GSRA Newsletter

Vol. 9, Number 7 www.MyGSRA.com July 2015

Come Join Us in Savannah on the 16th and 17th. The Annual Meeting is shaping up to be an in-depth look at "Where Do We Go From Here." Not only will we work through the issues, but there will be time for fun and camaraderie. Go to www.mygsra.com to register for the meeting and get hotel information.

DCH Says SHBP Plan Features and Vendors Stable in CY 2016; Governor-Mandated Study Confirms Excessive Member Costs

In a recent meeting with GSRA representatives, the Department of Community Health Commissioner Clyde Reese stated that DCH expected to present the CY 2016 SHBP benefits and rates to the Board for approval on August 13, 2015. He emphasized that DCH wants to "remain focused on stability and continuity with the Plan's current vendors and options." However, there was no mention in the meeting of member premium rates.

Focusing on stability and continuity appears to be based on a report to evaluate various aspects of the SHBP costs that was requested by the Governor and General Assembly and conducted by AON Hewitt Consulting. The bottom-line conclusion by the consultants is that active and pre-Medicare members are paying a greater percentage of their medical expenses than most of the comparative public employers. The 2015 Medical Cost Benchmarking report states that,

> *"After adjustment for the key cost drivers—geographic location, demographics, adult lives per employee and plan design value—to normalize the comparison, the SHBP allowed [TOTAL] costs move to third lowest (out of seven) when benchmarked.*
>
> *"After adjustment for the . . . key cost drivers . . . the average [ACTIVE] employee member payments remain higher than all but one Comparator. . . .*

The AON-Hewitt report substantiates the many GSRA articles since CY 2013 that the decisions of the Board of Community Health to *increase the member premiums and the out-of-pocket costs (through plan design) has shifted much of the cost for medical care to the members*. During this same time, the Plan reserves have improved while holding the state's contributions fairly stable. All recommendations shown in the AON Hewitt report appear to be "long-term" and/or administrative in nature. The long-term recommendations, in all probability, will require many resources with difficult implementation issues. Most of the administrative recommendations, if implemented, seem to have limited effect on cost or member satisfaction. Highlights about cost and recommendations from the "Benchmarking Report" are reported in this article. GSRA appreciates the concern by the Commissioner to stabilize the plan in 2016 since the members have been subjected to so

many changes beginning in 2013. We also recognize the effort required to implement changes to the SHBP. However, editorial comments about some of the fund costs and the recommendations are shared with GSRA members in this article.

The Benchmarking Report

The AON Hewitt Benchmarking Report stated that the purpose of the study was to provide information as requested by the Governor and General Assembly in the Amended FY 2015 Appropriations Act. The original recommendation for the study was identified in the Governor's FY 2016 Zero Based Budget (ZBB) Report. It referred to the 2014 study by the Pew Charitable Trusts that the SHBP total costs are nearly 25% higher than other southern states' employee health plans' costs. The ZBB report recommended that the causes of the SHBP costs and options for reducing such costs be identified. The General Assembly echoed the sentiments presented by the Governor's ZBB and expanded the study to also examine options for providing health benefits for the non-certificated school employees. Key information about comparisons, costs and recommendations is gleaned from the Benchmarking report and reported.

Comparators & Normalization

AON Hewitt and the state chose the public employee plans with which the SHBP Active and pre-65 retiree costs and plans would be compared. These public employee medical plans are: **Florida, Kentucky, Mississippi, South Carolina, Tennessee and the Board of Regents.** The various costs of the seven plans were normalized by **adjusting the key cost drivers: geographic location, demographics, adult lives per employee and plan design value.** Historically, medical costs have varied by geography – even within the State of Georgia. Normalizing the primary demographics of persons covered means to adjust for similarity or differences in age and gender. Adjustments must also be made for the average number of adults covered per employee. The final factor to be normalized among the Comparators is the plan design (primarily deductibles, OOP maximums, wellness benefits and tobacco surcharges).

Key Observations

AON Hewitt reports 2 key observations. First that the relatively high per employee total cost is based on the three drivers—geographic location, demographics, and adult lives per employee—and that these three drivers differ by OOP costs and premium deductions.

