DOAA
Georgia Department
of Audits & Accounts

Greg S. Griffin
State Auditor

January 13, 2025

The Honorable Blake Tillery,
Chairman, Senate Appropriations Committee
Members of the Senate Appropriations Committee
Members of the General Assembly
Dr. Sonny Perdue,
Chancellor, University System of Georgia
Members of the Board of Regents of the University System of Georgia
Mr. Russel Carlson,
Chancellor, Department of Community Health
Members of the Board of Community Health

Ladies and Gentlemen:

Attachments to this letter provide the results of our special examination of potentially moving members of the University System of Georgia healthcare plan (USGHP) to the State Health Benefit Plan (SHBP). This examination was conducted at the request of the Senate Appropriations Committee under the authority of O.C.G.A. § 50-6-4.

As noted in Attachment A, we found if USGHP members are moved into SHBP, the employer share for USG active and pre-65 retirees would increase by at least $177 million. While many factors ultimately impact the cost of moving USGHP members, the additional costs are primarily due to SHBP employers paying a higher share of plan costs and additional USG employees opting for employer-funded health insurance. Attachment B includes a report from The Terry Group, an actuarial and analytics firm, that was critical to completing our review.

We appreciate the cooperation and assistance provided by the Georgia Department of Community Health and the University System of Georgia.

Respectfully,

Greg S. Griffin
State Auditor

GSG/da

Attachment A
DOAA Analysis of Moving USG Healthcare Plan Members into the State Health Benefit Plan

If University System of Georgia healthcare plan (USGHP) members are moved into the State Health Benefit Plan (SHBP), the employer share for USG active and pre-65 retirees would increase by an estimated $177 million annually. This includes $85 million for the USG population that currently has coverage, as well as $92 million assuming an additional 10% of USG employees opt for health coverage. USG personnel stated that its institutions could not afford the higher employer cost without additional revenue.

Higher costs for the existing USGHP population are primarily driven by the higher subsidy paid by SHBP employers. Additional USG employees would opt for health coverage due to the lack of a SHBP spousal surcharge, lower employee premiums, plan designs and incentives more beneficial to the employee, and coverage of weight loss drugs.

The fiscal year 2025 Appropriations Act required USG to provide "a quarterly report to the House and Senate Appropriations Committees on the status of the University System of Georgia moving to the State Health Benefit Plan." On September 18, 2024, USG submitted an initial report to the General Assembly that provided summary information comparing USGHP to SHBP. However, USG has not taken action to move to SHBP and is awaiting direction from the governor and General Assembly.

DCH's Response: *"We are in full agreement with DOAA special examination, Analysis of Moving USG Health Plan Members into the State Health Benefit Plan. The analysis contains thoughtful, accurate, and valuable information and a fair representation and description of the plan options/designs/premiums. The information provided regarding the backgrounds of SHBP and USG is very helpful, and we agree with the potential cost impacts of moving USG Plan Participants over to SHBP." DCH also stated that "additional data and a separate financial actuarial analysis regarding USG OPEB Liability and the impact it will have on SHBP [would be] helpful…to make financial decisions regarding the SHBP Financial projections."*

USG's Response: *"We agree with DOAA's analysis of the cost implications of moving USGHP members to the SHBP. If a decision is made to move USG members to the SHBP plan, we would need to determine how the additional annual costs would be funded. In addition, further analysis regarding the impact to the USG OPEB liability would be valuable for future decision making."*

Our assessment of the implications of USGHP members moving into SHBP is based on the answers to the following questions:

Background

1. What are the populations covered by SHBP and USGHP?
2. What are the expenditures for SHBP and USGHP?
3. What are the differences in the member characteristics between SHBP and USGHP?
4. What are the differences in the health benefits for active employees/pre-65 retirees between SHBP and USGHP? For the post-65 members?
5. What are the differences in the cost sharing between employers and active employees/pre-65 retirees between SHBP and USGHP?
6. What are the SHBP and USGHP employer contribution amounts and methods?

Impacts of Moving USGHP Members to SHBP

7. What would be the cost implications to USG of moving USGHP members into SHBP?
8. What would be the cost implications to USGHP members of moving into SHBP?
9. What would be the impact on the Other Post-Employment Benefit (OPEB) liability if USGHP members are moved into SHBP?
10. What are potential policy considerations if USGHP members are moved into SHBP?

DOAA contracted with the Terry Group (Terry) to provide actuarial support and analysis. Pertinent information from Terry's analysis is included in this report; the Terry report is Attachment B.

Question 1: What are the populations covered by SHBP and USGHP?

SHBP consists of three plans that provide healthcare coverage for three groups of employees and retirees, as shown in Exhibit 1. SHBP provides a healthcare plan for public school teachers, which includes librarians; a plan for other public school employees such as classroom aides and bus drivers; and a plan for state employees, which includes individuals who receive compensation from a department, agency, or institution of state government, including the General Assembly. USGHP provides coverage to USG employees and retirees. Both SHBP and USGHP include coverage to employee and retirees' spouses and dependents. Because SHBP covers a larger group of employees than USGHP, SHBP has significantly more members.

Exhibit 1: SHBP and USGHP Covered Employees (2023)

SHBP
664,000 Members[1]

Teachers Plan
58% of Members

- Public school certified employees (e.g., teachers, principals)
- Regional and county librarians
- Retirees with 10 or more years of credible service as a public-school teacher receiving benefits through the Teachers Retirement System

School Employees Plan
23% of Members

- Classroom aides, bus drivers, and lunchroom employees
- Maintenance, custodial, administrative, and clerical employees
- Any other school employee who does not have a professional certification
- Retirees in the Public-School Retiree system or Teachers Retirement System

State Employees Plan
19% of Members

- Individuals who receive compensation from a department, agency, or institution of state government
- Other contracted groups
- Retirees in the Employee Retirement System and Judicial Retirement System

USGHP
101,000 Members[1]

USG Plan

- USG central office staff
- USG Institutions - Faculty and Staff
- Retirees who are eligible to receive health insurance by BOR policy

[1] Members include active employees, retirees, and dependents
Source: SHBP and USG documents

Question 2: What are the expenditures for SHBP and USGHP?

In fiscal year 2024, SHBP had expenditures of $4.58 billion, while USGHP expenditures totaled $653 million (Exhibit 2). The difference in the number of members is the primary reason for the large difference between the plan expenditures. As shown in Exhibit 1, SHBP has 664,000 members compared to the 101,000 in USGHP.

Exhibit 2 includes all expenditures paid by the plans, including claims and administrative costs. The expenditures are paid for using both employer and employee premiums. The expenditures *do not* reflect any employee out-of-pocket costs such as co-pays and deductibles. These are considered employee costs.

Exhibit 2: SHBP and USGHP Expenditures, FY23-25

	2023	2024	2025 (Projected)
SHBP	$4.16 billion	$4.58 billion[1]	$5.12 billion
USGHP	$0.64 billion	$0.65 billion	$0.70 billion

[2] SHBP 2024 Expenditures are projected.
Source: SHBP and USG data

Question 3: What are the differences in the member characteristics between the SHBP and USGHP?

SHBP and USGHP members are comparable in many ways. While SHBP has significantly more members than USGHP, the percentages of active/pre-65 retirees and post-65 retirees are similar between the two plans, as shown in Exhibit 3.

Exhibit 3: SHBP and USGHP Breakdown of Populations (2023)

	SHBP		USGHP	
	Members	% of Total	Members	% of Total
Active/Pre-65 Retiree	534,000	80%	83,000	83%
Post-65 Retirees	130,000	20%	18,000	17%
Total	664,000	100%	101,000	100%

Source: Aon presentation

SHBP and USGHP are similar demographically, as shown in Exhibit 4. The groups are similar in the average age of all members, as well as the average age of employees, spouses, and children. The average family size and the percentage covering a spouse is also similar. SHBP has a higher percentage of female members.

Exhibit 4: SHBP and USGHP Demographic Information for Active and Pre-65 Population (2023)

	SHBP	USGHP
Average Age	36.6	37.1
- Employees/Retirees	47.3	46.6
- Spouses	49.8	49.7
- Children	14.5	13.2
Percent of Membership Female	59%	53%
Average Members per Enrollee	2.0	1.9
% of Enrollees Covering Spouse	35%	34%

Source: Aon presentation

According to Terry, SHBP and USGHP members have a similar health status. Terry calculated a risk score[1] for the SHBP and USGHP populations. The risk score is a proxy for a group's disease burden and a common metric of relative health status. As shown in Exhibit 5, the two groups' risk scores are similar, meaning that moving USGHP members would have minimal impact on the SHBP average per member claims cost.

Exhibit 5: SHBP and USGHP Risk Score

Risk Score Component	SHBP	USGHP
Age/Sex	0.27	0.27
HCC	0.83	0.84
Total Risk Score	1.10	1.11

Source: Terry analysis

Even if USGHP's per member claim cost for active and pre-65 retirees was significantly lower than projected, the impact on SHBP would be small. For example, if USG claims were 20% lower on average, the combined group's per member costs would decline by roughly 2.5%. This is because USGHP would represent approximately 13% of total membership for a combined population.

Question 4: What are the differences in the health benefits for active employees/pre-65 retirees between SHBP and USGHP? For the post-65 members?

According to a 2024 study conducted by Aon,[2] SHBP provides a "richer" benefit for active employees and pre-65 retirees, with its plans expected to pay a slightly higher portion of claims costs. However, USGHP provides a significantly higher benefit for post-65 retirees than SHBP. The Aon study found the following:

- Member premiums are significantly lower for SHBP than USGHP.
- Incentive opportunities are much higher for SHBP than USGHP.
- USGHP members would have no working spouse surcharge under SHBP.
- USGHP members would gain coverage under SHBP for bariatric surgery and weight loss medications, including GLP-1s (e.g., Trulicity, Wegovy).[3]

SHBP and USGHP contract with third-party administrators for claims processing and other administrative services. SHBP contracts with Anthem Blue Cross Blue Shield (Anthem), Kaiser Permanente (Kaiser), and UnitedHealthcare (United). USGHP contracts with Anthem and Kaiser. The plans offered by these vendors are either self-insured or fully insured.

- **Self-Insured** – The employer directly assumes the cost of health insurance claims for its employees. SHBP provides self-insured plan options through Anthem and United, which are available to all active employees and pre-65 retirees. USGHP provides self-insured plan options through Anthem, which are available to all active employees and pre-65 retirees.
- **Fully-Insured** – The employer contracts with a health insurance plan that assumes financial responsibility for the enrollees' medical claims and for all incurred administrative

[1] Terry used the HHS-HCC risk model, which uses a patient's demographics and current year diagnosis to calculate a risk score. A pared down version of the HHS-HCC risk score model was used.
[2] Aon is the plan actuary for both SHBP and USGHP.
[3] USG noted USGHP members do have access to GLP-1s for the treatment of diabetes.

costs. SHBP and USGHP offer a fully insured HMO plan through Kaiser for active employees and pre-65 retirees. Kaiser is only available in the Metro Atlanta region and Athens.

The majority of SHBP active and pre-65 retiree members are covered by an Anthem plan (87%), with 8% covered by Kaiser and 5% covered by United. Most active and pre-65 retiree USGHP members are covered by an Anthem plan (90%), with 10% covered by Kaiser.

SHBP and USGHP provide various options for health coverage, as described in Exhibit 6. SHBP offers seven plans and USGHP offers four plans. SHBP and USGHP offer four tiers of coverage (employee only, employee and children, employee and spouse, and employee and family).

Exhibit 6: SHBP and USGHP plan types, employee premiums, and distribution of members across plans[1]

Health Reimbursement Arrangement (HRA)[2] (Gold, Silver, Bronze)	Health Maintenance Organization (HMO) – Self-Insured[3]	Health Maintenance Organization (HMO) – Fully Insured	High Deductible Health Plan (HDHP)	USGHP Comprehensive Care
SHBP  $82-195 Employee only premiums	SHBP  $158-197 Employee only premiums USGHP  $274 Employee only premiums	SHBP  $158 Employee only premiums USGHP  $206 Employee only premiums	SHBP  $73 Employee only premiums USGHP  $98 Employee only premiums	USGHP  $220 Employee only premiums
• Employer-funded and sometimes referred to as Health Reimbursement Accounts • Tax-free reimbursements for medical expenses up to a fixed dollar amount • Unused amounts may be rolled over	• Provides comprehensive services in a particular geographic area • Members pay a fixed, prepaid fee • Covers most types of preventative care	• Has predictable copays and small deductibles for complex medical events • Care must be coordinated by Kaiser Permanente (primarily in a KP facility) • Plan is not available statewide (available in Metro Atlanta and Athens)	• Features a higher deductible and lower insurance premiums • Insured is responsible for routine out-of-pocket expenses until deductible is met • Includes catastrophic coverage to protect against large medical expenses	• Traditional health plan with moderate monthly premiums and a great deal of flexibility • Member shares in cost of coverage after meeting deductible through a combination of copays and coinsurance • Provides in-network and out-of-network coverage

[1] Plan enrollment is as of 7/1/2024. Shown are the plan year 2025 monthly premiums paid by employees/pre-65 retirees for employee only coverage.
[2] SHBP has three HRA options; each provides different coverages.
[3] SHBP has two HMO-self-insured options.
Source: SHBP and USG documents and data

The Aon study found that plan design is similar in value for SHBP and USGHP. Plan design includes items such as deductibles, copays, out-of-pocket maximums, and pharmacy costs. Enrollment in the plan options varies significantly between SHBP and USGHP members, likely due to differing premiums and availability of plans. SHBP members are primarily enrolled in either the Health Reimbursement Arrangement (HRA) plan (45%) or a Health Maintenance Organization (HMO) fully insured plan (45%). USGHP members are primarily enrolled in either a High Deductible Health Plan (HDHP) (38%) or a Comprehensive Care plan (38%). Enrollment in the HMO is much lower for USGHP than SHBP, possibly due to higher premium for USGHP members. Significantly more USGHP members opt for the low cost HDHP.

