AGENDA

Task Force on Employee Wellness and Consolidation of Agency Group Insurance

Tuesday, October 25, 2011
8:00 to 9:30 a.m.
Department of Health and Human Services' TAN (1st Floor)
Conference Room
401 Hungerford Drive, Rockville

call-in phone number is 240-773-8122 and the pass-code is 777933

8:00 Welcome from Bill Mooney, Task Force Chair
Public/Visitor Comments
Approval of Minutes

8:10 Presentation/Discussion with representatives from Kaiser Permanente – The Consolidation Committee asked for a discussion with Kaiser as they are not part of the self-insured plans. Kaiser will address issues including how Kaiser integrates wellness and disease management into its staff-model HMO; the types of wellness/disease management programs Kaiser offers to its own employees and whether these same programs are available to other Kaiser members; whether Kaiser has local capacity to serve a substantial number of new members; and how Kaiser sets its rates for county agencies/large agency contracts (as prices are slightly different for the county agencies.)

8:30 Adjourn as Full Task Force and break-out into committees – Consolidation of Agency Group Insurance (Paul Heylman, Chair; this committee will stay in the Tan Conference Room) and Employee Wellness (Farzaneh Riar, Chair; this committee will move to the Green Conference Room). Representatives from Kaiser have been asked to join the Wellness Committee for any follow-up questions on Kaiser Wellness Programs. Members of the Consolidation Committee are welcome to join the Wellness Committee if they have further questions.

9:30 Adjourn

- **Montgomery County Task Force Meeting**
- **October 25, 2011**

Kaiser Permanente
The Future of Healthcare is Now Open

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Requested Items to Cover

1. How does Kaiser as a staff-model HMO integrate **wellness and disease management** into it's delivery of health care?
2. What types of wellness/disease management/cost containment strategies does Kaiser Permanente have **for its own employees** and are these efforts available to others receiving medical coverage through Kaiser?
3. Does Kaiser have capacity locally to **serve a substantial number of new clients** if the county increased the use of Kaiser?
4. Does Kaiser have **partnerships with unions**? How has that worked? Is Kaiser a union environment?
5. How does Kaiser **set its rates** for county / large agency contracts (prices are slightly different for each of the agencies – why)?

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Requested Items to Cover

- **Wellness and disease management in delivery of care**
- **Programs for Kaiser Permanente employees**
- Capacity to serve new clients
- Union partnerships
- Rate setting

