

August 14, 2015

To: Retirees, UWG Association of Retired Faculty and Staff

From: Anne C. Richards

**RE: USG HEALTHCARE TRANSITION PROCESS for MEDICARE-ELIGIBLE RETIREES
PREPARING FOR PHONE CALLS WITH BENEFITS ADVISORS**

A group of volunteer retirees from the USG Retiree Council have been providing feedback to the USG about the effectiveness of communications related to the upcoming transition to a new healthcare model. The same group was given an opportunity to participate in and/or listen in on mock or demonstration telephone conversations between a retiree and an AON benefits advisor. There were six of these mock demonstrations, which took place on August 4, 5 and 6. I was able to listen in on the very first demonstration call but missed others because I was out of state for a family get-together. The purpose of these calls was to give the group an experience of what the enrollment process would be like in the Fall.

Yesterday, Monica Fenton, Director of System Benefits - Healthcare & Pharmacy, conducted a part Web-Ex, part phone-in discussion of how these mock sessions went in the hopes of learning things that could be passed along to AON so that any problems can be identified in advance and corrected before retirees take part in the calls that will result in their choosing a new supplemental healthcare plan and a new prescription drug plan. A representative from AON, Matthew Berkeley, was also a participant in this discussion. Karin Elliott, Associate Vice Chancellor for Total Rewards, USG, was also on the line.

What follows are some highlights of yesterday's conversation, along with some reflections of mine related to the August 4th mock call I was able to hear. **NOTE:** Because I participated in these calls via telephone and not Web-Ex, in many cases I do not know who said what during these interchanges. Where I recognized voices, or where people provided their names before speaking, I have noted this.

Each mock/demonstration call lasted 45 minutes and was followed by a half-hour talk-back session, where those participating in the call and those listening in on the call could share their experience of what transpired in the call, offer suggestions, and ask questions. Each call involved a different staged scenario - with retirees scripted to be living in different locations in the state, having different medical problems or issues and different prescription drug needs.

Call scheduled for 11 am, August 4, 2015

In the call I heard, the retiree was asked what was most important for him so far as a healthcare plan was concerned. Getting access to particular prescriptions? Having no responsibility for co-pays or deductibles? Having the freedom to see any doctor? Keeping particular doctors he already had? Using a particular pharmacy closest to where he lived? Getting a bill by regular mail or having his premium deducted automatically?

At the end of the call I heard, the person being introduced to the AON process was asked to select one word that captured his experience of the call. His choice was "overwhelming" and I definitely agreed with him. In rather lickety-split fashion, the Benefits Advisor explained such things as:

- *Differences between Medicare Advantage Plans such as HMOs, PPOs, etc.
- *Differences between Medicare Advantage Plans and Medicare Supplement Plans (Medigap plans)
- *A variety of limitations or restrictions on Medicare Part D plans such as quantity limits for particular drugs, depending on whether they are Tier I, II, III, IV or V type (a LOT to sort out on just this one issue).
- *Issues related to how the donut hole matter will be handled by particular plans.
- *Issues related to which doctors and hospitals might be included, or not, by particular healthcare plans.
- *Issues related to whether some prescription drug plans allow for or disallow mail orders.
- *Issues related to what happens if people travel outside of the country.

There was, in my opinion, and in the opinion of others listening in on this call, far too much information to take in and process intelligently during the time allotted for the call. We were reminded that actual calls can take up to 90 minutes rather than the 45 minutes this one took and that retirees are likely to be far better prepared for their actual calls than the person participating in the mock call on this occasion. We were told that the Benefits Advisor will "pace the call to what the person requires," will "take as long as it takes" to communicate important issues effectively. There will be "no time constraints on the phone calls" when retirees actually sign up for coverage and it is understood that there are likely to be "multiple phone calls" before a retiree feels ready to make a decision about a particular plan. We were told that a considerable amount of the material covered by the Benefits Advisor in this call will be reviewed during the upcoming meetings on different campuses to be held in August and September - so retirees will already know about a lot of information we heard for the first time on this call and won't have to spend time with Benefits Advisors going over these things on the phone. It was agreed that this would definitely be helpful to retirees so they can simply focus on the details of the plan they want and not begin learning about the different categories of plans. That being the case, **it's going to be VERY IMPORTANT for everyone to attend one of the meetings in August and September - prior to speaking with a Benefits Advisor.**

