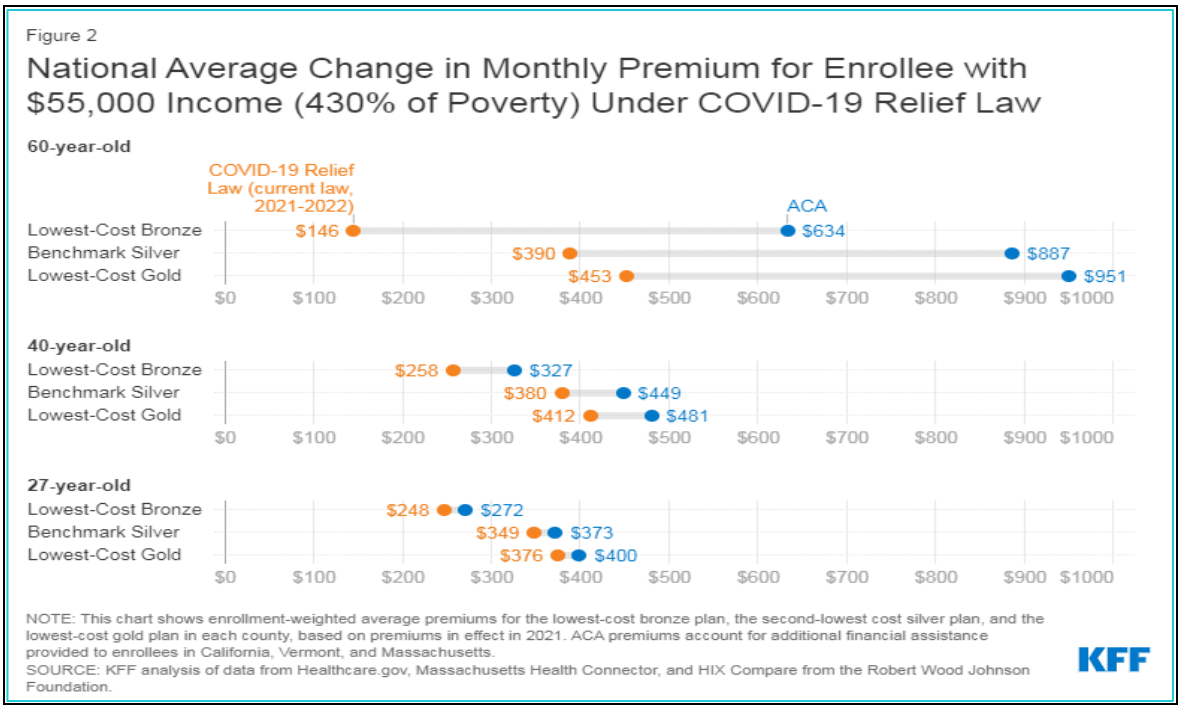
Under existing federal law, spouses could only access the Marketplace to purchase subsidized coverage if they are ineligible for affordable and minimum value coverage under the TRS program (with affordability being measured only on the cost of the employee only coverage option). Eliminating coverage for spouses could be done in two ways: 1) eliminating coverage for spouses across the entire TRS program, or 2) giving districts the options to eliminate coverage for spouses for their own district. The latter option may be preferable, particularly to those districts that provide additional subsidies to spouses in the current program, but districts would need to be careful to ensure that they avoid any problems associated with how they offer coverage as part of their cafeteria plan. If the proposal to change the “family glitch” is finalized, eliminating coverage may not be necessary because spouses could qualify for subsidized Marketplace coverage based on the current TRS program.