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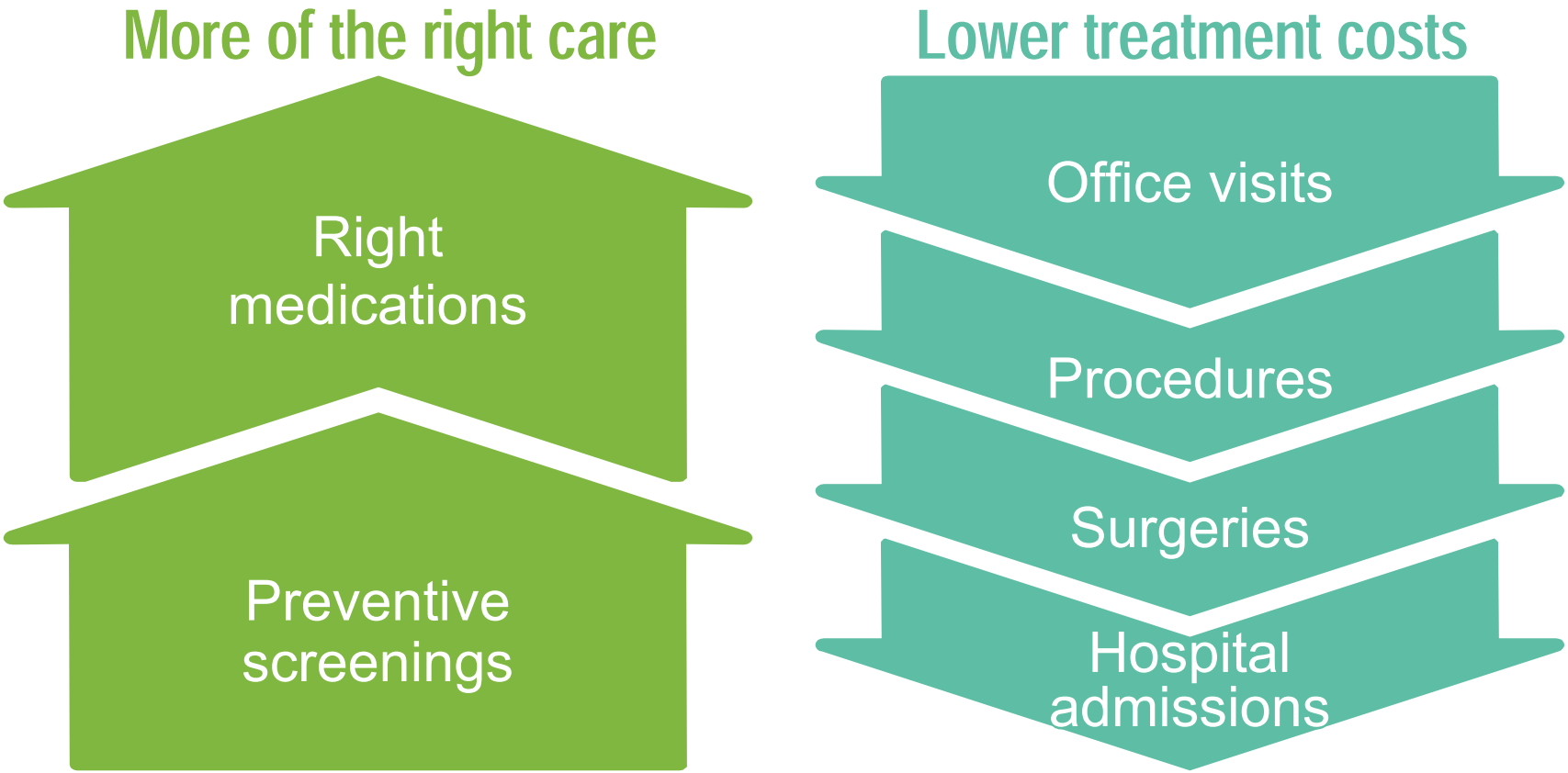
Superior value of integration



Source: Data from MarketScan, a service of Thomson/Reuters. As of February 2011.