Like Aon, Terry found the plan design for active pre-65 members is similar in value for SHBP and USGHP. Actuarial Value (AV), a commonly used metric to express the value of a medical benefit plan design, represents the percentage of total claims cost expected to be paid by the plan. As shown in Exhibit 7, SHBP's AV ranged from 0.764 to 0.905 with a total AV of 0.839. USGHP's AV ranged from 0.795 to 0.893 with a total AV of 0.827. It should be noted that the AV does not consider the

amount of the premium, surcharges, or wellness incentives. The premiums are included in the comparison of plans with similar AV values shown below.

- The USGHP Comprehensive Care ($220 monthly premium) and the SHBP Silver HRA ($131 monthly premium) are roughly equivalent.
- The USGHP High Deductible Health Plan ($98 monthly premium) and the SHBP HRA Bronze ($83 monthly premium) are roughly equivalent.
- The USGHP self-insured HMO ($274 monthly premium) design is approximately 2% richer than the SHBP self-insured HMO design ($158 Anthem HMO monthly premium).
- SHBP's fully insured Kaiser HMO ($158 monthly premium) design is approximately 1% richer than the USGHP fully insured Kaiser HMO ($206 monthly premium) design.

Exhibit 7: SHBP and USGHP plan actuarial values for active and pre-65

SHBP			USGHP		
Plan	**Actuarial Value**	**Members**	**Plan**	**Actuarial Value**	**Members**
HRA Gold	0.869	47,514			
HRA Silver	0.826	88,466	Comprehensive Care	0.828	30,856
HRA Bronze	0.794	107,870	HDHP	0.795	31,671
Anthem HMO	0.849	224,821	Anthem HMO	0.874	11,786
UHC HMO	0.849	17,508			
UHC HDHP	0.764	10,128			
Kaiser HMO	0.905	41,537	Kaiser HMO	0.893	6,864
Total	0.839	537,844	Total	0.827	81,177

Source: Terry analysis

SHBP and USGHP also differ in incentives, surcharges, and weight loss benefits (see Exhibit 8). SHBP offers its members the ability to earn a significantly higher wellbeing incentive than USGHP members. SHBP also has a lower tobacco surcharge and does not charge a spousal surcharge (USGHP charges $150 for each). Finally, SHBP benefits include access to bariatric surgery and weight loss medications, including GLP-1s, while USGHP does not provide access for weight loss purposes.

Exhibit 8: SHBP and USGHP Incentives and Surcharges (Plan Year 2024)

	SHBP	**USGHP**
Wellbeing Incentive	Up to $480/year per employee and spouse	Up to $100/year per employee and spouse
Tobacco Surcharge	$80/month	$150/month per member
Working Spouse Surcharge	None	$150/month
Notable Benefit Differences	Bariatric Surgery and GLP-1 weight loss medications – covered	Bariatric Surgery and GLP-1 weight loss medications - not covered

Source: SHBP and USG documents and Aon presentation

USGHP and SHBP provide very different benefit designs for post-65 retirees, with USG retirees receiving a significantly higher benefit, as shown in Exhibit 9. SHBP post-65 retirees have a choice between two carriers and two plans, standard and premium. SHBP subsidizes the cost of the plans by $237 annually per member. By contrast, USGHP provides $2,640 annually to its post-65 retirees

in a health reimbursement account. The retiree then selects a plan through a private retiree exchange that has many plans and carriers. The USGHP post-65 retiree can use the $2,640 to pay for premiums for Medicare supplement plans or Medicare Advantage plans. If the retiree has funds remaining in their HRA, they can use these funds to pay for approved medical expenses such as co-pays.

Exhibit 9: SHBP and USGHP Post-65 Retiree Subsidy (Plan Year 2024)[1]

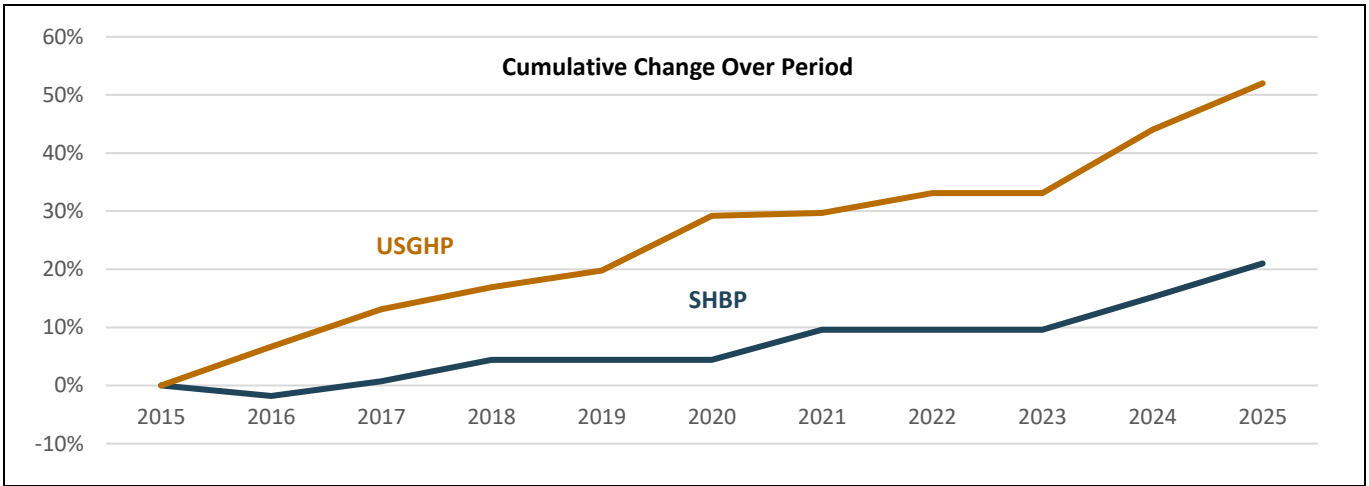
	SHBP	USGHP
Average	$237/per eligible member per year ($0 for Standard Plans and $751 for Premium Plans)	$2,640/per eligible member per year
Choice	Medicare Advantage Plans; 2 options – Standard and Premium 2 carriers – Anthem and UnitedHealthcare	Private Retiree Exchange Many plans and carriers Mix of Medicare Advantage and Medicare Supplement and Medicare Part D Prescription Drug Plans

[1] Post-65 retiree subsidies for plan year 2025 are $2,640 for USGHP and $176 for SHBP
Source: SHBP and USG documents and Aon presentation

Question 5: What are the differences in the cost sharing between employers and active employees/pre-65 retirees between the SHBP and USGHP?

SHBP provides a higher employer subsidy than USGHP. SHBP's higher employer subsidy results in a lower share of costs to SHBP members compared to USGHP members. The cost sharing difference can be attributed to USGHP members seeing higher premium increases than SHBP members over the past 10 years, as shown in Exhibit 10. Between plan years 2015 and 2025, SHBP members experienced a 21% increase in their premiums, while USGHP members experienced a 52% increase.

Exhibit 10: Cumulative and Annual Average Member[1] Premium Change (Plan Years 2015-2025)



Average Increase from Prior Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
SHBP	-1.8%	2.5%	3.7%	0.0%	0.0%	5.0%	0.0%	0.0%	5.0%	6.0%
USGHP	6.7%	6.0%	3.4%	2.5%	7.8%	0.4%	2.6%	0.0%	8.1%	7.9%

[1] The contributions shown are for the active/pre-65 population.
Source: SHBP and USG data and Aon presentation

Exhibits 11, 12, and 13 show various comparisons of the employee and employer share of costs for SHBP and USGHP. The measures use different calculations, but all show that SHBP employers bear a larger share of costs when compared to USGHP employers. As a result, USGHP members bear a higher share of costs of their healthcare than SHBP members.

Exhibit 11 shows two measures—the average employer subsidy and composite employer provided value.

Exhibit 11: SHBP and USGHP Values for Active and Pre-65 Retiree Members Only (Plan Year 2024)

	SHBP	USGHP
Average Employer Subsidy[1]	84%	77%
Composite Employer Provided Value	73%	68%

[1] This is a 2024 projected average subsidy.
Source: Aon presentation

- **Average Employer Subsidy** – This measure is calculated as a percentage of total plan costs, which includes the plan paid claims and administrative fees. Member out-of-pocket costs, including copays and deductibles, are not included in this calculation. SHBP employers pay 84% of the plan costs and SHBP member premiums pay 16%, while USGHP employers pay 77% of the plan costs and members pay 23%.

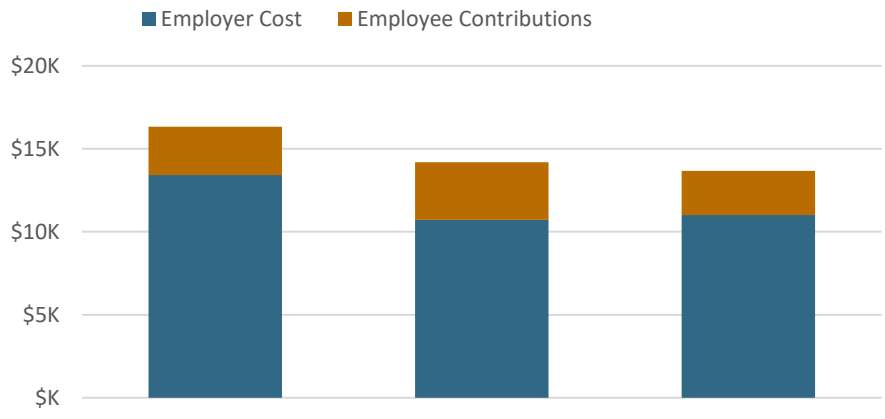
  A 1982 Resolution of the General Assembly provides that employees shall contribute 25% of SHBP's cost. While neither plan follows the resolution, it is a benchmark to measure the percentage of costs employees are contributing.

  In 2009, revenue constraints led the Board of Regents to adopt a policy that employees would pay 30% of premium cost and USG would pay 70%. The General Assembly and governor endorsed the policy in the fiscal year 2010 Appropriations Act; however, USG stated it is not currently following this policy.

- **Composite Employer Provided Value** – This measure is the employer subsidy plus the member out-of-pocket costs. The higher the value, the more generous the employer subsidy. SHBP is again the more generous plan, but the difference between the two plans is slightly narrower than when only the composite employer provided value is considered.

Exhibit 12 illustrates in dollar terms the fact that active employees covered by USGHP pay a higher amount and cover a higher share of health plan costs than SHBP active employees (i.e., the USGHP employer share is lower than the SHBP employer share). It is important to note that health plan costs do not include out-of-pocket costs for members, such as deductibles and co-pays. The exhibit also shows how SHBP and USGHP compare to Aon's Health Value Initiative™ (HVI), a compendium of employer healthcare plan data that can be used to benchmark costs and employer shares.

Exhibit 12: Health Plan Costs Per Active Employee (No Pre-65 Retirees)[1]

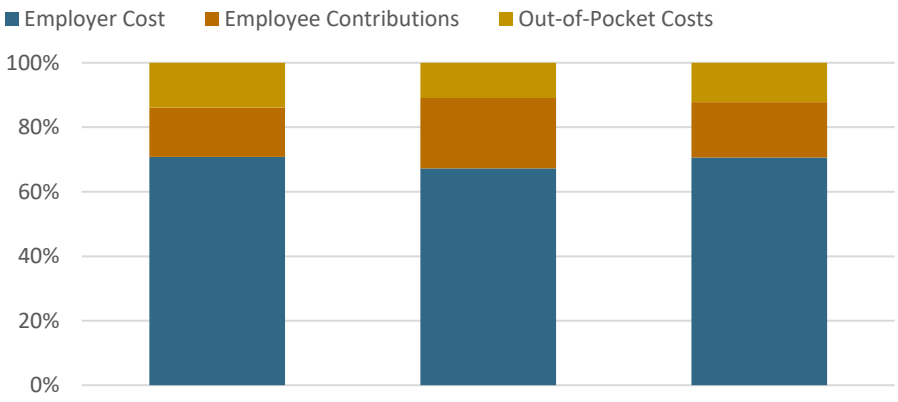


	SHBP	USGHP	Health Value Initiative
Employee Premiums[2]	$2,896	$3,476	$2,672
Employer Cost	$13,431	$10,716	$11,004
Total Health Plan Cost	$16,327	$14,192	$13,676
Employer Subsidy Percentage	82%	76%	80%

[1] The graph is based on 2023 benchmarking conducted by Aon.
[2] Only includes premiums, not deductibles, co-pays or other out-of-pocket costs.
Source: Aon presentation

As shown in Exhibit 13, the portion of healthcare costs borne by the employers is closer when out-of-pocket costs are also considered. While active USGHP members pay a larger portion of healthcare costs through premiums, their out-of-pocket costs represent a smaller percentage of the total cost than the out-of-pocket for active SHBP members. (A lower out-of-pocket percentage does not necessarily mean that co-pays and deductibles are lower; it may indicate that members do not seek care that will result in out-of-pocket costs.) The SHBP cost sharing mix is similar to Aon's Health Value Initiative.

Exhibit 13: Cost Sharing Mix For Active Employees Only (No Pre-65 Retirees)[1]



	SHBP	USGHP	Health Value Initiative
Out-of-Pocket Costs	13.9%	10.9%	12.2%
Employee Premiums	15.3%	21.8%	17.2%
Employer Cost	70.8%	67.2%	70.6%

[1] The graph is based on 2023 benchmarking conducted by Aon.
Source: Aon presentation

Question 6: What are the SHBP and USGHP employer contribution amounts and methods?

As shown above, SHBP and USGHP are primarily funded by employer contributions. These contributions ultimately pay plan costs for both active employees and retirees. As shown in Exhibit 14, the contribution amounts and methods by which the plans receive the contributions vary. SHBP is funded through several strategies, either a percentage of payroll for all eligible employees or a monthly flat rate per covered employee. Unlike SHBP, USGHP's employer share is dependent on the particular plan (e.g., Anthem HDHP) and enrollment tier (employee only, employee + child, employee + spouse, or family). Employer cost varies from $501.44 per month to $1,800.32 per month.

