

# San Francisco Health Service System Health Service Board

Blue Shield HMO

Plan Design Alternatives & Cost Implications

Beginning July 1, 2012

December 22, 2011

Prepared by Aon Hewitt  
Health and Benefits



# Contents

---

- Introductions
- Revised Plan Design Alternatives (Observations & Recommendations)
- Revised Premium (Contribution) Costs
- Revised Total Premium Costs & Savings
- Appendix
  - Benchmarking
  - Glossary

# Introduction

---

The benchmarking data (see appendix) provided during the December 8, 2011 Health Service Board meeting revealed a number of SFHSS plan design areas that are below market. The Blue Shield plan design alternatives focused on opportunities to mitigate the renewal monthly premium increase while maintaining plan competitiveness.

The plan design alternatives under consideration included:

- Office visit copay increase;
- Outpatient surgery copay increase;
- Inpatient hospital copay increase;
- Pharmacy copay increases; and
- Out-of-Pocket Maximum increases.

The Board requested a set of alternatives for the Status Quo Blue Shield HMO to offset the proposed 11.2% increase to be presented for consideration at the Special Board meeting in December. The Board's primary objective, while considering these plan design changes, is to offset as much of the renewal monthly premium increase as possible while staying within labor market benchmark presented.

# Blue Shield – Revised Plan Design Alternatives

Option	Office Visit Copay	Outpatient Surgery Copay	Inpatient Hospitalization Copay	Emergency Room Copay	Rx Retail/Mail Order GENERIC Copay	Rx Retail/Mail Order Formulary Brand Copay	Rx Retail/Mail Order Non Formulary Copay	Out of Pocket Hospital Maximum*	Active / Non Medicare % Change	Medicare MAPD/COB % Change	Financial Impact
<b>Current Design/ Status Quo</b>	<b>\$20</b>	<b>\$50</b>	<b>\$150</b>	<b>\$100</b>	<b>\$5/\$10</b>	<b>\$20/\$40</b>	<b>\$45/\$90</b>	<b>\$1,000/\$2,000</b>	<b>10.8%</b>	<b>17.6%</b>	<b>\$15,535,657</b>
Option A	\$25								-0.78%	-1.30%	(\$1,251,000)
Option B		\$100							-0.60%	-0.50%	(\$906,000)
Option C			\$200					\$2,000/\$4,000	-0.27%	-0.22%	(\$407,000)
Option D					\$10/\$20	\$25/\$50	\$50/\$100		-1.82%	-3.80%	(\$2,983,000)
Option E						\$25/\$50	\$50/\$100		-0.68%	-1.58%	(\$1,131,000)
Option F	\$25	\$100	\$200		\$5/\$10	\$25/\$50	\$50/\$100	\$2,000/\$4,000	These plan design combinations are not currently filed with the State and therefore are not available at this time.		
<b>Option G</b>	<b>\$25</b>	<b>\$100</b>	<b>\$200</b>		<b>\$10/\$20</b>	<b>\$25/\$50</b>	<b>\$50/\$100</b>	<b>\$2,000/\$4,000</b>	<b>-3.47%</b>	<b>-5.82%</b>	<b>(\$5,547,000)</b>

\*Medicare MAPD Out of Pocket will remain at \$6,700 per member.

## Observations and Recommendations

- Aon Hewitt evaluated current plans design to determine the optimal opportunities to offset the aggregate 11.2% 6 month renewal increase.
- The recent benchmarking data presented indicated that Office Visit, Outpatient Surgery, Inpatient Hospitalization, and Pharmacy copays were amongst the most viable candidates for adjustment.
- Aon Hewitt estimated that the number of non-preventative office visits per six months needed to exceed the premium contribution savings with recommended plan changes to be 2.7 per active family contract, 3.7 per early retiree contract or 2.9 for retiree with dependent contract.
- Aon Hewitt recommends Option G be implemented as this will provide the best opportunity to reduce the Blue Shield premium increase without increasing any of the plan provisions above benchmarks. Increase to the out of pocket maximum will coincide with these copay changes.