Other suggestions made by those involved in this call: Benefits Advisors should be reminded that they are working with elderly people who have hearing issues. They need to speak slowly. Accents may create communication issues. Retirees should be reminded to tell their Benefits Advisors to adjust the pace and tone of their speaking if the retirees have problems hearing them. Someone said it would be helpful if retirees were provided with a check list of information they should gather in advance of the call with the Benefits Advisor. We were told this will be coming in literature not yet mailed to retirees.

A discussion took place during the call about how much time would elapse between the retiree's payment of the premium and receipt of the reimbursement for this payment through the Health

Reimbursement Account (HRA). In early meetings with USG HR individuals, retirees had been told the process would take about 3 working days. In a subsequent phone call, USGRC volunteers were told the process would take 4-6 weeks (conservatively estimated) for the very first payment because of verification or authentication considerations. In the mock enrollment conversation I heard, the Benefits Advisor told the retiree that turn-around time would be 3 months for reimbursement for the first payment to be made in January, 2016. When asked by the retiree why things would take that long, the Benefits Advisor said that, after March, it will be handled month after month on approximately the 6th day of each month (**if an automatic payment plan is in place**). Between January and March, because this is a "new process for the USG," the System needs to "make sure everything is aligned. They have to review everything and get it all in place." To get reimbursement sooner (within 1-10 days) if waiting months constitutes a financial hardship for a retiree, **for premiums only** the retiree can call the Benefits Advisor and submit a request in writing for an expedited reimbursement so long as appropriate evidence of payment accompanies the request. I asked what appropriate evidence would involve. Response: A bill from the insurance company that serves as proof of what needed to be paid and a statement from a retiree's bank indicating payment of the bill in question has been made. I explained that getting such proof from a bank might take longer than 1-10 days if payment is made by check because the bank would have to wait until the check is deposited by the carrier and it subsequently clears through the bank. If payment is made automatically from an account, however, the transaction could be seen the next day.

I also asked a question sent to me by one of our retirees - about what sorts of expenses are considered "eligible" for reimbursement through the HRA. Response: There is an "extensive list" of what the HRA can reimburse retirees for which is based on the IRS tax code. The list will be available for all of us retirees on line on January 1, 2016. Prior to that date, its contents will be known to our Benefits Advisors, but we will likely not be able to learn everything that's on that list until January 1, 2016. Part of the problem in learning more along these lines is that the calls are expected to cover so much information as it is that going over such an "extensive list" is not considered feasible.

It was noted by a representative of AON that **plans available to a given retiree will be driven by the retiree's zip code.**

Feedback on call scheduled on August 5, 2015.

The retiree who served as the participant in this call said her feelings were as follows: "The more I got into it, the more overwhelmed and anxious" I felt. And this was a person who said she "deals with benefits." "I was stressed out." It was "very overwhelming" because there was "so much information" to consider.

She recommended that the Benefits Advisor give an overview or outline of what is going to be covered during the phone call. She also mentioned that one Benefits Advisor was on the line initially (who seemed to be someone in training) and then a noticeably more "seasoned person" came on the phone. She thought the Benefits Advisor needed to "exude confidence and knowledge of the plans and the process" and know his or her audience enough to "slow down the speed with which information is given." She thought her husband, who has a Ph.D. would find the process "overwhelming" as it took place on the call in which she participated. She

recommended retirees get "packets of information" in advance of the calls to be better prepared for the calls.