Exhibit 14: SHBP and USGHP Employer contributions

SHBP	Teachers Plan[1] $1,760 Paid by local school systems primarily via QBE earnings for **each covered employee**	School Employees Plan[2] $1,580 Paid by local school systems with school funds for **each covered employee**	State Employees Plan 29.45% of salary Paid by state agencies, contract organizations, and other groups included in the Plan for **every eligible employee**
USGHP	USGHP[3] $1,034 or 12% of average salary of eligible employees	SHBP and USGHP calculate employer share in significantly different ways. For this report, USG calculated amounts to allow a comparison with SHBP's employer share. Like an employee premium, the actual USGHP employer cost varies by USGHP plan and enrollment tier (employee only, employee + child, employee + spouse, or family). The employer cost varies from $501.44 per month for Kaiser employee only to $1,800.32 for family coverage for consumer choice HSA, comprehensive care, and Blue HMO.	

[1] The Teachers Plan includes librarians, whose employers pay $1,580 as of 1/1/25.
[2] This rate is effective as of 1/1/25.
[3] This rate is per active enrolled employees under age 65.
Source: SHBP and USG documents and data

Question 7: What would be the cost implications to USG of moving USGHP members into SHBP?

Moving USGHP members into SHBP would likely increase employer costs by at least $177 million. While many factors ultimately impact the cost of moving USGHP members, the additional costs are primarily due to SHBP employers paying a higher share of plan costs and additional USG employees opting for employer-funded health insurance. USG stated if a decision is made to move the USG members to SHBP, USG would need to determine how the additional costs would be funded. A combination of increases in state appropriations and tuition and fees rates would need to be evaluated.

Terry estimates the employer subsidy for the current USGHP population would increase by $85 million (14%) under SHBP. Approximately $53 million of the increase is due to lower premiums, with the remainder attributed to access to weight loss coverage and differences in surcharges. Terry

noted that the lack of a SHBP spousal surcharge, lower employee premiums, slightly richer designs/incentives, and weight loss drugs would contribute to more USG employees opting for coverage under the SHBP benefit plan. Terry considered a 10% increase in the percentage of USG employees opting for coverage to be reasonable. This would add another $92 million to the employer cost, bringing the final increase to $177 million (29% higher).

Similar to Terry, the 2024 Aon study estimates the employer subsidy for the current USGHP population would increase by approximately 12% due to lower employee premiums, slightly richer plan designs/incentives, and new access to weight loss drugs, including GLP-1s. Aon did not estimate the increase in the number of USG employees opting for coverage, but stated the increase would add to the 12%.

The various factors that impact the costs of moving USG employees to SHBP are associated with the employer share, covered benefits, and administration. These factors are discussed below.

Employer Share
SHBP has a higher employer subsidy than USGHP, which would result in higher contributions by USG institutions if its employees were moved to SHBP. The average employer subsidy shows SHBP employers pay 84% of the plan costs and SHBP members pay 16%, while USGHP employers pay 77% of the plan costs and members pay 23%. If USGHP moved to SHBP's employer subsidy rates, plan costs would shift from USGHP members to USG institutions.

Moving USGHP members into SHBP could coincide with an increase in SHBP employee premiums to reduce the employer share. Any reduction in the SHBP employer share would decrease the cost of moving USGHP members into SHBP.

Benefit-Related Costs
SHBP and USGHP provide different member benefits in several areas. For benefit areas that have significant differences, determining whether to maintain SHBP's current benefit or modify based on USGHP's benefit could impact the cost implication.

- **Post-65 Retiree Benefit** – Post-65 retirees in USGHP have a significantly higher benefit than SHBP post-65 retirees. As noted on page 7, USGHP provides $2,640 each year for each post-65 retiree's health reimbursement account, while the SHBP benefit averages $237 annually. For the benefits of USGHP and SHBP post-65 retirees to be consistent, the state could either incur additional costs or achieve savings.

  If USGHP post-65 retirees had the same coverage as SHBP post-65 retirees, the reduction in costs would be approximately $40 million. Changing the post-65 retiree benefit to the SHBP model would be disruptive to this population. To mitigate this issue, current USG post-65 retirees could be grandfathered to maintain their benefit after the move. At some point in the future, new USGHP post-65 retirees would receive the SHBP post-65 benefit.

  If the SHBP benefit was changed to match USGHP's benefit, the cost for SHBP's post-65 retirees would increase by more than $300 million. SHBP personnel expressed concerns regarding funding the USG post-65 retiree benefit for its population.

- **Wellbeing Incentive and Surcharges** – The SHBP wellbeing incentive is $380 higher than the USGHP incentive.[3] Higher wellbeing incentives for USGHP members moved to SHBP could cost approximately $4.3 million. If the incentive was changed to USGHP's $100 level, SHBP costs could decrease by approximately $6 million. The changes in the amount of wellbeing expenditures assume the same number of participants and that those participants earn the maximum wellbeing credit.

[3] The USGHP wellbeing incentive decreased from $200 in 2023 to $100 in 2024.

The USGHP tobacco surcharge is $70 higher per month than the SHBP surcharge. In fiscal year 2024, USGHP members paid approximately $2.8 million in tobacco surcharges. If USGHP members paid the reduced SHBP rate, they would have paid only $1.5 million. If the SHBP tobacco surcharge was changed to USGHP's $150, SHBP revenue would increase by approximately $9.4 million.

While USGHP has a monthly $150 spousal surcharge, SHBP has no comparable surcharge. In fiscal year 2024, USGHP members paid approximately $3.7 million in spousal surcharges, an amount that would not be collected if they were part of SHBP. In addition to the loss of surcharge revenue, Aon noted that a lack of any surcharge would result in additional members and claims. When USGHP initially imposed a spousal surcharge, the number of USGHP spouses and total members declined. Aon believes if USGHP members were moved into SHBP with lower premiums and no spousal surcharge, both members and spouses would return to state health coverage, resulting in additional claims costs.

Like Aon, Terry also noted the impact of the surcharge on enrollment. Terry found that approximately 16,000 active employees were not enrolled in medical benefits, a 29% opt-out rate. It is expected that moving to a benefit plan without a working spouse surcharge would lead to some of these employees opting back in to state health benefits. Terry estimated the impact of a 10% increase to the percentage of USG employees opting for coverage (from 71% to 81%).

It should be noted that SHBP had a spousal surcharge for several years. SHBP personnel stated the surcharge caused recruiting and retention issues for lower compensated school system employees in certain areas of the state, leading to its termination.

- **Weight Loss Coverage** – According to Aon, obtaining bariatric surgery and GLP-1 weight loss drug coverage would be a significant benefit change for USGHP members moving to SHBP. For plan year 2024, SHBP is projected to spend approximately $240 million on anti-obesity drugs, with the cost increasing significantly over the course of the year. At the cost of a recent month ($26.4 million), annual spending for the drugs would be nearly $320 million. Based on current medical information, Terry estimated that USGHP members moving to SHBP would cost an additional $30 million annually. However, it noted that the current medical information may understate the population that would use the medication. Based on the potential population that could be expected to use the medication, the weight loss coverage benefit could be more than $46 million.

- **Provider Rates** – While moving USGHP members to SHBP would increase the number of SHBP plan members, the increase will not necessarily lead to the ability to obtain lower provider rates. With 664,000 members, SHBP is already one of the largest state health benefit plans in the U.S. Adding 101,000 USGHP members will not materially change the size of SHBP for the purpose of negotiating lower provider rates. USG noted both SHBP and USGHP currently utilize the same Anthem provider networks and pricing, as well as the same PBM (pharmacy) network and pricing.

  In addition, there is no evidence to suggest that members of USGHP are healthier than SHBP members; therefore, there is no expectation that the average utilization of healthcare services in a single plan would decline.

Administrative Costs
SHBP and USGHP have both internal and external administrative costs. While third-party administrative fees would decrease, other administrative costs would remain stable or increase, as discussed below.

- **Third Party Administrative Fees (ASO fees)** – SHBP and USGHP pay third party fees for various administrative functions including claims processing. Due to its size, SHBP is already in the lowest tier for administrative fees. Adding USGHP would not result in administrative fee savings.

  USGHP administrative fees are higher than those of SHBP by approximately $9.03 per employee per month ($108 annually). With all employees in SHBP, the lower administrative fees would result in an annual savings of approximately $4.3 million.

- **SHBP & USGHP Administrative Costs** – Internal administrative costs would likely increase due to higher SHBP costs and no expected USG savings. To manage the additional members, SHBP indicated it would need to increase staffing at an estimated cost of $1.0-1.5 million annually. Both SHBP and USG officials indicated there would be one-time transition costs, but neither was able to estimate an amount. Finally, USG indicated that administrative savings after moving employees to SHBP would be minimal because it does not have dedicated staff for the healthcare plan at either their institutions or central office.

- **SHBP & USGHP Healthcare Portal** – SHBP and USGHP contract with third parties to provide portals for members to sign up and manage their benefits. SHBP contracts with ADP for health only and USG contracts with Alight for health and other benefits (vision, dental, life insurance, etc.). If USGHP members moved to the SHBP ADP portal for healthcare, USG would need to retain Alight for all other benefits. The cost of moving USGHP members to ADP is approximately $1 million annually with no corresponding reduction in USG costs with Alight.

Question 8: What would be the cost implications to USGHP members of moving into SHBP?

Terry developed "personas" reflective of the actual USGHP population to show the cost impacts of moving USGHP members to SHBP on a small group or individual basis, as shown in Exhibit 15. For these personas, total annual spend is lower for USGHP members under SHBP. The annual spend is a combination of premiums and out-of-pocket costs (co-pays and deductibles). For the personas that had higher average out-of-pocket costs, the difference in annual premiums were more than enough to offset the out-of-pocket costs.

The overall results from the high-level persona analysis indicate that the SHBP benefit is expected to be less costly on average per year, as shown in Exhibit 15. For example, an employee in the PPO (Employee Only PPO) would save either $794 or $828 annually (depending on the SHBP plan chosen). Similarly, a family with young children (Family All Young) would save either $1,657 or $1,556 annually depending on the SHBP plan chosen.

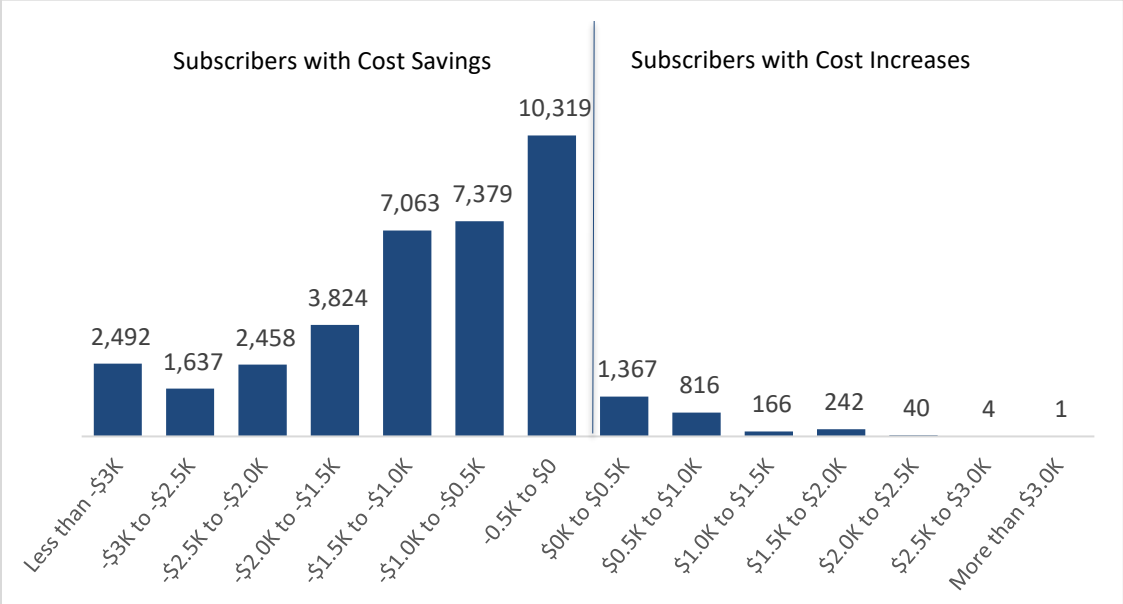
Exhibit 15: Estimated Total Annual Spend Increase or (Decrease) for USGHP Subscribers[1]

		Estimated Total Annual Spend				
Description	Subscriber Count	Current	Scenario 1	Scenario 2	Scenario 1 vs Current	Scenario 2 vs Current
Employee Only | PPO	9,149	$4,684	$3,890	$3,856	($794)	($828)
Employee Only | HSA	8,933	$2,915	$2,457	$2,769	($458)	($146)
Employee Only | HMO	3,531	$4,762	$3,677	$3,678	($1,085)	($1,085)
Employee + Child | All	3,228	$7,784	$5,997	$6,303	($1,787)	($1,480)
Employee + Spouse | All | Older	3,679	$9,778	$8,241	$8,564	($1,537)	($1,214)
Employee + Spouse | All | Younger	1,467	$7,888	$6,570	$6,800	($1,318)	($1,088)
Family | All | Young	1,229	$11,831	$10,174	$10,275	($1,657)	($1,556)
Family | All | Middle	3,380	$10,805	$9,357	$9,907	($1,448)	($897)
Family | All | Mature	3,212	$12,593	$10,629	$10,966	($1,964)	($1,627)

[1] To compare current USG to USG under SHBP, Terry developed two migration scenarios—referred to as Scenario 1 & 2. See Attachment B, page 4 for migration scenarios. For a detailed description of each persona, see Attachment B, page 12.
Source: Terry analysis

The analysis above shows the average impact for each persona but can mask the impacts on individual families. There are numerous differences between the USGHP and SHBP plan designs that would impact families based on their own utilization patterns. If USGHP families chose SHBP plans consistent with Scenario 1, out-of-pocket spending would increase for 42% of families. However, when premium differences are considered, total annual spend would increase for only 7% of families. The premium reductions offset the increased out-of-pocket spend for a significant portion of families, as shown in Exhibit 16. For example, 7,379 families would see savings of between $500-$1,000, while 816 families would see an increase in spending of $500-$1,000. Likewise, 7,063 families would see savings of between $1,000-$1,500, while 166 families would see an increase in spending of $1,000-$1,500.

