DOAA
Georgia Department
of Audits & Accounts

Greg S. Griffin
State Auditor

January 30, 2025

The Honorable Blake Tillery,
Chairman, Senate Appropriations Committee
Members of the Senate Appropriations Committee
Members of the General Assembly
Mr. Russel Carlson,
Commissioner, Department of Community Health
Members of the Board of Community Health

Ladies and Gentlemen:

The attachment to this letter provides the results of our special examination of the potential for cost savings within the State Health Benefit Plan (SHBP) that would not significantly reduce the health benefit. 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 that employer costs for SHBP are significantly impacted by plan design, employee premiums, and employee out-of-pocket costs. Each is part of the plan's health benefit; therefore, the ability to significantly change the cost profile or the cost trajectory of the plan is limited unless these areas are impacted. We also found that SHBP has taken a number of steps to assess and reduce health costs in recent years.

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

Respectfully,

Greg S. Griffin
State Auditor

GSG/da

Attachment A
Potential Cost Reductions at State Health Benefit Plan That Would Not Significantly Reduce the Health Benefit

Employer healthcare costs for SHBP are significantly impacted by plan design, employee premiums, and employee out-of-pocket costs. Each is part of the plan's health benefit; therefore, the ability to significantly change the cost profile for the state or the overall cost trajectory of the plan is limited unless these areas are impacted. Potential savings still available include typical administrative actions such as increasing dependent audits or lowering the threshold for high-cost claim review, as well as some health-related strategies such as increasing the use of telemedicine or on-site health clinics.

SHBP is a large healthcare plan with approximately 664,000 members and 2024 expenditures of $4.6 billion. Plan expenditures are paid by a combination of employer and employee premiums; the ratio of the two is considered the cost share of the plan. SHBP's expenditures *do not* reflect employee out-of-pocket costs such as co-pays and deductibles. These are considered employee costs, not plan costs. For an extensive discussion on SHBP's cost share, see DOAA's report *Analysis of Moving USG Healthcare Plan Members into the State Health Benefit Plan*.

In a healthcare plan as large as SHBP, many factors can result in increasing employer costs, such as health care inflation or employee premium increases that are not sufficient to maintain the cost share between employees and employer. Plan benefit changes may also increase employer costs. For example, prescription weight loss medication and bariatric surgery became a covered benefit in 2022, and the expected cost in 2024 for prescription weight loss medication is approximately $240 million. While SHBP has a history of assessing the plan and implementing changes to manage costs, cost reduction strategies may have a limited impact on changing the overall increasing cost of the plan.

SHBP recently contracted with a vendor to assist in developing a long-term strategy with two goals: to deliver better quality outcomes and value for members and to produce near-term savings while reducing long-term benefits expenses. SHBP is using the vendor's report to identify potential cost reduction strategies and to assist in designing requirements for a major procurement scheduled for 2025-2026.

While the potential for significant cost reductions without significantly reducing the health benefit may be limited, SHBP should continue to review and implement cost savings initiatives as appropriate.

DCH's Response: *The agency stated that the report "provides a clear and accurate description of the plan."*

Our assessment of potential cost reductions at SHBP that do not significantly reduce the health benefit is based on the answers to the following questions:

1. What is the SHBP health benefit?
2. What are the results of previous legislative requested studies?
3. What cost reduction strategies has SHBP implemented?
4. What cost reduction strategies could SHBP implement without significantly reducing the health benefit?
5. What are the experiences of other states' health benefit plans in attempting cost reduction strategies?

Question 1: What is the SHBP health benefit?

DOAA's analysis defines SHBP's health benefit as the plan design (medical and pharmaceutical coverage), cost share (difference between employer and employee premiums), and employee out-of-pocket costs (co-pays and deductibles). The health benefit is the amount an employee pays in premiums and out-of-pocket costs for the coverage the employee receives.

