

University System of Georgia

HEALTH INSURANCE PLANS

UPDATE ON THE PROCUREMENT PROCESS
AND OVERVIEW OF PROPOSED ACTION ITEM

NOVEMBER 13, 2013



TOTAL REWARDS STEERING COMMITTEE & PARTNERS

- Dr. Valerie Hepburn, Chair, University of Georgia, visiting professor of health policy
- Dr. William Custer, Georgia State University, professor of health care administration and risk assessment
- Russ Toal, Georgia Southern University, associate professor of health policy
- Dr. Phaedra Corso, University of Georgia, professor of health policy and health economics
- Tom Gausvik, Vice President for Human Resources, Clayton State University
- Susan Norton, Chief Human Resources Officer, Georgia Regents University
- John Brown, VC for Fiscal Affairs,
- Marion Fedrick, VC for Human Resources

- Karin Elliott, AVC for Total Rewards
- Monica Fenton, Director of System Benefits
- Sherea Frazer, Special Assistant to the VC for Fiscal Affairs

Partners

- Aon Hewitt
 - David Batten, Senior Vice President, South Large Markets
 - Stephanie DeLorm, Senior Vice President, Higher Ed Markets
- Legal - Daryl Griswold, AVC for Legal Affairs
- Procurement - Michael Herger, LiftSourcing

VALUE AND GOALS

- **SEEKING PARTNERS WITH COMMITMENT TO QUALITY, ACCESS, EFFICIENCY, VALUE TO USG AND STATE, RESPONSIVENESS, AND SHARED RESPONSIBILITY**
- **MORE THAN INSURANCE – A COMPREHENSIVE APPROACH TO IMPROVING MEMBER HEALTH AND OUTCOMES – AND REDUCING COSTS**
- **FOCUSED ON:**
 - **IMPROVING PATIENT OUTCOMES AND PROVIDER QUALITY**
 - **PROMOTING WELLNESS AND EVIDENCE-BASED SERVICES**
 - **ASSURING OPTIMAL PLAN PRICING, OPERATION AND PERFORMANCE**

General Procurement Approach and Timeline

- RFPs Issued November 1, 2013
- Submission Deadline - January 10, 2014
- Final Selection - April/May 2014
- Board Action on Plan Design and Pricing – August 2014
- Open Enrollment – October/November 2014
- New Plans Become Effective - January 2015

General Procurement Approach and Timeline

- For Self-Insured Option (~95,000 covered lives) - One overarching RFP with considerable flexibility to make selection based on range of considerations - quality, value, access, innovation, strength of sub-vendor integration, and price (discounts and administrative fees)
 - Medical Plan Administration (Claims Administration, Networks, Behavioral, Care Management, and Wellness)
 - Pharmacy Benefits to be optional carve-in or standalone provider
- For Fully-Insured, In-Network Only Option in Atlanta MSA (~6,000 covered lives) – Dedicated RFP for this Plan Option
- Retirees are included for now, but Medicare-eligibles/enrolled are proposed to be carved-out in the future

Number and Types of Plans

- Pricing Requested Based on 2014 Plan Designs
- In the future, anticipate two self-insured plans with statewide coverage:
 - Consumer Directed Health Plan (HDHP with greater decision tools) and HSA/HRA
 - PPO/POS with focus on medical home (with greater decision tools and provider engagement)
- One fully-insured plan option for “in-network only” in Metro Atlanta (assuming cost-benefit analysis supports this option)
- Availability of national networks and international reimbursement (at least one plan)
- Too much choice is costly and paralyzing
- One plan must provide “safe harbor” under ACA
- All plan deductibles and out-of-pocket (to include pharmacy) must be pooled

Anticipated Five-Year Staged Implementation

- Administrative fees and discounts aren't the primary costs; poor health, bad outcomes, and inappropriate utilization are the cost drivers in self-insured plans
- Select 5 to 7 key areas for initial performance improvement in member health outcomes with goal of bending cost curve
- Select 2 to 4 program strategies or developments which offerors must address for future implementation (what they have now, what they will have in the coming years and how that will benefit the USG population) – e.g., care management, patient medical home, wellness, reference-based pricing, etc.
- Structure methods for Offerors to address the dynamic future of health care and wellness

Areas of Strategic Focus for New Health Plans

- Using tools and technology provided by the plan vendor(s), increase consumer/member understanding of wellness, disease management and optimal health services utilization;
- Institute programs to engage members in Health Risk Assessment activities and structure programs for member engagement and follow-up action based on initial findings;
- Promote consumer linkage with primary care and a medical home;
- Reduce inappropriate Emergency Room utilization;
- Identify and reduce areas of high plan participant morbidity (based on current data: Diabetes, Asthma, CAD/CHF, Behavioral Health, and COPD) through active outreach and DSM programs;

Areas of Strategic Focus for New Health Plans

- Reduce inpatient readmission rates and actively engage with inpatient providers which perform well in Medicare readmission analyses;
- Reduce percentage of, and costs related to, high risk pregnancies and inappropriate pre- and post-natal care;
- Promote among members the documentation and understanding of BMI and begin efforts to reduce BMI, with focus on adults with a BMI greater than 30;
- Reduce the use of tobacco among members and dependents;
- Increase utilization of generic medications and mail order pharmacy and improve medication management and compliance;

Areas of Strategic Focus for New Health Plans

- Implement the utilization of health quality metrics and benchmarks;
- Reduce administrative costs and improve service outcomes and access to quality providers;
- Encourage cost-effective strategies to support the USG's health teaching, research and service missions; and
- Make high costs and specialty service purchasing decisions based on reference-based pricing.

The plans must be dynamic – and responsive to annual improvements based on data, cost trends and member experience.

ACTION ITEM - Medicare-Eligible Retirees Proposed Two Stage Process

Background: Approximately 1,000 of the 14,000 USG retirees/dependents are eligible for, but not enrolled in, Medicare. USG serves as the primary insurer which is costly and problematic for the members, because financial penalties are imposed (at the time of eventual enrollment) for each year beyond 65 that a person fails to enroll in Medicare.

In August 2013, the Board acted to close the loophole which allowed future Medicare-eligibles to remain with USG as primary coverage. Now, we need to get the “outliers” enrolled in Medicare.

- **Stage One** - During 2014, use a case finding and management process to move all/most of the 1,000 eligibles into Medicare. TRSC proposing that financial penalties be offset by USG.

ACTION ITEM - Medicare-Eligible Retirees Proposed Two Stage Process

- **Stage Two (a)** – During 2015, establish Defined Contribution Health Care Investment Account for all Medicare enrolled members. Assist members in making secondary coverage selections to be effective 2016.
- **Stage Two (b)** – Beginning 2016, provide secondary coverage to all current and future Medicare enrolled USG-retirees/dependents through a defined contribution health care investment account, which would allow the member to secure secondary coverage through a range of public and private market options. (Retain flexibility to explore options.) Primary coverage no longer would be an option for anyone who is Medicare-eligible.

NOTE: Retirees under 65 (and not Medicare-eligible) will retain coverage through the active employee plans. (~5,000 retirees/dependents)