(1) Georgia SHBP's variation for geographic location costs are 6% higher than the mean of the (7 employer) group;
(2) The SHBP age and gender mix is 2% higher than the mean of the comparative group,
(3) Adult lives per employee in the SHBP are 4% higher than the mean of the comparative group;
(4) SHBP's average estimated OOP costs are higher than all Comparators;
(5) For an average employee, the SHBP offers a lower average plan design value than all but one of the Comparators, resulting in the OOP responsibility for employees being 22% greater than the mean, even though most employees tend to enroll in the plans with higher average OOP costs;
(6) SHBP's employee payroll deductions are on the higher end of the Comparators—recognizing that the manner in which an employer subsidizes the various plans is the biggest driver of employee premium deductions.

Results of Cost Comparisons

The AON Hewitt report states that it is important to note that the three major factors in determining total allowed health plan cost are: (1) employee payroll deductions, (2) employee OOP costs (deductibles, copays, coinsurance), and (3) employer subsidy. When one of these pieces is changed, at least one of the other components will have an offsetting change. Other initiatives, such as wellness programs and contractual negotiations, can impact the overall total allowed cost while basic changes to employee deductions, plan design, or subsidy typically cannot.

The result of the various comparisons, including the normalized comparisons, are:

(1) The SHBP total unadjusted costs are on the high end of the Comparators—second highest—and

is similar to that documented in the Pew study (mentioned in the Governor's ZZB report);

(2) The adjusted (for key cost drivers) total costs are much more similar between the Comparators on a per employee basis – specifically, the SHBP moves from being the second highest to the third lowest of the group; and

(3) Employee Payroll Deductions (premiums) are somewhat impacted by the "adult lives per employee" but primarily impacted by the "employer's overall subsidy strategy."

Summary of Factors (Active Employees)

The report separates the active members from the pre-65 retirees and provides the resulting comparisons.

(1) The SHBP's total cost (premiums and OOP) is the highest for the employee of all Comparators and is 29% higher than the mean with all Comparators, but drops to 23% higher than the mean when wellness credits and the tobacco surcharge are considered;

(2) Employee out-of-pocket (OOP) costs is the highest of all Comparators and is 39% higher than the mean of all Comparators;

(3) SHBP employee deductions (premiums) are higher than all but two Comparators and is 18% higher than the mean of all Comparators, but drops to 15% higher than the mean after the tobacco surcharge is considered.

Benchmarking Report Recommendations

Telemedicine/Virtual medicine: As directed in the FY 2016 Appropriations Act that the SHBP adopt an emerging technology program allowing members to receive routine episodic care through a consumer oriented telemedicine vendor, the Benchmarking report further clarifies the benefits of such technology. As noted in the report, "this strategy is being considered for a 2016 implementation."

On-site Health Clinics to treat some health needs in a lower cost environment than currently treated may be viable for heavily populated areas of SHBP members. This strategy can require a significant amount of time for both feasibility review and implementation and, therefore, would likely be unavailable in 2016.

Delivery System Transformation is an evolving strategy in the marketplace around the Accountable Care Organizations (ACOs) that is a part of the Affordable Care Act (ACA). The SHBP should stay abreast of this evolving market and consider application to its program as more data and options become available.

Narrow Networks and/or Direct Contracting may be worth considering by SHBP given the SHBP's considerable size. The market is evolving around narrow networks that direct certain types of care to higher quality physicians and/or providers aimed at better outcomes and lower overall cost. This strategy could lead to negotiating a lower price with a higher quality, however, the administrative complexities and network disruption can make these strategies difficult to implement.

Decision Support Tools for plan modeling to help members find the right plan and can help better control costs for both themselves and the SHBP.

Advocacy to assist members to better understand the complex health care environment would give members support that can help control cost for members and the SHBP by improved health and quality. The Advocacy systems would include Navigators to help the member get the right care at the right price at the right time. Although the SHBP has elements of Advocacy today, this strategy would provide market options for greater personal member/advocate connections and greater member satisfaction.

