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Dear Members of the Health Benefits Advisory Committee,

On behalf of the Executive Steering Committee on Health Benefits (ESC), I would like to express our sincere thanks and appreciation to all involved for sharing your invaluable time and expertise in the preparation of this report. The responsible management of the University of California's health benefits program is extraordinarily complex, and of critical importance as part of our commitment to those who have dedicated their careers to the university.

We appreciate your commitment to maintaining the quality and sustainability of the UC employee health benefits program, and therefore agree with the committee's recommendations to maintain:

- A portfolio of options that provides a broad variety of plan models and price points; and
- A contribution strategy and methodology that recognizes the importance of the pay-banding and family-friendly attributes.

The ESC has decided to take immediate action with the following recommendations to:

- Increase Health Care Facilitator resources at locations in FY21-22, at a level to be determined as part of the FY21-22 budget process;
- Pursue out-of-state coverage for employee family members enrolled in HMOs; and
- Pursue advanced tools to assist employees making health plan choices.

The ESC has determined that the remaining report findings and recommendations will require further work and discussion before acting. These include opportunities to:

- Further explore the role of the UC Health Centers included in their 5-year roadmap, for example:
    - improve equity of access by expanding access to non-Health Center campus employees;
    - consider partnering with Kaiser to provide greater access to UC's tertiary and quaternary care; and
    - assess the impact of retaining health care dollars within the UC system;
- Potentially adjust the Risk Adjustment methodology; and
- Determine the future of the Core Plan.

Thank you again for your service to the University, and special thanks to Chair John Meyer for his dedication and thoughtful, inclusive leadership.

Sincerely,

Carrie Byington

Carrie Byington
Chair, Executive Steering Committee on Health Benefits

cc: Rachel Nava, Executive Vice President and Chief Operating Officer
Nathan Brostrom, Executive Vice President and Chief Financial Officer
Gerald Kominski, Professor, Health Policy and Management, UCLA
Jenny Kao, Chief of Staff to the President
Rachel Nosowsky, Deputy General Counsel, Health Affairs & Technology Law
Cheryl Lloyd, Interim Vice President, Systemwide Human Resources
Zoanne Nelson, Associate Vice President of Operations, UC Health
Laura Tauber, Executive Director, UC Self-Funded Health Plans
Susan Pon-Gee, Senior Director, Health & Welfare Benefits
Julian Ryu, Interim Executive Director, Strategy & Program Management Office

UNIVERSITY OF CALIFORNIA

HEALTH BENEFITS ADVISORY COMMITTEE

UC Employee Health Benefits Assessment

Final Report

December 2020

UNIVERSITY OF CALIFORNIA

RESPECTFULLY SUBMITTED BY

UC Health Benefits Advisory Committee (HBAC)

John Meyer, Chair, Retired Vice Chancellor of Administration, UC Davis
Ramona Agrela, Associate Chancellor & Chief Human Resources Officer, UC Irvine
Robert Anderson, Professor Emeritus, Economics, UC Berkeley
Roger Anderson, Council of University of California Emeriti Associations (CUCEA)
Kum-Kum Bhavnani, Professor of Sociology, UC Santa Barbara
Andrew Bindman, Professor of Medicine and Epidemiology & Biostatistics, UC San Francisco
John Bodenschatz, Delegate, UC Irvine Staff Assembly
Gregg Camfield, Executive Vice President and Provost, UC Merced
Michael Fehr, Representative, University Professional & Technical Employees, UCLA Library
Mary Gauvain, Chair, Academic Senate; Distinguished Professor of Psychology, UC Riverside
Kate Klimow, Staff Advisor to the Regents 2018-2020; Chief Administrative Officer and Director of External Relations, UC Irvine Beall Applied Innovation
Rick Kronick, Professor, Professor of Family Medicine and Public Health, UC San Diego
Sarah Latham, Vice Chancellor of Administration, UC Santa Cruz
Tim Maurice, Chief Financial Officer, UC Davis Health
Robert May, Professor of Philosophy and Linguistics, UC Davis
Patty Maysent, Chief Executive Officer, UC San Diego Health
Zoanne Nelson, Chief Strategy Officer and Associate Vice President, UCOP Strategy & Program Management
Pierre Ouillet, Vice Chancellor and Chief Financial Officer, UC San Diego
Frank Trueba, Council of University of California Retiree Associations (CUCRA)

Leadership Advisers to the Committee

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Cheryl Lloyd, Interim Vice President, UC Systemwide Human Resources

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Julian Ryu, Senior Program Manager, Strategy & Program Management Office
Laura Tauber, Executive Director, Self-Funded Health Plans, UC Health
Susan Pon-Gee, Senior Director, Health & Welfare, Human Resources Benefit Programs & Strategy
Robert Gaumer, Senior Counsel, Benefits, UC Legal
Wendy Welsh, Communications Strategist, External Relations and Communications
Michael Maniccia, Jacqueline Vo, Patricia Ryan, Jenny Wong, Diep Stephan, Deloitte Consulting

TRANSMITTAL LETTER TO ESC FROM THE HBAC CHAIR

October 22, 2020

TO: MEMBERS OF THE EXECUTIVE STEERING COMMITTEE (ESC)
Nathan Brostrom, Executive Vice President, Chief Financial Officer
Carrie Byington, Executive Vice President, UC Health (current chair of the ESC)
Gerald Kominski, Professor of Health Policy and Management, UCLA
Rachael Nava, Executive Vice President, Chief Operating Officer
Zoanne Nelson, Chief Strategy Officer and Associate Vice President

FROM: John Meyer, Chair, Health Benefits Advisory Committee

RE: Final Report of the Health Benefits Advisory Committee

Nathan, Carrie, Gerald, Rachael and Zoanne,

I am pleased to transmit for your consideration the final report of the Health Benefits Advisory Committee. This group was charged in the spring of 2019 to undertake a review of the UC health benefits portfolio. Like many such committees, our group consists of a broad cross section of the University of California community: members of the Academic Senate, campus and UC Health administrators, and representatives of emeriti, retirees, staff and union organizations. And, as is typical of our culture, all members held robust views yet also had an openness to consider perspectives which may be different from their own. I am grateful to the time and contributions made by each member of the committee.

The deliberations leading to this report were held during perhaps the most tumultuous health related event in our lifetimes: the COVID-19 pandemic. While UC Health and campus officials were managing this most extraordinary event, they also stayed engaged with this project and continued to dedicate time to discuss long-range policy issues as they were managing the pandemic crisis on an hourly basis. Adding to this challenge was the need to change consultants in the midst of our project. While unfortunate and the cause of some modest delay, in my view this action brought the quality of consultant resources this project required. I have great gratitude and respect for the Deloitte team.

I believe this report has done an admirable job in documenting the various issues that comprise the UC health insurance program. The report does not recommend sweeping restructuring of the health insurance program for staff or retirees. It includes recommendations for modest improvements and highlights many issues which will require more detailed and thoughtful consideration. That the report does not suggest major change may be a compliment to the program's history, administration and ongoing engagement with the UC community.

UC has long shown leadership in health plan administration. One example: the early adoption of a tiered system for employee's health insurance premiums based on income where lower paid employees pay a lower cost premium and employees with higher compensation pay a higher cost. This approach helps to ensure all within the UC community have access to relatively affordable health insurance coverage.

An issue that has long been obvious to most, but is even more apparent in light of the pandemic, is the critical importance of more universal health insurance coverage. As our colleagues within UC Health have underscored, the cost of providing care to those without adequate insurance, from both a financial and health perspective affects, us all. UC health benefits continue to be an important component of recruitment and retention of faculty and staff. A well covered university community can then better focus on its core missions.

While there is much to consider within this report, I take the Chair's prerogative to point out two particular issues within the report. First, we believe there would be great value from increased support for the health care facilitator programs on each campus. While I am aware UC is shifting to centralized models through service centers, health insurance is a most personal of benefits that often requires "high touch" and a sharp awareness of local issues. We believe the program offers great assistance in promptly resolving conflicts or process issues which otherwise may impede care. In addition, the programs assist in offering an overview of plans and can promptly respond to questions helping employees to select the plans best suited for their circumstances.

Secondly, the report also reflects much discussion of the appropriate role of UC Health within the UC health insurance program. During this process, UC Health leaders convened to develop principles on this matter. Our committee met with UC Medical Center CEOs on two occasions. I believe this served as a useful beginning of a much needed conversation, but as you'll note within our report, this matter is very complex and must be approached with great deliberation to avoid unintended consequences. While the committee supports objectives to make UC-based plans more price-competitive to allow employees and retirees to take advantage of UC's world class medical care, the strategies to accomplish this vary and we must be sensitive to those where price is a critical factor in their health plan choices. I admired the time and attention UC Health officials dedicated to this important issue. I am hopeful that our report thoughtfully articulates the various views and approaches on this matter for policy makers to consider.

When presented with the, um, *opportunity* to chair this committee, I was assured that adequate staff support would be provided. Such support exceeded all expectations. Much time went into this project. The directors from Human Resources and UC Health dedicated much time and talent to this effort. Legal and communications staff were engaged throughout. Executive leadership was also dedicated to a successful outcome. I would also like to acknowledge the ongoing engagement and commitment from the Academic Senate's Health Care Task Force. A special thank you from the entire committee and myself to Senior Program Manager Julian Ryu who was the ongoing staff member who kept this project not only afloat, but constantly sailing forward will some skillful tacking along the way. Julian brought just the right style for this task: pushing not shoving, patience with deadlines, and professionalism with kindness. He is an asset to the Office of the President.

I hope you will find the detailed discussion of health benefits useful and informative as you continue to manage this vast and complex program. Its importance is fundamental to the success of our faculty, staff and retirees.

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EXECUTIVE SUMMARY

BACKGROUND AND SCOPE

In May 2019, the Executive Steering Committee on Health Benefits (ESC) formed a systemwide Health Benefits Advisory Committee (HBAC) consisting of various stakeholders and guided by external consultants, to undertake a review of UC's health benefits programs and the various modes of delivery, plan design, and structure.

Following an evaluation of a Medicare Advantage PPO Plan Request-for-Proposal (RFP), HBAC began evaluation of the employee health benefits plans in August 2019 with the final report due October 2020. The final report contains recommendations and/or options for ESC consideration. The earliest any changes can be implemented is for calendar year 2022.

From its broad charge to "review UC's health benefits programs and the various modes of delivery, plan design and structure," HBAC identified "analysis areas" that appeared to have the best prospects for meaningful engagement. These analysis areas were addressed within the following four themes:

- *What Employees Pay and Why*

  The approach and rationale for determining the employee costs for enrollment in the different medical plan options made available to them.

- *Maximizing Portfolio Value*

  Examining the current medical plan offerings, potential alternatives, and how they may meet the desired distinct value propositions from employee and overall University perspectives.

- *Facilitating Member Engagement and Choice*

  How to maximize the value of UC medical benefits to employees by helping them choose the plan option that best fits their situation, and navigate the challenges of effectively using their plan to secure the highest quality and most cost-efficient care with the least difficulty.

- *Role of the UC Health Centers*

  The UC Health Centers deliver a significant portion of care to employees in the employee plans, and have custom arrangements with Blue & Gold and the PPO plans designed to mutually benefit employees and the University overall, including UC Health. HBAC explored objectives, options, and challenges in further expanding or diversifying the role of UC Health Centers in the medical plans.

Following an introduction and background, the report features a section for each analysis area beginning with a description of the current state followed by HBAC's assessment of identified options. The sections end with final HBAC recommendations and outcomes pertaining to the analysis area.

Analysis Theme 1: What Employees Pay and Why

Contribution Strategy and Methodology

CURRENT APPROACH

Contribution methodology refers to the method of determining what employees pay to enroll in the different health plans. UC's method is generally referred to as "managed competition," where the employee contribution is set based on a risk-neutral rate (the product of risk-adjusting the standard rate), with the employer contributing the same amount for each plan, and the employee paying the difference. Compared to other methods, this tends to increase the employee cost differential between high- and low-cost plans, encouraging enrollment in low-cost plans.

UC includes one major exception to this approach, applying a "minimum employee contribution" so that, if the contribution method would produce a plan contribution below the minimum (down to $0), the minimum would instead apply. Note that the Core plan is currently exempt from a minimum employee contribution.

UC's methodology is also characterized by a comparatively high subsidy of family members, and a pay-banding approach designed to adjust the cost of health plan enrollment based on the employee's UC income.

COMMITTEE DELIBERATIONS

Contribution Methodology:

- HBAC assessed the current managed competition model and explored potential alternatives. There was an ongoing philosophical debate on the employee contribution methodology that best achieves the ESC objectives – steering employees towards the lowest cost plan or to the UC Health System, which may generate a higher cost but provide benefits back to the University.

Contribution-Free plan:

- Employee contribution-free plans were discussed in two ways: 1) a plan that is intended to always be contribution-free; and 2) removal of the minimum contribution rule, allowing the contribution to reach its natural level, which may be $0, or more than $0 but less than the minimum.

- Arguments for maintaining the minimum contribution included the belief that pay-banding adequately protects lower-paid individuals, particularly when they enroll in HMOs, and that bearing some share of the health plan premium is a reasonable expectation.

- Arguments for removing the minimum contribution are that it is inequitable, providing less UC funding for someone who selects a low-cost plan, amounting to a "tax" on that enrollment that subsidizes enrollees in other plans, and that ultimately lowering the contributions would encourage more migration into the low-cost plan, which likely reduces University medical plan expense.

Family Friendly Subsidy:

- UC's basic policy of above-market contributions for dependents as an employment and social value is fully supported and not under reconsideration by the HBAC. At issue was whether to reduce the spouse subsidy on the basis that spouses often have their own employer coverage option, and that a large spouse subsidy causes spouses to select UC, switching the cost burden from their own employer to the University. There was not sufficient data regarding spouses with other coverage who opt for UC coverage. There was also no data to differentiate spouses by their circumstance in order to avoid the unintended consequence of making coverage unaffordable to a spouse with no other or poor options. The other issue is the degree to which individuals with or without children subsidize other employees' spouses.

Pay-banding methods:

- HBAC fully supports the purpose and general model of pay-banding. There was some exploration of interest in shifting the slope of pay-banded contributions to further benefit Pay Bands 1 & 2, or to reduce the negative impact on Pay Bands 3 & 4, improving benefit value and competitiveness for those groups.

RECOMMENDATIONS & OUTCOMES

Contribution Methodology:

- There is no consensus on whether to maintain the current contribution methodology or move forward with an alternative, and what that alternative might be. While many HBAC members believe the current methodology has historically and continues to serve the UC objectives, others believe that it may be time to re-examine the strategy and methodology given changes in the benefits portfolio and approach to risk, and that the current contribution method is complex, not intuitive, and layered with policies and practices. However, the current methodology has helped UC manage within its budget by successfully shifting more enrollment to low-cost plans. Different alternatives – assuming initial cost-neutrality for UC – shift costs to a certain segment of the population creating winners and losers. The two options modeled raised concerns from different Committee members. This is an area that ESC may choose to explore and model additional alternatives. There is consensus that if the ESC does choose to explore and model additional alternatives, they consult with stakeholders before they make any decisions on changes to the contribution methodology.

Contribution-Free plan:

While HBAC firmly agrees that affordable access to health care be provided to all employees, there was mixed opinion regarding contribution-free plans.

- There was insufficient support to recommend offering a plan contribution-free regardless of cost

- HBAC members disagreed on whether to recommend removing the minimum required contribution and allowing a plan to be contribution-free if it would reach that point through the contribution methodology.

  - Some HBAC members believe there should be no minimum *required* employee contribution; they assert that contribution-free plans should be allowed if their costs fall below the University's contribution derived by the contribution methodology. These members assert that keeping required minimum contributions will disadvantage lower income employees. Members that favor removing the minimum contribution believe the decision should be made independent of positioning of any plan.

  - Other HBAC members believe that employees should contribute to the cost even if costs fall below the University's contribution derived by the contribution methodology. These members assert that health care is an expensive benefit to the University and having some member financial responsibility is appropriate for all.

- The following concerns would need to be addressed before considering removal of the minimum:

  - Removing the minimum contribution while maintaining the rest of the model would heighten UC Health concerns that they would be less competitive (by lowering contributions for Kaiser)

  - Allowing HSP to be contribution-free would potentially attract those for whom the higher cost-sharing makes it a poor choice.

Family Friendly Subsidy:

- Ultimately, HBAC supports maintaining the current practice at this time. HBAC deemed modifying the subsidy as a future option if needed under the condition that:

  - Data analytics be explored to identify spouses with other coverage and to assess the subsidy's adverse impact to certain employee segments more likely to be single (such as employees under the age of 35).

  - Further assessment be conducted of the needs and preferences of a broader employee population that did not have representation on HBAC. The analysis should include implications of increasing the UC contribution to single employees and/or for coverage of children, and reducing the UC contribution for spouses.

Pay-banding methods:

- There was full support for the purposes and general model of pay-banding. There was little if any support to shift the pay band slope to improve competitiveness for pay bands 3 and 4. There was conceptual interest in lowering cost for pay bands 1 and 2, and/or fixing cost to a percent of salary. However, this would require shifting costs to higher paid employees, a change that wasn't seen as justified given relatively favorable current costs for pay bands 1 and 2.

Risk Adjustment

CURRENT APPROACH

UC employs a risk-adjustment model whose major components are age and sex, location, and a clinical risk factor derived from prescription drug data to create a risk score for each medical plan (except Core). There are two principle applications of the risk score:

- To create a "risk-neutral rate," essentially the rate that each plan would charge if UC enrolled the whole population (put another way, the average risk of the UC population). This risk-neutral rate is the basis for defining employee contributions, so the employee neither pays more for a plan that enrolls a higher-cost population (as with UC Care) or pays less for a plan that enrolls a lower-cost population (as with Kaiser).

- To establish a reconciliation payment each year, where plans whose relative risk increases during open enrollment (i.e., after they have set their rates for the coming year) receive a payment to correspond to their increased risk, and plans whose relative risk decreases contribute a payment. The reconciliation payments among the plans net to $0 each year.

Historically, this process of "paying plans for the risk they enroll" theoretically contributed to overall rate control by removing the practice of insured plans loading rates against the chance of seeing increased risk through open enrollment. With the movement to self/flex funding this value is now immaterial for a majority of the enrollment in the employee medical plans.

