Date: July 5, 2016
To: Joint Labor Management Benefits Committee
From: Staff
Subject: 2017 Flex Benefits Program Adoption
- Kaiser Contract
- Full/Narrow Network Disruption Analysis
- Health Plan Access by Residential/Worksite Proximity
- Projected Fiscal Year 16/17 Expenditures Update

RECOMMENDATION:
That the Joint Labor-Management Benefits Committee receive and file information regarding the 2017 Flex Benefits Program Adoption and related updates, including the Kaiser contract, Full/Narrow Network disruption analysis, health plan access by residential/worksite proximity, and projected Flex Benefits Fiscal Year 16/17 expenditures.

DISCUSSION:

A. Flex Benefits Program Adoption

At its meeting on June 9, 2016, the JLMBC made a series of recommendations with respect to provider selections, service provider renewals, and plan design for the 2017 Flex Benefits Plan Year. Actions taken by the JLMBC included the following:

- Recommended selection of Anthem Blue Cross as the provider of the Flex Program’s PPO, HMO Full Network, and HMO Narrow Network plans, as well as of an alternate regional network plan (“Vivity”) to be added as an additional option for Flex members, for a three-year contract beginning January 1, 2017, through December 31, 2019.
- Recommended selection of Kaiser Permanente as the provider of the Flex Program’s Staff Model HMO plan for a contract beginning January 1, 2017.
- Recommended annual renewals at a 0% rate increase for Standard Insurance for the Flex Program’s Life, Disability & AD&D insurance plans; WageWorks for the Flex Program’s tax-advantaged savings accounts third party administration; and Managed Health Network for the Flex Program’s Employee Assistance Program.
Recommended plan design changes for Plan Year 2017 including (a) adjusting the benefit levels for the Dental PPO Plan to include a Diagnostic & Preventive Waiver; equalizing the In/Out of Network Annual Maximum at $1,500, and increasing the Reasonable & Customary reimbursement from the 51st to the 90th percentile; (b) establishing a stand-alone vision plan for Flex members as a base benefit and administered on a composite rate basis; and (c) increasing the monthly disability earnings cap for 2017 to $3,166 per month.

The recommendations of the JLMBC were summarized in a report to City Council recommending adoption of the Flex Program for Plan Year 2017. This item was heard by the Personnel and Animal Welfare Committee on June 29, 2016, and adopted by the City Council on July 1, 2016.

Staff is now proceeding with the administrative, communications, and contractual tasks required to implement the adopted program for 2017.

**B. KAISER CONTRACT DEVELOPMENT**

At the JLMBC’s June 9, 2016 meeting, staff presented its finding that Kaiser’s proposal did not include commitments with respect to Wellness and on-site member advocacy resources that were commensurate with the proposals received from the non-staff model bidders. As a result, staff had recommended that the JLMBC request Personnel Department staff to, as part of contract development, negotiate further with Kaiser with respect to expanding its commitments in these areas. The JLMBC took the additional step of advising the Personnel Department that the contract term length of between 1-5 years should be determined by the degree to which Kaiser was able to improve its commitments in these areas, as well as its overall responsiveness in contract negotiations.

Staff and Kaiser representatives communicated shortly after the JLMBC meeting. Kaiser developed an initial proposal for expanding its wellness and member advocacy efforts. A meeting was held on June 21, 2016, for further negotiation. On June 27, 2016, Kaiser presented a revised written proposal in which it offered to expand its 2017 Wellness commitment to $350,000 and provide a Member Advocate resource to the City three days per week. Kaiser further indicated more flexibility in Wellness funding for plan years 2018 and 2019, and identified a number of resource options that could be made available prior to and within Plan Year 2017.

As staff indicated to Kaiser in the course of negotiations, two crucial aspects of evaluating any revised proposal regarding their Wellness or member advocacy resources involved (a) the degree to which their proposal was commensurate with the resources offered by the non-Kaiser healthcare provider (Anthem) and (b) the level of discretion they would be offering to the City to utilize those resources for funding the City’s Wellness Program infrastructure.

Kaiser’s revised member advocacy proposal represents significant progress towards the first objective. Although their member advocates would only be present three days per
week vs. five days from Anthem, Kaiser has indicated a willingness to renegotiate this after the first year based upon the first year’s experience and the City’s preferences.

With respect to Wellness, the initial year’s funding is still, in staff’s view, significantly less than that offered by Anthem. Staff has communicated to Kaiser that, although staff recognizes and appreciates the alternative resources included in Kaiser’s revised proposal beyond the $350,000, neither those resources nor the $350,000 are fully at the City’s discretion.