Dependent Eligibility Audit was implemented by the SHBP several years ago. However, a new dependent eligibility audit may be considered to ensure only eligible members are covered on the Plan.

Employer Subsidy Adjustment: As reflected in this study, the SHBP requires a greater proportion of overall health care cost to be borne by members. Therefore, in order to improve the relative position in overall cost share, the SHBP might consider making the plans offered more affordable through lower employee payroll deduction requirements and/or lower expected OOP costs.

Wellness Incentives that have been a part of the SHBP for several years with participation relatively low. The SHBP might consider re-communicating the program, potentially increasing the amount of incentive available to be earned and/or supporting portability of funds for members who choose to change plans during the annual open enrollment.

Medicare Retiree Individual Exchange Strategy was not a focus of this study; however, many employers with Medicare Retiree obligations are considering a move to the individual Medicare market to take advantage of the greater efficiency and choice availability. The SHBP might consider evaluating whether a move to the individual Medicare market would provide retirees with a greater choice of carrier, design, and price.

Benchmarking Report – Coverage for Non-Certs

The report discusses the historical funding for the costs associated with the "public school employees" referred to as the "non-certs." Although the local school systems payment for each enrolled employee was increased in FY 2016, there continues to be a shortage of $40 PEPM (per employee per month). Should the employers not increase their contribution, the Non-Cert member will need to bear the full $40 increase. Since the current active employee costs are already higher than the Comparators, adding another sizeable increase will cause even further erosion of the SHBP value as a part of compensation. The report provides possible premium scenarios to address the issue.

GSRA Editorial Comments

The AON Hewitt report validates the many articles that GSRA has published to the members regarding the SHBP's cost-shifting to the members. We should all remember the "hit" that the SHBP took during the 2008-2010 recession in that almost $1 billion was removed from the Plan by the state reducing contributions to the Plan. This caused the SHBP to become basically bankrupt on June 30, 2012 by $272 million[1] – it did not have sufficient funds to pay "Incurred But Not Received" medical claims.

Audit reports for the SHBP during FY 2013 and FY 2014 show that the SHBP has improved its financial position since FY 2012 by increasing revenue (primarily employee premiums) and decreasing benefit payments (changing the plan design to require members to pay an increased amount "out-of-pocket" at the point of receiving medical service). As a reminder, SHBP audit reports for FY 2012 through FY 2014 show that the reserve balance increased from a negative ($272,491,156) on June 30, 2012 to a positive $266,430,748 on June 30, 2014 **or by $538,921,904 during FY 2013 and FY 2014**. It is clear that most of the improved financial position is a result of cost-shifting to the members and this fact is borne out by the AON-Hewitt report by showing the SHBP members are paying a greater portion of their health care than most of the southern states. We point out that this improvement in financial position was also during a time when the state discontinued supporting the "Non-Cert" members and required that funds from the other subgroups of the SHBP subsidize these members.

GSRA agrees that the state's subsidy policy should be re-evaluated; however, requiring the Non-Cert members to pay a greater premium may be in violation of state law.

> O.C.G.A.20-2-920(b): *The Department of Education and local school systems shall contribute to the health insurance fund such portion of the costs of such benefits as may be established by the board to maintain the employee contributions consistent with other health insurance plans administered by the board.*

GSRA Comments on Specific AON *Hewitt* recommendations

a. Recommendations, such as telemedicine, onsite health clinics, and delivery system transformation, are long-term. These recommendations (as pointed out) are difficult to implement and require many resources. The delivery system transformation is not generally

[1] FY 2012 State Audit Report for the SHBP.

within the control of the SHBP – but after transformed may be of benefit to the members.

b. Contracting with "narrow networks" should be monitored. While narrow networks may provide savings, the diversity of the workforce and geographic distribution of SHBP members make "narrow networks" troublesome to members. The savings generated may be another process that transfers "out-of-pocket" cost to members because of unavailability of care-givers. We hear a lot of discussion from GSRA members about length of time to see a physician and the requirements for providers to seek approval for many services. A narrow network will only make this problem worse.