COMMITTEE DELIBERATIONS

- UC Health expressed interest in revisiting Risk Adjustment based on the following concerns: 1) it believes a clinical risk score based solely on prescription drug claim data inadequately reflects risk, understating it for the UC Health plans; 2) the reconciliation payments cannot be planned for, and are large amounts that can create funding challenges; 3) with UC carrying the risk of 3 of the 4 plans in Risk Adjustment since 2016, much of the funds movement due to reconciliation occurs between the self/flex-funded plans within UC.

- As a model that is applied based on relative risk among the plans, the essential requirement is the most equitable measure across plans, rather than the most accurate predictor within a given plan. While adding medical claims definitively adds to the ability to predict risk for a given population (even if medical claims capture is incomplete), it helps in relative risk scores only if data capture is comparable across plans.

RECOMMENDATIONS AND OUTCOMES

- HBAC generally supports certain principles of risk adjustment. HBAC recommends that employee contributions will continue to factor out the effect of the relative risk of the enrolled population – i.e., will not pay more if less healthy members enroll in their plan, or less if healthier members enroll in their plan. This is accomplished through a credible, industry-accepted risk adjustment methodology as used today.

- HBAC recommends Human Resources and UC Health examine options that include medical claims in clinical risk adjustment and to assess risk adjustment reconciliation.

Analysis Theme 2: Maximizing Portfolio Value

COMMITTEE DELIBERATIONS

- The committee examined each plan individually, and also explored different illustrative portfolio "packages" around designated themes or objectives, e.g., prioritizing channeling to UC Health Centers or moving to all high-deductible plans.

- An evaluation of the current employee plans (UC Care, Blue & Gold, Kaiser, HSP, Core) generally affirmed the value proposition each brings to the portfolio. Overall, after extensive discussion of the plans and alternatives, HBAC expressed little appetite to make large changes.[1]

- Portfolio Packages and new plan models:

    - HBAC examined options to fundamentally reshape the portfolio over three different meetings. The combination of uncertainties, limited data, and anticipated downsides combined with a lack of compelling alternatives lead to a conclusion to maintain the basic components of the current portfolio.

    - Hypothetical plan options were discussed to enhance UC Health's competitive position within the portfolio.

    - The "Navigator" model is a newer plan concept that centers on concierge level service and clinical care decision support for members. The objective is to improve experience with the self-funded health plan and lower cost through a "right-time, right-place, right-care" approach to addressing medical needs. HBAC discussed the Navigator's value proposition, and how it could address some needs of UC Care and HSP. There is awareness that some of the Navigator functions may need to be customized to avoid overlap with UC Health's role in assisting members with provider search and care advice and direction. The "one-stop-shop" value of the Navigator would also need to be coordinated with the Health Care Facilitator role.

RECOMMENDATIONS AND OUTCOMES

HBAC finds that while individual plan improvements should continue to be sought and made, there is neither the burning platform of failing plans nor a clearly articulated new portfolio with high confidence of a transformational advance and tolerable levels of disruption.

Key incremental recommendations are summarized below:

- Portfolio: Without a perceived urgent flaw requiring change in any of the existing plans, moving forward with a completely new portfolio hinged on a compelling argument for some fundamentally new plan or approach. For the near term, HBAC recommends proceeding with a "Modified Status Quo" portfolio, maintaining the existing plans with design, network or capability (e.g., care support) adjustments as deemed appropriate by ESC.

[1] Discussions focused on employee health plans. There remains a need for analysis with the Medicare and non-Medicare plans within the retiree portfolio.

    - Going forward, HBAC recommends restricting the Core plan to employees who are otherwise ineligible for full medical plan offerings; this would include part-time employees (17.5 to 22 hours).

- UC Health Exclusive Provider Organization (EPO) plan: Advanced as a potential option for UC Health to have full control of design, features and pricing in order to compete unencumbered by the cost of external providers, this was ultimately not embraced systemwide at this time by UC Health as presented to HBAC and consideration as a potential recommendation was deferred until further analysis can be undertaken. UC Health may consider proposing an EPO as a local level pilot in the future.

- Navigator model: Some HBAC members consider this to be a plan approach with strong value-add potential and little downside risk, although the concept may not be fully understood. The navigator model would serve as a feature within the health plans and be distinct from the services of Health Care Facilitators. Some members seek assurances that a navigator approach does not create additional confusing or conflicting bureaucracy when coupled with the Health Care Facilitators. The navigator approach aligns better with PPO models, so it is considered a possibility for UC Care and HSP, but not for the Blue & Gold plan.

- Health Savings Plan: HBAC recommends maintaining the plan in the portfolio with enhanced employee support and education. The plan meets the needs of many at a lower cost to themselves and the University. Given modest but consistent enrollment growth over time, questions about the future of UC Care, and the value of retaining the plan to the members currently enrolled, it appears to be in UC's interest to maintain the plan in the portfolio. Enhanced service and care-seeking support through concierge/navigator functions overlaying HSP could make it more attractive to members.

- Out-of-state/international coverage: HBAC recommends that options be considered to allow members at a reasonable cost to maintain their HMO enrollment and provide out-of-state or international health plan coverage.

- Kaiser plan: HBAC recommends keeping Kaiser in the UC portfolio.

Analysis Theme 3: Facilitating Employee Engagement and Choice

COMMITTEE DELIBERATIONS

Employee engagement refers to the level of understanding and interaction that employees have related to their medical plan. An engaged employee group understands what choices they have, selects a plan that best fits their personal needs, and knows how to optimize their plan when health needs arise.

HBAC discussed several areas related to engagement including how well employees currently understand their options and what resources were currently available to help educate them on the plans.

Specific options and methods examined by the committee included:

- Plan Selection Tools and Information: Today, the University offers a robust website to assist members. While the current website provides detailed information on the health plan options, it does not provide personalized help for plan selections. HBAC did express interest in the introduction of more advanced analytical tools to help employees make optimal choices.

- Navigator / Advocacy Models to Improve Plan Utilization: Recognizing that health care is complex and members need more guidance on how to access care and make best use of their benefits, HBAC discussed several options including expansion of the current Health Care Facilitators (HCF) and the potential for navigation or advocacy vendors that engage employees.

RECOMMENDATIONS AND OUTCOMES

HBAC recommends that the University take a more proactive approach to facilitating employee choices that better align their circumstances with best-fit plan selection. To do this:

- HBAC strongly recommends substantial expansion of and investment in the current Health Care Facilitator program, including increased publicity and additional resources.

- HBAC recommends that HR continues its efforts to move forward with the revamping of the benefits site, particularly if any portfolio changes are implemented with input from UC Health on content and design to be approved by ESC.

- HBAC recommends UC explore use of a plan selection tool during 2021 (for 2022 plan year) to help employees determine which plan is best for their personal situations, including more advanced tools that allow individual input of individual circumstances, preferences and utilization patterns to promote data-driven feedback and suggestions. Tools and information to enhance plan selection should be aligned with a clear approach for UC Health objectives.

Analysis Theme 4: Role of the UC Health System

CURRENT APPROACH

- Beginning with the 2011 introduction of Blue & Gold, continuing through the introduction of UC Care in 2014 and the development of UC Health ACO that now bears full risk for its share of Blue & Gold membership, UC has migrated from a model where the University and UC Health largely regarded each other as any other employer and any other provider, to one where the interests have become more aligned for the common benefit of all.

- Through the narrow-network HMO and the favored Tier 1 of UC Care, the share of provider payments to UC Health has increased from 20% to 30% while available at just half of the campuses. Generally, this approach has been financially viable to UC Health, as it has taken on risk within the Blue & Gold plan through its ACO.

- By discounting its reimbursement below its commercial Health Net and Anthem rates, UC Health has helped to maintain moderate overall rate increases for the UC plans, largely achieved without cost-shifting through increased deductibles and copayments.

COMMITTEE DELIBERATIONS

- At the August 2020 HBAC meeting, UC Health provided a 5-year vision and roadmap with proposed tactics to improve employee access, manage employee contributions, efficiently deliver quality care, promote UC health plans to employees, and optimize the Kaiser relationship.

- UC Health expressed great interest in taking care of our employees. Measurement of service, quality and value, including expanding access at current locations and ultimately to all campus locations, will be made readily available to all stakeholders.

- Where the efforts of UC Health are clear gains for employees, HBAC support is universal: expanding access, innovations in care, quality and service, and moderating reimbursements.

- Much of the discussion of capturing a larger share of UC patient care was focused on Kaiser. Approaches to migrating enrollment centered on the relative cost positions. Additionally, there was much interest in repatriating care that Kaiser commonly directs to external providers for care they do not provide themselves, often tertiary/quaternary care, to UC Health rather than other competitors such as Dignity.

- There was extensive discussion on how to steer employees to select UC health plans to enable greater use of UC providers. There was disagreement on whether increasing enrollment costs for Kaiser or limiting provider choice would be acceptable outcomes.

- UC Health provided information about UC Health Centers' funds transfers to other parts of the University and its cost of supporting underfunded care in the community. This opened discussion around a wider view of cost that would account for the value of keeping medical dollars within UC for care delivered by UC providers.

- HBAC discussed the potential for piloting plan options, designs or programs in a given location, either to demonstrate an opportunity for systemwide application, or to address a distinct market need in a single location. UC Health suggested pursuing pilots to identify paths to expand affordable access to employees. UC Health also believes it should explore and pilot changes on a local basis to enhance the attractiveness of the self-insured plans for employees while minimizing any disruption to employees or UC as an employer. HBAC debated the merits of maintaining an equity principle if UC were to pursue pilots.

- In response to UC Health's proposal to self-fund Kaiser and the value of doing so, Human Resources expressed concerns that without further analysis: 1) there is no indication that this would lower plan costs and it may raise them; 2) this has not been an attractive product in the market and is mostly tied to the option of a high-deductible plan; 3) Kaiser admits its self-funding model has challenges and doesn't promote it; and 4) as a closed model, Kaiser is unlikely to grant access to levels of data or discretion over care management and external referrals that differ from its standard practice.

RECOMMENDATIONS AND OUTCOMES

- HBAC fully agrees with efforts of UC Health to extend access to all UC campus employees across the 10 campuses, especially those who live where market conditions limit choice or access within the community. UC Health will work with the affected locations on priorities, plans, and timing.

- HBAC recognizes UC Health's desire to deliver care to a greater share of the UC employee population. Some HBAC members have concerns on achieving this, however, by limiting provider choice and any action to do so should consider disruption to plan participants. A majority of HBAC members also were not supportive of an approach to shift cost to Kaiser enrollees.

- To provide UC's Kaiser enrollees with greater access to UC Health's distinguished level of care (specialty, tertiary/quaternary), HBAC recommends seeking negotiation with Kaiser to send its UC members to UC Health providers for the services that are not done within the Kaiser system. Most HBAC members recommend the following conditions: no increase in the Kaiser premium for UC resulting from this policy and no substantial burden on the patient.

- HBAC supports the continuation of offering medical benefit equity across locations. While UC offers all employees access to the same plans when possible at the same costs, in reality not all employees live in an area with equal access to providers. The options for local healthcare vary considerably across campuses; as a result, campuses can incur different costs towards medical health benefits. At the same time, there is value in innovation, creating demonstration projects or testing new options or variations in specific locations before a systemwide launch. There may also be the need to introduce a solution for a specific location to address an issue or opportunity that is unique to a given location, especially at under-served campuses. Upholding an equity principle should be undertaken in a manner that maximizes positive outcomes for a particular location. While some members expressed support for pilots, others need to better understand details and criteria of pilots before endorsement by ESC.

- Some HBAC members support an ESC-sponsored study by an independent third party to assess the impacts of retaining premium dollars within the UC Health System. Other HBAC members do not believe there was enough discussion or understanding of the objectives to support the study. If a study were pursued, HBAC believes that ESC should draft the charge and choose the third party. HBAC recommends that the study include broad University input and have a transparent approach.

INTRODUCTION

CHARGE OF THE HEALTH BENEFITS ADVISORY COMMITTEE (HBAC)

The University of California recognizes that its comprehensive health benefits are highly valued by employees and retirees, and understands the critical role these benefits play in overall employee compensation, recruitment and retention. Providing quality health benefits and keeping them as affordable as possible for employees and retirees — as well as UC — is an important part of our long-term strategic planning.

The University has maintained a wide range of health benefit offerings while covering more than 80% of the $2.39 billion total cost of medical benefits anticipated for 2020 for UC faculty, staff and retirees during a dramatic rise in care costs and budget uncertainty. Ongoing external cost increases and a changing employee and retiree demographic profile pose potential risks to the long-term viability of our current health benefits portfolio. These factors require proactively evaluating our programs while balancing coverage and affordability for employees and retirees at all income levels; differentiating from organizations with whom we compete for talent; and leveraging the strength of UC's own health care system, where appropriate, among other priorities.

In October 2018, within its final report, the UC Health Restructuring Advisory Committee (commissioned by the UC President) suggested that the President undertake an evaluation of the University's employee and retiree health benefits and included the following statement in its report, *"It is beyond the scope of the Committee's charge to evaluate the plan structure and offerings of University employee health benefits; the Committee nevertheless believes that a thorough evaluation of the University's approach to employee health benefits would be timely and important."*

The President accepted the committee's recommendations and charged the University's Executive Steering Committee on Health Benefits Programs (ESC)[2] to undertake this work. The ESC then formed a systemwide Health Benefits Advisory Committee (HBAC) consisting of various stakeholders and guided by external consultants, to undertake a review of UC's health benefits programs and the various modes of delivery, plan design and structure to make recommendations to ensure their overall attractiveness and affordability.

HBAC launched their work in May 2019 starting with an evaluation of a Medicare Advantage PPO plan RFP. HBAC then began evaluation of the employee health benefits plans in August 2019 with this final report completed in October 2020. The final report contains recommendations and/or options for the ESC to consider. The earliest any changes would be implemented is for calendar year 2022.

HBAC SCOPE AND METHODOLOGY[3]

[2] The role of the ESC is explained in the Health Plans & Administration section

[3] Given the evaluation of retiree health issues in the 2018 Retiree Health Benefits Workgroup, and the 2019 implementation of the Medicare Advantage PPO plan at significant savings, the focus of HBAC was placed on the plans for employees. This does affect the non-Medicare retirees who share the same benefit plans, but for simplicity we refer only to employees throughout the report.

The scope of the HBAC report is to assess the following broad areas for options and/or recommendations:

- UC's current medical benefit plans for employees and various health benefits models
- Current methodology for employee contributions and rate setting, including risk adjustment
- Relationship with UC providers
- An overall strategy for sustaining quality employee health benefits into the future

In February 2020, HBAC established a more granular set of analysis areas to assess for the final report shown below in Table 1.

TABLE 1

Theme	Analysis Area
What Employees Pay and Why	Risk adjustment
	Family friendly subsidy
	Contribution methodology
	Pay-banding methods
Maximizing Portfolio Value	Optimizing portfolio options to UC employees
Facilitating member engagement and choice	Optimizing member choices and communications
Role of UC Health Centers (UCHCs)	Role of UC providers to employee health benefits

BACKGROUND ON UC HEALTH BENEFITS

Health Benefits Administration and Governance

Effective January 1, 2017, the UC President designated authority as plan administrator of UC's Health Plans to an Executive Steering Committee on Health Benefits (ESC).[4] The ESC meets monthly and consists of the Executive Vice President of UC Health, the Chief Operating Officer, the Chief Financial Officer, a representative of the President, and a representative of the Academic Senate.[5] The Deputy General Counsel for Health is a non-voting member. The ESC has established objectives to serve as the basis to make decisions related to employee and retiree health benefits. As such, the ESC will apply these objectives in assessing Committee recommendations:

- Offer high-quality benefits that support UC's employee attraction and retention goals. Benefits should be competitive with those offered by leading national universities and large California-based health systems.
- Provide choice in benefit plan offerings and support employee decision-making and plan selection through simplicity and effective communications.

[4] Plan administrator authority prior to January 1, 2017 was held by Systemwide Human Resources

[5] Chair of ESC rotates between the Chief Operating Officer and EVP of UC Health every two years.

- Provide affordable options for all covered groups. Promote affordability, accessibility and quality in our health plan offerings.
- Manage UC costs proactively to achieve financial targets. Annual increases to the overall budget for health benefits should not exceed 4%[6], while providing improved predictability to UC for premium increases, and to employees and retirees for premium contributions.
- Enhance University control over benefits offered to employees and retirees through negotiations with vendor partners, through the decision-making process of plan governance, and by self-funding benefit plans as appropriate.
- Facilitate and support the use of UC Health providers to provide high quality/cost effective care. UC Health's participation in the UC health plan offerings furthers the research, teaching and service mission of the University.
- Adopt and integrate innovations as a means of continuously improving the quality of UC's health plans. Innovation can also control cost growth while enhancing the health, well-being and engagement of UC employees, retirees and their families.

While the ESC holds decision-making authority, the Benefits Program & Strategy department within systemwide Human Resources manages the overall portfolio, including benefits compliance and policy, eligibility, overall benefits portfolio financials, including budget implications, employee premium contribution calculations, risk adjustment, open enrollment and employee communications. The portfolio currently consists of self-funded and insured plans. UC Health administers the self-funded plans. Systemwide HR oversees Group Insurance Regulations (GIRs) and other HR components for the self-funded plans. Financial accounting is managed by the systemwide Controller. *Appendix A* provides a summary of benefit plans as of May 2020. Table 2 illustrates how the responsibilities for benefits plan management are organized, and are described in greater detail below.

TABLE 2

UC Health (Plan Administrator)	UC Human Resources (Employer)	UC Financial Accounting (Controller)
• Member Communications • Member/Customer Service • Plan Management, including premium development, actuarial analyses and clinical oversight • Provider Network • UCMC Coordination • Vendor Administration	• Employee Communications • Benefit Portfolio Management, Policy, and Compliance • UC/employee contribution strategy • Provider Network Input and Feedback • Employee Experience Management • Financial, administrative and vendor oversight for fully-insured plans	• Financial Management and Reporting • Financial Accounting Policy • Financial Audit Coordination and Internal Controls

[6] 4% is per capita and not for overall budget

Since 2014, the University has self-funded UC Care. The Core and HSP plans were added to the self-funded portfolio in 2016. In 2019, the University adopted a flex-funded health plan model for UC Blue & Gold HMO. The University moved to self-funded plans in order to:

- Provide affordable, predictable year-over-year premium increases
- Ensure consistent inclusion of UC Health Centers in benefit design
- Keep money spent on health services within the UC system
- Provide an opportunity for UC providers to manage financial risk in the interest of the University
- Maintain control of plan designs, member experience and pricing
- Save on the premium tax that is charged on fully insured plans

For self-funded plans, UC Health is responsible for plan management, financial performance of the plans, plan design and rate development, provider network, UCHC coordination and plan member communications and overall member experience with the plans. The flex-funded plan, UC Blue & Gold HMO, is jointly administered by UC Health and HR, with UC Health responsible for managing the Accountable Care Organization (ACO), financial performance, rate-setting, and network management.