Although this approach may seem draconian, these examples will show that there is potential benefit to spouses under current law. Further, due to the high cost of coverage for spouses in the TRS program, the plan is being selected against, with only the highest cost spouses remaining in the program (claims for those with Employee + Spouse coverage is well in excess of the premiums collected). By providing a mechanism for these spouses to acquire subsidized coverage, TRS-

ActiveCare could lower the overall per member cost of the program, resulting in a benefit cost reduction for employees and employers, in addition to the potential cost reduction for spouses detailed below. Alternatively this issue could be mitigated somewhat by additional subsidies provided to coverage tiers with spouses by increasing the premium for employee-only coverage

Subsidy Examples

In the individual market, premium amounts vary by age, with younger participants paying lower amounts and older participants paying higher amounts. In addition, subsidies vary based on income. The chart below details the impact of market subsides on national average premiums that an individual would pay based on a $55,000 income:



While the impact is lower for younger participants, there is still savings under the current (though temporary) subsidy structure. However, for many spouses the cost of even gold coverage could be lower than the contribution requirements for spouses in the TRS program. Using Texas specific average premium data, the following examples provide a comparison of TRS required premiums for Primary coverage (though the results would be similar for all plans), which is the lowest cost TRS plan and a Gold level, to an individual market Gold plan, under various salaries, and ages. Costs are modeled below in three counties, Harris, Henderson, and Wichita, which represent the lowest cost areas, median costs areas, and highest costs areas in the state of Texas, respectively. Costs are also modeled for a 27-year-old, 40-year-old, and 60-year-old, assuming salaries of $35,000, $55,000, and $70,000 per year.

Under ARPA Subsidies (Current Law)

Age/Location	27-year-old – Wichita			40-year-old – Wichita			60-year-old - Wichita		
Salary	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**
Benchmark Silver Plan	$564.59	$564.59	$564.59	$688.49	$688.49	$688.49	$1,462.11	$1,462.11	$1,462.11
Max Monthly Cost to Individual (Salary x Max % of Income)	$116.67	$389.58	$495.83	$116.67	$389.58	$495.83	$116.67	$389.58	$495.83
Marketplace Subsidy (1-2)	**$447.92**	**$175.01**	**$68.76**	**$571.82**	**$298.91**	**$192.66**	**$1,345.44**	**$1,072.53**	**$966.28**
Lowest Gold Premium	$487.77	$487.77	$487.77	$594.82	$594.82	$594.82	$1,263.18	$1,263.18	$1,263.18
Monthly Gold Cost (Gold Premium – Subsidy)	$39.85	$312.76	$419.01	$23.00	$295.91	$402.16	$0.00	$190.65	$296.90
Current Spouse Cost (Primary+)	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00
Potential Spouse Savings (Current Cost – Cost of Gold Plan)	**$719.15**	**$446.24**	**$339.99**	**$736.00**	**$463.09**	**$356.84**	**$759.00**	**$568.35**	**$462.10**

Age/Location	27-year-old – Henderson			40-year-old – Henderson			60-year-old - Henderson		
Salary	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**
Marketplace Subsidy	$315.76	$42.85	$0.00	$410.66	$137.75	$31.50	$1,003.18	$730.27	$624.02
Monthly Gold Cost	$86.10	$359.01	$401.86	$79.40	$352.31	$458.56	$37.52	$310.43	$416.68
Current Spouse Cost (Primary+)	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00
Potential Spouse Savings	**$672.90**	**$399.99**	**$357.14**	**$679.60**	**$406.69**	**$300.44**	**$721.48**	**$448.57**	**$342.32**

Age/Location	27-year-old – Harris			40-year-old – Harris			60-year-old - Harris		
Salary	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**
Marketplace Subsidy	$190.78	$0.00	$0.00	$258.26	$0.00	$0.00	$679.53	$406.62	$300.37
Monthly Gold Cost	$105.41	$296.19	$296.19	$102.93	$361.19	$361.19	$87.51	$360.42	$466.67
Current Spouse Cost (Primary+)	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00
Potential Spouse Savings	**$653.59**	**$462.81**	**$462.81**	**$656.07**	**$397.81**	**$397.81**	**$671.49**	**$398.58**	**$292.33**

Under current law, there is potentially significant savings for spouses in the Marketplace, where in certain areas, premiums for Gold coverage is available at a lower cost than what is offered through TRS. When subsidies are considered, Gold level coverage can be secured at a lower cost in all areas for all ages at the salaries considered. It should be noted that the networks and drug formularies for this individual coverage would likely be more limited than what is offered through TRS, but the premium savings may be enough to warrant the transition. Further, premiums shown represent the lowest cost Gold plan in the Marketplace by location, so costs could vary if individuals were to select a more expensive Gold plan.