Monica asked if the information provided by the Benefits Advisor was "beneficial to helping" this individual "make a decision about her healthcare plan." The retiree said that when the second Benefits Advisor came on the phone, she felt able to do it, but she also said she needed to see information in front of her before making a decision - and couldn't make a decision just by talking with someone over the phone. She also felt that a person really needed to have detailed information about his or her medications in order to choose a pharmacy plan wisely.

Monica noted that during the mock enrollment process, there was more of a "condensed time" frame. Actual sessions could last much longer and the retiree has the option of scheduling multiple calls. In the Fall, the retirees will also have an informative "enrollment guide" available that can be accessed as they go along throughout the call.

Feedback on call scheduled on August 6, 2015.

The person who participated in this call said her experience was quite different from those cited above, perhaps because improvements had been made as the week went along. She assumed the person who handled her interview was "from the insurance company." But Monica explained that all the Benefits Advisors on the calls were from AON.

"At first it did seem overwhelming," this retiree said. But when the Benefits Advisor seemed very comfortable answering her questions about how the healthcare plan would apply if she traveled elsewhere, she was impressed. She said "I felt very comfortable once we finished. I understood more about the Medicare Advantage plan."

This individual had been given a script indicating she needed a plan to cover particular medications, but she decided to throw in a question about other medication that was beyond what was on the narrative she received. She noted that the Benefits Advisor "seemed very comfortable answering this also."

Brahm Verma said he had listened in on this call and thought the Benefits Advisor had a "polished presentation" and "did a very nice job." The call went "better than he anticipated it might." The retiree participating in the call said she thought the Benefits Advisor was "methodical and patient, because I could be trying" - and came up with the unscripted prescription change.

Mary Jane asked if the AON advisors were screened for getting kickbacks from particular insurance companies as they made suggestions about various plans to retirees.

Matt Berkeley explained that the Advisors are "not incented in any way to guide retirees in picking a plan." The sale does not influence them at all. They are salaried through AON.

Brahm Verma said he found it surprising that the sample plan being discussed in this call - Plan F - varied in cost based on the provider. He did not get a clear sense of why this was the case.

The Benefits Advisor indicated that the same Plan F was available from different carriers, and supposedly had the "same coverage," but each carrier charged a different monthly premium for the plan. AARP charged \$168, AETNA charged \$195, Blue Cross/Blue Shield charged \$170, and a fourth carrier charged \$147. Given this discrepancy in cost for what was described as the "same plan," Brahm asked how it was recommended he make a decision on this.

Matt Berkeley explained that Plan F was the same because "Benefits are all standardized" across the country, and AON "only works with reputable carriers." The "core benefits" in all plans "are exactly the same," according to Berkeley. They might have different premiums, however. And the retiree might happen to like one carrier over another and choose that carrier regardless of price.

Brahm said he understood that some plans might throw in a "Silver Sneakers" benefit - which involves giving retirees membership in a gym at participating gyms across the country. Berkeley said that United Health Care plans in some areas offer the Silver Sneakers benefit. Brahm said that this difference was not explained until he asked probing questions about the difference in plans. He had come to understand that some plans provide "fringe benefits" others don't - but the Benefits Advisor hadn't volunteered information about these so those listening in on the call didn't know about them.

Someone asked if the same plan might cost more because the carrier offered better service to its customers or clients. The same person explained how aggravating it could be to discover that a medication one needed was not on the formulary list for a given prescription drug plan.

Matt Berkeley explained that in terms of "service," all plans are "the same." If, for example, retirees who are Medicare-Eligible go to a hospital and are kept overnight or have surgery, the medical facility will get their Medicare card and simply bill Medicare for their treatment. The retiree doesn't get a bill and doesn't deal with the hospital. "So in terms of service, it's all the same so long as the hospital and treatment is approved by Medicare."

Patricia asked if all retirees, regardless of whether they lived in Georgia or Arizona would be given the same plans?

Matt Berkeley: "The plans are all standardized in **most** [emphasis mine] states."

Someone mentioned that it would be helpful to have mock sessions after retirees have all the information needed to make actual choices. At this point, too much information is simply unknown.