At the time UC Health assumed responsibility for plan administration of self-funded plans, EVP Stobo committed to the President annual premium rates would increase no more than 5%. After right-sizing of the premium in 2015, increases have been at or below this rate. Taking on risk for the health care of a defined population via the self-funded plans encourages the health centers to focus on keeping employees and their families healthy, improving medical outcomes, and operating efficiently to keep costs down.

Current Design Principles

The current health benefits portfolio has evolved through application of principles over the past several years (as shown in Table 3). Until articulated for the committee, these principles had not been formally documented or codified — however, the HR Benefits Program and Strategy team have applied them to guide portfolio decisions over the past decade. While these design principles have served to formulate and manage the health benefits portfolio, the ESC objectives serve as the basis for the ESC to make decisions. These design principles should be reviewed and aligned with the ESC objectives.

TABLE 3

Family Friendly: Provides affordable health plan coverage for the dependents of faculty and staff.	**Choice of Plans**: Employees and retirees have choice of multiple plan offerings.
Affordability and Protection for Lower-Paid Employees: Affordable – from the perspective of the employee/retiree. Protections are in place for those at the lower end of the salary distribution.	**Unique Value Proposition:** Each plan included in the health benefit portfolio has a specific and distinct value proposition. To meet the varied needs of a very diverse population, the portfolio includes plans with distinct plan design and delivery variations.
Everyone Contributes: UC faculty, staff, and retirees should participate and pay something towards their health care coverage.	**Access to UC Providers:** All non-Kaiser health plans list UC Health Centers in their network offerings. Employees and retirees have access to UC health providers if they are within the geography of a health center.
Cost Control for the University: The University sets the overall annual budget increase for health plan premiums at 4%. Costs for the portfolio and for each plan must be predictable and sustainable. Plan premiums must be priced according to the underlying cost of the provider network; no plan can exist at a low premium for a high-cost provider network.	**Managed Competition; Level Playing Field**: Employees and retirees are encouraged to select the most cost-effective plan for their needs. Risk premium adjustments are performed to remove adverse selection from a particular plan. Health plan carriers participate on a "level playing field." Carriers are not penalized for enrolling high-risk members into their health plans. Self-funded plans must be sustainable for the University and affordable to employees/retirees.
Consistency Across Campuses: All members, regardless of campus affiliation or location, have access to the same plan offerings and high-quality providers, at the same employee contribution rates. UC averages cost from all areas to come up with one rate.	**Simple for Employees and Retirees to Understand:** Health plan portfolio and choices among plans should be simple to compare and select (communications should facilitate informed choice).

In addition to the current design principles, other distinct features and trends of the UC health benefits portfolio are worth noting:

- **Pay-Banding** — UC adopted pay-banding to protect lower-compensated employees after the introduction of contributions for all plans (except Core). UC was an early adopter of this approach.
- **Risk Adjustment** — Risk adjustment was implemented to create a more level playing field for plans to compete. In other words, risk adjustment ensures that a plan is not priced higher because its subscribers have more costly and complex health issues. UC was an early adopter of this approach at the request of faculty.
- **Health Maintenance Organization (HMO) Enrollment** — As of March 2020, 77% of employees enrolled in HMOs, UC's HMO enrollment percent is high even by California standards.

Pay-Banding at UC

Pay-banding promotes affordability for lower-paid employees. Employee premium contributions are determined by annual salary: Pay bands 1 & 2 are subsidized by pay bands 3 & 4. The following reflects 2020 ranges:

Pay Band 1: $58,000 and under
Pay Band 2: $58,001 to $114,000
Pay Band 3: $114,001 to $171,000
Pay Band 4: $171,001 and above

Risk Adjustment Explanation

Risk adjustment is a process to adjust premiums by removing adverse selection from plans. Contract rates are set based on claims experience each year, either by Kaiser, as a fully insured plan, or by UC in consultation with Health Net, Anthem and outside actuaries for the other plans. UC then calculates a risk score for each plan based on pharmacy use, demographics and geography. Using the risk scores from each plan, UC converts the contract rates to risk neutral rates. UC contributions are then applied against the risk neutral rates to derive the employee contribution amount.

- **Collective Bargaining** – Nearly half of UC employees are represented by unions; UC strives to keep costs and benefits the same regardless of bargaining status. When a contract is open, contributions are held at prior year rates. Some unions negotiate maximum permissible contribution increases for certain plans which can cause differences in premium rates.

- **UC Health** – University health providers deliver a substantial share of the covered medical care for the UC population. UC Health has sought an increasing role in the management of benefits and alignment with UC Health interests.

Current Health Benefits Plan Portfolio

The current health benefits plan portfolio is outlined below in Table 4.

TABLE 4

Plan Name	Plan Type	Value Proposition
Kaiser Permanente	HMO	• Coordinated care managed in partnership with Kaiser PCP • Kaiser network of providers and facilities, with a focus on preventive care and wellness • Low monthly premiums and low, predictable out-of-pocket costs
UC Blue & Gold HMO	HMO	• Coordinated care managed in partnership with PCP, including UC providers (depending on region) • Network of specialists and facilities customized for UC, including UC health centers (depending on region) • Moderate monthly premiums and low, predictable out-of-pocket costs
UC Care	PPO	• Access to in and out-of-network providers, including international coverage while traveling and coverage for dependents who live outside California • UC Select network of UC providers and facilities (depending on region, with selected non-UC providers near UC campuses without a UCHC) • Higher monthly premiums and low, predictable out-of-pocket costs for UC Select providers (higher costs for out-of-network care)
UC Health Savings Plan (HSP)	PPO	• Access to in and out-of-network providers, including international coverage while traveling and coverage for dependents who live outside California • UC and employee pretax contributions to portable Health Savings Account, with option to invest HSA funds for long-term, tax-free growth • Low monthly premiums and higher out-of-pocket costs
CORE	PPO	• Access to in and out-of-network providers, including international coverage while traveling and coverage for dependents who live outside California • Coverage designed to offer protection for an expensive or catastrophic event • No employee contribution in exchange for a high deductible and higher out-of-pocket costs

Previous Health Benefits Initiatives and Projects

Past systemwide initiatives to review employee and retiree health benefits have preceded the formation of HBAC: The President's Task Force on Post-Employment Benefits (PEB) and the Retiree Health Benefits Workgroup (RHWG). These initiatives identified health benefits issues with outcomes that have informed HBAC and its current charge.

President's Task Force on Post-Employment Benefits

From 2009 into 2010, UCOP conducted a broad consultation with the University community and an extensive review by the President's Task Force on Post-Employment Benefits (PEB) driven by concerns of an increasing unfunded liability. The recommended changes to the University-sponsored retiree health program were adopted by the Board of Regents on December 13, 2010[7]:

- Lower the University's aggregate annual contribution towards retirees' total premiums over time to a floor of 70%.
- Implement a new eligibility formula applicable to all employees hired on or after July 1, 2013, and non-grandfathered UC Retirement Plan (UCRP) members employed prior to that date.

In addition to changes in the retiree health programs, the Regents also changed pension benefits at the December 2010 meeting. Most significantly, the Regents approved the establishment of a new tier of pension benefits applicable to employees hired or rehired on or after July 1, 2013, which would increase the early retirement age from 50 to 55 and the maximum age factor from age 60 to 65. In addition, UCRP members hired on or after July 1, 2013, pay 7% of covered compensation.

Retiree Health Benefits Workgroup (RHWG)

Beginning in 2010, the University changed its contribution policy for retirees such that the University contributions for retirees would no longer be tied to the contributions for employees in Salary Band 2. Instead, the University introduced distinct UC maximum contribution levels for retirees (separately for Medicare and non-Medicare retirees). Pre-2010, the University paid roughly 92% of retiree health premiums; however, beginning in 2010 the UC contribution averaged 89% to align more closely with the percentage the University contributed for active employees (in 2010, 87.7%). This policy change was due to the UC budget situation and the financial reporting obligations of the post-employment benefit.

Since these PEB changes were made in 2010, the University has continued to explore further modifications to retirement plan benefits to ensure that benefits are market-competitive and cost-effective.

In January 2018, in response to continuing concerns about benefit sustainability in the face of projected rising costs and liabilities, the UC President formed the Retiree Health Benefits Working Group. The charge to the Working Group was to explore potential strategies to ensure the long-term financial viability of the retiree health benefits programs.

[7] Meeting minutes from 12/13/2010 meeting can be found on the link below.
https://regents.universityofcalifornia.edu/minutes/2010/joint12.pdf.

In June 2018, the Working Group recommended modifying contributions of non-Medicare retirees over 65; however, the group made no other recommended changes to retiree health benefits in 2019. The Working Group did recommend continuing to meet in order to address mid- to long-term strategies.

In October 2018, the UC Health Restructuring Advisory Committee (commissioned by the UC President) recommended that the President undertake an evaluation of both the University's employee and retiree health benefits.[8] The President approved the recommendation.

In January 2019, Systemwide HR, with the approval of the ESC, launched a Request for Proposal (RFP) to explore the possibility of converting one or more retiree health plans to a Medicare Advantage PPO. The purpose of the RFP was to validate the savings modeled on the existing Medicare programs in order to address higher increases in the retiree health program. At the onset of the RFP, select UC Health, Academic Senate, and retiree association representatives participated in the RFP evaluation process.

In May 2019, the chair of the ESC formulated HBAC inclusive of Retiree Health Working Group members and new members to provide advice on the RFP process and then once complete, to address broader employee and health benefits programs expressed in this report.

HBAC First Charge - Medicare Advantage PPO RFP Evaluation

HBAC held its first three meetings in May and June 2019 to evaluate retiree health plan conversion options resulting from the Medicare Advantage PPO RFP. HBAC concluded that there were two viable options to present to the ESC regarding the RFP: 1) Replacing Health Net Seniority Plus only and 2) Replacing High Option, Medicare PPO, and Seniority Plus. On July 24, 2019, the ESC approved replacing Seniority Plus only with a new Medicare Advantage PPO to be administered by UnitedHealthcare.

The new Medicare Advantage PPO — UC Medicare Choice — yielded an enrollment of 16,054 (including dependents) for the 2020 calendar year. 9,728 retirees defaulted to UC Medicare Choice from Seniority Plus while 1,355 retirees elected UC Medicare Choice.[9]

HBAC Employee Health Benefits Project Approach

Having identified the broad "analysis areas" noted above, HBAC sought to bundle and sequence the discussion of issues so that they may be handled deliberately, and as comprehensively as possible in the time allowed. The approach has been to frame issues with the current objectives, methods to reach those objectives, and results of those methods. HBAC then proceeded to identify concerns or opportunities with the current benefits program and to explore alternatives. The intent has been to narrow focus on more promising alternatives and proceed toward direction on recommendations and/or options the Committee ultimately agrees have merit.

[8] The Health Benefits Restructuring Committee's recommendation in their report used the following language: *"It is beyond the scope of the Committee's charge to evaluate the plan structure and offerings of University employee health benefits; the Committee nevertheless believes that a thorough evaluation of the University's approach to employee health benefits would be timely and important."*

[9] 1,037 migrated from UC Medicare PPO, 181 from UC High Option, 122 from Kaiser Senior Advantage

HBAC Final Report Structure

The final report is divided into four sections

1. What employees pay and why
2. Portfolio optimization
3. Facilitating employee engagement and choice; and
4. The role of the UC Health System

Each section begins with HBAC's recommended next steps followed by a description of the current state and HBAC's assessment of identified options.

WHAT EMPLOYEES PAY AND WHY

Contribution Strategy and Methodology

CURRENT STATE

"Contribution Strategy" refers to the method chosen for determining employee contributions in order to achieve certain objectives — e.g., equity and cost control. The strategy can change as objectives change, or if the strategy is not meeting objectives. The University's current medical plan contribution strategy is built on a concept called "managed competition." The intent is for health plans to compete for enrollment through an attractive combination of benefit value and low price, with Risk Adjustment intended to contribute to a level playing field.

The University's current contribution strategy is defined by the following elements:

- **Managed Competition.** This approach is designed to work with a portfolio of plan options where the employer contributes up to a designated threshold amount, and employees choose their plan and pay the difference for higher-cost plans. The purpose is to manage the University's costs and encourage enrollment in lower-cost plans.

- **Minimum Contribution.** UC asks all employees to pay something for their coverage, on the premise that fiscal responsibility calls for some sharing of costs and risk on the most expensive employee benefit, and that committing to a free plan involves committing to fully absorb unpredictable rate increases into the future.

    - The Core plan is an exception to this and many other features of the UC health benefits program. See an explanation of this under "Portfolio Optimization — Current State."

- **Pay-Banding.** As a correlate to the Minimum Contribution principle, UC recognizes that employees' ability to pay varies greatly by their income, and so structures the contributions to require more from highly-paid and less from lower-paid employees.

- **Risk Adjustment.**[10] From a contribution perspective, the purpose of Risk Adjustment is to remove the relative risk of other enrollees from any individual's cost to enroll in their preferred plan. By basing employee contributions on the Risk-Neutral Rate (rate that would apply if all UC employees selected any single plan), the employee's contribution reflects the risk of the entire UC population, but not the relative risk of those enrolling in any given plan. This also helps to keep any single plan from experiencing a rate spiral where high-risk enrollment drives rates higher, causing lower-risk employees to leave and rates to go higher, to the point where the plan cannot be sustained.

    - UC employs Risk Adjustment for two major purposes: 1) to remove the effect of higher- or lower-risk enrollment on the employee's contribution; 2) to adjust payments to the health plans proportionate to the increase or decrease in risk that they experience through open enrollment after their rates were set. Both effects are

[10] Note that the next section of the report goes into a deeper review of the UC Risk Adjustment methodology including an assessment of potential options and proposed direction.

intended to preserve the ability to maintain a choice of different plan types and benefit levels.

- **University Budget Management.** Under the current contribution methodology there have been two approaches to UC's budget management:

    - Initially, UC's annual increase was based on a target-plan methodology: UC paid the same average percentage of the "low-cost statewide HMO," and this largely determined its annual expenditure.

    - Currently, UC adopts a "budget-first" approach, where overall health plan premium increases are capped (typically 4%). If the budget is exceeded, UC first funds the cost of the minimum-contribution plans, then the remaining available funds go toward increasing the UC maximum contribution or 'UC Max'. If the overall costs come in under budget, then UC essentially follows the earlier "target-plan" approach.

- **Statewide Equivalence.** Employee contributions are the same for all plans in most cases, regardless of location. The geographical variance in cost is averaged out for all locations, as is variable location experience (higher or lower than average).

    - Location costs vary by the mix of enrollment in that location — e.g., if they have more or fewer enrollments in high-cost plans or high cost providers, or a different mix of family enrollments. Locations without access to Kaiser have a greater mix of enrollment in higher-cost plans.

- **Funding.** The contribution strategy is agnostic as to whether a health plan is insured, insured with a risk-sharing arrangement, or self-funded. All plans are considered separately, and all rates, whether insured premiums or self-funded accruals, are treated equally. The contributions drawn from employees and locations represent a hard transfer of dollars whether for insured or self-funded plans.

    - The mix of insured, insured risk-sharing, and self-funded arrangements has changed significantly since 2014, with a shift toward self-funding. UC increasingly has favored taking on the risk for plan performance, rather than the fixed cost of insured arrangements.

- **Collective Bargaining.** The University fundamentally seeks to apply the same contributions to represented and non-represented employees. There are two general exceptions:

    - Certain unions have negotiated maximum increases in employee contributions, which have predominantly been no more than $25 / month (regardless of coverage tier) and attached to Blue & Gold and Kaiser HMOs only. This threshold has rarely been activated. However, recent new contract agreements include a threshold of no more than $10 / month, which is more likely to be reached.

    - Where a union contract is "open" — no new contract signed after the expiration of the prior contract — that union's members remain under the contributions that applied in the final year of their prior contract (referred to as "dynamic status quo"). As a point-in-time example, as of January 2019, 56% of represented employees were paying pre-2019 contributions.

Results

This approach has delivered on the UC objectives that underlie the model:

- Enrollment has steadily shifted toward Minimum Contribution plans, resulting in significant University savings. In 2018 alone, the savings to UC of this enrollment shift was $128M/Contract Rate basis (or the actual rates paid per the contract for each plan), $58M/Risk-Neutral basis (or the rates after they've been adjusted for risk)[11]. Lower-cost plans cost employees less as well, so this shift has also reduced the contributions of employees who select the Minimum Contribution plans.

- The model has been accepted by UC's unions as an objective method for defining costs and one that offers additional financial protections to lower-paid employees.

- While specific options have changed, UC has maintained a diverse portfolio with stable enrollment.

HBAC ASSESSMENTS AND OPTIONS

Observations and Opinions on Current State

The current managed competition model results in lower costs to enroll in Kaiser than in a plan that offers access to the UCHCs (with the exception of HSP, where the high deductible limits the plan's enrollment). This influences enrollment away from the UCHCs and toward Kaiser, and reduces revenues recirculated within the University, which are concerns for UC Health.

Managed Competition Model Observations

HBAC accepts the funding data provided by UC Health to illustrate the campus and public health financial support. However, there remain questions that affect the ability of HBAC to suggest actions or responses to this data.

- UC Health does not yet have a specific proposed recommendation in front of HBAC – how this information leads to action that would, from UC Health's perspective, level the playing field in plan cost and contributions.

- UC Health made statements about the competitive landscape not being a level playing field because Kaiser does not carry its fair share of Medi-Cal or uncompensated care. Another example of this is Kaiser closing some outpatient clinics during the spring as the biggest financial hits were happening to UC Health who had to keep all facilities open and staffed. Some members of HBAC believe that it is an issue of California public policy if Kaiser is bearing a lower burden of public health support, not something that should be resolved through the UC Health plans, particularly if employee contributions are being used to subsidize the cost.