The purpose of SHBP is to provide affordable and quality healthcare coverage. Employee health benefit plans are intended to attract and retain employees, as well as protect an organization's workforce by maintaining its employees' health. SHBP is also subject to regulatory requirements because of the number of employees covered. These regulatory requirements, such as the Affordable Care Act (ACA), mandate certain aspects of health insurance coverage.

Question 2: What are the results of previous legislative requested studies?

The potential for implementing cost reduction strategies that do not significantly reduce the health benefit has been studied previously. In fiscal year 2015, the General Assembly requested that SHBP complete a study that examined "why SHBP's costs are higher than other comparable government employee health plans and describe a variety of options for reducing costs without further diminishing health benefits received by members." The legislative request was based on a report from the Pew Charitable Trusts that showed SHBP was more costly on average than most other states. SHBP engaged Aon (SHBP's actuary) to complete the study.

Aon benchmarked SHBP to five southeastern states and USG's healthcare plan to compare costs. While SHBP appeared on the high end of the benchmarked group upon a superficial review, Aon noted that the comparison did not consider three underlying drivers of cost: geographic location, demographics, and adult lives per employee. The study found the cost of providing healthcare in Georgia was higher than the benchmarked states because of higher cost of services and higher utilization rates. Also, age and gender have a significant impact on the expected cost of a member. SHBP had a higher average active/pre-65 retiree age and the higher percentage of females than all but one of the benchmarked states. These two factors would lead to higher costs. After adjusting for these factors, SHBP costs were comparable with the benchmarked plans.

Aon identified several options for reducing costs without diminishing the value of the health benefits. These included increasing the use of telemedicine, on-site clinics, and dependent eligibility audits. Aon stated, "Several of the strategies noted have been (and are currently being) reviewed by the Georgia SHBP for potential implementation. Considerations around resource needs, timing constraints, return on investment expectations, physical space availability, broad population applicability, Georgia market availability, etc. must all be considered prior to the decision on which items should be implemented and when." The cost reduction strategies that SHBP has implemented or has considered are discussed in the remainder of this report.

Question 3: What cost reduction strategies has SHBP implemented?

SHBP routinely works with consultants, third-party administrators (TPAs), and vendors to identify specific factors that impact SHBP expenditures and develop new programs or provide new covered benefits intended to mitigate rising health expenditures. The examples below are not intended to encompass all SHBP cost reduction strategies but show a variety of strategies. SHBP's cost reduction strategies include:

- **Quarterly performance reviews** – SHBP conducts quarterly performance reviews with TPAs. These reviews cover a wide range of subjects, including cost containment efforts. Topics include cost and utilization trends, high-cost claims, health conditions, emergency room usage, and chronic conditions such as diabetes and hypertension. These reviews include recommendations for cost containment such as weight management programs, diabetes

management, second opinion programs, and surgical management solutions. For example, one TPA suggested an incentive strategy to increase colon cancer screening. These recommendations may include projected savings and return on investment.

