

# San Francisco Health Service System Health Service Board

Kaiser HMO

Revised Plan Design Alternatives & Cost Implications

Beginning July 1, 2012

December 22, 2011

Prepared by Aon Hewitt  
Health and Benefits



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# Introduction

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The benchmarking data provided at the December 8, 2011 Health Service Board meeting, revealed a number of SFHSS plan design areas that are below market. Several plan design alternatives were presented and discussed. The Kaiser HMO design alternatives focused on opportunities to bring plan design within benchmarks without eroding competitiveness.

The plan designs under consideration included:

- Increasing the office visit copay from \$15 to \$20; and
- Increasing the outpatient surgery from \$15 to \$25 or \$35.

The proposed plan design changes are within benchmarks and are applicable to maintain parity given that similar increases are being evaluated on the other plans offered to employees.

Although it was known that Senate Bill 946 (SB 946) would have an impact on Kaiser's renewal, it was not until December 9, 2011 that Aon Hewitt was provided with the financial information from Kaiser.

- SB 946 requires carriers to offer coverage of what it defines as "behavioral health treatments" for members with autism spectrum disorders (ASD). Additional details on SB 946 can be found in the Appendix

Aon Hewitt was asked to evaluate the member impact of these changes and the results are presented in the following exhibits for the Board's consideration.

*Please note that Kaiser is the only SFHSS plan increasing their premium based on this SB 946. Kaiser states they have a much larger number of child dependents compared to the other two plans.*

## SB-946 Autism Spectrum Disorder Premium Adjustment

- Financial impact to comply with SB 946 as of July 1, 2012 is as follows:
  - The impact to active employee /early retiree premium is an aggregate increase of \$922,000 (+0.734%)
  - No impact to the Medicare premiums.
- The cost of compliance was included into the baseline 6 month premium prior to plan design changes.
- Additional information on SB 946 can be found in the Appendix.

# Kaiser HMO – Revised Plan Design Alternatives

Option	Office Visit Copay	Outpatient Surgery Copay	Inpatient Copay	Active/ Non Medicare % Change	Medicare % Change	Financial Impact
Current Design/ Status Quo	\$15	\$15	\$100	5.7%	-2.6%	\$6,267,331
Option A	\$20			-0.679%	-0.673%	(\$998,000)
Option B	\$20	\$25		-0.684%	-0.684%	(\$1,010,000)
Option C	\$15	\$25		These plan design combinations are not currently filed with the State and therefore are not available at this time		
Option D	\$15	\$35				
Option E	\$20	\$35		-0.719%	-0.713%	(\$1,056,785)

## Observations and Recommendations

- The benchmarking data around Office Visit copays supports an increase in the copay to \$20 to be more in line with the labor market and in parity with recommended Blue Shield HMO changes.
- Aon Hewitt's initial recommendation for during the December 8 Board meeting of increasing the Outpatient Surgery copay from a \$15 copay to a \$50 copay was viewed as too large an increase. It was agreed during the meeting that there should be a differential between the Office Visit copay and the Outpatient Surgery copay.
- These plan design changes meet the Board's objectives:
  - Provides cost savings to the members and employers; and
  - Creates a meaningful differential between Office Visit and Outpatient Surgery.
- We recommend implementation of Option E, which includes both the Office Visit copay increase to \$20 and the Outpatient Surgery copay increase to \$35. As this will provide the optimal design by creating an Office Visit in line with benchmarks and a more moderate increase to the Outpatient Surgery copay while introducing a meaningful differential between the two.