Under ACA Subsidies (Original Law)

Age/Location	27-year-old – Wichita			40-year-old – Wichita			60-year-old - Wichita		
Salary	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**
Marketplace Subsidy	$321.63	$0.00	$0.00	$445.53	$0.00	$0.00	$1,219.15	$0.00	$0.00
Monthly Gold Cost	$166.14	$487.77	$487.77	$149.29	$594.82	$594.82	$44.03	$1,263.18	$1,263.18
Current Spouse Cost (Primary+)	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00
Potential Spouse Savings	**$592.86**	**$271.23**	**$271.23**	**$609.71**	**$164.18**	**$164.18**	**$714.97**	**($504.18)**	**($504.18)**

Age/Location	27-year-old – Henderson			40-year-old – Henderson			60-year-old - Henderson		
Salary	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**
Marketplace Subsidy	$189.47	$0.00	$0.00	$284.37	$0.00	$0.00	$876.89	$0.00	$0.00
Monthly Gold Cost	$212.39	$401.86	$401.86	$205.69	$490.06	$490.06	$163.81	$1,040.70	$1,040.70
Current Spouse Cost (Primary+)	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00
Potential Spouse Savings	**$546.61**	**$357.14**	**$357.14**	**$553.31**	**$268.94**	**$268.94**	**$595.19**	**($281.70)**	**($281.70)**

Age/Location	27-year-old – Harris			40-year-old – Harris			60-year-old - Harris		
Salary	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**	**$35,000**	**$55,000**	**$70,000**
Marketplace Subsidy	$64.49	$0.00	$0.00	$131.97	$0.00	$0.00	$553.24	$0.00	$0.00
Monthly Gold Cost	$231.70	$296.19	$296.19	$229.22	$361.19	$361.19	$213.80	$767.04	$767.04
Current Spouse Cost (Primary+)	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00	$759.00
Potential Spouse Savings	**$527.30**	**$462.81**	**$462.81**	**$529.78**	**$397.81**	**$397.81**	**$545.20**	**($8.04)**	**($8.04)**

If the subsidy structure reverts to the original law, the savings opportunity is a little cloudier. At certain ages, and in certain areas, the coverage available in the Marketplace would still be more expensive than what is available through TRS. However, in most areas and at most ages and salaries, the premium savings opportunity is still significant.

Summary

As noted, spouse coverage through the TRS-ActiveCare program is currently very expensive for participants. In the individual market, there are comparable plans available that could be procured at lower cost to the spouse in many areas, across many ages and salary levels throughout the state due to federal subsidies. As a result, it may be worth considering revising the way spouse coverage is offered to participants, by giving districts the option to eliminate it or increasing state/district subsidy levels to current group coverage for spouses. To determine whether this is a viable approach, TRS would need to do a deeper dive into the overall salary levels and geographic breakdown of the population to determine whether the individual market is truly more competitive than the current offering – as shown above, the impact would vary by district. However, at a high level, it does appear that there is an opportunity to provide more affordable coverage to spouses than what is currently provided through alternative approaches.

Voluntary Benefits

Overview

Voluntary benefits, otherwise known as supplemental insurance or employee-paid benefits, are products, benefits, or services offered by employers but mostly or fully paid for by employees via payroll deductions at a reduced group price. Voluntary benefits are a useful tool in recruitment and retention, as it allows employers to offer additional benefits, often filling in gaps of existing coverage, with little to no additional cost. For instance, each district could make the decision to offer the benefits with 100% employee paid or alternatively have the option to subsidize if they choose to do so. With an added focus on varying needs of employees at different stages of life, introducing a suite of voluntary benefits allows employers to address the concerns of employees across different life stages, income levels, and risk tolerances.