Exhibit 16: Estimated Total Annual Spend Increase or (Decrease) for USGHP Families



Source: Terry analysis

Question 9: What would be the impact on the OPEB liability if USGHP members are moved into SHBP?

Moving USGHP employees into SHBP will impact Georgia's OPEB liabilities. However, the impact amount will depend on several factors, including (but not limited to) plan migration, potential changes in plan utilization, changes in plan participation, and changes in anticipated future health care cost increases. The Plans' actuaries should determine the OPEB impacts of any significant changes in plan offerings for both USGHP and SHBP.

SHBP administers two OPEB Funds that were statutorily established in 2009 to provide for the cost of health insurance benefits for retirees, while USG administers one OPEB Fund statutorily established in 2007 for the same purpose. These funds are:

- **SHBP –** The Georgia State Employees Post-Employment Health Benefit Fund (State OPEB Fund) was created to provide post-employment health benefits due under the group health plan for members of the State Employees Plan and their dependents. The fund pays for covered healthcare expenses of retired state employees and administration costs. According to statute, assets held in the State OPEB Fund cannot be used for any other purposes.
- **SHBP –** The Georgia School Personnel Post-Employment Health Benefit Fund (School OPEB Fund) was created to provide post-employment health benefits due under the group health plan for members of the Teachers Plan and the School Employees Plan and their dependents. The fund pays for covered healthcare expenses and administration costs. According to statute, assets held in the School OPEB Fund cannot be used for any other purposes.
- **USG** – The Board of Regents Retiree Health Benefit Fund was created to provide post-employment health benefits due under the group health plan for members of USGHP and their dependents. The fund pays for covered healthcare expenses and administration costs.

According to statute, assets held in the USG OPEB Fund cannot be used for any other purposes.

According to Terry, for both USGHP and SHBP, Georgia's pre-Medicare OPEB liabilities are generally measured as an expected total claim cost amount, offset by participant cost-sharing. The total gross claim costs, including administrative costs, are projected into the future for as long as the plan is anticipated to be in place. Both current retirees and potential future retirees (active employees who could eventually meet eligibility requirements for coverage) are included in the calculation of the liability. Georgia's OPEB liabilities will be impacted by any changes that will alter either the gross claims and administrative costs paid for by the plan or the amount of cost-sharing shouldered by the retirees themselves. However, moving USGHP's Medicare-eligible population from the HRA arrangement to SHBP's Medicare Advantage offerings would likely result in significant savings from an OPEB perspective.

Question 10: What are other considerations if USGHP members are moved into SHBP?

As discussed on page 3, SHBP consists of three plans that provide healthcare coverage for groups of employees and retirees: teachers, public school employees, and state employees. To move the USGHP population into SHBP, either a fourth plan can be created within SHBP for USG employees and retirees or the USGHP population can be incorporated into the existing State Employees Plan. If the USGHP population is moved into the State Employees Plan, it would more than double the plan population, with USG members representing 54% of the total.

The method of moving USGHP members into SHBP would impact the employer share payment method and OPEB.

- **Employer Contribution Method** – As noted on page 11, SHBP is funded through several strategies, either a percentage of payroll or a monthly flat rate per covered employee. If USGHP is incorporated into SHBP as a fourth plan, its current funding strategy of paying set amounts based on plans and tiers chosen by each employee may need to be modified to be more consistent with SHBP's funding strategies. The funding strategy would need to be sufficient for the increased costs of SHBP.

  If USGHP members are moved into the State Employees Plan, the employer contribution would be based on a percentage of payroll and would likely increase significantly. The current funding rate for the State Employees Plan is 29.45% of an agency's salaries, while USGHP employer contributions are at approximately 12% when measured as a percentage of payroll. Given the significant change in the size of the State Employees Plan that would occur, as well as other factors that impact the plan rate (e.g., OPEB), it would be necessary to reassess the appropriate rate for all state agencies, including USG.

  If a fourth SHBP plan is created for USG employees, a flat rate per participating employee could be charged in a manner similar to teachers or public school employees. For each participating employee, the current monthly rate is $1,760 for the Teachers Plan and $1,580 for the School Employees Plan.[4] When measured per participating employee per month, USGHP employer contributions are approximately $1,034.

  Whether USGHP is moved into the State Employees Plan or a fourth plan is created, the funding strategy should consider the cost of covering SHBP benefits and plan design, as well as other factors such as OPEB targets for the USG population. If USGHP members are

[4] These rates are effective 1/1/2025. They were both $945 per participating employee in 2023 before increases in 2024 and 2025. This represents an 86% increase for the Teachers Plan and a 67% increase for the School Employees Plan.

moved into SHBP, the employer share for USG active and pre-65 retirees would increase by at least $177 million. Applying the State Employees Plan rate would increase USG employer contributions by approximately $745 million, the Teachers Plan rate would increase USG employer contributions by approximately $352 million, and the School Employees Plan rate would increase USG employer contributions by approximately $265 million.

- **OPEB** – As noted on page 16, SHBP administers two OPEB Funds and USG administers one OPEB Fund. If USGHP members are moved into a fourth SHBP plan, the new USG Plan would retain its OPEB fund. If USGHP members are moved into the State Employees Plan, the OPEB fund could also merge. SHBP personnel expressed concerns regarding merging the USG OPEB fund into the State Employees Plan's OPEB. Specifically DCH stated, "The concern regarding Other Post Employment Benefits centers on the state assuming responsibility for both the current and future liabilities associated with the plan… [T]ransferring USG into the State Health Benefit Plan would shift the responsibility for both active employees and retirees to the state. If the state had been responsible for these individuals' benefits from the outset, its approach to funding SHBP might have been different. Without a clear understanding of the full liability, the state may face the need for substantial funding measures to address this obligation."

Attachment B

USG Migration to the SHBP Medical Benefit Structure Considerations Report

Prepared for Georgia Department of Audits & Accounts

1/8/2025

The Terry Group
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Introduction

GA DOAA has requested that Terry Group (TG) consider potential impacts around migrating members in the current USG medical benefit structure into the current SHBP benefits structure. This report documents various comparisons and considerations for such a migration.

Comparison of USG and SHBP Active/Pre-Medicare Medical/Rx Benefits

Plan Designs

Actuarial Value (AV) is a commonly used metric to express the value of a medical benefit plan design. It represents the percentage of total claims cost that is expected to be paid by the plan for a given plan design on average.

We ran the 2025 active/pre-Medicare retiree plan designs for USG and SHBP through the TG AV model calibrated to the total active/pre-Medicare USG self-insured population. For USG, the HSA match has not been included in the plan value. For the SHBP, the non-incentive based HRA employer funding has been included in the plan value.

Group	Plan	Actuarial Value	Members
USG	Comprehensive Care PPO	0.828	30,856
USG	USG BlueChoice HMO	0.874	11,786
USG	HDHP	0.795	31,671
USG	Kaiser HMO	0.893	6,864
USG Total		0.827	81,177
SHBP	HRA Gold PPO	0.869	47,514
SHBP	HRA Silver PPO	0.826	88,466
SHBP	HRA Bronze PPO	0.794	107,870
SHBP	Anthem HMO	0.849	224,821
SHBP	UHC HMO	0.849	17,508
SHBP	UHC HDHP	0.764	10,128
SHBP	Kaiser HMO	0.905	41,537
SHBP Total		0.839	537,844

- The USG PPO and the SHBP Silver PPO are roughly equivalent
- The USG HDHP and the SHBP Bronze PPO are roughly equivalent
- The SHBP Kaiser design is ~1% richer than the USG Kaiser design
- The USG HMO design is ~2% richer than the SHBP HMO design

Note that the member-weighted average AV for each group is highly dependent on enrollment distribution. See below for the average AV under a USG to SHBP scenario where USG members all move to the closest matching SHBP plan:

Group	Plan	Actuarial Value	Members
USG	HRA Gold PPO	0.869	
USG	HRA Silver PPO	0.826	30,856
USG	HRA Bronze PPO	0.794	31,671
USG	Anthem HMO	0.849	11,786
USG	UHC HMO	0.849	
USG	UHC HDHP	0.764	
USG	Kaiser HMO	0.905	6,864
USG Total		0.823	81,177

Under this scenario, the average member-weighted AV is roughly equivalent under SHBP plan designs to the current USG designs and enrollment distribution.

Employer Subsidy

To compare the difference in employer subsidy between current USG and USG under SHBP we considered two migration scenarios:

1. USG members migrate to the most similar plan based on plan type and AV
2. USG PPO members migrate to SHBP PPO plans under the current SHBP member distribution, USG HDHP members migrate to the SHBP UHC HDHP, and the USG HMO members migrate to the similar SHBP plan offering (Kaiser and Anthem).

We estimated 2025 projected claims cost for current USG by trending 2023 incurred claims and adjusting for plan design changes. The 2025 projected claims costs for current USG plans were then adjusted to the applicable SHBP plan for each migration scenario using relative values based on the TG AV model calibrated to each USG self-insured plan type's population (PPO, HMO, and HDHP).

There are several other considerations that impact the employer subsidy estimates:

Administrative Costs

USG and SHBP both pay administrative fees to various vendors. Due to SHBP's size, it generally would receive the best available per employee/member rates for administrative services available to the general market of employers. One specific difference to call out is Anthem's per employee per month ASO fees for the medical benefit. The Anthem PEPM ASO fee is $9.43 PEPM higher for USG compared to SHBP's fee in 2025. The total impact of this difference is included in the USG under SHBP estimates. SHBP's total enrollment in UHC is smaller so the ASO PEPM pricing is not as favorable for those two self-insured plans (UHC HMO and UHC HDHP)- it is ~$10 PEPM higher than SHBP's Anthem ASO PEPM.

It has been shared with us that additional administrative costs due to an increased need for SHBP support staff to handle the additional enrollment could total $1-2 million. There is not expected to be any offset to USG costs because there is no dedicated staff attributed solely to the benefit plan. $1.5 million has been included in USG under SHBP estimates.

It has also been shared with us that there would be an additional $1 million in administrative costs due to the need to shift USG members to an ADP healthcare portal for medical benefits. Our understanding is that there would be no offsetting costs because Alight would still handle all other benefits for USG members. $1 million has been included in USG under SHBP estimates.

Weight Loss Coverage

USG plans do not currently cover bariatric surgery or weight loss drugs, while SHBP plans do. This benefit difference is not captured in the AVs discussed above but does represent a material potential cost increase if USG members migrate to the SHBP benefit plan. Based on national prevalence statistics and historical USG and SHBP data, we have included a ~$30.3 million increase as the impact of these coverages in the USG under SHBP estimates. This represents a short-term cost for adding these weight loss coverage options- there is the possibility of long-term healthcare savings if these treatments prevent or lessen the impact of obesity-related conditions in the future.

The bariatric surgery component of the total weight loss coverage estimate is based on the prevalence diagnosis codes for BMI found in USG's 2023 incurred claims data (applicable Z68.x codes). The Mayo Clinic states that bariatric surgery may be an option if "Your body mass index (BMI) is 40 or higher, called extreme obesity. Your BMI is 35 to 39.9, called obesity, and you have a serious weight-related health problem, such as type 2 diabetes, high blood pressure or severe sleep apnea. In some cases, you may qualify for certain types of weight-loss surgery if your BMI is 30 to 34 and you have serious weight-related health problems."[1] 11% USG's of self-insured active and pre-Medicare members were coded with an applicable Dx code for adult BMI > 30 or pediatric obesity. These prevalence percentages may underrepresent the actual prevalence of obesity in the USG population due to TG only having access to the first five diagnosis codes for each claim, under-coding of the applicable Dx codes by physicians, or members not seeking care in CY2023.

A recent study of 17 million privately insured adults over 2022-2023 found that among the sample population of adults with diagnosed obesity, 0.3% received bariatric surgery[2].

The average cost for bariatric surgery is between $17,000 and $26,000[3]- we assumed $21,500 for our estimates.

SHBP provided weight loss drug utilization data (excluding GLP-1 drugs also used for diabetes treatment) for the time period January 2024 – Oct 2024. SHBP experienced large increases in utilization and cost over the 10 months. Based on the October 2024 data, the total net cost per script was ~$1,118 and total scripts per member per month was 0.047.

To estimate the incremental impact of weight loss drug coverage to USG, we utilized SHBP's Oct 2024 average utilization multiplied by the total net cost per script from the SHBP data and multiplied by estimated member months to come up with an aggregate amount. It is our understanding that employers often receive rebates for weight loss drugs, so we adjusted the total to reflect a 37% average rebate amount.

There is a potential for substantial additional costs due to increased utilization, increased cost, and/or higher obesity prevalence than claims suggest. This represents a volatile, material risk to the total financial impact of moving USG

members to the SHBP benefit plan. For example, if you assume an obesity prevalence among the USG population more in line with the national average (~40%) for the bariatric surgery estimate and increase the incremental USG weight loss drug utilization by 50%, the $30.3 million estimate would increase to $46.6 million with all other assumptions being the same.

1. https://www.mayoclinic.org/tests-procedures/bariatric-surgery/about/pac-20394258
2. Lin K et al. "Metabolic Bariatric Surgery in the Era of GLP-1 Receptor Agonists for Obesity Management" *JAMA Network Open* DOI: 10.1001/jamanetworkopen.2024.41380
3. https://asmbs.org/resources/metabolic-and-bariatric-surgery/

Surcharges

USG has a $150 per employee/retiree, spouse, and child(ren) 18+ tobacco surcharge (i.e. maximum $450 tobacco surcharge per family). The employer subsidy calculations that follow include ~$3.0 million based on historical prevalence and recent enrollment data in current USG estimates. SHBP has a $80 per family surcharge if any member uses tobacco products. The employer subsidy calculations that follow include ~$1.5 million in USG under SHBP estimates.

USG has a $150 per working spouse surcharge. This is a surcharge that is applied when a spouse is eligible for coverage through their own employer but elects to enroll in the USG plan as a dependent. The employer subsidy calculations that follow include ~$4.0 million based on historical prevalence and recent enrollment data in current USG estimated costs.