c. Recommendations for increased "Decision Support Tools, Advocacy, Dependent Eligibility Audit, and Wellness Incentives are "good" things to consider implementing. However, these changes in administration of the Plan will probably have little effect on the cost to the members. Member satisfaction may be improved, but the cost of implementing these items versus satisfaction should be evaluated.

d. GSRA continues to be very concerned about SHBP policies for retired members. The recommendation that the Medicare Individual Exchange Strategy be considered is another way of changing the Medicare Retiree policy to what is referred to as a "defined contribution plan." That means generally that the member is given a dollar amount (that is established periodically) to help buy insurance at the marketplace. The member, as a general rule, will be subject to picking up all or most of the increases in the marketplace premiums. Such a change in policy will create another considerable hurdle for the SHBP—how to appropriately treat all of the retirees who do not have Medicare Part A and/or who have a "late" penalty for buying Part B Medicare since they did not enroll when first eligible. While it may be that some members will appreciate the additional options, the choices are usually made based on the "cost" either in premiums and/or out-of-pocket maximums.

e. The AON Hewitt report did not specifically mention the pre-65 retirees. One of the Governor's ZBB report recommendations was to "examine and report on alternative options for providing health care benefits to pre-Medicare retirees." These potential alternatives may include different plan designs, moving these retirees to a private exchange with defined contribution, or differential premiums for these retirees. When GSRA met with DCH Commissioner Reese, he stated that CY 2016 was a stabilizing year. GSRA and its members need to be vigilant and make State leaders aware of concerns about SHBP policies. We remind you that a legislative bill (HB 689) to require persons to pay the entire cost of medical insurance was introduced in the 2015 General Session. Although there are several interpretations of the impact of HB 689 on future employee populations, the current interpretation by the Department of Community Health is that all persons hired (active) and retiring after July 1, 2016 will be required to pay the entire cost of their medical insurance. Many political watchers do not believe that the bill will pass in the 2016 Session. However, we must be vigilant on any bill that affects benefits—it could always be amended to have a severe impact on SHBP active and retired members.

f. The AON Hewitt report did not address the funding of the SHBP and the Governor's 2016 ZBB report to reserve funds for the plan's Other Post-Employment Benefits (OPEB)—that is the liability for providing health insurance to retirees. The Amended FY 2015 Appropriation act provides for moving $187 million of SHBP assets to the OPEB Trust fund. GSRA has requested (under open records), a copy of the SHBP financial records for FY 2015. When received, a report will be provided on the status of the fund.

NOTICE: The GSRA Membership will vote on the President, President-Elect, and three at-large Board members at the Annual Meeting on August 17. We encourage you to be active in your association and want to hear from you if you are interested in becoming more active in the association. Let us know by sending an email to Help@mygsra.com and tell us a little about you – such as the department from which you retired, what your job was in that department, and what you would like to help GRSA accomplish.

May/June New Members

Name	County		Name	County		Name	County
May			Theodore Harris	Glynn		Ferrell Bryant	Pierce
Travis Allen	DeKalb		Margaret Lee	McIntosh		Paul Fowler	Fayette
Georgia Barnhill	Ware		Jena Moye	Seminole		Cynthia Hanna	White
Lynn Carrier	Forsyth		Elsie Searcy	Talbot		Georgette Milner	Harris
Steve Chapman	Pierce		Peggy Shipes	Chatham		Sandra Redding	Monroe
Randall Cox	Ware		William Smith	DeKalb		Christine Reilly	(Florida)
Dianne Denton	Pierce		Wayne Stone	Ware		Sloane Shepard	Cobb
Joanne Ellison	Talbot		Daniel Vickers	Atkinson		Margaret Thrower	Glynn
Robert Ellison	Talbot		Shirley Willis	Ware			
Kathleen Fallon	Chatham		**June**				

Don't Forget Your AMBA Benefits!

We encourage you to view the benefits available to you as a member of GSRA by visiting our contracted vendor, www.myAMBAbenefits.info/association/gsra or at 1-800-258-7041. You will see many discounted products (electronics, vacation) and benefits, such as long-term care or dental insurance.

Can We Help?

If you have questions or need help with anything to do with GSRA, please contact help@mygsra.com or call 770-312-2799. We will do our best to help you!