- **Pharmaceutical plan design changes** – SHBP reviews pharmaceutical usage and works with its vendor to design plan changes to contain costs. For example, the vendor suggested lowering the cost share for generic pharmaceuticals to increase generic usage. These recommendations include a projected cost savings.
- **OnMed CareStation** – In August 2024, SHBP installed an OnMed CareStation on Capitol Hill in the Twin Towers. OnMed stations allow patients to consult with a physician in an enhanced telemedicine setting. The goal is to make consulting a physician convenient for busy patients and to contain costs.
- **Chronic conditions** – SHBP management noted that care for members with chronic conditions such as diabetes are expensive to treat. While diabetes management programs have been in place for years, staff indicated that in March 2022 Anthem began offering a new diabetes management program focused on disease awareness and lifestyle coaching, and United began offering the program in April 2022. The program sets goals and milestones for members to meet, which are intended to help them better manage the disease. SHBP intends to evaluate this program annually.
- **Low cancer screening rates** – Treatment costs are higher for breast cancer patients who were diagnosed at more advanced stages, and SHBP indicated cancer screening rates varied across the state due to access. To address this, in November 2021 SHBP implemented the Mobile Mammogram program to close screening and access gaps in targeted regions. SHBP intends to evaluate this program annually.
- **Weight loss and bariatric care** – In January 2022, prescription weight loss medication and bariatric surgery became a covered benefit. For plan year 2024, SHBP is projected to spend approximately $240 million on anti-obesity medications, with the monthly cost increasing significantly over the course of the year. At the cost of a recent month ($26.4 million), annual spending for the medications would be nearly $320 million. While GLP-1s are expensive, they address two of the primary causes of poor health and cost—diabetes and obesity. Some believe that the long-term benefits of prescription weight loss medications may outweigh the costs, but the long-term impacts on health and costs are currently unknown.
- **Consultant review** –SHBP has engaged Aon consultants to assist in providing vendor oversight. Aon attends quarterly performance reviews with TPAs and provides insights and follow up. Aon also assists with expense projections, audits, and rate setting. For example, SHBP had Aon review the return on investment (ROI) for wellbeing programs to ensure the vendor was meeting the required targets. Aon determined SHBP was due a refund because the vendor did not meet the ROI targets.
- **Years of service policy** – In 2012, SHBP instituted a years of service policy that reduced the subsidy for some retirees.[1] Under the policy, a retirees' subsidy increases with additional years of service. For example, a pre-65 retiree with 10 years of service would have a monthly premium of $879.73 for the Anthem HMO, while one with 30 years of service would pay a monthly premium of $311.59.
- **New coverage options** – SHBP introduced new coverage options in 2008 (such as the Health Reimbursement Arrangements and High Deductible Health Plans) that—according to staff—would reduce costs and offer a more "consumer directed" approach. SHBP also eliminated Open Access Plans, which were expensive to operate.

[1] Prior to 2012, all retirees received the same subsidy regardless of years of service.

Question 4: What cost reduction strategies could SHBP implement without significantly reducing the health benefit?

SHBP is currently reviewing a wide variety of cost reduction strategies. SHBP contracted with a vendor to assist in developing a long-term strategy with two goals: to deliver better quality outcomes and value for members and to produce near-term savings while reducing long-term benefits expenses. SHBP intends to use the vendor's report to identify potential cost reduction strategies and assist in designing plan requirements for future procurements. The report was delivered to SHBP in March 2023.

The vendor provided SHBP more than 30 potential strategies categorized in 9 areas, as shown in Exhibit 1.

Exhibit 1: Cost Reduction Strategies Evaluated by SHBP

Benefit Strategy Area	Description	Number of Evaluated Strategies
Health Management	Addresses strategies such as chronic disease case management, members' digital tools for care navigation, and wellness programs.	3
Pharmacy Management	Addresses strategies to reduce pharmacy costs such as formulary design.	4
Network Contracting	Addresses strategies to adjust provider networks to generate cost savings, such as centers of excellence. Several strategies are detailed in Exhibit 3 under Provider Payment.	6
Payment Innovation	Addresses strategies that are risk-based arrangements that take a variety of forms but generally involve providers sharing in savings and accepting risk if costs exceed a target.	3
Contract Management	Addresses strategies to generate savings from contracts with third-party administrators. Includes optimizing time between requests for proposals and reducing administrative services only fees.	3
Portfolio/Benefit Design	Addresses strategies to adjust the number and type of plans offered. Includes recommendations to steer members to more cost-efficient plans.	6
Segment-specific Opportunities	Addresses strategies to decrease SHBP's costs associated with both pre-65 and post-65 retirees.	2
Program Integrity	Addresses strategies to contain costs through administrative actions. Includes actions such as lowering the threshold for high-cost claims audits, pre-payment reviews for billing anomalies, and medical policy optimization.	3
Optimize Contribution Structure	Addresses strategies to ensure revenue from employee and employer premiums is sufficient to cover plan costs.	2

Source: SHBP data

The strategies are a mix of those that reduce the health benefit and those that do not. For example, segment-specific opportunities could significantly reduce the health benefit of retirees, while program integrity strategies are typically administrative in nature and would not significantly reduce the health benefit.