- UC Health advanced an objective to have Blue & Gold contributions at or below the Kaiser level "over a period of time" without increased cost to locations ("Create an employee contribution strategy that encourages employees to enroll in plans with UC providers

[11] Risk Adjustment definition on page 20 explains Contract rates versus Risk-Neutral rates

without raising cost to the University"). This would be achieved by a combination of reduction in cost for services delivered (both UC and non-UC providers), benefit design changes, and changes in employee contributions that would likely increase the cost to Kaiser members over a number of years. There would be winners and losers in changing the contributions even if done over a period of time and the impact of this will need to be studied further. While executing this over time would lessen any sharply perceived changes by employees, it appears that the end-state would ultimately be the same – i.e., employees paying less to enroll in a UC Health plan not because it costs less, but because it makes greater use of UC Health providers.

- The current approach treats all premium dollars as equal expenses without distinguishing those funds returned to the University as payments for medical services by UC providers.
    - No clear metric has been advanced to date for valuing this recycling of dollars to the University generally, or individual campuses specifically. More research needs to be done if this is to be used as a specific factor in determining employee contributions.
- The Minimum Premium policy is a subjective determination that adds cost to people enrolling in the most cost-effective plans (Kaiser and HSP), denying them the full UC Max contribution provided to other employees. Their contributions ultimately go to reduce the costs for people enrolling in higher-cost plans (Blue & Gold and UC Care).
- Because the year-to-year contribution changes do not consistently align with the rate changes (e.g., a 3% rate change does not necessarily result in a 3% contribution change for a specific plan), UC Health, like all plan administrators, cannot anticipate the effect of its rate actions on employee contributions.
- UC's practice of maintaining nearly identical benefit cost-sharing across HMOs (copays, etc.) places all the cost differences in the enrollment contributions. Allowing different benefit levels would introduce another lever in the competition, allowing either higher copays to compete better on contributions, or lower copays to offer a different value proposition in lieu of contributions.

Pay-banding Observations

- There are two directly opposing concerns regarding Pay-banding:
    - Given the Managed Competition model, Pay-banding is insufficient to provide truly affordable access to the UC Care plan for low-income individuals. (While UC Care has the lowest enrollment share of PB1 and 2 employees, that population still comprises half of the UC Care enrollment.)
    - The UC subsidy was not intended to make all plans equally affordable, and without a way to test for household income, UC subsidizes some employees who have high-income spouses.
- Pay-banding moderates the competitive advantage of UC's benefit programs for faculty and others in higher pay bands, where benefits are not sufficiently low-cost to outweigh less competitive salaries.

Family Subsidy Observations

- UC has a comparatively higher subsidy of families than many other employers, leading to the concern that this causes UC to absorb a disproportionate share of family enrollment, including spouses who have other coverage through their own employment.
    - The Academic Senate has noted that this has not been supported by data. The recently completed Greenwald benefits survey[12] commissioned by UC Health does have some results to inform this issue, but generally this data is difficult to collect.

Options Considered

HBAC reviewed at a conceptual level the following alternative approaches to defining employee contributions; where noted, a couple of options were modeled as examples to assess impact and tradeoffs at a high level. Modeling was on a cost-neutral basis to UC, with contributions changing across employees (creating "winners and losers," which was part of the modeling).

Contribution Strategy - Methodology Options

- UC pays an equal percentage of each plan (modeled)
- UC pays a fixed percentage of the aggregate rates (modeled)
- Regional rating and contribution differences are used in lieu of statewide consistency
- Eliminate the employee minimum contribution (modeled as a part of the "aggregate percentage" model but not as a change to the status quo; modeled as "free plan" separately for Blue & Gold, Kaiser, HSP)
- Value equation approach, basing contributions on a complex of quality, service and cost indicators
- Subjective discretionary model, UC sets contributions based on desired outcomes

Contribution Strategy – Pay-banding

- Change slope to favor lower pay bands
- Change slope to favor higher pay bands
- Collapse Pay Bands 1 & 2 into one band
- Restrict pay-banding to safe harbor HMO
- Lower cost of high-cost plans (e.g., UC Care) to Pay Bands 1 & 2
- Fix contribution as a percent of salary within a pay band

[12] This survey was not part of HBAC's direct scope. It was a survey separately planned and sponsored by UC Health and run by Greenwald & Associates. It was introduced as a reference point for HBAC.

- Fix UC subsidy by pay band and plan
- Segment pay bands by enrollment share

Contribution Strategy - Family Subsidy

- End eligibility for spouse with coverage through own employer
- Reduce spouse subsidy, shift funds to employee and children (modeled)
- Extend the current lower spouse ratio to minimum contribution plans
- Improve subsidy for Pay Band 1 & 2 child coverage
- Differentiate contributions by number of children

<u>Contribution Methodology</u>

- The status quo managed competition model's effect on rate competition and plan selection has resulted in significant UC savings over time. However, changes in portfolio have made the current model complex and have created as many exceptions as applications to the rule.
    - Applying a budget cap in the current model, vs. the original approach of paying the same percentage of the target plan, can create complex allocations of budget dollars that result in non-intuitive outcomes that are hard to predict.
- UC Health proposes to:
    - Create an employee contribution strategy that encourages employees to enroll in plans with UC providers without raising cost to the University or employees overall, including the ability to have variations by campus for pilot programs
    - Modify the risk adjustment process so that plans are paid for the risk they take and the process does not require unanticipated large payments to and from plans or from the health centers through the Blue & Gold ACO due to risk adjustment reconciliation
- <u>Pay an equal percentage of each plan's premium</u>: This would improve the line of sight between annual rate actions and contribution effects (particularly if done on a contract rate basis). This approach would remove the need to set a minimum contribution and would align the spouse subsidy across all plans. It would fundamentally result in increasing the enrollment cost for lower-cost plans, and lowering it for higher-cost plans. This approach was specifically modeled with UC paying the same percentage of each plan's risk-neutral rate.
    - UC Care results in the largest decreases from $62 (at worst) to $265 (at best) per month while Kaiser and HSP would see increases in all categories.

- This approach significantly narrows the contribution differential between UC Care and Blue & Gold (from $264 to $62 per month for Pay Band 4 family and from $90 to $8 per month for Pay Band 1 single)

- Pay fixed percentage of aggregate rates: This is the model used for UC retirees. This method would result in increasing the cost for higher-cost plans and lowering it for lower-cost plans. This approach was specifically modeled without a minimum contribution plan.

    - HSP results in no contribution for all tiers in Pay Band 1 as the risk-neutral rate falls under the UC Max and no minimum is applied; Kaiser Pay Band 1 employee and employee plus child tiers would result in no employee contributions

    - This approach maintains the differential between UC Care and Blue & Gold, but the difference between Blue & Gold and Kaiser is increased from $28 to $65/mo for Pay Band 1 single, and from $139 to $218 for Pay Band 4 family – likely further influencing enrollment toward Kaiser

    - The most significant reduction is for HSP, further widening the "net financial value" between HSP and UC Care

- Apply multi-dimensional value models in lieu of the model based entirely on plan premiums.

    - A "value equation" model that may include quality, access, service, satisfaction and other dimensions was reviewed at a high level with HBAC. The challenge to this model is that it would be built on a number of subjective assessments of value and dependent on the quality and comparability of data on each point. While raised, HBAC did not delve into a deeper analysis or assessment of this option. Some interest/curiosity was expressed in this approach, but the challenges, complexity and uncertainty of outcome overcame the expediency of looking at options.

- Discretionary contribution-setting: With the reduction of the portfolio to one insured plan, and if Risk Adjustment reconciliations were deemed unneeded, UC may simply choose to set the contributions for its plans based on where it wants them to be, unconstrained by any objective model. Reaching consensus on the appropriate contributions, and gaining consensus from stakeholders such as the unions, could be a significant challenge.

    - One approach to this, raised by UC Health in the August meeting but not modeled, is to set Blue & Gold contributions below Kaiser, along with cost cutting and plan design changes to support a strategy of increasing the members who receive their care through UC providers. This could be done over time to moderate the effect in any one year.

    - As an example of the above, a UC Health representative urged HBAC to view how USC approaches contributions for Kaiser vs. its own medical plan. This was provided as part of comparator information in a previous HBAC meeting.

        - USC has the same benefits for their campus and medical center; Stanford's benefits differ between the two. USC and Stanford Health favor their internal plan with lower employee contributions than Kaiser; Stanford University does the opposite, with Kaiser being free to employees. (USC's employee HMO contributions for its lowest-cost HMO are double the UC

Kaiser contribution, and more than 40% above the Blue & Gold contribution.)

  - Since the current contribution methodology is designed to (and has) delivered savings by encouraging enrollment in low-cost plans, a change away from this model toward a discretionary approach with different objectives may have impacts on employee contributions, risk profiles of the plans, and other factors that would change the portfolio as it exists today.

- The equal percentage and fixed percentage of aggregate rates options were modeled as simpler alternatives to the status quo that presented alternative strategic objectives and different results. However, with each alternative favoring either lower-cost plans or higher-cost plans (a consequence of any change on a cost-neutral basis), there was opposition to each and no consensus on any change.

- There was discussion that if cost shifts can be subsidized either from an increased University budget, funding from UC Health, or shifts among employees, then models that bring contribution equivalence between Kaiser and UC Health options could be considered, including how these changes would impact employees.

- Regional rating: Some interest was expressed from different perspectives – helping locations with higher costs due to market/access, or freeing locations from supporting higher cost regions. Ultimately, no specific alternatives were advanced or evaluated. There is the possibility of demonstration pilots (discussed elsewhere), but implementation considerations need to be taken into account, such as union contracts, Redwood capabilities, etc.

<u>Contribution-Free Plans/No Minimum Contribution</u>

- <u>Contribution-Free plans were</u> modeled separately for Kaiser, HSP and Blue & Gold, with $0 contributions limited to single enrollees in Pay Bands 1 and 2, with other Pay Bands and coverage tiers reduced proportionally. Costs were shifted to the other plans, all Pay Bands and coverage tiers, but the resulting impacts to plan risk profile and premiums were not modelled and may change the impact numbers below.

  - Kaiser results in the highest share of “winners” at 34% (due to largest enrollment) with a moderate cost-shift of between $14 and $41 to other plans. This approach would result in a UC savings of $16M for each 10% migration from other plans.

  - HSP has the least-disruptive results (cost-shift of just $1-3) and best financial upside for UC ($48M savings for each 10% migration), owing to the low enrollment and low cost of the plan. However, this promotes a plan that may not be a sensible financial choice for low-income employees. The savings as modeled would also likely be reduced as higher-risk members transition to the plan, an effect moderated but not eliminated by risk adjustment. Beyond the financials, HSP is a more administratively complex plan for most enrollees, particularly when compared to the HMO models of Kaiser and Blue & Gold.

  - Blue & Gold results in the highest cost-shift — $18-55 — due to a combination of large enrollment and higher premiums, which require a higher subsidy than for Kaiser to reach the free status. This approach also undoes the Managed Competition model by creating lower contributions for a higher-cost plan. Contrary

to the savings that would result with migration to Kaiser or HSP as a free plan, each 10% migration into Blue & Gold in this scenario would cost an additional $21M for UC locations. Note that this modeled scenario does not account for benefits generated through additional Health Center revenue flowing back to the University.

- A reversal in UC's current philosophy of asking everyone to pay some contribution for their coverage by establishing a free plan has little support, as moving to a free plan in the current budget-challenged environment seems a poorly timed and potentially unsustainable approach. This could appear as an open-ended commitment that either harms cost-management or harms employee-relations with a reversal.

- Removing the minimum employee contribution: The discussion of a contribution-free plan produced a variant of that option in removing the minimum contribution and letting a plan be free if premiums naturally fall under the UC maximum contribution.

  - This was modeled under the "Pay fixed percentage of aggregate rates" contribution methodology discussed above. This approach resulted in HSP and Kaiser requiring no employee contributions in select pay bands and coverage tiers, and increased contributions applied to UC Care and Blue & Gold to keep UC cost neutral. The approach could be taken in the status-quo model as well.

  - This option had some support, as it supports low cost options for the lower pay bands and is easier to understand.

Family Friendly Subsidy

- UC's basic policy of generous contributions for dependents as an employment and social value is fully supported; fundamental change is not recommended. At issue was whether to reduce the spouse subsidy on the basis that spouses often have their own employer coverage option, and that a large spouse subsidy (improved for many through pay-banding) causes those spouses to select UC, switching the cost burden from their own employer to the University. There was also the acknowledgement that individuals and families composed of an employee plus children subsidize spousal coverage, which may particularly disadvantage younger people.

- Limited data regarding disproportionate spouse enrollment urges caution for changing. In addition, there were concerns around reducing spouse subsidy without reviewing market competition and the impact from a total compensation perspective. It should be noted that no members of HBAC represent employees under 35, so that population's opinions on this subject are not reflected.

- Reduce the spouse subsidy, shifting funds to employee coverage: As an example of what could be done, a model shifted the subsidy equally to all employees, producing a free plan for PB1 employees in Kaiser and HSP. In this modeling, all employee contributions were reduced $23/month, while net costs for spouse and family coverage increase from $20/month to $35/month depending on plan and Pay Band.

  - This shift would be expected to incrementally reduce the enrollment of spouses who have enrollment options through their own employment, where this additional cost would shift UC from being their more valuable to less valuable option. The degree of this shift cannot be estimated. Further, this would be a net benefit

reduction to those employees with spouses who do not have other coverage options, or whose options remain less attractive than the UC option.

- This scenario produces more winners than losers (55% to 45%) as contributions would be reduced for all employees while only a subset of employees who cover spouses would experience increases. Those whose coverage is single or employee + child(ren) are "winners", those with employee + spouse or family are "losers" in the contribution change.

Pay-banding methods

- Overall, there is reasonable satisfaction with the value of pay-banding to lower-paid employees. With a consensus that there is no need to make any major changes, no modeling was sought of the alternatives discussed. There may be interest but no urgency in establishing a more fixed basis for setting the pay bands.

RECOMMENDATIONS AND OUTCOMES

Contribution Methodology:

- There is no consensus on whether to maintain the current contribution methodology or move forward with an alternative, and what that alternative might be. While many HBAC members believe the current methodology has historically and continues to serve the UC objectives, others believe that it may be time to re-examine the strategy and methodology given changes in the benefits portfolio and approach to risk, and that the current contribution method is complex, not intuitive, and layered with policies and practices. However, the current methodology has helped UC manage within its budget by successfully shifting more enrollment to low-cost plans. Different alternatives – assuming initial cost-neutrality for UC – shift costs to a certain segment of the population creating winners and losers. The two options modeled raised concerns from different Committee members. This is an area that ESC may choose to explore and model additional alternatives. There is consensus that if the ESC does choose to explore and model additional alternatives, they consult with stakeholders before they make any decisions on changes to the contribution methodology.

Contribution-Free plan:

While HBAC firmly agrees that affordable access to health care be provided to all employees, there was mixed opinion regarding contribution-free plans.

- There was insufficient support to recommend offering a plan contribution-free regardless of cost

- HBAC members disagreed on whether to recommend removing the minimum required contribution and allowing a plan to be contribution-free if it would reach that point through the contribution methodology.

    - Some HBAC members believe there should be no minimum *required* employee contribution; they assert that contribution-free plans should be allowed if their costs fall below the University's contribution derived by the contribution methodology. These members assert that keeping required minimum contributions will disadvantage lower income employees. Members that favor

removing the minimum contribution believe the decision should be made independent of positioning of any plan.

- Other HBAC members believe that employees should contribute to the cost even if costs fall below the University's contribution derived by the contribution methodology. These members assert that health care is an expensive benefit to the University and having some member financial responsibility is appropriate for all.

- The following concerns would need to be addressed before considering removal of the minimum:
  - Removing the minimum contribution while maintaining the rest of the model would heighten UC Health concerns that they would be less competitive (by lowering contributions for Kaiser)
  - Allowing HSP to be contribution-free would potentially attract those for whom the higher cost-sharing makes it a poor choice.

Family Friendly Subsidy:

- Ultimately, HBAC supports maintaining the current practice at this time. HBAC deemed modifying the subsidy as a future option if needed under the condition that:
  - Data analytics be explored to identify spouses with other coverage and to assess the subsidy's adverse impact to certain employee segments more likely to be single (such as employees under the age of 35).
  - Further assessment be conducted of the needs and preferences of a broader employee population that did not have representation on HBAC. The analysis should include implications of increasing the UC contribution to single employees and/or for coverage of children, and reducing the UC contribution for spouses.

Pay-banding methods:

- There was full support for the purposes and general model of pay-banding. There was little if any support to shift the pay band slope to improve competitiveness for pay bands 3 and 4. There was conceptual interest in lowering cost for pay bands 1 and 2, and/or fixing cost to a percent of salary. However, this would require shifting costs to higher paid employees, a change that wasn't seen as justified given relatively favorable current costs for pay bands 1 and 2.

Risk Adjustment

CURRENT STATE

"Risk Adjustment" is a method used in assessing health programs to account for the fact that the cost and health care utilization results for a given population are affected by the inherent risks of that population. When analyzing the effectiveness of the performance of a given health plan or

program, this helps to distinguish controllable from uncontrollable elements of performance. It is widely used in public health programs; its use by employers is more limited due to the necessary volume and circumstances required for effective application.

Risk Adjustment has been an integral part of UC's contribution and rate-setting methodology since 2003. It is seen as an integral part of the managed competition model. This has helped the UC Care plan that has a much higher risk profile than the other plans, but this could also be achieved through other contribution methodologies.