# Kaiser HMO – Revised Premium (Contribution) Costs

	Kaiser	Active Employee			Non-Medicare Retiree			Medicare Retiree			
		EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2 (All Medicare)	EE+2
6 Month Contract Status Quo with SB 946	<b>Members</b>	\$0.00	\$6.33	\$250.23	\$3.17	\$269.61	\$711.92	\$0.00	\$172.17	\$515.87	\$614.52
	% Increase	0.0%	394.2%	7.9%	394.6%	6.7%	6.1%	0.0%	-2.8%	-2.8%	3.2%
	\$ Increase	\$0.00	\$5.05	\$18.27	\$2.53	\$16.87	\$40.69	\$0.00	(\$4.88)	(\$14.64)	\$18.98
	<b>Employer</b>	\$533.92	\$1,060.85	\$1,259.30	\$1,069.70	\$1,336.15	\$1,336.15	\$345.37	\$517.55	\$517.55	\$517.55
	% Increase	5.7%	5.2%	5.3%	5.5%	5.5%	5.5%	-2.7%	-2.8%	-2.8%	-2.8%
	\$ Increase	\$28.70	\$52.71	\$63.34	\$55.47	\$69.82	\$69.82	(\$9.76)	(\$14.64)	(\$14.64)	(\$14.64)
	<b>Total</b>	<b>\$533.92</b>	<b>\$1,067.17</b>	<b>\$1,509.52</b>	<b>\$1,072.86</b>	<b>\$1,605.76</b>	<b>\$2,048.07</b>	<b>\$345.37</b>	<b>\$689.72</b>	<b>\$1,033.42</b>	<b>\$1,132.07</b>
	% Increase	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%	-2.7%	-2.8%	-2.8%	0.4%
	\$ Increase	\$28.70	\$57.75	\$81.61	\$57.99	\$86.69	\$110.51	(\$9.76)	(\$19.52)	(\$29.28)	\$4.34
6 Month Contract With Revised Plan Design Recommendations	<b>Members</b>	\$0.00	\$2.55	\$244.73	\$1.27	\$265.84	\$705.02	\$0.00	\$170.96	\$512.23	\$610.18
	% Increase	0.0%	99.5%	5.5%	99.1%	5.2%	5.0%	0.0%	-3.4%	-3.4%	2.5%
	\$ Increase	\$0.00	\$1.27	\$12.78	\$0.63	\$13.10	\$33.79	\$0.00	(\$6.09)	(\$18.28)	\$14.64
	<b>Employer</b>	\$530.14	\$1,057.07	\$1,254.12	\$1,063.98	\$1,328.54	\$1,328.54	\$342.94	\$513.90	\$513.90	\$513.90
	% Increase	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%	-3.4%	-3.4%	-3.4%	-3.4%
	\$ Increase	\$24.92	\$48.93	\$58.16	\$49.75	\$62.21	\$62.21	(\$12.19)	(\$18.29)	(\$18.29)	(\$18.29)
	<b>Total</b>	<b>\$530.14</b>	<b>\$1,059.63</b>	<b>\$1,498.85</b>	<b>\$1,065.25</b>	<b>\$1,594.37</b>	<b>\$2,033.55</b>	<b>\$342.94</b>	<b>\$684.86</b>	<b>\$1,026.14</b>	<b>\$1,124.08</b>
	% Increase	4.9%	5.0%	5.0%	5.0%	5.0%	5.0%	-3.4%	-3.4%	-3.4%	-0.3%
	\$ Increase	\$24.92	\$50.21	\$70.94	\$50.38	\$75.30	\$95.99	(\$12.19)	(\$24.38)	(\$36.56)	(\$3.65)
Savings	Member	\$0.00	\$3.77	\$5.50	\$1.89	\$3.77	\$6.90	\$0.00	\$1.21	\$3.64	\$4.34
	Employer	\$3.77	\$3.77	\$5.18	\$5.72	\$7.61	\$7.61	\$2.43	\$3.65	\$3.65	\$3.65
	<b>Total Savings</b>	<b>\$3.77</b>	<b>\$7.55</b>	<b>\$10.68</b>	<b>\$7.61</b>	<b>\$11.38</b>	<b>\$14.51</b>	<b>\$2.43</b>	<b>\$4.86</b>	<b>\$7.28</b>	<b>\$7.99</b>

## Observations

- The monthly premium (contributions) costs are reduced by the following amounts for EE+2 coverage:
  - Active Employee: a savings of \$5.50 per month or \$33.00 per the six month period.
  - Early Retiree: a savings of \$6.90 per month or \$41.40 per the six month period.
  - Medicare Retiree: a savings of \$4.34 per month or \$26.04 per the six month period.
  - Total Aggregate Employer: a savings of \$116,896 per month or \$701,377 per the six month period.
- For Active Employees with two or more dependents, it would require 5 non-preventive office visits per family in six months to exceed the premium (contribution) cost savings realized from these recommended plan design changes.

# Kaiser HMO - Revised Total Premium Costs & Savings


	Total Premium Renewal Calculation (Kaiser)	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 with SB 946	Member	\$7,954,187	\$3,193,403	\$2,794,657	\$13,942,247	9.9%	7.1%	-1.9%	6.7%
	Employer	\$96,035,597	\$20,083,410	\$19,489,164	\$135,608,171	5.4%	5.5%	-2.7%	4.1%
	<b>Total Costs</b>	<b>\$103,989,784</b>	<b>\$23,276,813</b>	<b>\$22,283,821</b>	<b>\$149,550,418</b>	<b>5.7%</b>	<b>5.7%</b>	<b>-2.6%</b>	<b>4.4%</b>
6 Month Contract with Revised Plan Design Recommendations	Member	\$7,671,693	\$3,139,918	\$2,775,029	\$13,586,639	6.0%	5.3%	-2.6%	4.0%
	Employer	\$95,582,951	\$19,971,835	\$19,352,008	\$134,906,794	4.9%	4.9%	-3.4%	3.6%
	<b>Total Costs</b>	<b>\$103,254,644</b>	<b>\$23,111,752</b>	<b>\$22,127,037</b>	<b>\$148,493,434</b>	<b>5.0%</b>	<b>5.0%</b>	<b>-3.3%</b>	<b>3.6%</b>
Savings	Member	\$282,495	\$53,486	\$19,628	\$355,608	3.6%	1.7%	0.7%	2.6%
	Employer	\$452,646	\$111,575	\$137,156	\$701,377	0.5%	0.6%	0.7%	0.5%
	<b>Total Savings</b>	<b>\$735,140</b>	<b>\$165,061</b>	<b>\$156,784</b>	<b>\$1,056,985</b>	<b>0.7%</b>	<b>0.7%</b>	<b>0.7%</b>	<b>0.7%</b>