SHBP does not have a working spouse surcharge. Based on USG enrollment data as of August 24, there are ~16k active employees not enrolled in medical benefits which equates to a ~29% opt out rate for active employees. It is possible that moving to a benefit plan without a working spouse surcharge would lead to some employees currently opting out to opt back in to the benefit plan. We have included an estimate of the impact of a 10% increase to the total active employee opt-in rate (from 71% to 81%) for in USG under SHBP estimates (due to both dropping the surcharge and an overall increase in benefit generosity under the SHBP structure).

HSA Match

USG offers a match of up to $375 for single and $750 for non-single coverage to those enrolled in the HDHP plan and contributes to an HSA through payroll deductions. SHBP does not offer a match for their HSA-eligible plan. We did not have data for this item, so it is included as an impact to the potential range for each scenario.

Wellness incentives

USG offers a $100 per employee and spouse per year wellness incentive for those that complete certain activities to all active employees. SHBP offers a wellness incentive that potentially pays out $480 incentive credits to apply toward eligible medical and pharmacy expenses per employee and spouse per year for all active employees except those enrolled in the Kaiser HMO. We did not have data for this item, so it is included as an impact to the potential range for each scenario.

Prescription Drug Considerations

Based on 2023 incurred prescription drug claims and rebate data for both USG and SHBP, it appears that they have similar rebate arrangements, with rebates representing ~37% of total 2023 incurred prescription drug claims for USG and ~38% of total 2023 incurred prescription claims for SHBP. Therefore, we have assumed no Rx rebate impact in the employer subsidy comparisons below.

USG and SHBP may have different drug formularies which would impact drug utilization and costs. An analysis on the impact of drug formulary changes is beyond the scope of this report.

Estimated Employer Subsidy Impacts

	Current		Scenario 1	Scenario 2
Projected CY2025 Cost (Claims+Admin)	**$765,470,055**		**$767,693,736**	**$759,190,534**
*excludes Rx rebates	*$ Change*		*$2,223,681*	*($6,279,521)*
	% Change		*0%*	*-1%*
Weight Loss Coverage	**$0**		**$30,326,572**	**$30,326,572**
Contributions[1] and Surcharges	**$165,392,445**		**$112,951,007**	**$107,019,370**
	$ Change		*($52,441,438)*	*($58,373,075)*
	% Change		*-32%*	*-35%*
Employer Cost	**$600,077,610**		**$685,069,302**	**$682,497,736**
	$ Change		*$84,991,691*	*$82,420,126*
	% Change		*14%*	*14%*
Max HSA Match	*$14,851,125*		*$0*	*$0*
Max Wellness Incentive	*$5,300,900*		*$22,781,760*	*$22,781,760*
Employer Cost w/HSA and Wellness	**$620,229,635**		**$707,851,062**	**$705,279,496**
	$ Change		*$87,621,426*	*$85,049,861*
	% Change		*14%*	*14%*
Employer Cost w/+10% Opt-In	**$620,229,635**		**$800,588,427**	**$797,679,954**
	$ Change		*$180,358,792*	*$177,450,319*
	% Change		*29%*	*29%*

Additional details for the above table can be found in Appendix A. Costs above do not include prescription drug rebates (which are assumed to be relatively equivalent based on 2023 data as discussed above). Contributions[1] are based on the active and pre-Medicare retiree contributions[1] for calendar year 2025 that are currently applicable to most of the USG/SHBP populations (see Appendix A). Details for the other line items included in the above table are discussed in the report above.

The overall impacts between the two scenarios are similar. Ignoring the HSA Match/Wellness surcharge impacts, we estimate the employer subsidy for USG members would increase 14% under the SHBP benefit plan compared to current. Including the maximum impacts for the HSA Match and Wellness incentive changes still ends up with a 14% employer subsidy increase compared to current. If you consider a 10% additive increase to the USG active employee opt-in rate due to the overall increase to employee benefit generosity under the SHBP structure and dropping the working spouse surcharge you end up with a 29% employer subsidy increase compared to the current projected USG subsidy.

[1] *Employee contributions can also be referred to commonly as the employee premium or rate*

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Comparison of SHBP and USG Medicare Medical/Rx Benefits

For Medicare retiree benefits, USG and SHBP have two different coverage strategies.

USG provides an annual HRA funding amount which can be used to purchase supplemental Medicare coverage options on the Alight Retiree Health Solutions exchange. For 2025, a $2,640 HRA per Medicare eligible- retiree and covered dependent(s) is being provided.

SHBP provides employer-sponsored Medicare Advantage (MA) plans. For 2025, they are offering 4 plans (2 carriers, 2 plan options each). For 2025, SHBP is estimating a $176 per Medicare member per year subsidy.

Based on an estimated 20,200 current USG Medicare members- going from USG's current Medicare benefits to the SHBP benefits would save approximately $49.8 million over 2025 (not considering new entrants/deaths or OPEB valuation impacts).

Based on an estimated 130,000 current SHBP Medicare members- going from SHPB's current Medicare benefits to the USG benefits would cost approximately $320.3 million over 2025 (not considering new entrants/deaths or OPEB valuation impacts).

USG and SHBP Active/Pre-Medicare Population Health

Comparison of USG and SHBP Population Health

We were asked to analyze whether there was a difference between the general health status of the USG and SHBP populations.

A starting point for comparison is to look at average per member per month (PMPM) claim costs for the self-insured active/pre-Medicare populations for each group:

2023 Incurred Claims PMPM			
	Medical	Rx	Total
USG	$431.42	$219.08	$650.49
SHBP	$500.03	$236.15	$736.18
USG vs SHBP	-14%	-7%	-12%

The SHBP claims totals include base HRA claims dollars for the applicable plans, but not the earned incentive dollars. Claims costs can be impacted by more than health status- there are several considerations for this comparison. Three of the main variables affecting PMPM claims costs outside of health status include benefit richness, demographics (including geography), and medical networks.

Based on the member-weighted average AVs discussed earlier in the paper, we would expect a -1.4% difference in claims cost when comparing USG to SHBP based solely on benefit richness differences ((.827 / .839) – 1). This only explains a small portion of the observed claims cost difference.

Estimated age/sex demographic differences will be discussed below.

Based on prior work conducted by others, our understanding is that the SHBP population is more geographically spread than the USG population. Provider payment rates would vary throughout the state, and it is possible that the SHBP population has utilization in areas with higher payment rates which could drive higher average PMPM claims costs. A geographic payment rate impact analysis is beyond the scope of this report.

Based on our understanding of the USG and SHPB, USG offers plans with 2 self-insured networks and SHBP offers plans with 4 self-insured networks with the following enrollment distributions based on 2023 census snapshot information:

	% Total Members	
Network	USG	SHBP
Anthem PPO/POS	84%	49%
Anthem HMO	16%	45%
UHC PPO		2%
UHC HMO		4%

The USG and SHBP Anthem PPO/POS and HMO networks may not be the same but we would expect provider payment rates to be comparable for the two group's shared network types. An important observation here is that the SHBP membership is more heavily weighted in an HMO network. On average, the provider payment rates in HMO plans are expected to be lower relative to a PPO/POS network, so we would expect a lower average PMPM claims cost for SHBP all else being equal. The UHC portion of membership, which would have different provider payment rates than Anthem, likely has a minimal impact to the overall average due to it only being ~6% of total membership. The actual claims cost PMPM difference between USG and SHBP does not follow the expected relationship if only network differences are considered.

A commonly used metric to describe the relative health status of a population is a risk score. We ran the USG and SHBP populations through a pared down version of the HHS-HCC risk score model[1] and came up with the following results:

Risk Score Component	USG	SHBP
Age/Sex	0.27	0.27
HCC	0.84	0.83
Total	**1.11**	**1.10**

As discussed in Appendix B, this is not a full implementation of the HHS-HCC risk score model but the impact of not running the full model should be relatively consistent between the two populations. Due to data limitations, the model was only run on those members in both the census and the claims data. The age/sex factors based on the HHS-HCC model are roughly equal between the two groups. This is consistent with prior work conducted by others that found the average age, percentage female, average members per enrollee, and percentage of enrollees covering a spouse are similar between the two groups.

The HCC risk score is a proxy for the estimated impact of each group's disease burden. Based on the pared down version of the HHS-HCC risk score model we ran, the average impact is similar between the two groups.

Therefore, the relative health status seems to be similar between the two groups for members with claims based on the risk score from pared down model. If USG has a higher prevalence of members without claims than SHBP, that could potentially change the above average result (since members without claims would decrease the average HCC risk score).

The overall impact to the current SHBP average PMPM claims cost is likely to be minimal under a combined benefit structure. USG would represent ~13% of membership for a combined active and pre-Medicare retiree population, so even if USG claims were 20% lower on average the overall impact to the combined group's PMPM compared to current SHBP average PMPM claims would be roughly -2.5%.

USG Population

We were also asked to consider the USG self-insured population relative differences between plans.

USG Plan	Members	2023 Total PMPM	AV	% Members No Medical Claim	% Members No Rx Claim	Risk Score
Comprehensive Care	30,414	$859.57	0.828	8%	13%	1.35
HDHP	31,095	$363.62	0.795	15%	25%	0.80
BlueChoice HMO	12,418	$854.82	0.874	10%	15%	1.23

Notes about the above table:

- Members counts are based on a 2023 snapshot census.
- 2023 PMPMs are based on 2023 incurred claims.
- AVs are taken from the table discussed above.
- % No Medical Claim and Rx Claim are based on linking 2023 incurred claims to the 2023 snapshot census (ideally this statistic would be calculated based on monthly member-level enrollment information but that data was not available; this is a reasonable estimate).
- Risk score is based on the pared down HHS-HCC model[1].

The HDHP plan has the lowest 2023 PMPM (a -58% difference when compared to the Comprehensive Care PPO plan). Much of this difference is explained by the relative benefit richness and the relative health status of the members in both plans (represented by AV and Risk Score differences). There is a larger proportion of members without medical or Rx claims in the HDHP plan compared to the other two plans which also explains a portion of the average claims difference between plans.

1. See Appendix B for details

OPEB Impact Considerations

It is important to note that merging the current USG medical benefits structure into the current SHBP benefits structure will impact Georgia's OPEB liabilities as well. OPEB impacts will depend on several factors, including plan migration, potential changes in plan utilization, changes in plan participation and changes in anticipated future health

care cost increases. Because OPEB liabilities are long-term in nature, consideration must be given to the long-term potential impacts of decisions made today.

For both USG and SHBP, Georgia's pre-Medicare OPEB liabilities are generally measured as an expected total claim cost amount, offset by participant cost-sharing. The total gross claim costs, including administrative costs, are projected into the future for as long as the plan is anticipated to be in place. Both current retirees and potential future retirees (today's active employees who could eventually meet eligibility requirements and retire with coverage under the retiree plan) are included in the calculation of the liability. Georgia's OPEB liabilities will be impacted by any changes that will alter either the gross claims and administrative costs paid-for by the plan or the amount of cost-sharing shouldered by the retirees themselves.

As noted above, total 2025 claims and administrative costs associated with USG participants under the SHBP benefit plan structure are anticipated to increase under Scenario 1 and decrease slightly under Scenario 2, while total contributions and surcharges are expected to decrease. Assuming plan migration patterns for pre-Medicare retirees similar to those of the overall population, direct impacts to the claims costs for pre-Medicare retirees and the pre-Medicare OPEB liability can be expected to fall in a similar range while decreases to retiree contributions will have a leveraging effect on the overall pre-Medicare employer cost and resulting OPEB liability. It is unclear whether participation rates for pre-Medicare USG retirees would increase or decrease under the SHBP benefit plan offerings, but a change in participation for retirees and/or their spouses would have a direct impact on the 2025 employer costs and the pre-Medicare OPEB liability.

In addition to employer cost increases for 2025 it is important to consider anticipated future increases in health care costs when assessing the impact on OPEB liabilities. The OPEB liability is very sensitive to assumed increases in future health care costs. Merging the USG benefits structure into the SHBP benefits structure will impact the assumed health care trend rate used in measuring the OPEB liability associated with USG retirees. For the fiscal year ending June 30, 2024, USG's assumed health care trend rates for the next 10 years for pre-Medicare claims costs and contributions are about 1% to 2% higher than SHBP's (although the same ultimate rate of 4.50% is assumed.) If future increases in health care costs under SHBP's plan structure are anticipated to be lower than under USG's plan structure, this could offset the potential increases in OPEB liability noted above.

Health care coverage for Medicare-eligible retirees under USG's benefit structure is very different from SHBP's. As stated above, USG provides an annual HRA contribution for Medicare-eligible retirees which can be used to purchase Medicare coverage through the Alight Retiree Health Solutions exchange. SHBP offers four employer-sponsored Medicare Advantage plans. It is our understanding that USG would likely continue to offer the annual HRA contribution going forward, in which case there would be no impact to the measurement of the OPEB liability for USG's Medicare-eligible retiree population. However, moving USG's Medicare-eligible population from the HRA arrangement to SHBP's Medicare Advantage offerings could result in significant savings from an OPEB perspective.

It is important to consider the OPEB impacts of merging the USG and SHBP benefit plan structures. We recommend engaging the Plans' actuaries in pricing the OPEB impacts of any significant changes in plan offerings for both USG and SHBP.

USG Persona Analysis

We were asked to consider the impacts of migrating USG members to the SHBP medical plan on a more micro level. For this consideration, we developed "personas" reflective of the actual USG population. Personas were developed at both the subscriber/family unit level and at the member level based on a 2023 snapshot census and 2023 incurred medical and prescription drug claims data for USG. A clustering algorithm was run on the entire self-insured active and pre-Medicare retiree population to support the development of these personas[1].

To model the impact of migrating from the USG to the SHBP benefit structure for each of these personas:

- We compared estimated annual out of pocket claims (OOP) spend, monthly contributions and total annual spend (OOP + contributions) under the current USG benefit structure and migration Scenarios 1 and 2 for the subscriber/family unit level.
- For the additional analysis of member level impacts, we compared estimated annual out of pocket claims (OOP) spend under the current USG benefit structure and migration Scenario 1.

Scenarios are described in the report above (pg. 4). OOP was estimated using member level modeling of the 2025 plan designs of major plan provisions[1].