- UC introduced Risk Adjustment as part of a package with the Minimum Premium and Managed Competition models. The Risk Adjustment model accounts for the following variables that are outside the control of any individual health plan. The variables accumulate to a score, where 1.0 is the average score of UC members enrolled in plans participating in Risk Adjustment, scores above 1.0 mean higher risk, and less than 1.0 means lower risk.
    - Demographics — age and sex
    - Clinical profile — represented by the individual's prescription drug utilization; this profile is derived from a widely-used external program named DxCG
    - Geographic distribution between North and South — North, being more expensive, adds to risk of cost
    - Average contract size (ACS) — the number of dependents per enrolled subscriber
- While risk scores change each year for every plan, certain patterns are consistent year-to-year:
    - Blue & Gold tends to be closest to the UC average, with a score closest to 1.0. Consequently, Risk Adjustment has the smallest effect on employee contributions for Blue & Gold.
    - UC Care consistently has the highest score, above 1.2, or 20%+ above the UC average. Most PPO plans with traditional benefits will tend to draw higher-risk, sicker people, and older employees who can more readily afford the higher contributions. The higher risk adjustment score reduces the employee contribution for UC Care.
    - Kaiser consistently has a risk score below the UC average, around 0.9, or 10% below the UC average. A below average risk adjustment score raises the Risk-Neutral Rate (premium) for Kaiser, but since even that higher rate is below the maximum amount UC will pay, it ultimately doesn't affect the employee contribution for Kaiser, where the minimum contribution applies.
    - HSP consistently has the lowest risk score, around 0.75, or 25% below the UC average. Because the plan has low enrollment, the risk score fluctuates more, but remains the lowest. People who have higher health care needs will generally avoid plans with higher deductibles. As with Kaiser, because HSP is at the minimum contribution, Risk Adjustment ultimately doesn't affect HSP employee contributions.
- The other major application of Risk Adjustment is to "pay the plans for the risk they enroll," executed through annual reconciliation payments. If a plan's relative risk decreases at open

enrollment, the plan owes money back, on the basis that it needs less premium to support the population it enrolled. If a plan's relative risk increases at open enrollment, it is paid extra for the added risk it has taken on.

  - One objective of this model is that, by paying more if the plan sees increased relative risk, the plan can avoid adding margin to the rates to cover that risk, which would pay all plans for a risk that will materialize only for some.

  - The evolution from multiple insured plans to predominantly self-funded plans alters the rationale for having risk adjustment reconciliation payments. In a fully self-funded program, the reconciliations would serve no purpose and it serves limited purpose now with a mostly self-funded program. If the reconciliation process is eliminated, UC will need to make sure that Kaiser does not load rates to cover unanticipated risk. The current risk-sharing arrangement with Kaiser should minimize their incentive to do this.

- The clinical risk element is developed using only prescription drug data, not medical claims/diagnoses. While the addition of medical data improves models as a predictor of *absolute* risk, it may harm the accuracy of relative risk if plans do not have similar mechanisms to capture medical claims data. This is an area for further review to determine if there is a more accurate method for risk adjustment.

  - The principal impediment in the current portfolio is the Blue & Gold plan. With fee-for-service reimbursement, a complete claim, including diagnosis and procedure data, must be submitted in order for the provider to be paid. Health Net's contracts for all medical groups and some hospitals use "capitation," where providers are paid a fixed monthly fee for all patients enrolled in their group, rather than fee-for-service claims for each service performed. Under capitation, an encounter record is to be submitted like a claim, but it does not affect provider reimbursement if it is missing or incomplete. Consequently, encounters have been historically considered less complete than claims. The degree of missing encounter data is not quantified, and at least some UCHC representatives are highly skeptical of this concern, believing that pharmacy-only data understates the severity of their patient population. However, if data is less complete, the risk of the population will be understated compared to other plans that do acquire complete data.

  - While the plan was fully insured and Health Net was at risk, they contended that their capitated model put the plan at a disadvantage in medical data capture, and would not agree to the inclusion of medical claims in Risk Adjustment. With UC's transition to the flex-funded model, the University is at risk for the Blue & Gold Risk Adjustment reconciliations, and this is now UC's decision. In this decision, UC will be equally affected by any data capture issues with UC and non-UC providers.

Results

- Plans have historically executed the model, although each year UC Health has raised issues with the methodology.

HBAC ASSESSMENTS AND OPINIONS

- UC Health believes that there are significant problems with the current methodology, including the complexity and lack of transparency, concerns about accuracy of the risk

adjuster and inability to predict both the reconciliation amounts required to be transferred and the impact on employee contributions.

  - UC Health believes that there are more accurate risk adjustment models on the market today. This is very important because of its use in determining employee contributions in the current methodology. Some Academic Senate HBAC members expressed the prospect that Kaiser may also have understated risk. If true, the net effect in UC's relative risk model with different risk adjuster is unknown and may end up favorable to Kaiser.

- It is difficult to manage the financial performance of and produce rates for plans with annual reconciliation payments that have large swings both up and down that cannot be anticipated and budgeted for.

- The fluctuations in risk adjustment are reflected in shifting employee contributions, which then impact enrollment decisions. This causes the trend to tend to reverse itself in the following year, particularly for UC Care. It also distorts actual increases in premium year to year as it translates to the increases in contributions from employees. For example in past years, a 3% rate increase for UC Care became a 30% increase in employee contributions one year and a 5% increase in rates became a 0% increase in employee contributions this year. When risk increases, it pushes down the Risk-Neutral Rate, making the contributions more attractive. Lower contributions attract more lower-risk members, which pushes up the Risk-Neutral Rate. As contributions increase in response, lower-risk members leave the plan and the cycle repeats.

  - An additional consideration is to apply a longer measurement period (e.g., rolling 3 years) to smooth pendulum swings in risk scores and volatility. This application would more likely fit with the contribution application of Risk Adjustment, but not the reconciliation aspect.

  - HBAC has discussed the potential for UC Care to morph into a materially different type of plan; such a change could make the risk volatility question moot, as no other plan experiences this dramatic problem, or may suggest elimination of risk adjustment depending on what the change is.

- While Risk Adjustment was initiated with five separate insured plan vendors, as of 2020 there are now three self-funded/flex-funded plans with UC at risk, and Kaiser as the lone insured plan — meaning reconciliation dollars are divided only between the University and Kaiser.

  - Risk Adjustment remains a consensus-driven process among all parties at risk. In the current model, both Kaiser and UC would need to agree on a change in methodology.

  - There is a distinction within the University reconciliations. For Blue & Gold, the reconciliation for the share of membership enrolled with UC providers is the responsibility specifically of the UCHCs within their ACO budget, giving them a vested interest in this process. Reconciliation dollars for the other half of the Blue & Gold reconciliations, as well as for the UC Care and HSP plans, are the responsibility of the University.

Options Considered

- Explore options for adding medical claims to the clinical component of Risk Adjustment.
    - While alternative risk adjustment tools are available and some were shared in HBAC materials, there is no expectation that the tool itself would be cause for a change in risk adjustment. If the medical component is reconsidered, this may be with the existing tool or with other vendors.
- Continue to apply Risk Adjustment to the setting of employee contributions, but discontinue the reconciliation step where plans are paid more, or must return premium dollars based on increases or decreases of relative risk at open enrollment.
- Discontinue Risk Adjustment entirely, introducing some other mechanism for maintaining richer PPO plans in the portfolio.

RECOMMENDATIONS AND OUTCOMES

- HBAC generally supports certain principles of risk adjustment. HBAC recommends that employee contributions will continue to factor out the effect of the relative risk of the enrolled population – i.e., will not pay more if less healthy members enroll in their plan, or less if healthier members enroll in their plan. This is accomplished through a credible, industry-accepted risk adjustment methodology as used today.
- HBAC recommends Human Resources and UC Health examine options that include medical claims in clinical risk adjustment and to assess risk adjustment reconciliation.

Portfolio Optimization

CURRENT STATE

Choice and access have been core UC values in delivering a health benefits program that offers options to meet the diversity of circumstances and interests of the UC population. The definition of "choice" has evolved over time, and UC offers fewer plans than it did 15 years ago. However, to date, UC has not gone the direction of some employers in narrowing the choice in plans to one or two and offering that to the exclusion of other basic options. However, plans that are offered need to have a distinct value proposition and fill a niche in the portfolio that meets the needs of a reasonable share of the population. Other considerations regarding the current plans include:

- The portfolio includes each of the major benefit alternative models: Network HMO (Blue & Gold), Group-model HMO (Kaiser), traditional PPO (UC Care), High-Deductible PPO with savings vehicle (HSP). Core represents a different model (indemnity catastrophic), but while it functions as an option for all, it was not specifically introduced to serve that purpose. See below for more detail on Core.

- For many years, UC enrollment has been about 75% in HMOs, indicating the value members place on low cost (both contributions and predictable cost-sharing), simplicity, and the ability to deliver desired providers and maintain strong benefits (modest copays) within the plans.

- UC Care and HSP fulfill the desire of a consistent subset of UC employees to have broad in- and out-of-network access. Compared to the HMOs, they experience the challenges of plan complexity (custom three-tier plan for UC Care with sicker, higher utilizing members, HSA account management and high cost-sharing for HSP) that tend to produce lesser plan satisfaction results.

- The need for UC Care to include non-UC providers in copay-based Tier 1, high utilization, very rich benefits and a difficult population to manage in a PPO fee-for-service environment raise concerns with long term sustainability. The cost trend in this plan has been controlled through discounts from UC providers and modest plan design changes. It is probably time to consider a major redesign of UC Care.

- The Core plan is an anomaly in UC's benefits portfolio in a number of ways:

    - Initial and current value propositions: Originally, Core was intended as catastrophic coverage for those working 17.5-20 hours per week and ineligible for other UC coverage, and as a default for employees not selecting a plan. Currently, its enrollment is chiefly among those working more than 20 hours, and the default enrollment was discontinued four years ago. (Note that the Core plan pre-dates the ACA and its coverage options for otherwise uninsured.)

    - The value proposition today is a best fit for high-income employees in reasonable health who can have a free plan in lieu of the higher pay-banded contributions of other plans, and readily afford Core's higher cost-sharing. However, Core's enrollment share of PB3/4 employees is only slightly higher than the UC average. Core has a high share of PB1 employees, indicating they are not thinking past the free plan and considering their cost exposure in the event of illness. (UC Health

indicates that data from the recent Greenwald survey indicates that many of the PB1 Core enrollees have high-income spouses.)

- Anomalies: Core is an exception to UC's contribution model in that it is a free plan, not subject to Pay-Banding, and Risk Adjustment is not applied because its rate is so much lower than other plans that it is fundamentally on a different scale — less than half of HSP, about 20% of UC Care.

- Some enrollees in Core are covered through spouses' employers and choose it instead of waiving coverage (which would cost the University nothing) because it is free to them. Enrollment in Core saves the University money compared to employees choosing a different plan. However, a significant increase in Core enrollment would challenge UC's portfolio management approach by losing the employee contributions of the migrating population to Core, removing them from the risk adjustment pool, and likely needing to increase the premium that is paid 100% by the University.

- Funding models:

  - UC Care, HSP and Core are self-funded in the traditional sense. UC develops accrual rates (the self-funded plan equivalent of "premiums" on the insured plans), paying providers (including UC Health providers) for the claims incurred. The location and member cost is fixed at the plan rates, but if claims incurred exceed the funding from the rates, claims will be paid from fund balances and plan reserves.

  - Blue & Gold is "flex-funded", where the University has the risk for paying the claims, but remains fully insured, as a licensed and regulated Health Net HMO. UC funds the capitation payments and claim payments paid to providers on a month-by-month self-funded basis. If total claims costs exceed 125% of expected — an extremely unlikely event — then Health Net would be responsible for costs above that amount.

    - Behavioral Health coverage for the Blue & Gold membership is fully insured under the Health Net contract.

  - Kaiser is insured with a risk-sharing arrangement for costs above and below plan premiums, up to a maximum of 5%. For example, if costs are 4% below premium, UC gains the surplus; if costs are 4% above premium, UC owes the deficit to Kaiser. If costs are 6% above or below premium, the gain or loss is capped at 5%. In either case, the funds are transferred through adjustments to future premiums, amortized over two years.

Results

- The Blue & Gold plan removed many of UC's direct provider competitors from the network, leaving them available only through the PPO plans. This has doubled the share of HMO members who select UCHCs since 2010 and ultimately enabled the development of the ACO model at all UCHCs.

- Blue & Gold delivered a double-digit reduction from what would have been the rates of the commercial Health Net plan. The shared risk in the ACO model has kept renewal rates low

since its development, and flex-funding reduced the cost even further — below 4% premium increases since 2016.

- UC Care is a rich-benefit PPO plan that has maintained a cost reasonably tied to the Blue & Gold rate, with contract rates between 28-31% higher each year from 2015-2020, even though the risk profile of the membership has worsened over that time. Membership in the plan has been stable.

- The UC Care plan has also doubled the percentage of care (measured by claims dollars) delivered by the UC providers through a low cost copay-based Tier 1 benefit and the UCHCs have given a larger discount for their services in return for the volume.

- Kaiser has consistently gained UC enrollment share, becoming the largest employee plan. Key reasons for Kaiser's success in member capture are:

    - Kaiser has consistently had the lowest employee contribution every year for active employees as determined by the current "managed competition" model, which is an important driver of employee choice.

    - Kaiser has a very large and growing market presence in California because of an attractive combination of low cost and comprehensive benefits. As of 2018, Kaiser had 35% of the California commercial/ASO market, and 52% of the insured enrollment for large groups (CHCF data). Many new employees come to UC as established Kaiser members.

    - Kaiser regularly has the highest plan satisfaction among UC members – 11 percentage points higher than Blue & Gold, 20 points higher than UC Care, and 30 points higher than HSP in 2019[13].

- Enrollment has been steady in PPOs, with a modest shift from UC Care to HSP. Within HMOs, there has been a shift from network HMOs to Kaiser, driven in part by Kaiser's lower employee contributions, structural changes to the network HMO and entry into Santa Cruz County in 2017. Kaiser gained enrollment as Health Net was split into two plans: Blue & Gold and the full network plan. This made the full network plan more expensive. Then the full network plan was eliminated so that non-Blue & Gold providers were available only through the PPO plans. Throughout this period of disruption, Kaiser became an attractive option for those who were willing to change providers to avoid increased costs.

- HBAC was presented modeling of the financial value of UC Care vs. HSP and Core, based on the employee contributions (sensitive to coverage tier and Pay Band), using the 2018 claims distribution of the UC Care enrollees. This modeling showed that the vast majority of UC Care enrollees would have saved money in HSP, and the majority (particularly higher pay-bands) in Core, assuming that the rates and plan designs stay the same. This was a one-year analysis and did not calculate the additional value for HSP of rolling over funds in an employee-owned Health Savings Account. This would add to the HSP value proposition. It also did not look at the impact of higher-risk members migrating to the plan, resulting in higher premium rates and increasing the employee contributions. The model did not depend on assumptions about the effective use of the savings account, cost-transparency tools, etc.; it was a pure application of contributions, claims incurred and benefit cost-

[13] *Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2019 survey*

sharing. This model rests on some actuarial assumptions for distribution of services by type and in/out-of-network.

- Despite HSP's better financial proposition, the plan still has just one-third the membership of UC Care and less than 10% of the combined HMO enrollment after 12 years as a systemwide offering. Likely reasons are a combination of a) comfort with the more traditional PPO model, b) discomfort with the complexity of a savings-account model, c) concern over the risk of higher cost-sharing, d) limited education on the use and value-proposition of HSP, and e) inertia.

- While there was some limited advocacy of separate portfolios/contributions for UCHC employees vs. campus employees in subgroup discussions, there was little discussion of it in HBAC overall and the idea generated some strong opposition. Potential union issues were considered a strong practical impediment, along with a desire to maintain a universal approach to medical benefits for University employees.

PORTFOLIO OPTIONS AND ANALYSIS

HBAC's examination of the medical benefit portfolio took two basic forms:

1. An analysis of each current plan, its value proposition and performance, and consideration of some example ways each might be changed to better meet emerging needs and interests.

2. An exploration of a few different illustrative portfolio packages, and benefits and issues if each might be pursued.

Current Plans

UC Care

- Most members of HBAC believe a plan like UC Care fills a valuable niche in UC's portfolio, and do not see a burning platform that would prompt a major change or removal. A significant share of employees continue to choose the plan, helped by rate stability derived from UC Health provider discounts, and UC Health data indicates that the plan has operated with a modest surplus since inception in 2014.

    - Particularly given the HMO consolidation to a single narrow-network HMO using community providers, a wide-network PPO plan is considered an imperative by many.

    - The custom 3-tier structure is inherently more complicated than an HMO, and in the early days of the plan prompted questions about how the tiering works. With time a better understanding of how the plan works has developed.

- UC Health indicates that the concern is regarding future sustainability, as the plan has delivered on a commitment to hold plan premium increases to no more than 5% through repeated rate passes by UC Health, and no comparable rate concessions have been made by external providers. At times, there have also been minor plan design changes to hold the rate increases at or below 5%.

- UC Care contributes a margin to UC Health that is three times higher per subscriber than Blue & Gold, indicating that UC Health is more willing to reduce income from members that it takes risk for and can manage through the Blue & Gold ACO rather than from a fee-for-service, unmanaged, sicker population in the PPO plans. Potential UC Care plan changes were addressed as follows:

    - There was no discussion of network changes or plan design changes within the current structure – e.g., converting Tier 1 from copays to coinsurance, raising deductibles, narrowing the Tier 1 network. These are left to ongoing plan administration.

    - An option introduced for discussion was to convert UC Care into an HRA plan model. The objective would be to achieve a lower cost point through higher cost-sharing, while preserving benefit steerage to UC Health and introducing the value of a savings component.

        - A Health Reimbursement Arrangement (HRA) is a tax-free savings account that is generally less valuable to the enrollee than the HSA account that is part of the Health Savings Plan. Only the employer can contribute to the account. Employer contributions are notional until used by the employee for eligible costs and account balances are usually lost to an employee who leaves the plan or employment prior to retirement.

        - The advantage to UC is that the HRA carries fewer plan design restrictions than an HSA plan, allowing UC to preserve plan designs that promote use of UC Health providers through a favorable deductible and copayments.

        - This option drew little interest from HBAC. The complexity of the HRA model was considered a drawback, as was the likely communication difficulties that would be expected in operating HRA and HSA plan types side-by-side.

    - Expanding concierge-level service and care management and coordination are considered opportunity areas for plan satisfaction, the effective and efficient use of care (also aiding financial stability) and further increasing the portion of care delivered by UC Health providers. This functionality may include UC Health-specific operations (e.g., second surgical opinion service, chronic condition management, adopting a PCP-gatekeeper model) and separate vendor programs such as "navigator" models.

    - Establishing a risk-sharing arrangement with UC providers for the PPO plans that could mimic the one in place for Blue & Gold could help control cost and better manage the health of the members. There is a challenge with PPO plans to attribute members correctly to PCP's and control usage of other providers by members that is different than with HMO's that require a PCP gatekeeper.