From an employee perspective, the availability of voluntary benefits provides them with additional options to balance varying levels of risk tolerance associated with potential out-of-pocket expenses. These benefits have grown considerably in popularity over the years, and it continues to be an expanding industry in the health care arena.

Types of Voluntary Benefits

Types of benefits include the following:

- Dental – discounted coverage for dental exams, cleanings, and dental procedures
- Vision – discounted coverage for eye exams, glasses, and/or contacts
- Cancer & Critical Illness - Provides payout beyond medical plan reimbursement and limited income if compensation is interrupted because of diagnosis of specific disease (e.g., cancer, heart attack, stroke)
- Life Insurance – provides payment to designated beneficiaries upon death of insured person (e.g., term, whole life, universal)
- Disability – provides financial support to employees that become disabled and are no longer able to work
- Accident - Provides payout beyond medical plan reimbursement and limited income if compensation is interrupted because of accident. May also include a wellness benefit
- Hospital Indemnity – Provides payout beyond medical plan reimbursement and limited income if compensation is interrupted because of hospitalization and other medical events; can overlap with accident benefit
- ID Protection – provides coverage for the costs of associated with identity theft. Offering addresses increasing frequency of theft, loss of time, and fear.
- Group Auto & Home – provides coverage for drivers, homeowners, and renters, offering meaningful savings and value-added benefits to participants above what they can secure on their own

- Group Legal – provides coverage for legal services (e.g., court appearances, document review and preparation, family, and real estate matters, etc.)
- Pet Insurance – provides coverage for veterinary treatment of wellness, illness, emergency, and more (limits on types of pets and age)
- Hearing Aid Assistance – provides discounts on hearing aids
- Emergency Savings & Financial Planning – helps address unexpected financial need without draining retirement accounts. Helps participants manage budget
- Long Term Care – provides reimbursement for cost of care provided for assistance with activities of daily living

Considerations

For TRS, there are several things to consider as it relates to offering voluntary benefits to employees, including:

- TRS is in a unique position to secure many of these benefits at attractive rates that would not be available to districts on their own or replace the need for districts to secure on their own. This would serve as an additional selling point around the benefits of participating in the TRS-ActiveCare program.
- Many of these benefits pair well with high deductible health plans like those that are offered as part of the TRS-ActiveCare program.
- These benefits are often highly valued by employees, which would help to improve satisfaction rates in the program, and further the draw to TRS.

There are also some complexities to consider relating to offering voluntary benefits under TRS-ActiveCare, including:

- The introduction of these benefits would require a change in legislation, as TRS-ActiveCare was created specifically to offer health insurance to districts. Voluntary benefits are currently outside the purview of TRS.
- The addition of these benefits would require some additional administration, which would generate some costs to set up. Further, there would be costs related to negotiating the rates and renewals of these benefits annually. However, the costs associated with this administration could be passed on in the cost of each benefit.

Conclusion

Overall, the introduction of these benefits could have many benefits for TRS, if the program gains the ability to offer them. As noted, these benefits address varying needs of employees across different stages of life. Further, it would serve to improve the value proposition of joining and remaining in TRS. Assuming there is interest, it may be worth performing focus groups across districts to determine which benefits may be the most valuable to offer to employees.

Data Management

Knowledge is power. Complete information is most powerful.

Data mining analyzes your plan data to find out what factors are most responsible for driving your costs. Knowing that information is the first step to strategic healthcare cost management. It gives you insights to make effective plan or vendor contracting changes — without simply shifting costs to your participants.