## Observations

- The recommended plan design changes result in a total six-month saving of \$1,056,985.
  - Employer six-month savings of \$701,377
  - Member six-month savings of \$355,608

# Appendix

# Kaiser 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
SFHSS	29,030	\$15	\$100	\$15	\$100	\$5	\$15
CalPERs	N/A	\$15	\$0	\$10	\$50	\$5	\$15
County Gov't	N/A	\$15	\$250	N/A	\$75	\$9	\$24
AH1	65,283	\$15	\$0	\$15	\$50	\$10	\$20
AH2	31,495	\$15	\$250	\$15	\$100	\$5	\$20
AH3	17,177	\$20	\$100	\$20	\$100	\$5	\$15
AH4	15,967	\$15	\$100	\$15	\$50	\$5	\$20
AH5	13,831	\$20	\$100	\$20	\$100	\$10	\$35
AH6	6,668	\$20	\$0	\$20	\$100	\$10	\$20
AH7	6,128	\$20	\$20	\$50	\$100	\$10	\$15
AH8	5,723	\$15	\$0	\$15	\$35	\$10	\$15
AH9	5,473	\$15	\$0	\$15	\$100	\$10	\$30
AH10	5,227	\$15	\$100	\$15	\$75	\$10	\$20

Data Source: Based on Aon Hewitt's and Kaiser Book of Business

## Kaiser Statement on SB 946

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- The following is Kaiser statement on SB 946

*“Kaiser Permanente will work in close collaboration with the Department of Managed Health Care (DMHC) as we implement the provisions of SB 946. We have begun to design programs which will provide our members those services newly required by this law, complementing the health care services we already provide to children with autism spectrum disorders.*

*While that important work continues, we will continue to fulfill our responsibility to take care of the health care needs of our more than 13,500 members with autism spectrum disorders. We are proud of our expertise in this area and the health care services --- including evaluation, diagnosis, and treatment --- which we provide. Kaiser Permanente is also a leader in the field of autism-related research, and our experts are engaged in several major research efforts, including one of the largest studies to identify the causes of autism.*

*As the Governor pointed out in his signing message, there are a number of areas in the bill which require clarification, and we hope that the DMHC can make progress in clarifying the distribution of responsibility for the provision of services among health plans, the school system, and state social services agencies, so that families can access services for their children in the most appropriate settings.*

*We are ready to work with the DMHC to address these and other areas of concern in the law, so care providers and health plans have clear guidance, families understand coverage and access, and regulators will be able to interpret the law fairly and consistently. “*

## SB 946 Q & A

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- **Generally speaking, what does the California law do?** The law (Senate Bill 946, by Senator Steinberg), requires California health plans, including Kaiser Permanente, to offer coverage of what it defines as “behavioral health treatments” for members with autism spectrum disorders (ASD). It also requires plans to maintain adequate networks of autism service providers. ASD is a complex developmental disorder that typically requires a combination of health care, educational and social services, which are provided by a number of different entities.
- **Is Applied Behavior Analysis (ABA) part of the law?** Yes. Behavioral health treatments including ABA and other evidence-based behavior intervention programs are part of SB 946. These behavioral health treatments must be prescribed by a physician, and the treatment plan must be developed and/or provided by a “qualified autism service” provider or “professional,” which is specifically described in the new law.
- **Will all of the autism spectrum diagnoses be covered?** Yes. The law states that pervasive developmental disorder or autism must be covered. Pervasive developmental disorder includes autistic disorder, Asperger’s disorder and pervasive developmental disorder - not otherwise specified (PDD-NOS).
- **Is the effective date for all plans July 1, 2012, or the first plan anniversary commensurate with or immediately following July 1, 2012?** Programs should be available on or before July 1, 2012. The effective date is not tied to the plan anniversary.
- **What, if any, financial impact will this law have on rates, and when will it impact customers?** At this time, Kaiser Permanente is evaluating the impact SB 946 may have on future premiums. Any rate changes resulting from this law would impact renewals that occur on or after the law's effective date of July 1, 2012.
- **How might this change impact utilization for a typical group?** Kaiser Permanente's Actuarial team is currently assessing the utilization impact. We do not yet know what that will be.

# Glossary

## **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.