Louie (from Valdosta) said he considered the demonstration sessions to be "quasi-mock" sessions rather than "true mock sessions" because there was inadequate time for all follow-up questions to be asked.

Brenda asked if the variation in premiums that Brahm had noted above could be attributed to particular "perks" or "fringe benefits" provided by given carriers. If one company charges more

for the "same plan" is it because we are actually paying for the perks (such as "Silver Sneakers")?

Matt Berkeley said the "perks are very limited at best." You are paying for "core benefits." It may be that in one area of the state or country there is a wide range of costs for the same benefits. He said retirees should think about the situation as similar to going to a car dealership. In one lot a particular car might be available for \$100. In another, the same car might cost \$125. Similarly, each insurance company has its own system for determining the price it charges for a given healthcare plan. All a retiree needs to know is that the plan's core benefits are the same.

Jim Gonzalez said that, as a psychologist, he deals with insurance companies all the time and has learned that different providers pay differently for the same type of therapy. He understands that the variance has to do with the relationships that particular insurance companies have with core providers and hospitals with whom they contract.

Matt Berkeley noted that "some areas are healthier than others too."

Brenda said that if she lived in California, perhaps paying \$275/month might not be seen as that much. But living in Georgia, such a premium seemed quite high to her.

Another person on the call said she's been in the insurance industry and has learned that costs are determined a lot by contracts insurance companies can get with providers in the area. She noted that the amount to be provided to retirees for their healthcare, which she had read about in today's *Atlanta Journal-Constitution* didn't seem to allow for making high premium payments for healthcare.

Some on the call expressed confusion about how the papers had learned about the amount to be provided to retirees for their healthcare and prescription drug plans when retirees themselves didn't know. I explained that the Board of Regents had met yesterday and approved the amount. Karin Elliott said that details about this amount will be provided at the August and September meetings.

Brahm Verma asked if the service provided by given carriers happened to be different, how will Benefits Advisors assist retirees in choosing between them?

Matt Berkeley reiterated that, as long as the services provided are "Medicare-approved," he hasn't heard of any issues about service and didn't expect that retirees will see any differences in service - whether dealing with Humana, United Health Care, Blue Cross/Blue Shield, etc. He said if anything comes up where a retiree has a problem with a provider that cannot be resolved, the retiree should first call his or her Benefits Advisor. And if that individual can't resolve the problem, AON has set up an "Advocacy Services" group or team that will take on the task of working the problem out.

John said he lives in Alabama. His current doctor accepts Medicare but will not accept all supplemental insurance. Neither AETNA nor HUMANA are accepted by this doctor. Matt explained that some Medicare Advantage Plans accept only doctors in particular networks.

Jim Gonzalez explained that acceptance depends on whether the doctors have contracted with a particular insurance company to accept their reimbursement rates for medical services.

Matt maintained that "As long as a doctor accepts Medicare patients, you can use the Medicare supplemental plan you have." Medicare bills the supplemental plan, not the doctor.

Someone else explained that he has a physician who doesn't accept Medicare, but can file claims with Medicare on behalf of the patient. This individual pays out-of-pocket for medical consults and treatment, and then receives a check subsequently from Medicare once paperwork regarding his claim is filed.

Matt explained that doctors can handle billings of this sort.

Jack pointed out that a given doctor may charge higher rates than Medicare will pay back, so it's important to talk to a provider about this.

Matt asked if the doctor was charging Medicare-approved rates or higher rates?

But he went on to say that as long as someone files with Medicare, everything is OK. Medicare will push an unpaid balance on to the Supplemental plan. If a retiree has plan F, for example, he or she only pays the premium, not the extra costs.

Someone else asked a question about three different insurance companies, some of which are more well known than others, yet all charge different premiums for the "same" coverage. He wanted to know if Matt was saying it doesn't matter which company a retiree chooses.

Matt: There are some people who like Blue Cross/Blue Shield, even though it's a little higher in cost. It's a personal choice for the retiree. We recommend you get the lowest price available, however.