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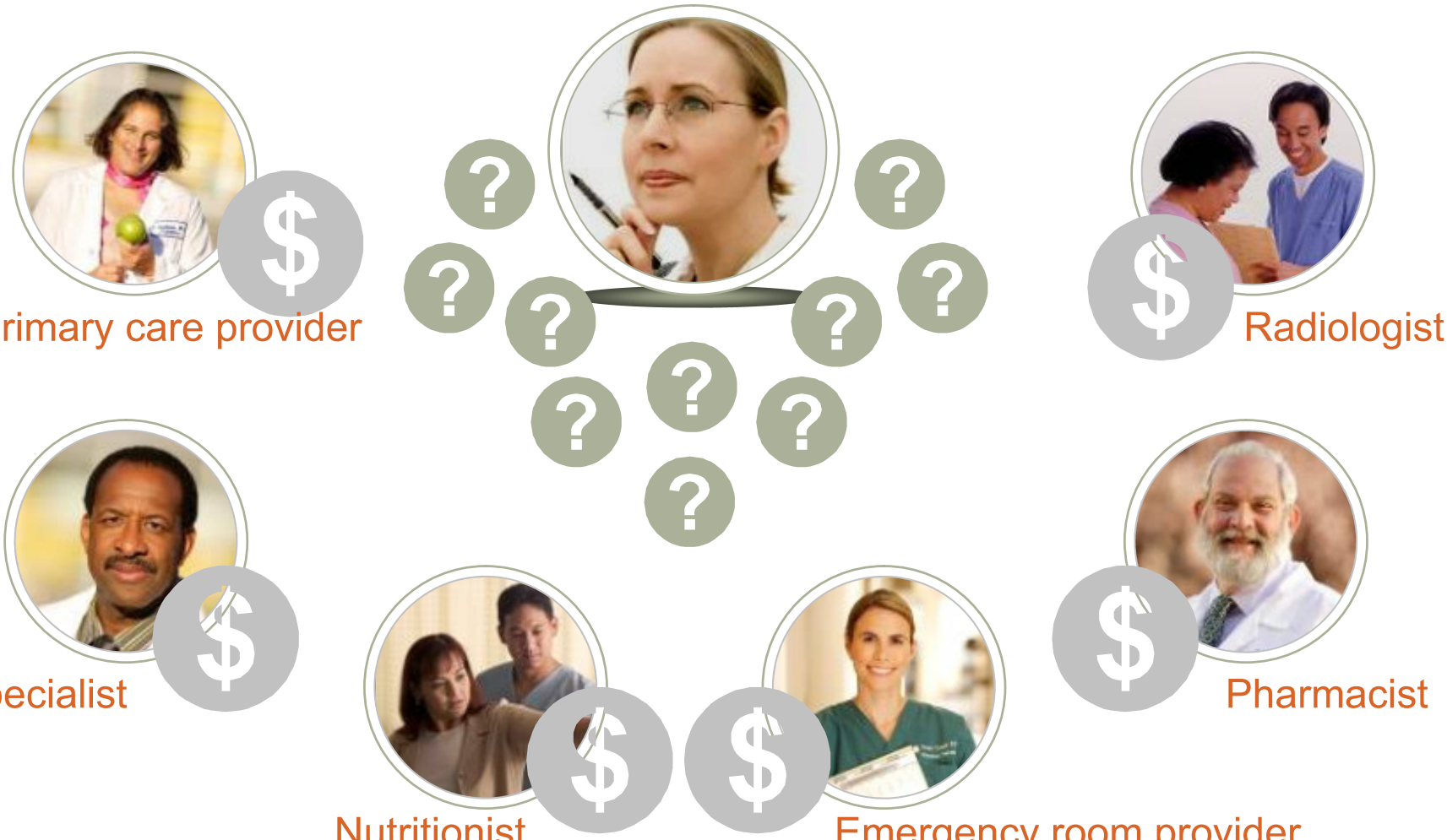
The typical care experience



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Member-centered engagement

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Making wellness and disease management a reality