# Blue Shield – Revised Premium (Contribution) Costs

	Blue Shield	Active Employee			Non-Medicare Retiree			Medicare Retiree			
		EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+2	EE+2 (All Medicare)	EE+2
6 Month Contract Status Quo with SB 946	<b>Members</b>	\$0.00	\$125.35	\$586.70	\$62.67	\$388.65	\$929.75	\$0.00	\$222.57	\$667.08	\$763.67
	% Increase	0%	47%	25%	47%	15%	13%	0%	18%	18%	13%
	\$ Increase	\$0.00	\$39.89	\$116.49	\$19.94	\$51.72	\$104.46	\$0.00	\$33.68	\$101.05	\$86.42
	<b>Employer</b>	\$652.94	\$1,179.55	\$1,259.30	\$1,387.47	\$1,713.45	\$1,713.45	\$446.17	\$668.74	\$668.74	\$668.74
	% Increase	10.8%	8.0%	5.3%	9.6%	9.8%	9.8%	17.8%	17.8%	17.8%	17.8%
	\$ Increase	\$63.54	\$87.20	\$63.34	\$121.76	\$153.53	\$153.53	\$67.36	\$101.03	\$101.03	\$101.03
	<b>Total</b>	<b>\$652.94</b>	<b>\$1,304.90</b>	<b>\$1,846.00</b>	<b>\$1,450.14</b>	<b>\$2,102.10</b>	<b>\$2,643.20</b>	<b>\$446.17</b>	<b>\$891.31</b>	<b>\$1,335.82</b>	<b>\$1,432.41</b>
	% Increase	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	17.8%	17.8%	17.8%	15.1%
	\$ Increase	\$63.54	\$127.09	\$179.83	\$141.70	\$205.25	\$257.99	\$67.36	\$134.71	\$202.08	\$187.45
6 Month Contract With Revised Plan Design Recommendations	<b>Members</b>	\$0.00	\$102.86	\$528.23	\$51.43	\$366.17	\$888.60	\$0.00	\$209.72	\$628.55	\$732.16
	% Increase	0%	20%	12%	20%	9%	8%	0%	11%	11%	8%
	\$ Increase	\$0.00	\$17.40	\$58.02	\$8.70	\$29.24	\$63.31	\$0.00	\$20.83	\$62.52	\$54.91
	<b>Employer</b>	\$630.45	\$1,157.06	\$1,254.12	\$1,348.56	\$1,663.29	\$1,663.29	\$420.48	\$630.21	\$630.21	\$630.21
	% Increase	7.0%	5.9%	4.9%	6.5%	6.6%	6.6%	11.0%	11.0%	11.0%	11.0%
	\$ Increase	\$41.05	\$64.71	\$58.16	\$82.85	\$103.37	\$103.37	\$41.67	\$62.50	\$62.50	\$62.50
	<b>Total</b>	<b>\$630.45</b>	<b>\$1,259.92</b>	<b>\$1,782.35</b>	<b>\$1,399.99</b>	<b>\$2,029.46</b>	<b>\$2,551.89</b>	<b>\$420.48</b>	<b>\$839.94</b>	<b>\$1,258.76</b>	<b>\$1,362.37</b>
	% Increase	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	11.0%	11.0%	11.0%	9.4%
	\$ Increase	\$41.05	\$82.11	\$116.18	\$91.55	\$132.61	\$166.68	\$41.67	\$83.34	\$125.02	\$117.41
Savings	Member	\$0.00	\$22.49	\$58.47	\$11.24	\$22.48	\$41.15	\$0.00	\$12.85	\$38.53	\$31.51
	Employer	\$22.49	\$22.49	\$5.18	\$38.91	\$50.16	\$50.16	\$25.69	\$38.53	\$38.53	\$38.53
	<b>Total Savings</b>	<b>\$22.49</b>	<b>\$44.98</b>	<b>\$63.65</b>	<b>\$50.15</b>	<b>\$72.64</b>	<b>\$91.31</b>	<b>\$25.69</b>	<b>\$51.37</b>	<b>\$77.06</b>	<b>\$70.04</b>

## Observations

- The monthly premium (contributions) costs are reduced by the following amounts for EE+2 coverage:
  - Active Employee: a savings of \$58.47 per month or \$350.82 per the six month period.
  - Early Retiree: a savings of \$41.15 per month or \$246.90 per the six month period.
  - Medicare Retiree: a savings of \$31.51 per month or \$189.06 per the six month period.
  - Total Aggregate Employer: a savings of \$501,574 per month or \$3,009,443 per the six month period.