Subscriber/Family Unit Level Persona Analysis

The subscriber/family unit level clustering algorithm resulted in 10 identifiable cohorts of the USG population which were roughly defined as follows:

1. Employee Only subscribers in the Comprehensive Care plan
2. Employee Only subscribers in the HDHP plan
3. Employee Only subscribers in the BlueChoice HMO plan
4. Employee Plus Children subscribers in all plans
5. Employee Plus Spouse subscribers in all plans with a higher average EE/SP age
6. Employee Plus Spouse and Family subscribers in all plans with lower-than-average EE/Sp/Ch ages (young families)
7. Family subscribers in all plans with average EE/Sp/Ch ages (middle families)
8. Family subscribers in all plans with higher-than-average EE/Sp/Ch ages (mature families)
9. Spouse Only and Spouse Plus Children split family subscribers
10. Children Only split family subscribers

In further reviewing the results, we split cluster 6 results to manually separate the Employee Plus Spouse and Family subscribers that were clustered together by the algorithm into separate clusters and ignored clusters 9/10 due to low prevalence and unreasonable average claims costs showing up in the data.

Note that it is generally possible to find additional clusters within a population, especially as the number of attributes that are considered in defining clusters is increased. There will always be a balance between defining high clusters/personas at a high level on one end and defining smaller more nuanced clusters at the other end. High level clusters are designed to give a quick way to understand the impact of design changes on personas. We opted to begin our analysis with their higher-level clusters, and then later in this section we provide modelling of expected member impacts at an individual user level to illustrate the range of member impacts at a granular level.

To model the impact of migrating from the USG to the SHBP benefit structure for each of these personas, we compared estimated annual out of pocket claims (OOP) spend, monthly contributions and total annual spend (OOP + contributions) under the current USG benefit structure and under migration Scenarios 1 and 2 described in the report above (see pg. 4). OOP was estimated using member level modeling of major plan provisions[1].

The three tables below show estimates for these three comparisons for each of the nine family/subscriber unit personas considered. Each line can be thought of as an "average" subscriber for each persona (based on the averaging of individual family unit modeled results and the distribution in each persona).

		Estimated Annual OOP				
Cluster - Description	Subscriber Count	Current	Scenario 1	Scenario 2	Scenario 1 vs Current	Scenario 2 vs Current
Cluster 1 - EE Only | PPO	9,149	$1,864	$2,216	$2,296	$352	$432
Cluster 2 - EE Only | HDHP	8,933	$1,663	$1,406	$1,843	($257)	$180
Cluster 3 - EE Only | HMO	3,531	$1,218	$1,648	$1,648	$430	$430
Cluster 4 - EE+Ch | All	3,228	$3,422	$3,299	$3,763	($122)	$342
Cluster 5 - EE+Sp | All | Older	3,679	$4,397	$4,266	$4,780	($131)	$384
Cluster 6a - EE+Sp | All | Younger	1,467	$3,001	$2,789	$3,224	($212)	$223
Cluster 6b - Family | All | Young	1,229	$4,097	$4,868	$5,238	$770	$1,141
Cluster 7 - Family | All | Middle	3,380	$4,920	$4,734	$5,563	($186)	$644
Cluster 8 - Family | All | Mature	3,212	$5,177	$5,433	$6,029	$256	$852

- On average, out of pocket costs under the SHBP benefit structure would be similar to current under Scenario 1 and higher under Scenario 2. This roughly follows the pattern of the results in the 'Projected CY2025 Cost (Claims+Admin)' line of the Estimated Employer Subsidy Impacts table found on page 7 (i.e. larger member OOP cost means lower employer claims cost). The largest OOP impacts to Personas were estimated to be:
    - The EE Only | HMO persona where the assumption is a one-to-one migration for both scenarios and the SHBP plan design is leaner (this is true for all HMO subscribers, but results are blended over all self-insured plans for other personas)
    - The Young Family persona which has a plan distribution and claims utilization pattern that is impacted more negatively by the differences between USG and SHBP plan designs
    - Personas in Scenario 2 which had higher proportion of HDHP plan enrollment (which were assumed to migrate to the leaner SHBP HDHP plan) and PPO enrollment (which were assumed to migrate similarly to SHBP's current enrollment distribution of their HRA plans, which has the largest proportion in the relatively lean Bronze plan)

		Monthly Contributions				
Cluster - Description	Subscriber Count	Current	Scenario 1	Scenario 2	Scenario 1 vs Current	Scenario 2 vs Current
Cluster 1 - EE Only | PPO	9,149	$235	$140	$130	($95)	($105)
Cluster 2 - EE Only | HDHP	8,933	$104	$88	$77	($17)	($27)
Cluster 3 - EE Only | HMO	3,531	$295	$169	$169	($126)	($126)
Cluster 4 - EE+Ch | All	3,228	$363	$225	$212	($139)	($152)
Cluster 5 - EE+Sp | All | Older	3,679	$448	$331	$315	($117)	($133)
Cluster 6a - EE+Sp | All | Younger	1,467	$407	$315	$298	($92)	($109)
Cluster 6b - Family | All | Young	1,229	$645	$442	$420	($202)	($225)
Cluster 7 - Family | All | Middle	3,380	$490	$385	$362	($105)	($128)
Cluster 8 - Family | All | Mature	3,212	$618	$433	$411	($185)	($207)

- On average, contributions are universally lower under the SHBP benefit structure under both Scenarios 1 and 2. This follows the pattern of the results in the 'Contributions and Surcharges' line of the Estimated Employer Subsidy Impacts table found on page 7 (i.e. lower contributions for Scenario 2 compared to Scenario 1)

		Estimated Total Annual Spend				
Cluster - Description	Subscriber Count	Current	Scenario 1	Scenario 2	Scenario 1 vs Current	Scenario 2 vs Current
Cluster 1 - EE Only | PPO	9,149	$4,684	$3,890	$3,856	($794)	($828)
Cluster 2 - EE Only | HDHP	8,933	$2,915	$2,457	$2,769	($458)	($146)
Cluster 3 - EE Only | HMO	3,531	$4,762	$3,677	$3,678	($1,085)	($1,085)
Cluster 4 - EE+Ch | All	3,228	$7,784	$5,997	$6,303	($1,787)	($1,480)
Cluster 5 - EE+Sp | All | Older	3,679	$9,778	$8,241	$8,564	($1,537)	($1,214)
Cluster 6a - EE+Sp | All | Younger	1,467	$7,888	$6,570	$6,800	($1,318)	($1,088)
Cluster 6b - Family | All | Young	1,229	$11,831	$10,174	$10,275	($1,657)	($1,556)
Cluster 7 - Family | All | Middle	3,380	$10,805	$9,357	$9,907	($1,448)	($897)
Cluster 8 - Family | All | Mature	3,212	$12,593	$10,629	$10,966	($1,964)	($1,627)

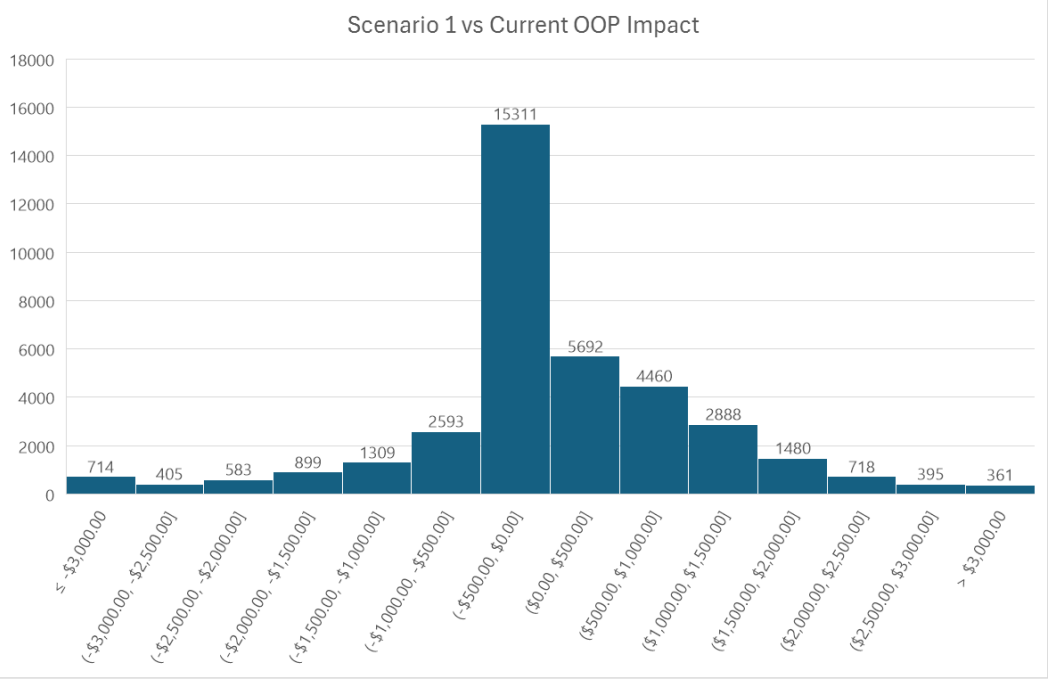
- On average, total annual spend is universally lower under the SHBP benefit structure under both Scenarios 1 and 2. For personas that had higher average OOP spending estimates under the SHBP design, the difference in annual contributions was more than enough to offset the OOP increase.

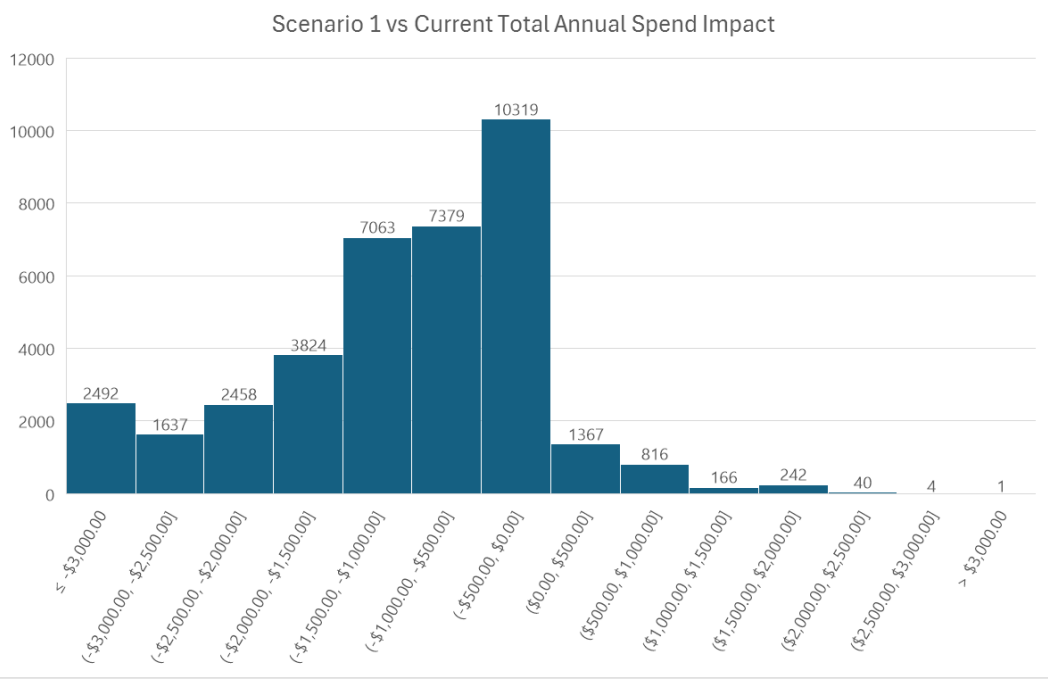
The overall results from the high-level persona analysis indicate that, across different subpopulations of USG (the personas), the SHBP benefit plan is expected to be less costly on average on an annual basis.

Subscriber/Family Unit Level Impact Distributions

It is important to note that the analysis above is based on high level personas and as such can mask the impacts this migration would have on individual families. There are numerous differences between the USG and SHBP plan designs which would impact families uniquely based on their own utilization patterns. The below charts show the distribution of the impact at a family unit level for the estimated annual OOP spend and annual total spend (OOP + contributions) for Scenario 1. For Scenario 2, three sets of charts are included to show the impact assuming 100% migration from the current USG PPO to the SHBP HRA Gold, to the SHBP HRA Silver, and to the SHBP HRA Bronze.