Having a comprehensive data warehouse provides TRS a powerful tool that aggregates all of your health plan data from every vendor you work with: medical carriers, pharmacy benefit managers (PBMs) and other program administrators. This approach frees you from having to rely on vendor reporting when you make decisions about cost management. That's important because, in our experience, the data that vendors report is often limited.

Some primary reasons for why plans utilize a data warehouse include:

- Gives you rich insights into which medical conditions and treatments are driving costs
- Identifies high-volume and high-cost providers and facilities to reduce pricing abuses and identify where to use provider-specific initiatives
- Flags abnormal claims to catch vendor-processing errors
- Measures and monitors the health status and risks of your participant population
- Reviews participant compliance with evidence-based medical guidelines
- Evaluates if your plan design is effectively steering patients to seek care in cost efficient settings
- Includes objective advice on how to effectively target your healthcare cost-management strategies
- Provides information to use in vendor bids or audits
- Enables you to benchmark your cost and utilization patterns
- Allows you to conduct ad hoc special studies on specific issues or plan changes.

Health cost data mining allows you to create sustainable solutions to uncover and manage the root causes of rising healthcare costs and improve population health. Moreover, you are able to proactively monitor your data, searching for trends or anomalies so you can be proactive in identifying cost savings opportunities

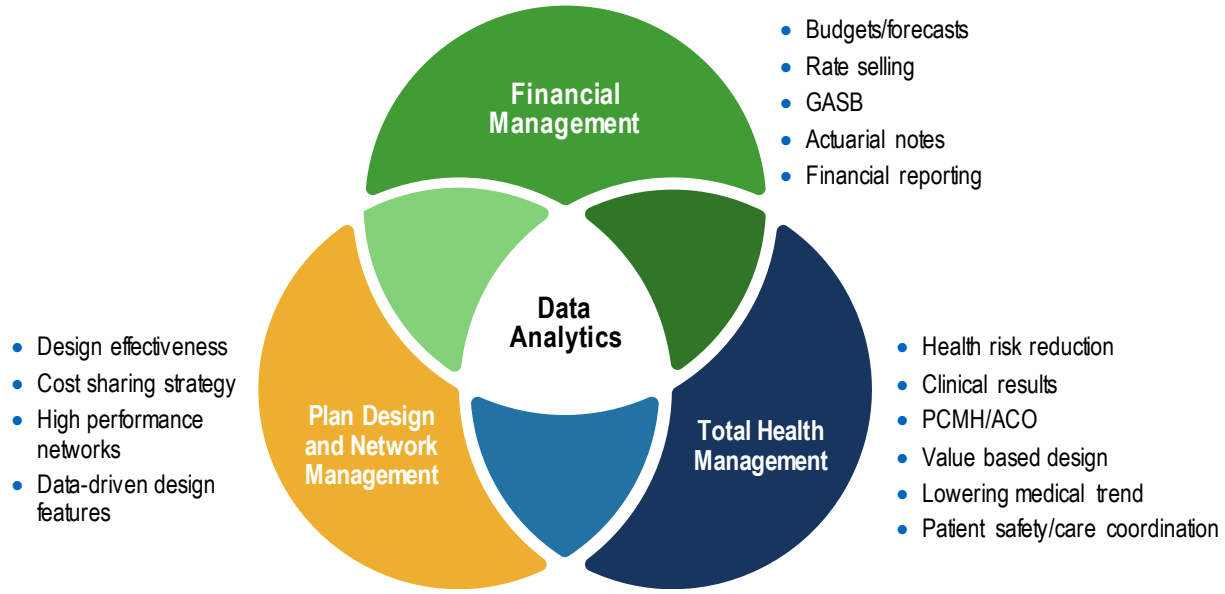
The bottom line is data mining provides a powerful tool for identifying concrete issues so you can address them. The insights generated allows you to make well-informed decisions that improve the value of your plan. It can also be used to test plan management strategies and monitor the results. Sponsors of self-funded health plans can gain greater control over benefit plan direction and value when they get their data into a data warehouse.