Mary Jane: If you find you do not like the Supplemental Plan you have, can you change it?

Matt: With Supplemental plans, you can change any time during the year. You don't have to wait for an open enrollment period. **But in most cases, you'll be subject to underwriting health questions. If you start with a plan that has various benefits and reduce your plan down, you can do that no problem at all. But if you start with one plan with reduced benefits and want to increase your benefits at some point, then you will be subject to underwriting which means you will be asked to answer particular health questions. And as a result of your answers, you may be denied coverage under another plan. Each insurance company asks different questions in these circumstances. You have to "do due diligence" in picking your supplemental plan. You want to make sure whatever doctors you have are accepted in the network that plan requires. Network-based plans are much lower in premiums but have costs associated with most services.**

Question: Do the premiums for Medigap plans rise? If so, at what point and how much would the average increase be?

Matt: Every year, supplemental plan premiums are based on your age. Each year you get older, your premium goes up in price until age 80. After that it remains the same. Once a year, the insurance company has the right to increase the price of your premium by an average of 3-5%. This is not based on you as an individual, but is an across-the-board increase based on costs for everyone in the plan. So each year you could face two different price increases - one for your age, and one for the across-the-board increase.

Barbara: Since many of the meetings scheduled for August and September will take place before we get enrollment kits, will you go over things in the kits in meetings before we get the packet?

Matt: We will go over all this at those meetings. There will be a one hour presentation and a one-hour question/answer period. We will go in-depth about Medicare options, the reimbursement process. All that will come up.

Feedback regarding the session held on August 5, 2015

Jack explained that, during the mock session he had with a Benefits Advisor (Ricca), he was given a choice of two plans based on two medications he was taking. He said he didn't think this was the right way to go in handling matters of concern to him. He was not asked about any concerns he might have about lowering the monthly cost of his prescription drug plan. He was not asked about how his plans for travel might impact his choice of a plan. He said he would rather have various options given to him instead of having a plan based solely on particular medications. He was not told that if he moved to a different Supplemental plan or from a Medicare Advantage Plan to a Supplemental Plan there would be issues regarding underwriting. The Benefits Advisor mentioned two things that were inaccurate. She said that over-the-counter medications were not covered by the prescription drug plan and said she didn't see an option for signing up with Kaiser since I live in the Athens area. Neither of these statements is correct. Is there any way we can pre-identify comprehensive plans, similar to what is offered to current employees as a starting point?

Feedback regarding another session held last week.

Louie: In my session, my Benefits Advisor was also Ricca. I want her as my permanent Benefits Advisor. The information was "overwhelming" at first, but I came out reassured. I was almost ready to sign up then and there. The only question I got was whether I was on dialysis or not. Ricca went over different plans clearly. But I realized that this was not a full mock session - it was just a taste of how the actual enrollment session will go. I think we should have an opportunity to see how a real mock session goes, one that takes 1 hour to 1 and 1/2 hours.

Someone mentioned having listened to Jack's session. He noted that the Benefits Advisor started with the drugs Jack was scripted to be taking - and didn't bring up doctors. But what if you change your prescriptions? The Benefits Advisor never brought up the fact that maybe the new prescriptions might not be in the formulary.

Jack: She also gave me an "unrated" Advantage Plan based on two prescriptions.

Matt: People often change prescriptions. All we can do as Benefits Advisors is inform you about what we know of at the time we're enrolling you. During the course of a year, something else can come up. If something comes up mid-year, you can take your drug card and call either your Benefits Advisor or your Insurance company. If a particular drug is not covered by your prescription drug plan, all drug companies have to provide you with some alternative. As a last resort, your doctor can write a letter to the insurance company saying you need a particular drug.

Monica: Having that formulary list is helpful. CVS provides this as a resource so you can check on this.

Brahm: Where do we find the formulary? [No response given that I noted.]