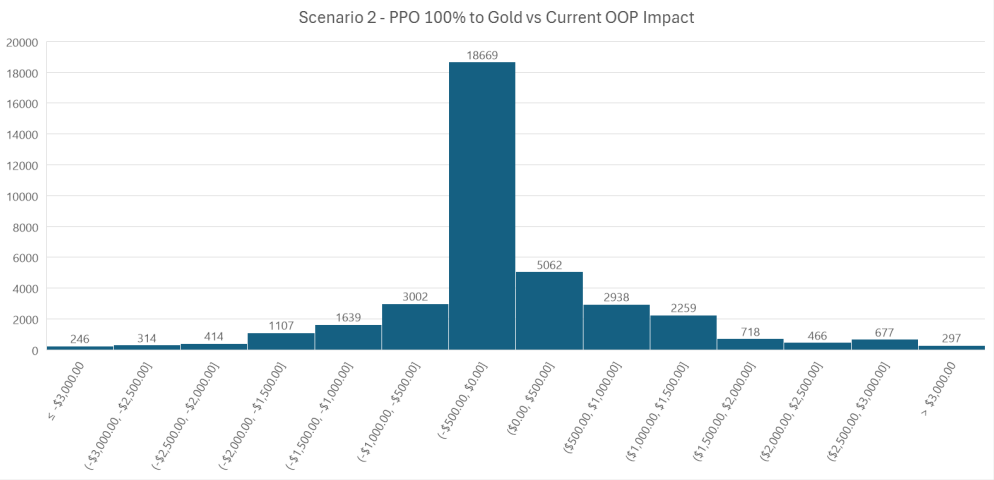
Scenario 1 Impact Distributions

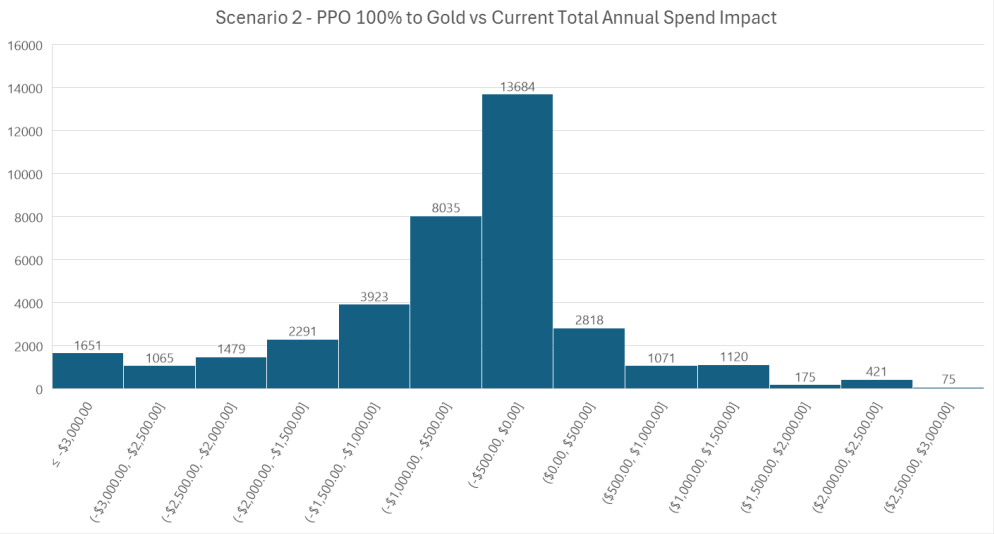




Under Scenario 1 assumptions, 42% of families are expected to be worse based on estimated annual OOP alone spend due to plan design differences under the SHBP benefit plan. Including the impact of contribution differences, 7% of families are expected to be worse off under the SHBP benefit plan based on estimated total annual spend. The contribution differences are expected to make up for the increased OOP spend for a significant portion of families.

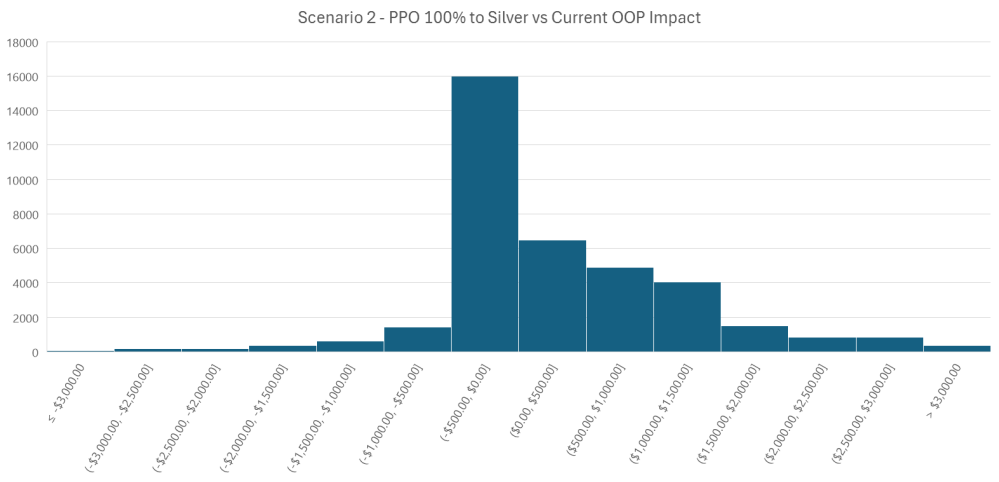
Scenario 2 – PPO 100% to Gold Impact Distributions

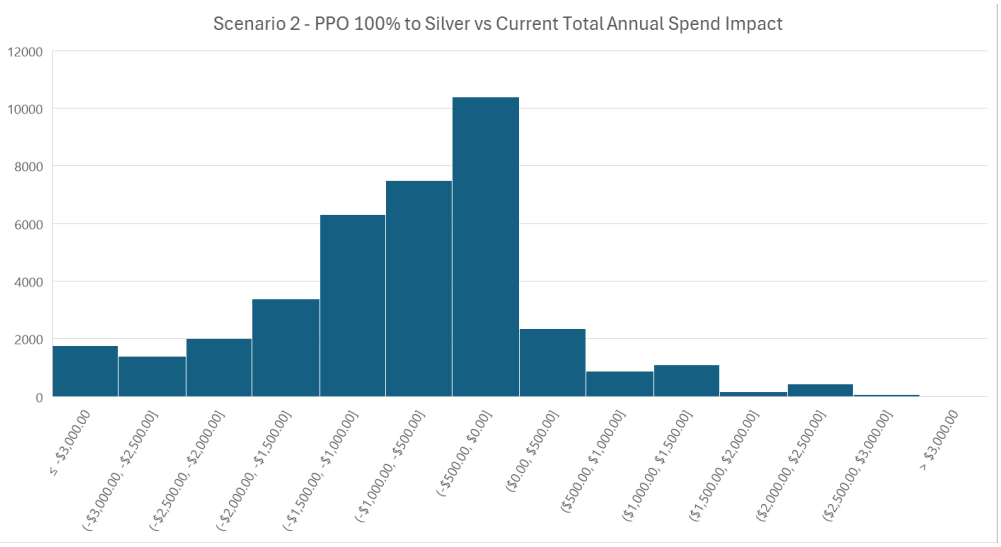




Under Scenario 2 (with 100% of the USG PPO population assumed to migrate to the SHBP HRA Gold), 32% of families are estimated to be worse off based on annual OOP spend due to plan design differences under the SHBP benefit plan. Including the impact of contribution differences, 15% of families are expected to be worse off under the SHBP benefit plan based on estimated total annual spend. Like Scenario 1, the contribution differences are expected to make up for the increased OOP spend for a significant portion of families.

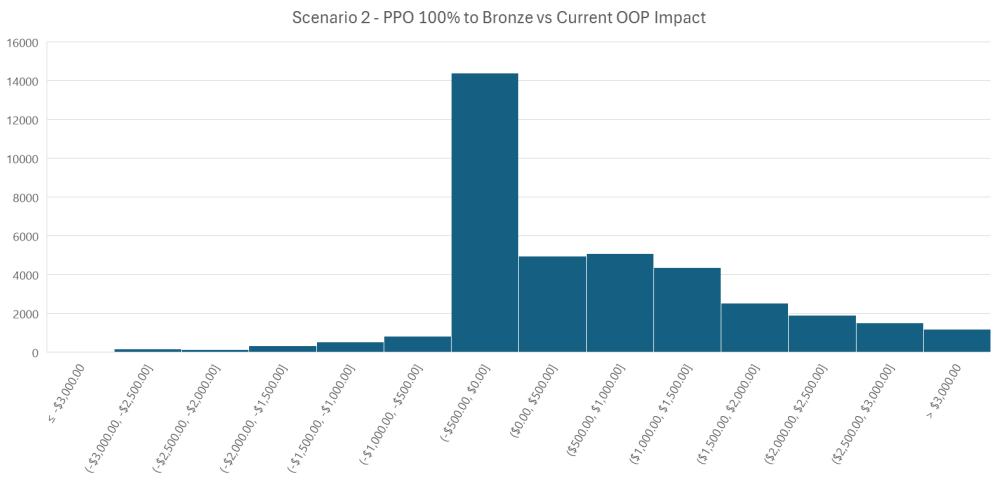
Scenario 2 – USG PPO 100% to Silver Impact Distributions

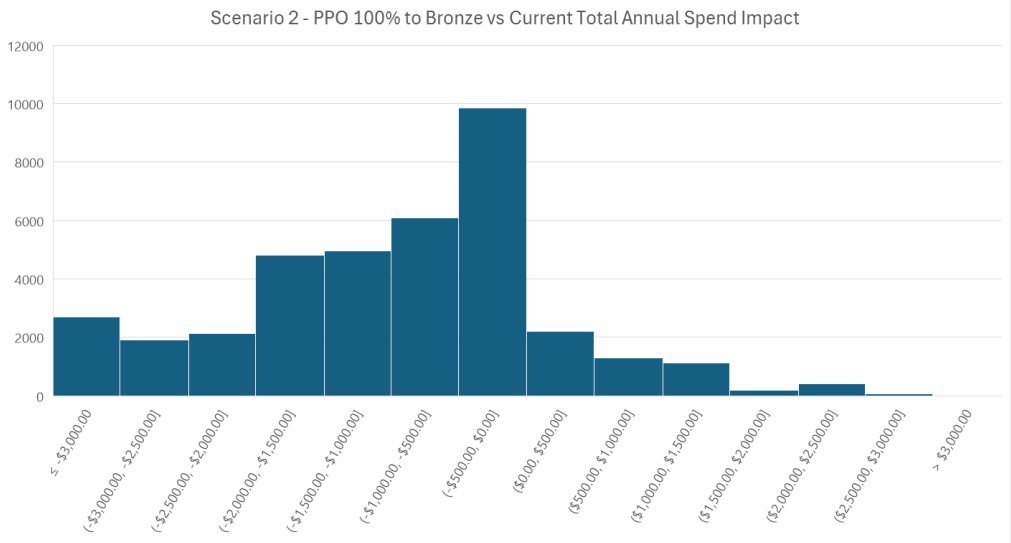




Under Scenario 2 (100% of the USG PPO population assumed to migrate to the SHBP HRA Silver), 50% of families are expected to be worse off based on estimated annual OOP spend due to plan design differences under the SHBP benefit plan. Including the impact of contribution differences, 13% of families are expected to be worse off under the SHBP benefit plan based on estimated total annual spend. Although more families are worse off on the OOP side when compared to 100% of the USG PPO migrating to SHBP HRA Gold, adding in the impact of contribution differences gets us to a similar end point (13% vs 15%).

Scenario 2 – USG PPO 100% to Bronze Impact Distributions





Under Scenario 2 (100% of the USG PPO population assumed to migrate to the SHBP HRA Bronze), 57% of families are expected to be worse off based on annual OOP spend due to plan design differences under the SHBP benefit plan. Including the impact of contribution differences, 14% of families are expected to be worse off under the SHBP benefit plan for the estimated total annual spend. Again, although more families are worse off on the OOP side when compared to 100% of the USG PPO migrating to SHBP HRA Gold and Silver results, adding in the impact of contribution differences gets us to a similar end point (13% - 15% range of worse off under the three sub-scenarios).

Overall, we would expect participants in the USG PPO to generally migrate to a mix of the Gold, Silver, and Bronze plans, so ultimately results would be a blend of the three sub-scenarios presented above. There is also the likelihood that members will migrate in other ways not reflected in the above scenarios as well.

Member Level Persona Analysis

The range of impacts to families are due to different impacts of specific plan design elements on individuals within those families. To illustrate this, we created personas at the member level to show out of pocket impacts for Scenario 1. We ran the member level clustering algorithm set to develop 30 different clusters. From those 30 clusters, we combined several of the resulting clusters to develop 6 different personas:

1. Child low utilizer
2. Adult low utilizer
3. Adult average utilizer
4. Adult high utilizer with high specialist office visit spend
5. Adult high utilizer with high inpatient spend
6. Adult high utilizer with high prescription drug spend

Below are estimated OOP impacts for each of these personas split by current USG plan enrollment. These are based on averages of member level modeling for members that are included in each persona.

Current PPO Members

		Estimated Annual OOP			
Persona	Member Count	Current	Scenario 1	Scenario 1 vs Current	% Change
Child | Low	3,911	$663	$1,081	$418	63%
Adult | Low	3,819	$1,573	$1,730	$157	10%
Adult | Average	2,854	$1,724	$2,047	$323	19%
Adult | High | Specialist	449	$3,830	$3,899	$69	2%
Adult | High | IP	890	$1,322	$1,599	$277	21%
Adult | High | Rx	284	$4,309	$4,398	$89	2%

- The low utilizer children persona is estimated to have a high OOP percentage increase. Much of this can be attributed to PCP office visits having a copay in the USG PPO, but being applicable to the deductible and coinsurance in the SHBP HRA Silver plan
- The high utilizer adult with significant IP spend persona has a similar reason for a larger increase than the other high utilizer adult categories- IP admission has a copay in the USG PPO but is applicable to the deductible and coinsurance in the SHBP HRA Silver plan. The USG IP Admit copay is a richer benefit to members on average.

Current HDHP Members

		Estimated Annual OOP			
Persona	Member Count	Current	Scenario 1	Scenario 1 vs Current	% Change
Child | Low	7,054	$1,048	$941	($107)	-10%
Adult | Low	6,202	$1,422	$1,095	($327)	-23%
Adult | Average	146	$3,338	$2,752	($586)	-18%
Adult | High | Specialist	110	$5,546	$4,996	($551)	-10%
Adult | High | IP	484	$1,691	$1,391	($300)	-18%
Adult | High | Rx	89	$5,835	$5,136	($699)	-12%

- The persona results are generally consistent. One of the benefit differences between the USG HDHP plan and the assumed SHBP HRA Bronze plan is that for the USG HDHP plan in non-single coverage tiers, members are subject to the family deductible and out of pocket maximum. For families with only one high utilizer, this represents a more generous benefit.

Current HMO Members

		Estimated Annual OOP			
Persona	Member Count	Current	Scenario 1	Scenario 1 vs Current	% Change
Child | Low	3,740	$427	$550	$123	29%
Adult | Low	2,105	$892	$1,164	$272	30%
Adult | Average	740	$997	$1,634	$637	64%
Adult | High | Specialist	64	$4,940	$3,690	($1,250)	-25%
Adult | High | IP	210	$944	$1,376	$432	46%
Adult | High | Rx	94	$3,478	$3,422	($56)	-2%

- The high adult utilizers with significant specialist office visit spend and with significant Rx spend personas have unique results for the HMO impact. On average the SHBP HMO plan design is less rich than the USG HMO design. For the specialist spend persona the large decrease is driven by a $55 specialist office visit copay decrease ($45 SHBP HMO vs $100 USG HMO) for members who have tens of specialist office visit claims over the course of the year. For the Rx spend persona, the SHBP HMO is again richer than the USG design- flat copays for all tiers in the SHBP HMO compared to coinsurance with minimum/maximum copays for brand and non-formulary tiers.