OUT-reach

- Proactive search for care gaps

IN-reach

- Connect patient to all care when present

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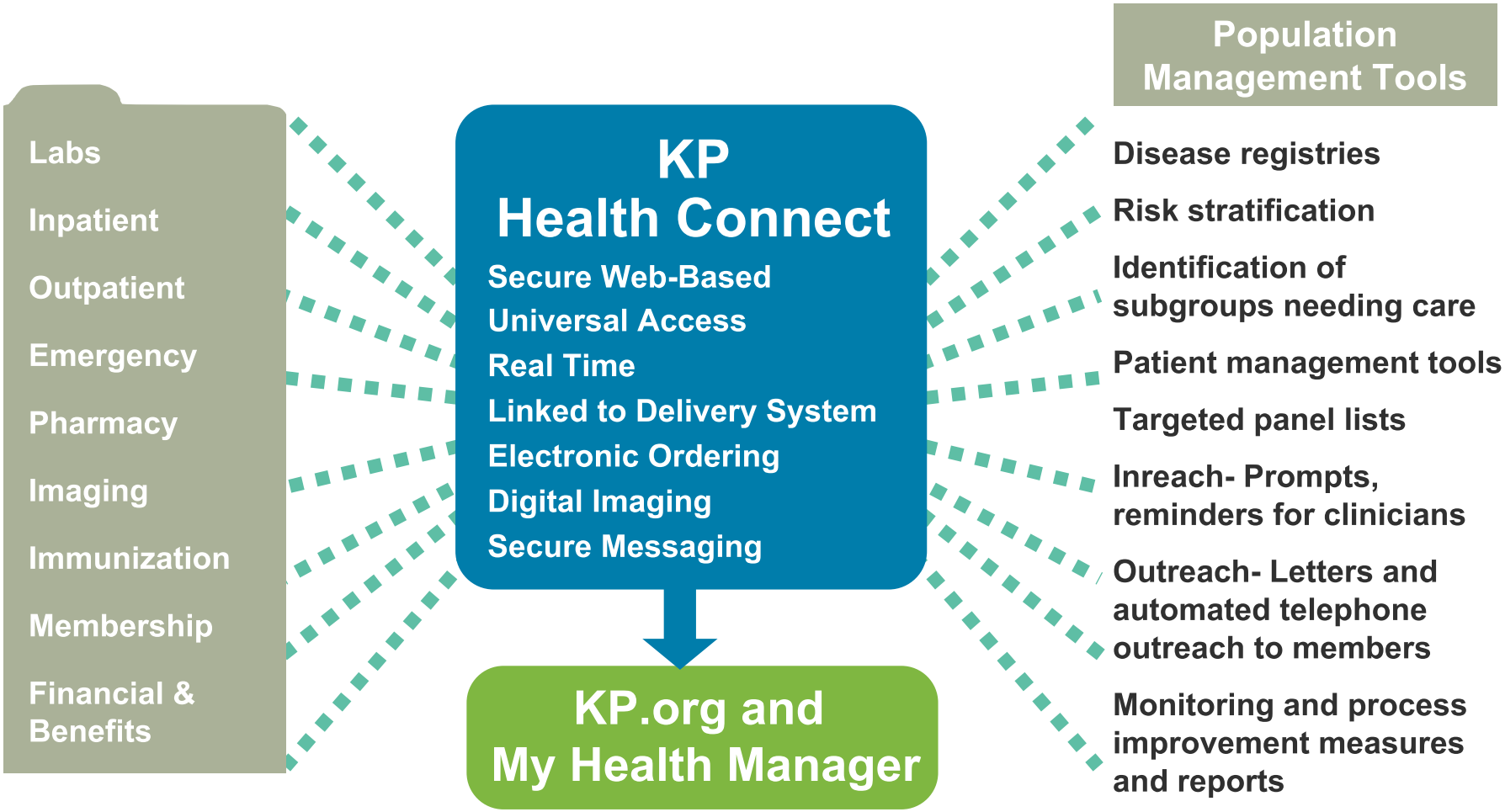
Our system in action



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Systems built to drive outreach

Performance Reporting

REGION MA
AREA NOVA
PHYSICIAN NGUYEN, LO-AN T (M.D.)

MOB RESTON
DEPARTMENT Internal Medicine

	Q4-09	Q1-10	Q2-10	CURRENT	Regional Rank	Local Rank	Target	Total pts not at target
Asthma: Use of Appropriate Medications	100%	100%	100%	100.0%	36 of 289	5 of 14	96%	-
Current # of eligible asthma patients : 8								
Dept Avg	90.1%	90.4%	91.8%	91.4%				
Cardiovascular Conditions: Lipid Control	88.6%	85.2%	90.1%	90.0%	1 of 220	1 of 10	60%	4
Current # of eligible CAD(CVD) patients : 57								
Dept Avg	59.9%	62.2%	65.7%	66.5%				
Diabetes: Lipid Control	81.7%	85.1%	87.7%	85.9%	2 of 231	2 of 11	68%	18
Current # of eligible diabetes patients : 120								
Dept Avg	58.9%	59.7%	63.1%	62.6%				

- We keep track of patient care gaps by every physician
- Our systems can sort, filter, slice, and dice to find gaps
- Our systems can export a list into Excel and we call/write