# Blue Shield – Revised Total Premium Costs & Savings


	Total Premium Renewal Calculation	Total Premium Costs				Increase from 2011-2012			
		Active Employees	Non-Medicare Retirees	Medicare Retirees	Total	Active Employees	Non-Medicare Retirees	Medicare Retirees	Total
6 Month Contract Status Quo SB 946	Member	\$19,435,437	\$3,608,304	\$847,057	\$23,890,798	28.4%	18.4%	16.1%	26.3%
	Employer	\$97,478,458	\$22,741,649	\$9,662,540	\$129,882,647	7.8%	9.7%	17.8%	8.9%
	<b>Total Costs</b>	<b>\$116,913,895</b>	<b>\$26,349,953</b>	<b>\$10,509,597</b>	<b>\$153,773,445</b>	<b>10.8%</b>	<b>10.8%</b>	<b>17.6%</b>	<b>11.2%</b>
6 Month Contract with Revised Plan Design Recommendations	Member	\$17,209,054	\$3,347,139	\$802,766	\$21,358,959	13.7%	9.8%	10.0%	12.9%
	Employer	\$95,675,123	\$22,091,902	\$9,106,179	\$126,873,204	5.9%	6.6%	11.0%	6.3%
	<b>Total Costs</b>	<b>\$112,884,177</b>	<b>\$25,439,041</b>	<b>\$9,908,945</b>	<b>\$148,232,163</b>	<b>7.0%</b>	<b>7.0%</b>	<b>10.9%</b>	<b>7.2%</b>
Savings	Member	\$2,226,384	\$261,165	\$44,291	\$2,531,840	11.5%	7.2%	5.2%	10.6%
	Employer	\$1,803,334	\$649,747	\$556,362	\$3,009,443	1.8%	2.9%	5.8%	2.3%
	<b>Total Savings</b>	<b>\$4,029,718</b>	<b>\$910,912</b>	<b>\$600,653</b>	<b>\$5,541,283</b>	<b>3.4%</b>	<b>3.5%</b>	<b>5.7%</b>	<b>3.6%</b>

## Observations

- The recommended plan design changes result in a total six-month saving of \$5,541,283.
  - Employer six-month savings of \$3,009,443
  - Member six-month savings of \$2,531,840

# Appendix

# Blue Shield HMO Plan Design Benchmarking

 Indicates where benchmark is higher than existing HSS design

Employer	Subscriber Count	Physician Copay	Hospital Copay	Outpatient Surgery Copay	Emergency Room Copay	Rx Generic Copay	Rx Brand Copay	Rx Non-Formulary Copay
HSS	22,972	\$20	\$150	\$50	\$100	\$5	\$20	\$45
CalPERs	N/A	\$15	\$0	\$250	\$50	\$5	\$15	\$45
County Gov't	N/A	\$15	\$250	N/A	\$75	\$9	\$24	\$39
BS1	37,746	\$15	\$100	N/A	N/A	\$10	\$25	\$50
BS2	8,927	\$10	\$0	\$0	\$100	\$8	\$25	\$40
BS3	8,638	\$20	\$500	\$150	\$100	\$15	\$35	\$50
BS4	8,378	\$20	\$100	\$0	\$100	\$10	\$30	\$55
BS5	7,907	\$20	\$350	\$100	\$100	\$10	\$35	\$50
BS6	6,848	\$10	\$0	\$10	\$75	\$5	\$15	\$35
BS7	6,252	\$15	\$100	\$100	\$100	\$15	\$25	\$40
BS8	5,562	\$5	\$0	N/A	N/A	\$5	\$10	\$35
BS9	5,216	\$25	\$100	\$100	\$100	\$10	\$25	\$40
BS10	5,017	\$20	\$0	\$0	\$100	\$10	\$20	\$40

Data Source: Based on Blue Shield Book of Business

# Glossary of Terms

## **Administrative Service Fee**

Fee paid to an insurer or other third party for processing claims, managing regulatory requirements and other tasks related to group health coverage.

## **Benefit Parity**

When the types and costs of services covered by different health plans are equivalent.

## **Blended Rate**

A combined insurance premium that is a composite of two or more rates. An insurer may bring two classes of members into a single risk pool, in order to offer a more equitable premium.

## **Capitated Rate**

Fixed per-person payment, made by insurer to the healthcare provider.

## **Case Management**

Coordination of medical services, to ensure more effective and integrated care.

## **CMS**

Centers for Medicare & Medicaid Services – the US federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program.

## **Disease Management**

A system of coordinated health care interventions and communications, designed to enhance a patient's compliance with treatment and medication orders.

## **ERRP**

The Early Retiree Reimbursement Program provides reimbursement to participating employment-based plans for a portion of the costs of health benefits for early retirees and early retirees' spouses, surviving spouses, and dependents. The program was authorized in the federal Affordable Care Act.

## **Flat Renewal**

When an insurer provides the same benefits with no increase in premium rates year over year.