Health Plan Management – Data Analytics is Key

As part of your ongoing cost-management efforts, you should analyze your data to be sure the strategies you are using are most effective for addressing your cost drivers. A health plan management model emphasizes the integration of three important pillars:

- **Financial management**: Aspects of a health plan that are related to budgets, forecasts, rate setting, and reporting
- **Plan and network management**: Information that supports design effectiveness, network performance, cost sharing strategies and vendor management
- **Total health management**: Information that supports and informs clinical results, health risk factor reduction strategies, innovative delivery systems (e.g., Patient Centered Medical Home, Accountable Care Organization), value-based design modeling, patient safety and care coordination, and medical trend management

Data analytics and data management cross all functional areas and are instrumental in proactive program management. The diagram below illustrates how these three pillars fit together for the best outcomes and how data is the integrating factor:



Many of these sections have been discussed throughout this report. Using data analytics is important to understand the interrelationships between each pillar and how each works together across a wide range of experts to deliver this integrated plan management model.

We believe data management is instrumental and a key to successful program management. TRS has made great strides in this area and will continue to enhance their capabilities. However, it is a challenge to create, incorporate and maintain all the functional areas and tools necessary to run a data warehouse. There are financial limitations to running a data warehouse as a single plan, and we have found other states have challenges managing systems that meet their long-term needs. Larger data warehouse organizations, who do data management as their main business, have broader information and technologies available. For instance, there is no comparative data within your own data to provide ongoing benchmarks, norms, etc.

Currently, TRS has a custom warehouse built and is focused on developing applicable tools and reporting to support many areas. TRS currently contracts with outside vendors for some of this functionality such as groupers, risk models, etc. necessary to get to the analytics that are important for rating and claims analysis.

Exhibits

School District Health Plan Eligibility Structure

State A	State	School Districts with State Health Plan Coverage	School Districts with State Level Education Health Plan Coverage	School Districts with School District Level Health Plan	Rules for District Participation (entry/exit) to State Health Plan or State Level Education Health Plan
AL	Alabama		State Level Education Health Plan - Required		
AK	Alaska	State Health Plan - Required			
AZ	Arizona	State Health Plan - Required			
AR	Arkansas	State Health Plan - Required			
CA	California	State Health Plan - Voluntary			(unable to locate district entry/exit rules)
CO	Colorado		State Level Education Health Plan - Voluntary		(unable to locate district entry/exit rules)
CT	Connecticut	State Health Plan - Voluntary		Option of School District Level or State Health Plan (entire District)	3 year participation requirement; entire city/town/school must join Year 1 Penalty: lesser of 5% of premium or group total cost less than rates Year 2 Penalty: lesser of 3% of premium or group total cost less than rates
DE	Delaware	State Health Plan - Required			
FL	Florida			School District Level	
G	Georgia	State Health Plan - Required			
HI	Hawaii	State Health Plan - Required			
ID	Idaho	State Health Plan - Required			
IL	Illinois			School District Level	
IN	Indiana	State Health Plan - Required			
IA	Iowa			School District Level	
KS	Kansas			School District Level	
KY	Kentucky	State Health Plan - Required			
LA	Louisiana	State Health Plan - Voluntary		Option of School District Level or State Health Plan (entire District)	premium rate applicable to the employees and retirees are the greater of the premium rate based on the loss experience of the group under the prior plan (for three years then convert to the published OGB rates) or the premium rate based on the loss experience of the classification into which the group is entering