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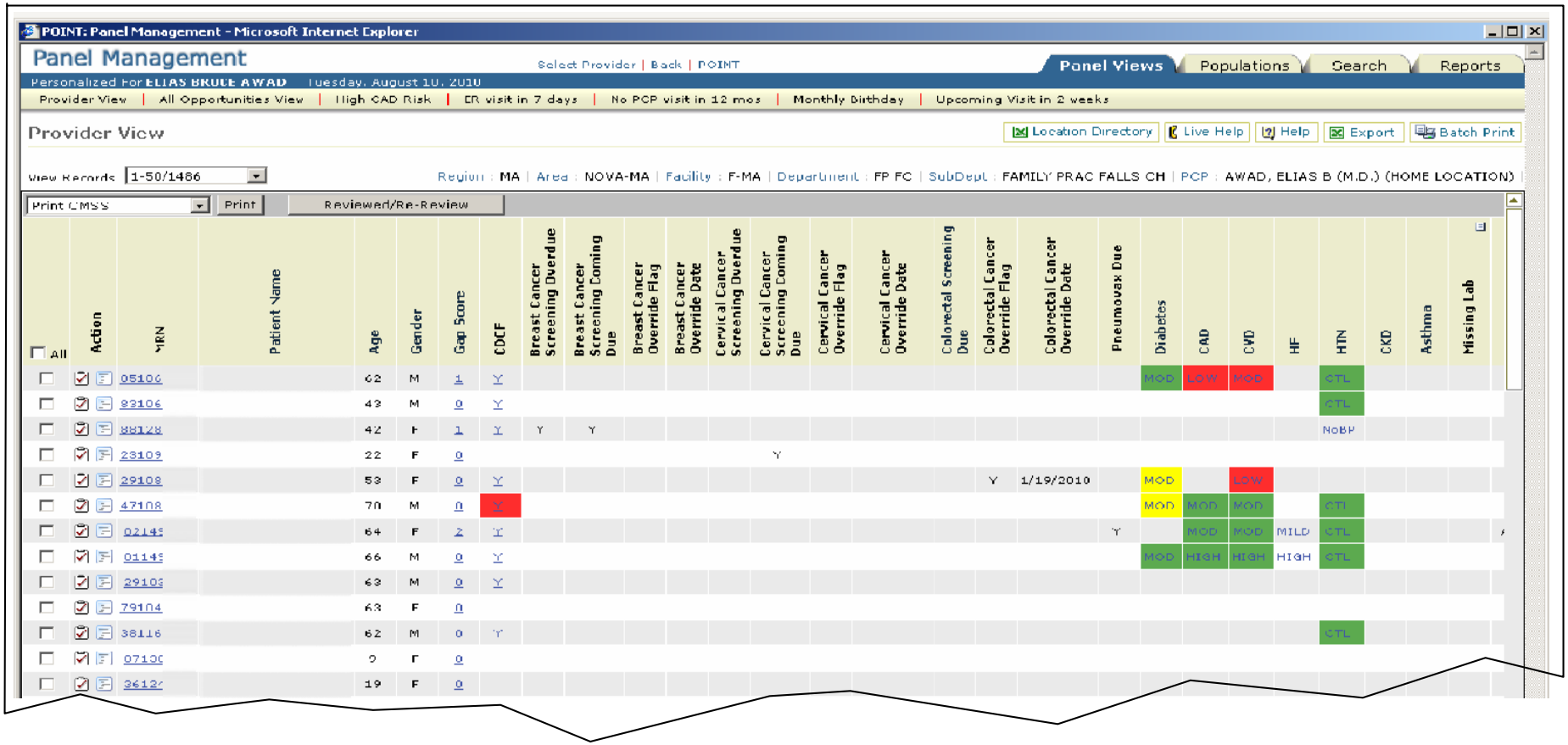
Systems built to drive outreach



- Physicians can dive from global reports into their own patients
- Sort, filter, query as needed to find the ones in need of care