Blue & Gold

- There is general agreement that the plan fills a need for UC's portfolio – a non-Kaiser HMO where cost is effectively managed, members are generally satisfied with plan performance, and UC Health has developed an ACO model that rewards its own clinical efficiency with predictable and sufficient reimbursements.

- UC Health expressed concern that Health Net historically has not been a very helpful partner in creating innovative ways to attract membership to the Blue & Gold plan and to UC providers specifically. With new account management and leadership at the top for California, this relationship has improved over the last six months.

- From Human Resource's perspective, Health Net has been a strong partner in assisting UC with developing a custom plan with a narrow network, helping UC transition from a fully-insured to a flex-funded financial model, completing a seamless transition with assuming behavioral health services for UC employees, building data analytics incorporating needs of UC and providing support with steering UC employees to UCHC providers.

- The most negative effect of narrowing the network for Blue & Gold remains in Santa Cruz, where the Palo Alto Medical Foundation (PAMF) was excluded from the network due to cost, and due to Sutter's "all or none" approach to network participation. Other examples of locally dominant provider groups excluded initially – Alta Bates in Berkeley and Sansum in Santa Barbara – were eventually incorporated into the network with UC-specific discounts.

- A persistent concern for Blue & Gold (and Kaiser) is the inability to provide international coverage for a sabbatical or out-of-state coverage for a dependent child away at school for more than urgent/emergent care, requiring a plan switch to a PPO plan.

- If UC Care were substantially changed – e.g., removal of key network providers or reduction in Tier 2 benefits – then some believe the Blue & Gold network would need to be revisited. If, for example, prominent regional providers were available only out-of-network in a PPO plan, there would be an expectation to address network concerns.

- An approach to create a Blue & Gold option cost-equivalent to Kaiser by reducing benefits (increasing member copayments) was quickly dismissed as undesirable, given the significant copayment changes that would likely be required; it would simply trade a contribution disadvantage for a benefit disadvantage.

- Blue & Gold tiered benefit: Move to a lower or even $0 copay for services from UCHCs within the Blue & Gold benefit, with the objective of a) incenting Blue & Gold enrollees away from other providers to UCHCs, and b) attracting UC Care members using UCHCs into Blue & Gold (i.e., giving up access to out-of-network providers in exchange for UCHCs at a lesser contribution and much lesser cost-sharing).

    - The tiered benefit was introduced for discussion by UC Health, in part as follow-through on a desired location-specific copay-waiver program for UC Health providers that was not able to be implemented. A similar concept was introduced in the August presentation under the category of Promote Plan Value to Members ("Reduce/eliminate copays for UC-provided care, including telehealth and behavioral health for some campuses"). This idea is still being pursued by a couple of campuses for implementation in 2022, but not at all.

- UCHC EPO ("Exclusive Provider Organization"): Implement a self-funded plan consisting only of UCHCs and any necessary affiliated partnerships to deliver comprehensive care. The plan would be offered only in the areas served by UC providers, and therefore, the pricing of the plan and risk management is fully within UC Health control. UC Health would bear full risk for the plan, fundamentally "insuring" the plan for the University.

- This option is one of the more complex and consequential under consideration and not supported by UC Health. Issues include: a) how best to construct the remainder of the portfolio; b) equity of benefit options for non-UCHC regions; c) effect on overall UC cost; d) managing consistency and value of employee choice with provider and plan type.

Health Savings Plan

- While HSP has clear objective value, its challenges have tended to "brand" it as a difficult and sometimes confusing plan.

  - HSP could save money for the vast majority of UC Care enrollees while using the same care and same providers (i.e., without any special use of "consumer" aspects of the plan). UC contributes toward the HSA to help offset the annual out-of-pocket maximum; $500/yr for individual and $1,000/yr for family. Generally healthy members under age 50 who could afford the higher cost-sharing for an occasional medical need (particularly Pay band 3 and 4) have the potential to grow a sizeable Health Savings Account over time through tax-advantaged employee contributions that could be used in retirement, investing money that would otherwise go toward higher contributions in other plans. HSP is viewed as complex with its HSA feature and high-risk with its high deductible and coinsurance. Cost transparency tools in the market have not proven effective at affecting provider selection. Employee contributions are little different from Kaiser, which has the advantage of simplicity (where care decisions are guided by the plan) and financial protection (cost-sharing is limited to fixed copayments). HSP has the lowest member satisfaction rating of all UC plans, 46% (2019, those rating plan 8 or above on a scale of 10).[14]

Kaiser

- HBAC members generally view Kaiser as a program that offers: 1) a plan valued by members for its simplicity, convenience and low cost; 2) an alternative for employees who do not wish to seek medical care where they work; and 3) familiarity for those who have received care from Kaiser in the past. Overall, HBAC members believe it delivers high satisfaction, strong primary care and prevention, and helps UC live within its budget.

- UC Health would like UC employees to get the best treatment available to them for serious conditions, such as complex cancer care. UC Health Centers are all ranked among the best in California and two are in the top ten in the country for quality of care. UC Health recognizes the quality of Kaiser's primary care, but points out that no Kaiser hospitals are among the top facilities in the state. The five UC health centers are all National Cancer Institute designated cancer centers, which means they are among the best in the country, whereas Kaiser has none.

- HBAC recommends keeping Kaiser in the UC portfolio.

Core

- Core plan alteration or elimination: Core was introduced for reasons that have little to do with how and by whom it is currently used, and is an anomaly in UC's portfolio in several

[14] *Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2019 survey*

ways. For these reasons, its form or continuance in the portfolio is a matter of HBAC consideration.

  - Option to discontinue: As the plan sits without a clear value proposition within the portfolio, removing it will clarify the plan options, particularly if UC enhances its communications, chooser tools, and becomes more proactive in helping employees find a best-fit option. However, removal would be seen as a negative from the enrolled population who have found some preferred value in it, and could raise UC's costs for those employees.

  - Option to enhance: The value of the Core option to higher-income individuals could be significantly enhanced by making Core HSA-eligible (which requires only modest plan design tweaks). Employees then could make tax-free contributions into the account to fund near-term cost-sharing and savings toward retiree health costs. As contemplated and unlike HSP, an HSA for Core would not receive any funding from UC.

  - Option to maintain: The plan could be maintained as is, or only as an option for the 17.5-20 hour population that has no other enrollment option. The principle argument for status quo would be to avoid the downsides that come with either an enhancement or discontinuation — i.e., "leave well enough alone." A final option would be to freeze enrollment.

- Arguments were advanced in HBAC for both continuing and discontinuing the Core plan.

  - The fundamental argument for continuing the plan is that there is nothing in the operation of the plan that is creating problems or concern today; it is a conscious choice for those who enroll (default enrollment ended several years ago) and thus fills a desired value proposition, and it is much lower-cost for UC than other plans. If discontinued, UC would pick up much of the cost difference.

  - The arguments for discontinuing the plan generally relate to its anomaly status within the portfolio: it is an exception to the required minimum contribution and pay-banding policies, and not included in the risk adjustment pool; it is not HSA-eligible due only to nuances of plan design, reducing its value to members. If UC introduces more advanced plan selection tools, Core is likely to create challenges and potentially draw certain enrollment away from HSP. It is also likely that some members have coverage options through spouses and enroll in the plan because it is free instead of declining coverage.

- The continuation of Core likely rests significantly on the degree of other changes in the portfolio. The closer UC hews to the status quo, the less compelling the argument to discontinue Core.

  - If discontinued as a general option, the committee discussed continuing it for the 17.5 - <20 hour population which is eligible only for Core. This might rest on a deeper review of how many of these employees are enrolled today, and whether ACA options change this value to employees.

  - If Core were discontinued with all enrollees maintaining coverage and enrolling in HSP, the financial impact to the University would have to be modeled.

Portfolio Packages

Over three separate sessions, HBAC explored different approaches to revising the portfolio, moving from the broadly theoretical to more plausible illustrative options based on discussion.

March 2020 HBAC Meeting			
Simplified	**High Deductible**	**Maximum UCH Channeling**	**Current "Plus"**
UC Care w/Navigator HSP w/Navigator *eliminate* Core Blue & Gold Kaiser	"HRA" UC Care HSP Core w/HSA Blue & Gold Kaiser	UCHC EPO 3-Tier HSP *eliminate* Core Tiered Blue & Gold Kaiser	UC Care w/Navigator HSP w/Navigator Core w/HSA Tiered Blue & Gold Kaiser
HBAC did not focus on any package as a proposed option; discussion addressed the rationale for defining a portfolio with a basic strategy or theme – e.g., simplifying by eliminating an option, making high-deductible plans a focus, prioritizing the channeling of care to UC Health, or adding a value element to each of the existing plans.			
June 2020 HBAC Meeting			
Modified Status Quo	**Remodel**	**UCHC-Centric**	**Navigator**
UC Care 2.0 Blue & Gold HSP w/Navigator Kaiser	Blue & Gold 3 (POS) Blue & Gold 2 (copay = KP) Blue & Gold 1 (copay > KP) HSP Kaiser	Blue & Gold UCH-only Blue & Gold HSP Kaiser	Navigator – PPO Navigator – EPO Navigator – HSA Kaiser
Redesign of UC Care to moderate cost relative to other options	*Restructure to offer different levels of B&G benefits, replace UC Care with B&G POS*	*Restructure to maximize attractiveness of UCHC options*	*Self-funded Navigator model with single administrator becomes universal platform outside of Kaiser*
These portfolios were offered as "compass points" – not end-state recommendations, but fundamentally different directional choices that may help surface committee opinions. Core was specifically set aside for this discussion. *The absence of a traditional PPO (UC Care or equivalent) was considered a significant drawback to the Remodel and UCHC-centric scenarios. The "Blue & Gold 1" plan in the Remodel scenario was broadly considered a non-starter because of how much higher the copays would need to be raised to reach the contribution goal. There was some discomfort with the single-vendor approach in the Navigator model, but the opinions were restrained due to limited knowledge of the Navigator model itself.*			
July 2020 HBAC Meeting			
Modified Status Quo	**UCHC Cornerstone**	**Navigator**	
UC Care 2.0 Blue & Gold HSP Kaiser	Navigator – PPO Blue & Gold UCH-only EPO Navigator – HSA Kaiser	Navigator – PPO "Leveled" PPO Navigator – EPO Navigator – HSA Kaiser	
Current portfolio remains in place, incremental design/network/tool changes as with general ongoing management	*UCH EPO allows UC Health to develop and price a product with complete independence; cornerstone to portfolio*	*Same as June, with addition of Greenwald-suggested "Leveled" model (buy-up options) and fuller explanation of Navigator*	
HBAC did not come to consensus opinions; none of the new portfolios had clear advocacy of any segment.			

Greenwald Survey Recommendations[15]

UC Health retained Greenwald & Associates to conduct an employee survey to gain input from employees regarding the existing portfolio of health options and communications models, and shared these results with HBAC.

Greenwald indicated that employee needs would be met by four distinct plan types:

- Fixed model: Limited network with low contributions and copays, similar to UC's Blue & Gold and Kaiser plans.
- Savings model: Plan with HSA savings vehicle and low contributions, similar to UC's HSP plan.
- Freedom model: A rich benefit plan with wide networks, requiring higher contributions, similar to the UC Care plan.
- Leveled model: An individually customizable plan with buy-up options for select services. There is no corresponding current UC plan. There were no cited examples of this plan design in practice with a current organization. A related idea for UC is to include buy-up options in HMO plans that would allow for coverage of an out-of-state dependent student.

Preferences expressed in the survey regarding provider networks, copays over coinsurance, and employee contributions and cost-sharing maximums seem also to be met by the current portfolio.

From the survey results, Greenwald concludes that benefits are generally too rich, and too similar in design and networks, to create value differentiation and clear choices and confuse employees. However, the similarity of benefits across Blue & Gold, Kaiser and UC Care Tier 1 has been intentional, requiring employees to focus on cost, network and care model, which are thought to be distinctive enough.

Navigator Model[16]

The premise of the "Navigator Model" is that health care coverage and delivery have been defined by its fragmented components and economic interests: doctors, hospitals, pharmacy industry, health insurers, and increasingly proliferating specialty solutions – behavioral, wellness, disease management, complex care, etc. The job of navigation falls to patients/consumers ill-equipped to navigate this complexity, resulting in underuse, misuse, and overuse of care, raising costs while lowering quality. The associated consequence is an expensive employee benefit that often under-delivers in terms of satisfaction and health status.

Navigator programs address these issues by becoming the single, member-centric point of contact for the plan for provider selection, care support, program and tool access, and traditional benefits questions and services. The Navigator coordinates with health plan or employer selected specialty partners. Timely, comprehensive personal health data informs Navigator interactions

[15] This survey was not part of HBAC's direct scope. It was a survey separately planned and sponsored by UC Health and run by Greenwald & Associates. It was introduced as a reference point for HBAC.

[16] Further information on how Navigator models can assist employee make choices suited for them is provided in the next section on Facilitating Choice & Communication

with the member, and enables "opportunity interactions" where member contact for service issues may turn to recognition and guidance of care needs.

There can be gradations of Navigator models, but at a minimum it encompasses a comprehensive approach to health care advocacy and aiding members to get to the "right care, right time, right place" and accessing the tools and programs available through the plan to optimize their health.

Issues addressed by HBAC included:

- In the market generally and for UC's program specifically, the Navigator model is typically best-matched to a self-funded PPO, rather than an HMO or other provider-risk model where the care gaps that the Navigator model proposes to address are owned by providers – as in Blue & Gold.

- The Navigator model may contain some overlap in role with UC's Health Care Facilitators, though it appears they would be compatible functions.

- Similarly, even under PPO plans such as UC Care, UC Health has developed and continues to enhance its own care management programs designed to provide the type of care support and direction that the Navigator model identifies as its core value proposition. Since the Navigator would have to be customized to fit UC if implemented, this interaction would need to be worked out, including how referrals to UC Health would be prioritized.

HMO Enrollees with Out-of-State Family Members

A persistent portfolio challenge has been the issue of employees enrolled in HMO plans who must disenroll for out-of-state or international coverage for themselves or a dependent outside the HMO's service area. While both UC Care and HSP are options for this coverage and HSP has lower contributions, UC Care appears to be the more commonly chosen option, likely because of the perceived complexity and the limited value of an HSA account from temporary enrollment. A similar problem exists for faculty taking a sabbatical out-of-area.

HBAC reviewed several options that have the potential to minimize the issue:

- Health Net offers a PPO wrap product that could be used to cover domestic out-of-area dependents. This would allow the family members to stay in the HMO, and have the student covered under the PPO. This is available only domestically; it would not be an option for international coverage. Use of the option may require UC to split eligible family members. Further review is needed to better understand financial and operational considerations. Kaiser does not have a similar solution for UC at this time.

- Another option is to consider creating a special out-of-area plan, using a national vendor or TPA with a national network. Similar to the Health Net PPO, this option may require UC to split eligible family members. Further review is needed to better understand financial and operational considerations.

- For those on international sabbaticals, the University could consider offering an expatriate plan (which are commonly available through Blues, Aetna, and Cigna). These plans in the past were explored and were found to be more expensive than having the employee go into UC Care and access coverage through that plan.

- Finally, most universities do offer student plans, so employees could consider this option. From a cost perspective, this is sometimes more cost-effective than paying the higher contribution for the family to move to UC Care.

RECOMMENDATIONS AND OUTCOMES

HBAC finds that while individual plan improvements should continue to be sought and made, there is neither the burning platform of failing plans nor a clearly articulated new portfolio with high confidence of a transformational advance and tolerable levels of disruption.

Key incremental recommendations are summarized below:

- Portfolio: Without a perceived urgent flaw requiring change in any of the existing plans, moving forward with a completely new portfolio hinged on a compelling argument for some fundamentally new plan or approach. For the near term, HBAC recommends proceeding with a "Modified Status Quo" portfolio, maintaining the existing plans with design, network or capability (e.g., care support) adjustments as deemed appropriate by ESC.
    - Going forward, HBAC recommends restricting the Core plan to employees who are otherwise ineligible for full medical plan offerings; this would include part-time employees (17.5 to 22 hours).

- UC Health Exclusive Provider Organization (EPO) plan: Advanced as a potential option for UC Health to have full control of design, features and pricing in order to compete unencumbered by the cost of external providers, this was ultimately not embraced systemwide at this time by UC Health as presented to HBAC and consideration as a potential recommendation was deferred until further analysis can be undertaken. UC Health may consider proposing an EPO as a local level pilot in the future.

- Navigator model: Some HBAC members consider this to be a plan approach with strong value-add potential and little downside risk, although the concept may not be fully understood. The navigator model would serve as a feature within the health plans and be distinct from the services of Health Care Facilitators. Some members seek assurances that a navigator approach does not create additional confusing or conflicting bureaucracy when coupled with the Health Care Facilitators. The navigator approach aligns better with PPO models, so it is considered a possibility for UC Care and HSP, but not for the Blue & Gold plan.

- Health Savings Plan: HBAC recommends maintaining the plan in the portfolio with enhanced employee support and education. The plan meets the needs of many at a lower cost to themselves and the University. Given modest but consistent enrollment growth over time, questions about the future of UC Care, and the value of retaining the plan to the members currently enrolled, it appears to be in UC's interest to maintain the plan in the portfolio. Enhanced service and care-seeking support through concierge/navigator functions overlaying HSP could make it more attractive to members.

- Out-of-state/international coverage: HBAC recommends that options be considered to allow members at a reasonable cost to maintain their HMO enrollment and provide out-of-state or international health plan coverage.

- Kaiser plan: HBAC recommends keeping Kaiser in the UC portfolio.

Facilitating Employee Engagement & Choice

CURRENT STATE

The University of California offers a comprehensive set of health benefits and recognizes the critical role these benefits play in overall compensation, recruitment and retention of employees. Maximizing benefit value requires helping employees to find and effectively use the plans best suited to their personal situations. Personal, subjective preferences such as having access to out-of-network coverage even if it's not used are perfectly valid individual considerations, but the University's role is to make sure that the employee can weigh objective factors that are not necessarily recognized or easily understood. Since both personal needs and medical plans change over time, this educational purpose should be recognized as a recurring need and not a one-time exercise.

Health care has always been complex and continues to rapidly transform, creating both opportunities and challenges to health care consumers. To better help members navigate the continually evolving ecosystem, employers use a multitude of strategies, all designed to help their employees get the right care, in the right place, at the right time. A critical foundation for providing this education is the focus on effectively communicating with members, using multiple channels.