School District Health Plan Eligibility Structure

State Abb	State	School Districts with State Health Plan Coverage	School Districts with State Level Education Health Plan Coverage	School Districts with School District Level Health Plan Coverage	Rules for District Participation (entry/exit) to State Health Plan or State Level Education Health Plan
ME	**Maine**		State Level Education Health Plan - Voluntary	Option of School District Level or State Level Education Health Plan (entire District)	State of Maine enacted L.D. 1326 allowing School Administrative Units seek less expensive health insurance alternatives in 2011; Eligibility for enrollment in the Plan is determined by the collective bargaining agreements negotiated; nearly 67,000 members from 99 percent of Maine's school districts, is community-rated (from 2012, most recent data found); that is, the price of coverage is negotiated on the basis of group-wide utilization costs, and accounts for neither geographic variation nor an individual employer's demographic mix, prior utilization, or loss experience. This community-rated plan is designed in part to subsidize, through members who are actuarially favorable, the premiums paid by members who are actuarially less attractive to insurers. The Plan as designed economically benefits employees of educational institutions whose work forces are older or less healthy than other members of the group, or who reside in regions—typically Northern and Eastern Maine—with higher health care costs and, on average, lower salaries than their Southern Maine
MD	**Maryland**			School District Level Health Plan	
MA	**Massachusetts**	State Health Plan - Voluntary		Option of School District Level or State Health Plan (entire District)	generally, school districts follow municipality
MI	**Michigan**			School District Level Health Plan	
MN	**Minnesota**	State Health Plan - Required			
MS	**Mississippi**	State Health Plan - Required			
MO	**Missouri**	State Health Plan - Required			
MT	**Montana**		State Level Education Health Plan - Voluntary	Option of School District Level or State Level Education Health Plan (entire District)	May withdraw by providing 90 days written notice and dissolved with mutual consent of all the participating districts, the multidistrict cooperative formed under the multidistrict agreement

NE	**Nebraska**	State Level Education Health Plan - Voluntary	Option of School District Level or State Level Education Health Plan (entire District)	(unable to locate district entry/exit rules)
NV	**Nevada**		School District Level Health Plan	
NH	**New Hampshire**		School District Level Health Plan	

School District Health Plan Eligibility Structure

State Abb	State	School Districts with State Health Plan Coverage	School Districts with State Level Education Health Plan Coverage	School Districts with School District Level Health Plan Coverage	Rules for District Participation (entry/exit) to State Health Plan or State Level Education Health Plan
NJ	**New Jersey**	State Health Plan - Voluntary		Option of School District Level or State Health Plan (entire District)	Exit: 60 days notice (75+preferredy)required; in default if premiums not paid within 31 days of due date and coverage will terminate for all employees and dependents; NJDPB notifies the Department of Education, as appropriate, that the employer failed
NM	**New Mexico**		State Level Education Health Plan - Required		NMPSIA currently provides benefit and risk coverage to all public school districts except Albuquerque Public Schools, all charter schools, and other educational entities. Not all participating employers provide all lines of coverage offered through the NMPSIA program. (unable to locate entry/exit rules)
NY	**New York**	State Health Plan - Required			
NC	**North Carolina**	State Health Plan - Required			
ND	**North Dakota**	State Health Plan - Required			
OH	**Ohio**			School District Level Health Plan	many participate in consortiums
OK	**Oklahoma**	State Health Plan - Required			
OR	**Oregon**		State Level Education Health Plan - Voluntary	Option of School District Level or State Level Education Health Plan (entire District)	When OEBB started in 2008, districts with a previously established trust or were self-funded could opt out of OEBB. Otherwise, districts were required to join OEBB when their current collective bargaining contracts expired, no later than October 2010. The Oregon Educator's Benefit Board (OEBB) administers health plans for about 157,860 school district, education service district, and community college employees / Although OEBB manages plans for most educators and staff, including all education service districts and community colleges, there are some school districts that obtain health
PA	**Pennsylvania**	State Health Plan - Required			

RI	**Rhode Island**	State Health Plan - Required	
SC	**South Carolina**	State Health Plan - Required	
SD	**South Dakota**		School District Level Health Plan