Someone mentioned that Kaiser didn't have a full-service operation in Athens, and this may be why the Benefits Advisor said it wasn't on the list in Athens.

Someone mentioned that many retirees have to go through "**step therapy**" with drugs before their prescription drug plan will pay for particular drugs. They start with one and if that doesn't work, the prescription drug plan may authorize using another (typically more expensive) form of the drug. She **asked if retirees and/or spouses will have to start over on this step arrangement when they change to another drug company.**

Matt: **YES you would. Because the new drug company is not associated with the one you had. But when we look at plans, we can "red flag" this issue and explain this to you. We will go through this information with you.**

Louie: Right now, under our Medicare Drug plan, no matter where I go in Valdosta to buy a prescription, the price of the drug is the same. Will I now need to find the cheapest drug price?

Matt: We'll be asking you: Do you like your local pharmacy? You may find some plans have better deals at some pharmacies rather than others. What we try and do is plug that in and calculate that in the price you pay.

Brahm Verma: I want to make a couple of observations.

This is such a complex set of conditions to understand. You have a presentation to give. I hope you will emphasize the need to prepare before we get the call from the Benefits Advisor. Hopefully, our HR staff will assist us. This is a very complicated issue and there are a lot who will not understand this in two hours or more.

Matt: We will do this and give you instructions as to how to go on line and look things up in advance.***

*** Still a problem for those retirees who have limited literacy and/or do not use a computer.

Someone noted that last year, when she received the guide from HR about benefits, it indicated that the amount the employer contributed was \$3,360. That was \$280/month. Now she has learned that in the coming year this amount will be \$228. So the University System is giving retirees less money this year than they got last year for healthcare. Isn't this a bit unfair given the complicated process retirees are going to be put through?

Karin Elliott explained that when the amount of the contribution was determined, the USG had two primary goals in mind: (1) we wanted to make sure retirees were not paying more for their insurance in 2016 than they did today, (2) we wanted to insure that the University System of Georgia was not paying any more for their coverage than was the case in 2015. That's how we came up with the amount. Funding from the USG stays the same in 2016 as it did in 2015. When compared to what you get today, there are a lot of components that go into the funding and calculations that led to the amount being provided. We had some retirees not previously enrolled in Medicare, Part B. That made things more expensive. The cost of the plans provided by AON is much lower. As a result, the majority of retirees will not pay more in 2016 than they did in 2015.

Mary Jane: How long will we be able to sustain the relationship with our Benefits Advisor? Will it be ongoing? Do we partner with someone just through the enrollment process or thereafter as well?

Response: Unless you want a different advisor, you will keep the same one.

Question: How long will AON be with us?

Response: As long as the USG will be with AON.

Mary: I thought the amount we would receive was not known. How did you know what it was?

Anne Richards: I attended the meeting yesterday at the Board of Regents.

Brahm Verma: This brings up an issue of concern to me. I want there to be better communication.

Mary: I knew nothing about such a thing.

Karin Elliott: We did communicate this at the April meetings. And we did release a communication to all institutions yesterday, right after the Board approved this amount. As we come out to individual institutions, it will be communicated.

Confusion occurs on the phone call about the amount in question: \$2,736.00/year or \$228/month.

Someone mentioned that "This is lower than what we received in 2015. Retirees are getting less and being thrown into a more complicated system."

Question: Can we expect that every year this amount will be less and less?

Karin Elliott: This is something we will talk about. We will look at this every year just as we do today. We will do this review based on what is the medical trend in the market. Every year the amount could increase, decrease, or stay the same. When looking at the amount the USG funded last year, what's important is what you paid last year. You'll find that the premiums you'll be paying for plans are "much less in the Exchange." For some retirees, "the amount [given by the USG] will pay for the entire premium." We looked at things actuarially. Funding for us is the same from 2015 to 2016. You will get information mailed to your home about all this.

In the meantime, retirees were encouraged to attend one or more of the meetings that have been set up for them in August and September. If someone has not received the list of when and where these meetings will be held, contact the USG HR office.