Today, UC provides an integrated benefits website that serves as the primary benefits resource providing access to vendor links and materials and use of the Health Care Facilitators.

- The website provides employees (and retirees) with "static" information related to their benefit programs, where they can go online and read about what is offered and how the plans work. On that site, they can also access the vendor links to find a provider or reach out to their health plan directly. The website includes:
    - Detailed benefit design materials (including SBCs)
    - Side-by-side benefit comparisons of the plans
    - Employee contribution information
    - Vendor links to find a provider and other plan administrator specific information
    - Links to information on what is happening on their own campus
    - Links to PPO and Blue & Gold microsites to support the open enrollment process, with plan choice information including what is covered and what is changing for 2021
    - Links to UC Path and UCRAYS for employees and retirees to enroll in benefits
    - Open enrollment information

The site also has information on the UC Health Care Facilitators whose role it is to help employees navigate the health care system when the need arises.

- The Health Care Facilitator is an "ombudsman" — someone who understands how the UC health plans work and can help members navigate the system when they have trouble. They can help members with claim issues, questions about the plan, etc. They are an additional resource who can act as a liaison with the member to resolve administrative issues with the plan. The Health Care Facilitators can answer questions about the plan, but do not direct members as to which plan to choose, and they do not provide clinical guidance.

Greenwald's survey indicated that employees do not feel they have good information to make decisions, ideally all in one location, and that there is some lack of familiarity with the existing site, or a desire for additional content or functionality. HR shared an objective to enhance the site in the future to include interactive tools not available today to help members actively choose a plan. Because the University has passive enrollment that does not require the employee to make a choice each year and will default them into their existing plan, inertia may become the dominant factor in plan selection.

Currently, there are observable cases where individual choices are poorly matched to the medical plan options UC makes available purely from a financial standpoint. This can leave an employee over- or under-insured, or simply paying more for the same providers and care available through another option. There are often other intangibles that drive employee choice like risk tolerance, not wanting a gatekeeper PCP or hassle factor that can be the deciding issue for them. An example where this might be true is a UC Care enrollee using Tier 1 providers that are in the Blue & Gold network, who could save money by enrolling in Blue & Gold.

Key findings of the Greenwald survey regarding information and support indicated that employees would like:

- Simplified choices: Employees indicated they need more help choosing which plan is right for them.
    - 36% of participants indicated they need help picking a plan, and 55% said they don't understand their current plan very well.
    - Even those who understand the plan well (21%) indicated they would like help.
    - It is important to provide different pathways for employees to connect and learn about their choices, as people absorb information differently (some like to talk with a person, some like to read on their own, and others like tools/technology).
- Enhanced support tools: Employees indicated they want one stop shopping, where they can find everything when choosing a plan. They would also like more access to resources to help them better understand their choices and how their plans work.

OPTIONS AND ANALYSIS

As an option to improve employees' understanding, and ultimate use of their health plan, HBAC discussed several topics such as use of a navigator or advocacy model, as well as expanding the UC website tools to include an online selection tool.

Plan Selection Tools and Information

Improving the benefit value of the current offerings will require helping employees find their best match ("right – fitting"), communicating the plans in a way that employees truly understand and finally, helping employees engage and act as educated health care consumers.

- Today, the challenge with effective choice is that members don't necessarily know how to make the right choices. What stands in the way of good choice making are such things as: complexity, lack of understanding, cognitive and behavioral biases, inertia, habits, immediate costs versus delayed benefits, lack of feedback and lack of time to sit and read through materials during open enrollment. A prime example of this is when employees under- or over-insure themselves; for example, when a lower-paid person enrolls in Core because of the $0 contributions but is unable to pay the high cost-sharing in the event of an episode of illness.

- To help members make better choices, HBAC discussed use of online tools that take the member through the choice-making process, either by asking critical questions, using imported member data (such as past claims) or both. Based on responses, the tool takes the member through a guided approach that in the end takes them to the plan that best meets the needs they identified through the process. Use of such a tool would require an investment from the organization (both from a time and financial investment), but organizations who have utilized them provide positive feedback on their effectiveness.

- UC Health would like to more actively promote the value of "picking UC" during open enrollment and during new employee orientation.

Navigator/Advocacy Model in Facilitating Choice

Recognizing that health care is complex and members need more guidance on how to access care when it is needed, there are a growing number of vendors who are in the marketplace selling advocacy or concierge services. These navigator/advocacy/concierge vendors work with large self-insured plans to support their members, providing them with education and guidance when questions or issues arise related to their health care (or health care benefits). Their services include both clinical and member service support. Their role is to help the member resolve administrative issues (e.g.: claim or benefit questions), as well as clinical ones — providing medical guidance, as needed, when new diagnoses arise. They act as a liaison between the member and the health care system, helping navigate them to the highest quality, lowest cost provider.

To address the employee concerns regarding lack of resources available to understand their plans, the addition of a vendor focused on providing advocacy services, particularly from a clinical perspective would benefit those enrolled in UC health plans, particularly those enrolled in UC Care and HSP (as the HMOs, through use of the PCP, do provide some level of advocacy for members.)

If such a model is adopted, it will be important to coordinate the role of the vendor with the UC Health Care Facilitators to make sure they work in an integrated fashion, optimizing the value of all resources available to members.

RECOMMENDATIONS AND OUTCOMES

HBAC recommends that the University take a more proactive approach to facilitating employee choices that better align their circumstances with best-fit plan selection. To do this:

- HBAC strongly recommends substantial expansion of and investment in the current Health Care Facilitator program, including increased publicity and additional resources.

- HBAC recommends that HR continues its efforts to move forward with the revamping of the benefits site, particularly if any portfolio changes are implemented with input from UC Health on content and design to be approved by ESC.

- HBAC recommends UC explore use of a plan selection tool during 2021 (for 2022 plan year) to help employees determine which plan is best for their personal situations, including more advanced tools that allow individual input of individual circumstances, preferences and utilization patterns to promote data-driven feedback and suggestions. Tools and information to enhance plan selection should be aligned with a clear approach for UC Health objectives.

ROLE OF THE UC HEALTH SYSTEM

HISTORICAL CONTEXT

The role of the UC Health System in the delivery of employee health benefits to the University's population became integral to most topics addressed by the Committee.

A fundamental UC Health objective is for the UC Health system to deliver a greater share of the patient care to University employees and families. This objective was an ongoing and prevalent HBAC discussion topic throughout the project.

- Prior to 2011, UC providers and the UC employee health plans acted independently with neither side providing or receiving any special treatment. While there were no special rate or benefit arrangements, there was an objective to keep each UCHC in at least one of the HMO plan offerings.
    - One small exception was the gradual introduction of a program where employees could fill 90-day prescriptions at UCHC pharmacies, while the UCHCs guaranteed that the price would not exceed the mail-order price — essentially, an opportunity to re-channel mail order scripts to the UCHC pharmacies at no additional cost to the plan, which has not resulted in any significant numbers of prescriptions being filled this way to date.
- Beginning with Blue & Gold in 2011, UC began to favorably position UCHCs by limiting competition (narrowing the HMO network) or offering preferential benefits (UC Care Tier 1), in return for UC providers reducing their reimbursements below the contracted rates with the health plan administrators (Blue Shield, Anthem or Health Net) that had been in place and take on risk through an ACO budget model.
- The University's initial purpose in introducing Blue & Gold was to positively affect the plan's medical benefit costs. With the introduction of risk taking by the health centers through the ACO beginning in 2016, and the corresponding moderation in cost of almost half of the claims attributed to UC providers, there have been some changes in network that reduce competition for UC providers and further encourage growth in enrollment of this plan. UC Care was created to replace the fully insured PPO with a self-funded program so that the University could have more ability to customize, price, and encourage use of UC providers through tiering. The increased channeling to UC Health that emerged in these plans was a positive effect of execution rather than a baseline objective.
- Medical plan management has gradually migrated from Human Resources to UC Health, essentially following the funding model (insured, flex-funded, and self-funded), with Plan Fiduciary responsibility now vested in the Executive Steering Committee rather than systemwide HR.

FACTS & FIGURES

- **Share of UC medical spend:** Since 2010, the year prior to the introduction of Blue & Gold, portfolio actions have produced increases in utilization in UC providers and Kaiser, and

losses for non-UCHC community providers — principally those higher-cost providers no longer accessible through an HMO.

- **UC medical benefits**: In 2019, the UC medical benefit program paid $595M to the UC Health System for patient services (non-Medicare), representing 30% of UC's overall payments (including prescription drugs), while 33% was to Kaiser.

	2010	2019	Change
UC Health	20%	30%	+10 pp
Kaiser	24%	33%	+9 pp
Other	56%	37%	–19 pp

- **UC Care and Blue & Gold shares**: The 2019 UC Health share of medical payments was 42% for UC Care and 46% for Blue & Gold (including prescription drugs), both approximately doubled since 2010, indicating that with the right incentives members will choose UC providers.

- **UC Health flow of funds**: UC Health transfers over $1.3B to non-UC Health operations of the University and invests over $1.4B in underfunded care to support Medicare and MediCal services (2019 figures).

- **Choice by geographic distance**: Systemwide, selection of UC Health providers by Blue & Gold members within 15 miles of their closest UCHC stayed roughly the same from 2014-2019 (70% to 71%); selection for those outside 15 miles grew from 31% to 45%, yielding an overall increase from 45% to 49%. (2014 is used as the baseline year because that is when the original geographic selection study was done.) Effective 2020, new members who do not select a primary care physician are defaulted to a UC Health provider within 15 miles (instead of 5 miles previously), when available.

- **UC Benefits as share of UCH revenue**: The non-Kaiser UC plans deliver approximately 1% of the margin that UC Health earns from commercial health plans, and UC's Kaiser plan delivers approximately 2% of the revenue that UC Health earns from Kaiser.

- **Blue & Gold discounts and risk**: For Blue & Gold, UC Health provided an effective 13% "family discount" (better than their standard reimbursement rate in the Health Net commercial HMO), which amounted to $44M in 2019. Medical risk in the Blue & Gold plan is divided among the UC Health System (53%) through the ACO, the plan (26%) and non-UC providers through capitated arrangements (21%). Health Net holds all risk for behavioral health, and medical risk above an aggregate stop-loss of 125% of premiums (which is unlikely to ever happen).

- **UC Care/HSP discounts and risk**: Information on the aggregate discount compared to the pre-self-funded PPO is not available.

    - The risk for these plans is borne by the University, not UC Health specifically.

- **UC Health margin**: Combined, the employee plans represent 2.3% of the overall UC Health margin. Commercial plans, including UC's employee plans, provide critical margin for the

UCHC's to provide care to Medi-Cal members and to cover uncompensated care. This is an important part of UC's mission to provide health care services to all Californians.

- **Trend in plan rates**: On a risk-neutral basis, Blue & Gold premiums have increased 3% per year since taking on risk share (2016-20); UC Care has increased 4% per year since inception in 2014, both are significantly below what the market would have required if the plans had been fully insured with no benefit of special discounts from UC providers.

COMPARATORS – ACADEMIC MEDICAL CENTERS

HBAC was presented external information on academic health centers in two forms: a) summarized results of interviews with academic medical centers (AMCs)[17], where identities were blinded, and b) contribution and plan design information for academic health centers based on publicly available data, where the identities are disclosed.

Hospitals commonly prioritize directing employee health care internally rather than paying competitors to provide the service. The hospital funds benefits for all its employees, and keeping care in-house represents an expense savings; the question of revenue is not generally relevant.

For a multi-campus university where some campuses have a health center and some do not, the dynamic is a bit different. The health providers have the desire to treat their own employees and keep revenues in house (while also paying the health plan premiums for their employees) while managing cost for the rest of their campus and those campuses that do not have medical centers. Notable observations from this data included the following (note that no findings represent a scientific sampling):

- Most plans have some steerage mechanism to the AMC; the most common model is a richer PPO tier. Steerage is often more pronounced where the AMC is separate from the campus.

- Separate benefits for campus and health center appear in nearly half of the examined universities. Separate benefits always appear where the campus and university share a name but are separate legal entities.

- Interviewees reported that different perspectives and objectives between campus and health center are common; employee choice was often a value cited by campus representatives.

- It was not uncommon for AMCs to express a desire to develop a commercial health product, but this usually had not been realized.

PRINCIPLES ARTICULATED BY UC HEALTH

UC Health advanced the following vision and principles:

[17] Note that UC Health calls their hospital systems "Health Centers". Academic Medical Centers (AMCs) is the common industry term for academic health systems.

Vision

- Align around a vision and five-year roadmap for UC health plans that leverages UC's collective position of employer, payer, and provider to the maximum benefit of the University and our employees.

- Make UC-branded health plans the clear choice for all our employees, retirees and their families by offering innovative, differentiated, compelling, affordable and comprehensive health plans with outstanding member experience.

- Build on the success of the UC-branded health plans by offering them to other public and private employers to bring the best health care to Californians.

Principles

1. Employees are the priority — the UC Health campuses will not put forward a roadmap that negatively impacts employees from an overall cost perspective.

2. The value of UC health providers to the health plans will be transparently measured by metrics that include access, service, quality and value and are essential for monitoring and demonstrating health outcomes.

3. The roadmap will address the provision of convenient and accessible options to UC Health primary care providers or affiliates for all ten campuses ("15 minutes from home" metric) within 5 years.

4. UC Health will take the long view for the desired end state with strategies that will attract UC employees to UC plans over a period of time.

5. UC Health will continue to be committed to the University's mission of teaching, research and public service, while remaining competitive on cost.

6. The roadmap will include campus specific pilots or demonstration projects that allow progress on local campuses.

UC HEALTH PRIORITIES FOR ACTION

Improve Access

The UC Health objective:

Expand UC provider and affiliate primary care network at all campus locations including UC staffed onsite clinics serving non-Health Center campuses; increase telehealth options; reduce wait times for appointments with UC providers.

UC Health has initiated access expansions at Davis (campus clinic), Merced (area clinic), Santa Barbara (two area UCLA Health clinics), Santa Cruz (Canopy Health expansion), and offering the Berkeley student health center within the Anthem network. Its objective is to expand UC branded or affiliated health services at all campuses, particularly those that are underserved either through limited availability of community providers such as Merced or with limited local choice and competition (Santa Barbara). UC Health also is expanding access in its current operations —

e.g., access within 15 minutes or 15 miles of employee residences, expanded hours of operation, 24-hour phone coverage. Delivery of UC telehealth services has increased exponentially in response to COVID and is considered a key method for expanding access and geographic reach.

Efficiently Deliver Quality, Accountability through Metrics, Optimize Kaiser Relationship, Regional Pilots

- UC Health proposes to share financial performance risk of plans that UC providers participate in and are self-funded by the University. This takes an industry principle that providers are best positioned to make care decisions that is appropriate and efficient, and the application of provider financial risk — as with capitation, where providers are paid a fixed amount for caring for a population with a diverse and known risk profile — activates this efficient care delivery.

- Goals include eliminating excessive variations in care, building population health capabilities, and optimizing the right care in the right setting; improving value to members through high quality and competitive cost. These population health and care management ideas include second-surgical opinions and chronic disease management.

- UC Health advances the commitment to transparency and accountability and will establish a report card for all UC health plans to measure performance including access, patient satisfaction, cost, value, and quality.

- UC Health seeks a fundamental repositioning of UC Health plans vs. Kaiser. Specific objectives include 1) resetting contributions to more favorably position UC Health and change the enrollment distribution over time, and 2) repatriating to UC Health significantly more of the care that Kaiser directs to external providers (e.g., Dignity Health). The roadmap will include campus specific pilots or demonstration projects that allow progress on the priorities above, including changes that can lower employee costs.

Promote Plan Value to Members

UC Health desires to modify plan design to encourage members to choose UC providers and enhance enrollment process to encourage members to pick UC plans.

HBAC THOUGHTS AND OPINIONS

UC Health Principles

The vision and principles are generally accepted by HBAC as adding value to the health program made available to the University population. There are some areas of concern or open questions in the approach to operationalizing these principles that could benefit from further clarity or examples.

- Some in the committee have noted that the University benefit plan comprises a very small share of UC Health's overall business (identified above), with little potential to materially affect their financial health, although the Health Center CEOs say that its importance is really about wanting to "take care of our own." They also want to provide the highest quality care available to them, such as what can be accessed through UC's five NCI designated cancer centers.

- "Win-win" propositions where the UC Health plans attract more enrollment by being made more valuable to the members and the University are entirely welcomed; concerns have been raised by some if it requires reducing choice, raising enrollment cost or reducing benefits for competing plans and providers.

    - Historically, Human Resources has made decisions that altered or constrained choice in the benefit plan to achieve certain aims and there have always been some winners and some losers: consolidating to a single network-model HMO (2008); introducing a narrow-network HMO that raised employee cost for the higher-cost HMO providers (2011); removing the higher cost HMO, leaving only the still-higher cost PPO to access certain providers (2014). These actions always weighed the balance of interests within the overall UC benefit program – e.g., both plan sustainability and a majority of the enrollees were helped by the introduction of Blue & Gold, though some individuals were disadvantaged.

    - The ESC has a stated objective to "facilitate and support the use of UC Health providers to provide high quality/cost effective care." UC Health's participation in the UC health plan offerings furthers the research, teaching, and service mission of the University. The challenge will be to find a way to meet this objective while upholding other ESC objectives to minimize disruption to members and create value to the health plans. The 2013 decision to remove Brown & Toland/CPMC from Blue & Gold in return for cost concessions from Canopy Health/UCSF to support the objectives of UCSF Health is an example.

- Employee choice — of plan types and providers — has been a consistent UC value proposition over time. While choice is an ESC objective and was reflected as a value in early HBAC documentation, the committee did not specifically address its status as a priority or how it balances with potential objectives to increase the share of UC Health services in the UC medical plans. The Executive Steering Committee may want to further define what choice means.

- For UC Health to provide health services to a larger share of the employee population, there are several distinct population/care segments from which UC Health may draw: Kaiser enrollees; members in Blue & Gold, UC Care and HSP who use other providers; and tertiary/quaternary (T/Q) care for all members using non-UC Health providers, including Kaiser. In addition, UC Health believes there are opportunities to attract new employees who must make a health plan choice to "pick UC". UC Health sees employee share growth in its health plans as a key component of its overall strategic plan and will develop specific success metrics as they build out their tactical roadmap.