School District Health Plan Eligibility Structure

State Abb	State	School Districts with State Health Plan Coverage	School Districts with State Level Education Health Plan Coverage	School Districts with School District Level Health Plan Coverage	Rules for District Participation (entry/exit) to State Health Plan or State Level
TN	**Tennessee**	State Health Plan - Voluntary		Option of School District Level or State Health Plan (entire District)	Tennessee Code 8-27-304: may withdraw following at least 24 months of participation and comply with equivalency provisions of § 8-27-303(a)(2)
TX	**Texas**		State Level Education Health Plan - Voluntary	Option of School District Level or State Level Education Health Plan (entire District)	May choose to leave TRS-ActiveCare by notifying TRS by Dec. 31 of the year before the plan year they intend to leave the plan; may only re-join TRS-ActiveCare after a period of five plan years. Prior to enactment of SB 1444 (2021),
UT	**Utah**	State Health Plan - Voluntary		Option of School District Level or State Health Plan (entire District)	(unable to locate district entry/exit rules)
VT	**Vermont**		State Level Education Health Plan - Voluntary	Option of School District Level or State Level Education Health Plan (entire District)	Either party may terminate this Service Contract, without cause, at the expiration of the initial/renewal term expiration by prior written notice to
VA	**Virginia**			School District Level Health Plan	
WA	**Washington**	State Health Plan - Required			
WV	**West Virginia**	State Health Plan - Required			
WI	**Wisconsin**	State Health Plan - Voluntary		Option of School District Level or State Health Plan (entire District)	Exit rules: if joined prior to 01/01/1988, minimum of 12 months participation requirement for plan eff 01/01/1988 and three year requirement after.
WY	**Wyoming**	State Health Plan - Voluntary		Option of School District Level or State Health Plan (entire District)	Initial five (5) years of plan participation required; District prohibited from participation in the state group insurance plan for a period

State Health Plans - Program Eligibility Structure

State Abbrev	State	Retirees	School District	School University	Local Govt/Pol Sub	Other Agencies
AL	Alabama	x				x
AK	Alaska	x	x		x	
AZ	Arizona	x	x	X		
AR	Arkansas	x	x			
CA	California	x	x	X	x	x
CO	Colorado			X		
CT	Connecticut	x	x	X	x	x
DE	Delaware	x	x	X	x	x
FL	Florida	x		X		
GA	Georgia	x	x			x
HI	Hawaii	x	x	X	x	
ID	Idaho	x	x	X	x	x
IL	Illinois	x		X	x	x
IN	Indiana	x	x			
IA	Iowa	x				
KS	Kansas	x				
KY	Kentucky	x	x	X	x	x
LA	Louisiana	x	x	X	x	
ME	Maine	x		X		x
MD	Maryland	x		X	x	x
MA	Massachusett	x	x	X	x	x
MI	Michigan	x				
MN	Minnesota	x	x	X	x	
MS	Mississippi	x	x	X		
MO	Missouri	x	x	X	x	
MT	Montana	x				
NE	Nebraska	x				
NV	Nevada	x		X	x	x
NH	New	x				
NJ	New Jersey	x	x	X	x	x
NM	New Mexico			X	x	

State Health Plans - Program Eligibility Structure

State Abbrev	State	Retirees	School District	School University	Local Govt/Pol Sub	Other Agencies
NY	New York	x	x	x	x	x
NC	North Carolina	x	x	x	x	
ND	North Dakota	x	x	x	x	
OH	Ohio					
OK	Oklahoma	x	x		x	x
OR	Oregon	x		x	x	
PA	Pennsylvania	x	x			
RI	Rhode Island	x	x	x		
SC	South Carolina	x	x	x	x	x
SD	South Dakota	x		x		
TN	Tennessee	x	x	x	x	x
TX	Texas	x		x		x
UT	Utah	x	x	x	x	
VT	Vermont	x				x
VA	Virginia	x		x		
WA	Washington	x	x	x	x	x
WV	West Virginia	x	x	x	x	
WI	Wisconsin	x	x	x	x	
WY	Wyoming	x	x	x	x	