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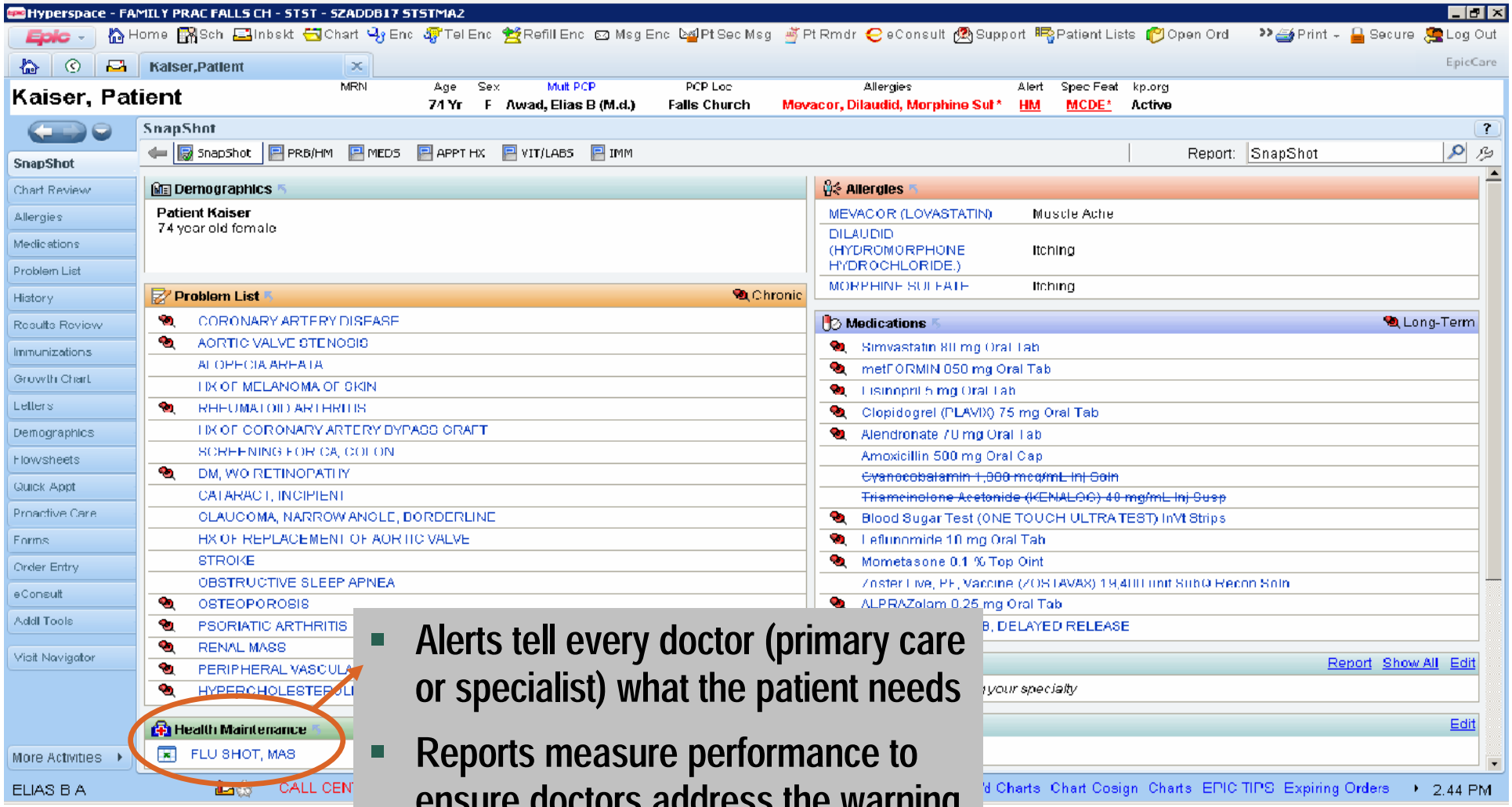
Systems built to drive in-reach



- Alerts tell every doctor (primary care or specialist) what the patient needs
- Reports measure performance to ensure doctors address the warning