Note that some of the persona/plan combinations above have small sample sizes, but in general the results of the member level persona analysis are explainable by the utilization patterns and specific plan design differences between the current and assumed migration plans.

Additional Considerations

There are other factors that can influence member impacts, but these factors have not been included in the above analysis:

- Surcharges, wellness incentives, and the USG HSA match were not included in the above results. On average with respect to these items, the SHBP benefit plan is more beneficial to subscribers in total than the USG plan. For surcharges, SHBP is universally better for all subscribers. For wellness incentives and the HSA match, the only exceptions where SHBP provides a lower benefit are subscribers who receive the HSA match but no wellness incentives ($375-$750 less benefit under SHBP annually) and EE+Ch subscribers in the USG HDHP plan who receive the full HSA match and wellness incentive (USG – $750 match + $100 incentive = $850 total; SHBP – $480 wellness incentive; $370 less benefit under SHBP annually).
- Weight loss coverage was not factored into the above results. There would be out of pocket costs associated with that benefit in the SHBP benefit design, but if members were to seek that same treatment under the USG benefit design, they would pay full cost.
- Kaiser HMO members were not included in the clustering analysis. Based on the TG modeled actuarial values, the average annual out of pocket costs for these members would go down ~8%. Based on USG's current Kaiser HMO enrollment distribution and 2025 contributions for both groups, subscribers would save $979 on annual contribution costs ($423 average USG contribution vs $342 average SHBP contribution).
- For Scenario 2, current USG HDHP plan members are assumed to migrate to the SHBP UHC HDHP plan. USG's HDHP plan uses the Anthem POS network so there is the possibility for some provider disruption for members who utilize providers who are in network for Anthem but not for UHC. A network disruption analysis is beyond the scope of this report.

1. See Appendix C for details

TERRY

Disclosures

General

This report is intended for the Georgia Department of Audits and Accounts to support efforts to respond to a request from the Georgia Senate Appropriations Committee. This report should not be relied upon for any other purpose.

The results included in this report are estimates based on reasonable actuarial assumptions and methodologies in accordance with the applicable Actuarial Standards of Practice (ASOPs). A more thorough analysis including considerations beyond the scope of this report (including but not limited to analyzing medical network differences between USG and SHBP plans, prescription drug formulary differences between USG and SHBP plans, geographic distribution difference impacts and more recent data) could result in different results. Actual experience may deviate from the results included in this report.

Megan Heine, Yi-Ling Lin and Bobby Schenck are members of the American Academy of Actuaries and collectively meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein and are available to DOAA (or others at DOAA's direction) to provide supplementary information and explanation.

Data

We have relied on data and other information provided to us by GA DOAA. General categories of data considered for this report include:

1. Detailed medical and prescription drug claims data for active and pre-Medicare retirees for USG and SHBP for the years 2022 and 2023
2. Aggregate medical prescription drug claims data for active and pre-Medicare retirees for USG and SHBP for the years 2022 and 2023, including HRA costs for SHBP
3. Weight loss drug data for SHBP over the time period Jan 24 – Oct 24
4. Snapshot census information for USG and SHBP for 2022 and 2023
5. Plan information for USG and SHBP (including designs, fully insured plan premiums, contributions, surcharges, etc.)
6. Administrative cost information
7. Prior related analyses conducted by other firms

We did not audit the data or verify its accuracy, but instead have relied on those persons collecting and preparing the data for its accuracy. Various reasonableness checks were conducted over the course of the analyses performed and any resulting limitations were accounted for as noted throughout the report. To the extent that the data used has errors, the results of our work may be affected.

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Appendix A

Current 2025 USG Costs Estimate by Plan

Plan	Members	CY2025 PMPM Cost	CY2025 Cost
Comprehensive Care PPO	30,856	$1,040.79	$385,376,980
USG BlueChoice HMO	11,786	$1,048.36	$148,271,197
Kaiser HMO	6,864	$727.84	$59,951,095
HDHP	31,671	$452.23	$171,870,783
	81,177	**$785.80**	**$765,470,055**

2025 USG costs for self-insured plans were developed using 2023 incurred claims by plan trended forward and adjusted for plan design changes.

Scenario 1 Cost Estimate Details

USG Plans	Members (Active+ Pre-Medicare Retirees)	2025 USG PMPM Claims Cost (No Admin)
Comprehensive Care PPO	30,856	$1,012.04
USG BlueChoice HMO	11,786	$1,018.28
Kaiser HMO (Fully Insured)	6,864	$727.84
HDHP	31,671	$427.01
	81,177	$760.67

SHPB Plans	SHBP Members in SHBP Plans	USG Members in SHBP Plans	SHBP Relative Value Factor	USG PMPM Cost in SHPB Plans (No Admin)	Projected 2025 Claims Cost for USG in SHPB Plans
Gold	47,514	-	-	$0.00	$0
Silver	88,466	30,856	1.001	$1,012.74	$374,988,897
Bronze	107,870	31,671	1.012	$432.08	$164,212,139
Anthem HMO	224,821	11,786	0.982	$999.99	$141,430,533
UHC HMO	17,508	-	-	$0.00	$0
Kaiser HMO	41,537	6,864	1.009	$734.57	$60,505,407
HDHP	10,128	-	-	-	-
	537,844	81,177			$741,136,976

Projected Claims Cost	$741,136,976
Projected Admin Cost	$26,556,760
Total CY2025 Cost	**$767,693,736**

*excludes Rx rebates and weight loss coverage

Scenario 1 assumes all USG PPO members migrate to the SHBP Silver plan, all USG HDHP members migrate to the SHBP Bronze plan, all USG Kaiser members migrate to the SHBP Kaiser plan, and all USG HMO members migrate to the SHBP Anthem HMO plan.

The relative value factor is used to adjust projected 2025 USG claims by plan to reflect the applicable SHBP design. The relative value factors were developed separately for the USG PPO, HMO, and HDHP populations to reflect the

different impacts plan design changes have to different average claim levels. Note that Kaiser HMO is fully insured and the premium for a combined USG+SHBP offering would be different than both current premiums. The analysis uses the actuarial value difference of the plan designs as an estimated impact to current USG Kaiser costs.

Scenario 2 Cost Estimate Details

USG Plans	Members (Active+ Pre-Medicare Retirees)	2025 USG PMPM Claims Cost (No Admin)
Comprehensive Care PPO	30,856	$1,012.04
USG BlueChoice HMO	11,786	$1,018.28
Kaiser HMO (Fully Insured)	6,864	$727.84
HDHP	31,671	$427.01
	81,177	$760.67

SHPB Plans	SHBP Members in SHBP Plans	USG Members in SHBP Plans	SHBP Relative Value Factor	USG PMPM Cost in SHPB Plans (No Admin)	Projected 2025 Claims Cost for USG in SHPB Plans
Gold	47,514	6,012	1.044	$1,056.74	$76,241,095
Silver	88,466	11,194	1.001	$1,012.74	$136,041,697
Bronze	107,870	13,650	0.967	$978.55	$160,281,125
Anthem HMO	224,821	11,786	0.982	$999.99	$141,430,533
UHC HMO	17,508	-	-	$0.00	$0
Kaiser HMO	41,537	6,864	1.009	$734.57	$60,505,407
HDHP	10,128	31,671	0.952	$406.36	$154,437,288
	537,844	81,177			$728,937,145

Projected Claims Cost	$728,937,145
Projected Admin Cost	$30,253,389
Total CY2025 Cost	**$759,190,534**

*excludes Rx rebates and weight loss coverage

Scenario 2 assumes all USG PPO members migrate to the SHBP Gold, Silver and Bronze plans similarly to the current SHBP enrollment distribution, all USG HDHP members migrate to the SHBP UHC HDHP plan, and all USG Kaiser members migrate to the SHBP Kaiser plan, and all USG HMO members migrate to the SHBP Anthem HMO plan.

The relative value factor is used to adjust projected 2025 USG claims by plan to reflect the applicable SHBP design. The relative value factors were developed separately for the USG PPO, HMO, and HDHP populations to reflect the different impacts plan design changes have to different average claim levels. No adjustments were made to reflect different provider payment levels between the USG HDHP plan network and the SHBP UHC HDHP plan network. Note that Kaiser HMO is fully insured and the premium for a combined USG+SHBP offering would be different than both current premiums. The analysis uses the actuarial value difference of the plan designs as an estimated impact to current USG Kaiser costs.

The increased administrative cost compared to Scenario 1 is due to the UHC administrative cost being ~$10 PEPM higher PEPM than the Anthem administrative cost.

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2025 Contributions

	USG Plans			
	PPO	HMO	HDHP	Kaiser HMO
EE Only	$220.00	$273.78	$97.72	$206.16
EE+Ch	$427.82	$524.62	$207.70	$395.56
EE+Sp	$499.14	$612.08	$242.32	$461.48
Family	$713.04	$874.38	$346.18	$659.26
Sp Only	$279.14	$338.30	$144.60	$255.32
SP+Ch	$493.04	$600.60	$248.46	$453.10
Ch Only	$207.82	$250.84	$109.98	$189.40

	SHPB Plans					
	Gold	Silver	Bronze	Anthem HMO	HDHP	Kaiser HMO
EE Only	$194.67	$131.17	$82.67	$157.53	$72.69	$157.53
EE+Ch	$355.26	$247.31	$164.86	$292.12	$147.89	$292.12
EE+Sp	$482.76	$349.41	$247.56	$404.77	$226.60	$404.77
Family	$643.35	$465.55	$329.75	$539.36	$301.80	$539.36
Sp Only	$288.09	$218.24	$164.89	$247.24	$153.91	$247.24
SP+Ch	$448.68	$334.38	$247.08	$381.83	$229.11	$381.83
Ch Only	$160.59	$116.14	$82.19	$134.59	$75.20	$134.59

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Appendix B

TG utilized a pared down version of the “2024 Benefit Year Risk Adjustment Updated HHS-Developed Risk Adjustment Model Algorithm "Do It Yourself (DIY)" Software” released by CMS on September 6, 2024, to calculate the risk scores found in this report. This model is commonly known as the HHS-HCC Risk Adjustment model and is utilized for the risk adjustment premium stabilization program created with the passage of the ACA. There is a large literature available for further details about both this model and risk scores in general.

Details about the pared down model/methodology:

- We utilized 2023 incurred medical claims data linked to a 2023 snapshot census for USG. USG claims data only had the first five diagnosis code fields available.
- We utilized 7/2022-6/2023 paid medical claims data linked to a 2023 snapshot census for SHBP. This was due to data limitations with the full calendar year SHBP data.
- To limit bias due to the differing data availability between the two groups:
    - We only calculated risk scores for members in each census that were also present in the claims for both groups.
    - We only included the first five diagnosis code fields in the SHBP claims data
- “Gold Level” coefficients were utilized to calculate the risk score

The following items from the full algorithm have been excluded in the pared down version of the model/methodology utilized for this report:

- Infant model (members aged 0 and 1)
- Variables found in Table 6 of the DIY software (Adult Rx, Interaction, and other miscellaneous variables), except for the Grouped HCC variables
- Variables found in Table 7 of the DIY software (Child miscellaneous variables), except for the Grouped HCC variables

The assumption is that the bias from the above exclusions will be generally consistent between both groups and the relative risk score differences should be a reasonable proxy of the full model results for health status comparison purposes.

A full version of the HHS-HCC model or use of another risk scoring model should be utilized if more accurate risk scores are desired for any future purposes.

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Appendix C

Clustering Algorithm

The family/subscriber unit persona analysis was based on running the K-Prototype clustering algorithm[1] run on USG's self-insured population with various categorical and numerical variables including plan, ages, and allowed costs by various categories.

For the member level clustering, we ran the algorithm to develop 30 clusters. We combined some similar clusters to develop the 6 personas included in the report above:

1. Child low utilizer
2. Adult low utilizer
3. Adult average utilizer
4. Adult high utilizer with high specialist office visit spend
5. Adult high utilizer with high inpatient spend
6. Adult high utilizer with high prescription drug spend

For the subscriber/family unit level clustering, the initial results were identified with the following general characteristics:

1. Employee Only subscribers in the Comprehensive Care plan
2. Employee Only subscribers in the HDHP plan
3. Employee Only subscribers in the BlueChoice HMO plan
4. Employee Plus Children subscribers in all plans
5. Employee Plus Spouse subscribers in all plans with a higher average EE/SP age
6. Employee Plus Spouse and Family subscribers in all plans with lower-than-average EE/Sp/Ch ages (young families)
7. Family subscribers in all plans with average EE/Sp/Ch ages (middle families)
8. Family subscribers in all plans with higher-than-average EE/Sp/Ch ages (mature families)
9. Spouse Only and Spouse Plus Children split family subscribers
10. Children Only split family subscribers

Cluster 6 was split into the following:

6a. Employee Plus Spouse subscribers in all plans with lower-than-average EE/Sp ages
6b. Family subscribers in all plans with lower-than-average EE/Sp/Ch ages

Clusters 9 and 10 were ignored for the analysis due to unreasonable claims data found during review of summary statistics of the clusters.

[1]N. J. de Vos, *kmodes categorical clustering library*. 2015–2021. [Online]. Available: https://github.com/nicodv/kmodes

Member Level modeling

Member level modeling for the persona analysis was based on a 2023 snapshot census and 2023 incurred claims data. No cost or utilization trend was assumed for this modeling. Member level modeling was based on the following service categories:

- Preventative
- PCP OV
- Specialist OV
- ER (excluding those that resulted in an admission)
- Urgent Care
- IP Admission
- All other medical
- Generic Retail
- Brand Retail
- Non-Formulary Retail
- Generic Mail
- Brand Mail
- Non-Formulary Mail

The relevant deductible, copay, and coinsurance applicability/amounts were assigned to the above service categories. Family deductible and out of pocket maximum impacts were applied proportionally over all members of a family. Base HRA funding was applied for the three SHBP HRA plans.

Note that member level modeling will yield different out of pocket estimates than out of pocket estimates based on actuarial values.