- There are differences in circumstances and preferred tactics among the UC Health Centers that make systemwide proposals more challenging, but UC Health's desire to do pilots and demonstration projects allow one campus to try something and if it works can be expanded to other locations.

Proposals to Improve Access

UCH's commitment to provide access to all campuses is universally welcomed. Plan and specific time horizons are significant advances in raising confidence that objectives will materialize. Primary care doctors will refer within network and through their normal referral patterns, as

they do today. New clinics being established in Santa Barbara and Merced will include physician privileges at the local hospitals. Higher level acuity cases will likely be referred to UC.

Efficiently Deliver Quality, Drive Accountability through Metrics, Optimize Kaiser Relationship, Pilots

- UC Health presently takes risk for the cost of care in Blue & Gold ACO for members who are attributed to UC providers (about 45% of the Blue & Gold premium). For all other areas where the University is at risk, it is the University at large and not UC Health specifically that is at risk, as is typically the case with conventionally self-funded employers who are not health care providers.

- The care efficiency initiatives that UC Health is adopting broadly in its business can only help the University and its benefit plans.

- The UC Health commitment to transparency and metric-based evaluation of initiatives is considered an important way to measure success and achievement of their vision and principles.

- The options and potential actions with regard to Kaiser drew considerable discussion within HBAC.

    - The contribution options are discussed above and later in this report.

    - There is support that care that is currently being sent outside of the Kaiser system to non-UC providers should be sent to UC providers as long as there is no negative financial impact to the plan and that care coordination and administrative requirements can be handled. In addition, there is openness to consider UC providing tertiary/quaternary wrap coverage for Kaiser members, particularly for cancer services.

    - UC Health encourages using the combined negotiating power of the University as a provider, employer and payer with all health plans, including Kaiser, which should result in more competitive contracts. Concern was expressed by a few that doing so could negatively impact Kaiser's willingness to offer the same benefit plan at the same price.

    - In response to UC Health's proposal to self-fund Kaiser and the value of doing so, Human Resources expressed concerns that without further analysis: 1) there is no indication that this would lower plan costs and it may raise them; 2) this has not been an attractive product in the market and is mostly tied to the option of a high-deductible plan; 3) Kaiser admits its self-funding model has challenges and doesn't promote it; and 4) as a closed model, Kaiser is unlikely to grant access to levels of data or discretion over care management and external referrals that differ from its standard practice.

RECOMMENDATIONS AND OUTCOMES

- HBAC fully agrees with efforts of UC Health to extend access to all UC campus employees across the 10 campuses, especially those who live where market conditions limit choice or access within the community. UC Health will work with the affected locations on priorities,

plans, and timing.

- HBAC recognizes UC Health's desire to deliver care to a greater share of the UC employee population. Some HBAC members have concerns on achieving this, however, by limiting provider choice and any action to do so should consider disruption to plan participants. A majority of HBAC members also were not supportive of an approach to shift cost to Kaiser enrollees.

- To provide UC's Kaiser enrollees with greater access to UC Health's distinguished level of care (specialty, tertiary/quaternary), HBAC recommends seeking negotiation with Kaiser to send its UC members to UC Health providers for the services that are not done within the Kaiser system. Most HBAC members recommend the following conditions: no increase in the Kaiser premium for UC resulting from this policy and no substantial burden on the patient.

- HBAC supports the continuation of offering medical benefit equity across locations. While UC offers all employees access to the same plans when possible at the same costs, in reality not all employees live in an area with equal access to providers. The options for local healthcare vary considerably across campuses; as a result, campuses can incur different costs towards medical health benefits. At the same time, there is value in innovation, creating demonstration projects or testing new options or variations in specific locations before a systemwide launch. There may also be the need to introduce a solution for a specific location to address an issue or opportunity that is unique to a given location, especially at under-served campuses. Upholding an equity principle should be undertaken in a manner that maximizes positive outcomes for a particular location. While some members expressed support for pilots, others need to better understand details and criteria of pilots before endorsement by ESC.

- Some HBAC members support an ESC-sponsored study by an independent third party to assess the impacts of retaining premium dollars within the UC Health System. Other HBAC members do not believe there was enough discussion or understanding of the objectives to support the study. If a study were pursued, HBAC believes that ESC should draft the charge and choose the third party. HBAC recommends that the study include broad University input and have a transparent approach.

APPENDIX

Appendix A: Summary of UC Health Plans

UC Employee Health Plans as of May 2020

Plan Name	Vendor	Plan Type	Funding Arrangement
UC Blue & Gold HMO	Health Net	Commercial HMO with custom network	Flex-Funded
Kaiser Permanente HMO - CA	Kaiser Permanente	Commercial HMO	Insured
UC Care PPO	Anthem	PPO with custom network	Self-Funded
UC Health Savings PPO Plan		High-deductible Health Plan PPO with Health Savings Accounts	Self-Funded
Core PPO		Catastrophic Coverage	Self-Funded

Note: Employee Health Plans above apply to non-Medicare retirees

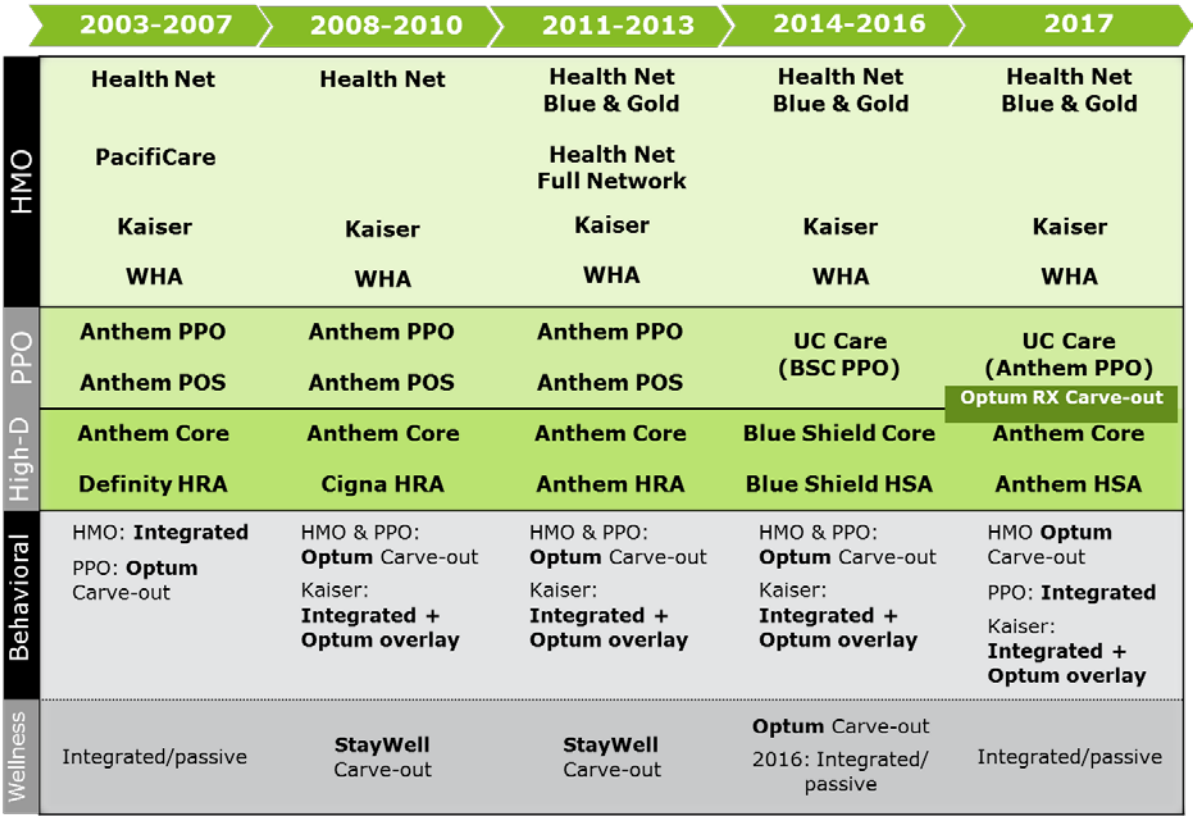
UC Retiree Health Plans as of May 2020

Plan Name	Vendor	Plan Type	Funding Arrangement
UC Medicare Choice	UnitedHealthcare	Medicare Advantage PPO	Insured
Senior Advantage	Kaiser Permanente	Medicare Advantage HMO	Insured
High Option	Anthem	Medicare supplement	Self-Funded
Medicare PPO		Medicare supplement	Self-Funded

Appendix B: UC Health Benefits Program Evolution Timeline

2003	● Blue Cross ("PLUS") replaces Aetna POS plan; PPO plan introduced with Blue Cross UBH (Optum) introduced as behavioral health carve-out on PLUS and PPO ● UCHC "Walk-up mail order" introduced with Blue Cross ● Pay bands (two) and minimum contribution introduced
2004	● Consumer-Directed Health Plan (HRA-PPO) introduced as pilot at SB and SF campuses with Definity Health ● Pay bands expanded (four)
2006	● HMO office visit copayments increased from $10 to $15 ● UCHC "Walk-up mail order" expanded to all plans
2008	● PacifiCare eliminated, network HMO consolidated to Health Net; Health Net becomes *de facto* contribution target plan ● HRA-PPO expanded to a system-wide offering; CIGNA replaces Definity Health ● UBH (Optum) behavioral health carve-out introduced for all plans except Kaiser, Core, and Medicare plans; applied as overlay to Kaiser ● StayWell wellness carve-out with member incentive introduced for all plans except Kaiser ● UC initiates Data Warehouse with Thomson Reuters ● Preventive care at 100% for all except Kaiser
2010	● WHA terminates Medicare Advantage product ● Retiree medical contributions separated from Pay Band structure ● Generic Rx copay reduced ● Phase I of federal mental health parity
2011	● **Custom Blue & Gold network HMO implemented with Health Net** ● Anthem replaces CIGNA as HRA-PPO administrator ● ACA changes: Dependent eligibility to age 26; Kaiser preventive care at 100% ● Further Mental Health Parity changes, including cross-accumulation of deductibles and out-of-pocket maximums
2013	● HMO office visit copayments increased from $15 to $20
2014	● Removal of Health Net full network HMO, Anthem PPO, PLUS and HRA-PPO plan ● Introduction of UC Care and BSC HSA-PPO plan ● Blue Shield replaces Anthem as administrator of non-Medicare PPO plans, Medicare PPO, and High Option; BH carved in for Medicare PPO ● Optum replaces StayWell as wellness vendor; Kaiser members become eligible; spouse incentive ended ● Medicare Exchange introduced outside California
2015	● 90-day supply maintenance medications may be obtained at participating retail pharmacies ● Chiropractic and acupuncture added to HMO ● Kaiser risk sharing introduced
2016	● PPO bid process replaces Blue Shield with Anthem, replaces Optum BH carve-out with integrated BH, introduces Optum carve-out Rx effective Jan 2017 ● Carve-out wellness and wellness incentive terminated

Appendix C: Health Benefits Portfolio Evolution



	2003-2007	2008-2010	2011-2013	2014-2016	2017
HMO	**Health Net** **PacifiCare** **Kaiser** **WHA**	**Health Net** **Kaiser** **WHA**	**Health Net Blue & Gold** **Health Net Full Network** **Kaiser** **WHA**	**Health Net Blue & Gold** **Kaiser** **WHA**	**Health Net Blue & Gold** **Kaiser** **WHA**
PPO	**Anthem PPO** **Anthem POS**	**Anthem PPO** **Anthem POS**	**Anthem PPO** **Anthem POS**	**UC Care (BSC PPO)**	**UC Care (Anthem PPO)** **Optum RX Carve-out**
High-D	**Anthem Core** **Definity HRA**	**Anthem Core** **Cigna HRA**	**Anthem Core** **Anthem HRA**	**Blue Shield Core** **Blue Shield HSA**	**Anthem Core** **Anthem HSA**
Behavioral	HMO: **Integrated** PPO: **Optum** Carve-out	HMO & PPO: **Optum** Carve-out Kaiser: **Integrated + Optum overlay**	HMO & PPO: **Optum** Carve-out Kaiser: **Integrated + Optum overlay**	HMO & PPO: **Optum** Carve-out Kaiser: **Integrated + Optum overlay**	HMO **Optum** Carve-out PPO: **Integrated** Kaiser: **Integrated + Optum overlay**
Wellness	Integrated/passive	**StayWell** Carve-out	**StayWell** Carve-out	**Optum** Carve-out 2016: Integrated/ passive	Integrated/passive

Appendix D: History of UC Self-Funded Plans

2014	• Self-funded UC Care PPO plan replaces Anthem PPO and POS plans • Established reporting under Risk Services with shared governance between HR and UC Health (CFO, COO, EVP)
2015	• Transition of UC Care to management under UC Health
2016	• Health Center ACOs created for Health Net HMO
2017	• President Napolitano changes her delegation of authority from HR to ESC • Other PPO health plans transition to management under UC Health
2018	• Health Net HMO transitions from fully-insured to flex-funded structure

Appendix E: Charge Letter from Rachael Nava

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April 23, 2019

MEMBERS OF THE RETIREE HEALTH BENEFITS
WORKING GROUP

Dear Colleagues:

I write to provide an update on the review of retiree health benefit programs and next steps. As you are aware, the Retiree Health Benefits Working Group was established in January 2018. After reviewing the retiree health benefits programs and modeling of program alternatives, the Working Group submitted an interim report in July 2018. The Working Group's recommendations included modifying the contributions of non-Medicare retirees over 65; making no other immediate plan changes due to that year's modest cost increase; and continuing its work to address longer -term issues. The knowledge and perspectives of the Working Group members has provided important counsel to the University.

A meeting was recently scheduled for the Working Group and then subsequently postponed due to scheduling conflicts and internal discussions regarding how best to continue this work, given that an expanded scope of activities is being considered. We regret these scheduling delays occurred and are committed to quickly refocusing our efforts on the long-term viability of this important retiree benefit.

Before speaking to the expanded scope, let me first address the Request for Proposals (RFP) that was issued in January to explore the possibility of converting one or more plans to a Medicare Advantage PPO. Prior to issuing the RFP, Systemwide Human Resources (HR) proposed the plan to the UCOP Executive Steering Committee on Health Benefits Programs (ESC), which has the fiduciary responsibility for the University's health benefit plans. The stated purpose for the RFP was to validate the savings modeled on these types of emerging Medicare programs in order to address anticipated higher increases in the retiree health program, which for the 2020 rate year are expected to be in the high single/low double digits.

The ESC, which I chair, agreed that HR should proceed and that representatives from the Academic Senate and CUCRA/CUCEA be invited to participate in the RFP evaluation process. Nominations were sought, and members have been participating in weekly meetings since February. Written and oral presentations were recently evaluated but a vendor has not been selected; an analysis as to whether the plan would be implemented, its relationship to existing plans and potential impacts to retirees has not been completed; and therefore any final decisions regarding implementation have not yet been made.

Due to the lull in Working Group meetings, the Working Group has not yet been engaged in this effort, but this will change effective immediately. Questions recently raised about the process are well founded-that is, to ensure any changes are approached thoughtfully. It is appropriate to put these questions before the Working Group (actually, its successor group as described below) which will then provide its best advice to university leadership. We will also reach out to the Academic Senate's Health Care Task Force. While the University does maintain authority and responsibility for any plan changes, working together on this important issue will without a doubt provide a better result.

Regarding the future of the Retiree Health Benefits Working Group itself, we have, as mentioned above, been in the process of initiating a broader review of the UC Health Benefits Portfolio. A principle reason for this is the recommendation of a committee which reviewed many aspects of UCOP's Health Division. In October 2018, the UC Health Restructuring Advisory Committee suggested the President undertake an evaluation of UC's employee health benefits, stating, "It is beyond the scope of the Committee's charge to evaluate the plan structure and offerings of University employee health benefits; the Committee nevertheless believes that a thorough evaluation of the University's approach to employee health benefits would be timely and important."

President Napolitano accepted this recommendations and charged the ESC in late January with the task of convening and overseeing a new Advisory Committee to review UC's Employee Health Benefits Programs and various modes of delivery, plan design and structure, and make recommendations to ensure their overall attractiveness and affordability. Since retiree health benefits are a component of UC's Employee Health Benefit Programs, the ESC decided it would be more effective to combine the Working Group with the new Advisory Committee. To take advantage of the expertise already developed, the Working Group will be supplemented with a limited number of new members, ex officio members may transition, and the group will be retitled the UC Employee Health Benefits Advisory Committee.

I am also taking this opportunity to make changes designed to improve the governance and effectiveness of this new committee. First, I have asked John Meyer to serve as Advisory Committee Chair. John is a retired administrative Vice Chancellor from UC Davis and has been CUCRA's representative to the Working Group. I will ask CUCRA to nominate another representative so that it is fully represented and not encumbered by John's role as chair. I am confident the Advisory Committee will be well-positioned for success under John's leadership and appreciate his willingness to take on this important assignment. We will also provide resources from the Strategy and Program Management Office, and I have asked our Chief Strategy Officer, Zoanne Nelson, who also serves on the ESC, to join the Committee. HR, UC Health and UC Legal subject matter experts will support, but not be members of, the Committee.

We plan to quickly bring the Advisory Committee together to begin the process of reviewing and commenting on the results of the RFP process. The Advisory Committee will also engage in discussions about its broader charge, with the expectation that recommendation s to the ESC and the President on the broader effort will be provided by April 2020. The earliest those recommendations could be adopted would likely be for the 2021 plan year.

I appreciate the concerns that have been raised and am committed to moving forward with an inclusive and transparent process. Please let me know if you have any questions. I can be reached at Rachael.Nava@ucop.edu or 510-987-0500. Thank you for your participation and commitment.

Sincerely,

Rachael Nava
Executive Vice President - Chief Operating Officer and Chief of Staff to the President

cc: Chancellors
Jack Stobo, Executive Vice President, UC Health
Nathan Brostrom, Executive Vice President and Chief Financial Officer

Gerald Kominski, Professor, Health Policy and Management
Zoanne Nelson, Chief Strategy Officer and AVP, Strategy and Program Management Office
Rachel Nosowsky, Deputy General Counsel, Health Affairs & Technology Law
Mike Baptista, Executive Director, Benefit Programs and Strategy
Laura Tauber, Executive Director, UC Self-Funded Health Plans
Marianne Schnaubelt, President, CUCRA
Caroline Kane, President, CUCEA