## **Fully Insured Plan**

When an employer contracts with another organization to assume all financial risk for the enrollees' utilization of services and incurred administrative costs.

## **Grandfathered Status**

A term used in federal health reform legislation, generally interpreted as an existing health plan that does not make significant changes to benefits, copays or premiums.

## **HMO**

A Health Maintenance Organization that assumes the financial risks and responsibilities of providing comprehensive health care in a particular geographic area to HMO members in return for a fixed, prepaid fee. Financial risk is sometimes shared with physicians' groups and other medical service providers.

## **Indemnity Plan**

A type of medical plan that reimburses the patient and/or provider as expenses are incurred.

## **IPA**

An Individual Practice Association or health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs.

## **Large Claim Pooling**

A system designed to help stabilize premium fluctuations in smaller insured groups. Expensive claims (those over a stated amount) are charged to a larger number of plan participants, so the costs are spread in aggregate across a greater number of plan participants.

## **Limited Network**

When, to contain costs, an insurance plan offers medical service only through specific contracted doctors and hospitals.

## **Medical Group**

See *IPA*

## **Medicare**

A health insurance program administered by the federal government providing coverage to people who are aged 65 and over, or who meet other special criteria. Traditional or "fee-for-service" Medicare has a standard benefit package that covers medically necessary care that members can receive from nearly any hospital or doctor in the country. Medicare Part A is hospital insurance. Medicare Part B is medical insurance. Medicare Part D covers prescription drugs.

## **Medicare Advantage**

With this type of health plan, the enrollee assigns Medicare benefits to a health plan while he or she is enrolled. The federal government then pays the insurer a capitated rate, or set amount, every month for each participant. Plan enrollees receive service only from within the network contracted by the Medicare Advantage plan.

## **Migration**

Movement of enrollees between different health plans.

## **Non-Medicare Rates**

Health insurance premiums for a group of enrollees who are not eligible to participate in Medicare.

## **Network Model HMO**

An HMO that contracts with multiple physician groups and/or hospitals to provide services to enrollees. (See *HMO*.)

## **Open Network**

A health plan that allows enrollees to obtain service from any doctor or hospital.

## **Per Capita**

Average per person.

## **Performance Guarantees**

Standard for quality of service provided by the insurer, as established by the contract with the employer. Financial penalties may be levied if the insurer fails to meet specific, required measures.

## **Premium**

Agreed-upon fees paid for health benefits coverage during a defined benefit period. Premiums can be paid by employers, unions, or employees. Premium costs are often shared among these entities.

## **PMPM**

Per member per month.

## **PPO**

A Preferred Provider Organization plan, where coverage is given to participants through a network of selected hospitals and physicians. Enrollees may go outside the network, but then incur higher deductibles, higher coinsurance rates, or non-discounted provider charges.

## **Rate Guarantee**

When an insurer contractually agrees to lock in premium costs for a certain period of time.

## **Renewal**

Continuing insurance coverage with an existing insurance plan by contractual agreement.

## **Re-rating**

While negotiating premium rates, an insurer calculates the probability of how much utilization is likely to occur by a particular group. If a significant factor changes, such as the number of expected enrollees, the insurer may recalculate the rates.

## **Risk**

In general, risk is the probability that a return on investment will be lower than expected. With regard to health insurance, risk is based on the amount of money assigned to meet the care needs of a pool of covered individuals, and which party agrees to assume responsibility for any financial shortfall.

## **RFP**

A Request for Proposal with clearly defined criteria for comparison that allows providers of a product or service to bid on the right to supply that product or service.

## **SB 946**

Requires carriers to offer coverage for behavioral health treatment for members with autism spectrum disorders (ASD). Effective date is not tied to the plan anniversary. Programs should be available on or before July 1, 2012.

## **Self-Insured Plan**

A type of health plan in which the employer and plan participants directly assume the costs of

health care and administrative services for individuals in the plan.

## **Senior Advantage**

See *Medicare Advantage*.

## **SSSG**

Similarly situated Subscriber Group – enrollee groups that have very similar characteristics, such as equivalent demographics and utilization.

## **Staff Model HMO**

A type of HMO where patients receive service in the HMO's own facilities from health care professionals who are employees of the HMO. (See *also HMO*.)

## **Trend**

Future projections based on factors, such as enrollment, utilization, service and administrative fees, which impact health plan risk and premium costs.

## **Utilization**

The extent to which an insured group uses a particular health care service in a specified period. Typically expressed as the number of services used per year per 100 or per 1000 persons.