Using the metrics in Exhibit 2, SHBP evaluated each of the strategies and determined whether to implement, designate for further study, or disregard. One strategy implemented was substantially

increasing the employer costs for public school teachers and employees to better align revenues and expenditures.

Exhibit 2: Strategy Evaluation Metrics

Impact Area	Description
Financial	Annual cost savings opportunity
Member	Breadth and level of disruption to members
Provider	Breadth and level of disruption to providers
Quality of care	Access to or quality of service
Timing to impact	Timing to implement and ramp up to impact
Implementation cost	One-time cost
Execution uncertainty	Industry experience in implementing strategy

Source: SHBP data

Question 5: What are the experiences of other states' health benefit plans in attempting cost reduction strategies?

Other states have implemented a variety of cost reduction strategies, and several are similar to those either implemented or being evaluated by SHBP. Replicating cost reduction strategies between states is difficult because each state employee health plan (SEHP) operates within its own unique environment. Each state's political, market, and operational environment make it a difficult to replicate all strategies. For example, some states are dominated by a small number of hospital systems or states may have employees in lightly populated, rural areas; those factors limit cost containment strategies that depend on competition.

A Georgetown University Health Policy Institute survey of SEHP administrators asked which cost containment strategies they had implemented in the last three years. Forty-seven SEHP administrators responded to the survey that informed the report, *Opportunities for State Employee Health Plans to Drive Improvements in Affordability*, released June 2021. One purpose of the study was to assess a range of cost containment strategies implemented by SEHPs. Exhibit 3 shows examples of those strategies and Georgia's implementation status as reported by SHBP personnel.

The report noted the difficulty of documenting cost savings from these strategies. For example, 30 of the 47 states offer members a high deductible health plan (HDHP), but only one state reported documented cost savings from its HDHP. Similarly, 19 states implemented risk sharing agreements (which involve providers sharing in savings and accepting risk if costs exceed a target), but only three states reported documented cost savings.

Exhibit 3: Potential Cost Reduction Strategies Implemented by Other States

	Georgia SHBP				
	Implemented	Considered but Not Implemented	Not Considered	Under Review	# of States Implementing as of 2021
Benefit Design					
High Deductible Health Plans Lower monthly premium, enrollee pays higher out of pocket.	✓				30
Value-based Design Incentivizes use of generic drugs, chronic disease management, etc., by lowering cost to enrollee.	✓				18
Wellness Program Encourages enrollees to adopt healthy behaviors.	✓				15
Reference Pricing A provider determines the maximum it will pay for a service in a geographic area.		✓			10
Provider Payment					
Centers of Excellence Health plans incentivize providers demonstrating better patient outcomes at a lower cost. Used for conditions like heart disease and cancer.	✓				23
Primary Care Initiatives Worksite Clinics are a common example.	✓				19
Risk Sharing Agreements These risk-based arrangements take a variety of forms but involve providers sharing in savings and accepting risk if costs exceed a target.				✓	19
Direct Contracting A self-insured entity negotiates directly with providers rather than through a TPA.			✓		14
Narrow & Tiered Networks Limiting networks generates savings by encouraging providers to agree to discounted prices in exchange for higher patient volume.				✓	16
Rate Setting Plan establishes a non-negotiable price for each health care service.				✓	7
Other					
Management of Chronic Conditions Programs to manage cost of chronic conditions.	✓				41
Case Management for High-Cost Enrollees Identifies individuals likely to incur high costs and teaches them to take better care of themselves.	✓				37
Prior Authorization or Referrals Requires a provider to get approval from insurance before a patient receives a service.	✓				33
Behavioral Health Management A holistic approach to improving mental health.				✓	10

Source: Georgetown University Health Policy Institute, SHBP