Staff and Kaiser are continuing negotiations. Further updates will be provided at the JLMBC’s next meeting.

C. DISRUPTION ANALYSIS: FULL/NARROW NETWORK

Segal Consultants has been working with Anthem to evaluate disruption for the Full and Narrow Networks. Segal/Anthem have determined the following:

- **Full Network & HPN Population** - 100% of the members (which includes both employees and dependents) enrolled in Blue Shield’s Full Network HMO in 2015 would be able to continue accessing care through their existing medical group through Anthem’s Traditional (“Full”) HMO network.

- **Narrow Network** – 97% of the 16,068 members (which includes both employees and dependents) enrolled in Blue Shield’s Narrow Network HMO plan in 2015 would be able to continue accessing care through their existing medical group through Anthem’s Narrow Network plan – this means that 15,585 members would not experience provider disruption, while 483 members would experience disruption. The disruption rate of 3% is considerably less than the 8-15% disruption experienced in the 2014 Narrow Network transition to Blue Shield1. The vast majority (83%) of the disrupted members fall within the following three provider groups:

  1. St. Joseph Hoag Health (305 members)
  2. Access Medical Group (76 members)
  3. Hemet Community Medical Group (22 members)

For the 305 members of St. Joseph Hoag, Anthem has Select (“Narrow”) Network HMO provider contracts with other medical groups such as Greater Newport Physicians (Orange Coast and Saddleback), MemorialCare, and Monarch Health Care that may have primary care physicians affiliated with the St. Joseph Hoag Health Network medical groups. These include the following:

  - Mission Heritage Medical Group
  - Mission Hospital Affiliated Physicians

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1 The initial projected disruption was 8%, but this number rose to 15% when the City was informed shortly before implementation that a provider group with a large population would not be part of the Narrow Network; this provider group population was subsequently accommodated on a manual basis, leaving the ultimate disruption level closer to the original projection of 8%.
For 65 members affiliated with Access Medical Group, they could continue seeing the same physician through the UCLA Santa Monica Bay Physicians Group. Furthermore, Anthem has indicated a willingness to pursue a Select ("Narrow") HMO network contract with Access Medical Group that could further mitigate patient/provider disruption.

For Hemet Community Medical Group members alternatives may include PrimeCare or Riverside Physician Network.

Staff will continue working with Anthem and its consultants to minimize disruption and communicate alternatives to impacted members. Further work is also being conducted regarding PPO plan disruption.

D. HEALTH PLAN ACCESS BY RESIDENTIAL/WORKSITE PROXIMITY

In prior discussions, staff and the JLMBC’s consultants have noted that Vivity is a regional network focused on the Los Angeles and Orange County regions. Following an inquiry from a Flex Program member, staff recently clarified the ability for members to enroll in Vivity is not limited to the proximity of their residence to their desired primary care provider, but can also include proximity of their worksite.

The California Department of Managed Care regulates HMO plans and has established certain minimum standards with respect to provider access and availability. For primary care providers, enrollees must have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider. Because worksite proximity is an option, members could theoretically enroll in Vivity even if their residence is outside of the Los Angeles or Orange County regions. This is because virtually every City employee works within the City of Los Angeles.

Presently the Flex Program’s Third-Party-Administrator (TPA) draws employee home address information from the City’s payroll system. This address information is used for the purpose of determining plan enrollment eligibility. Staff is working with the TPA to determine if a separate work address data field can be created that could be used to establish health plan enrollment eligibility; or if, alternatively, an option exists to remove any recordkeeping restrictions that would limit a member’s ability to enroll in a plan based only on their residential proximity to a service provider. This would expand member access to their desired health plans, although it would be crucial for the City to effectively communicate the implications of this, particularly for members with dependents that reside a significant distance from the service provider. Staff will provide further updates on this matter as information becomes available.
E. FLEX PROGRAM PROJECTED EXPENDITURES FY 16-17 UPDATE

With the Flex Benefits vendor selection and plan design decisions finalized, staff is refining projections of Plan costs on a total premium as well as net General Fund basis. The adopted budget amount for the Civilian Flex Program for FY 16/17 is $247,569,086. Preliminary estimated net expenditures for FY 16/17, prior to validation of all rates and assumptions, are presently $247,752,332. Projected expenditures are therefore in line with the adopted budget amount for FY 16/17. Actual expenditures may vary based on net enrollment trends as well as the migrations between the health plans pursuant to the October Open Enrollment. The projection makes no assumptions about utilization of the new “Vivity” option or where any enrollment in that option from the City’s existing health plans would come from.

Submitted by: ________________________________

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