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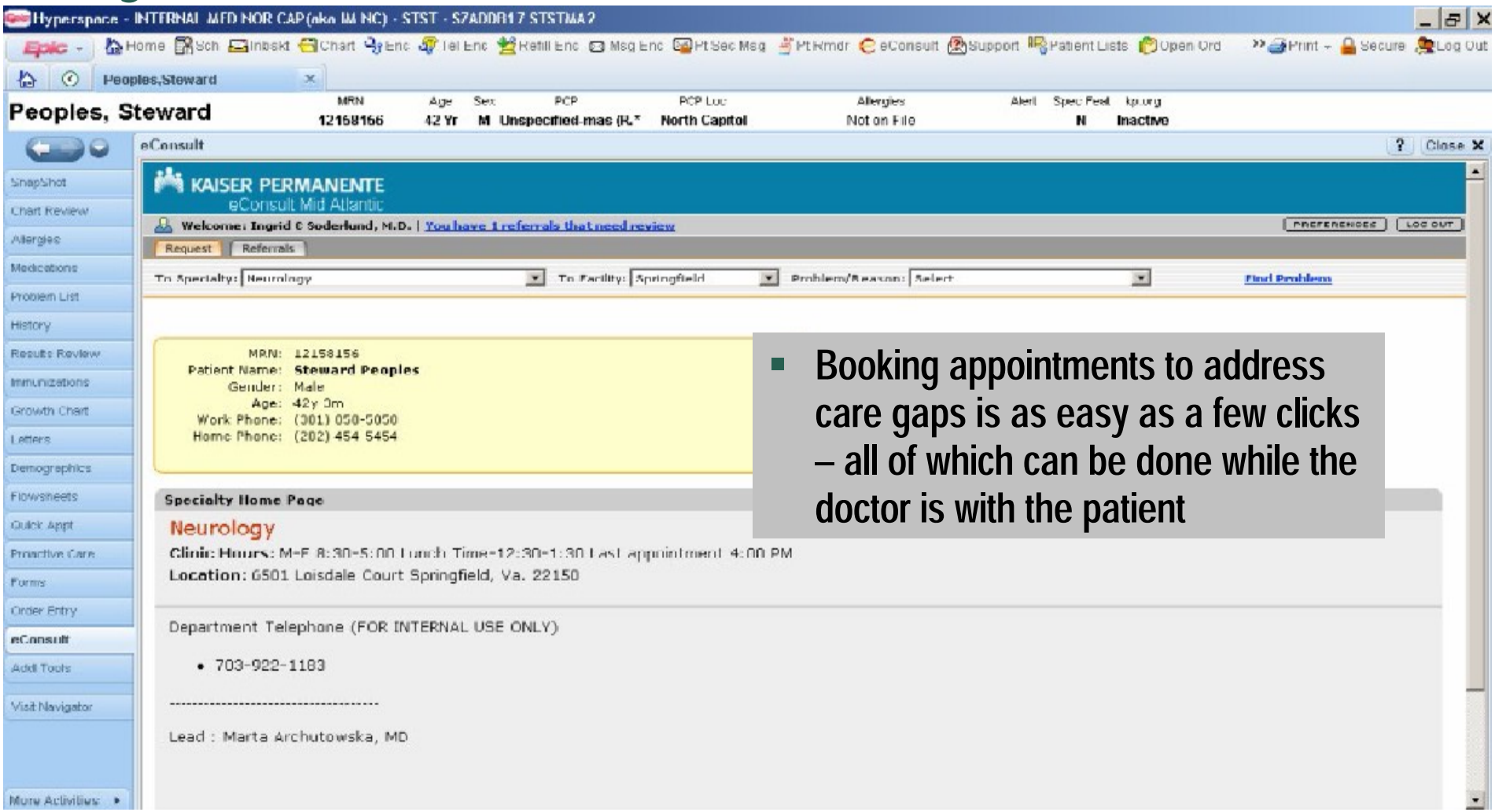
Systems built to drive in-reach



- Booking appointments to address care gaps is as easy as a few clicks – all of which can be done while the doctor is with the patient

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Systems built to drive in-reach

Kaiser Permanente Appointment Confirmation

Patient Name:	**Kaiser Member**
MRN:	
Appointment Type:	**Ec Co Endo**
Appointment Date:	**Oct 19, 2010**
Appointment Day:	**Tuesday, 2:10 PM (ET)**
Coverage :	**MAS KP-MID ATLANTIC/DCH SG $20/$30 (9427) 0109**
Coverage Copay:	**$30.00**
Provider:	**T LEE M.D.**
Facility:	**Falls Church**
Department:	**ENDOCRIN FALLS CH**
Location:	
Cancellation Number:	**(800) 777-7904 (24 Hours A Day, 7 Days A Week)**
Rebook Number:	**(800) 777-7904 (Mon-Fri, 7 AM to 8 PM)**

Appointment Messages:

Patient Handouts:

JAMA Patient Page: Managing type 2 diabetes
American Academy of Family Physicians -- Diabetes: New Treatments
MEDLINEplus Diabetes
KP Community Wellness Library Clinical Videotapes
JAMA Patient Page: Neuropathy

- The patient leaves with a confirmed appointment
- Many times it is same day at the same building

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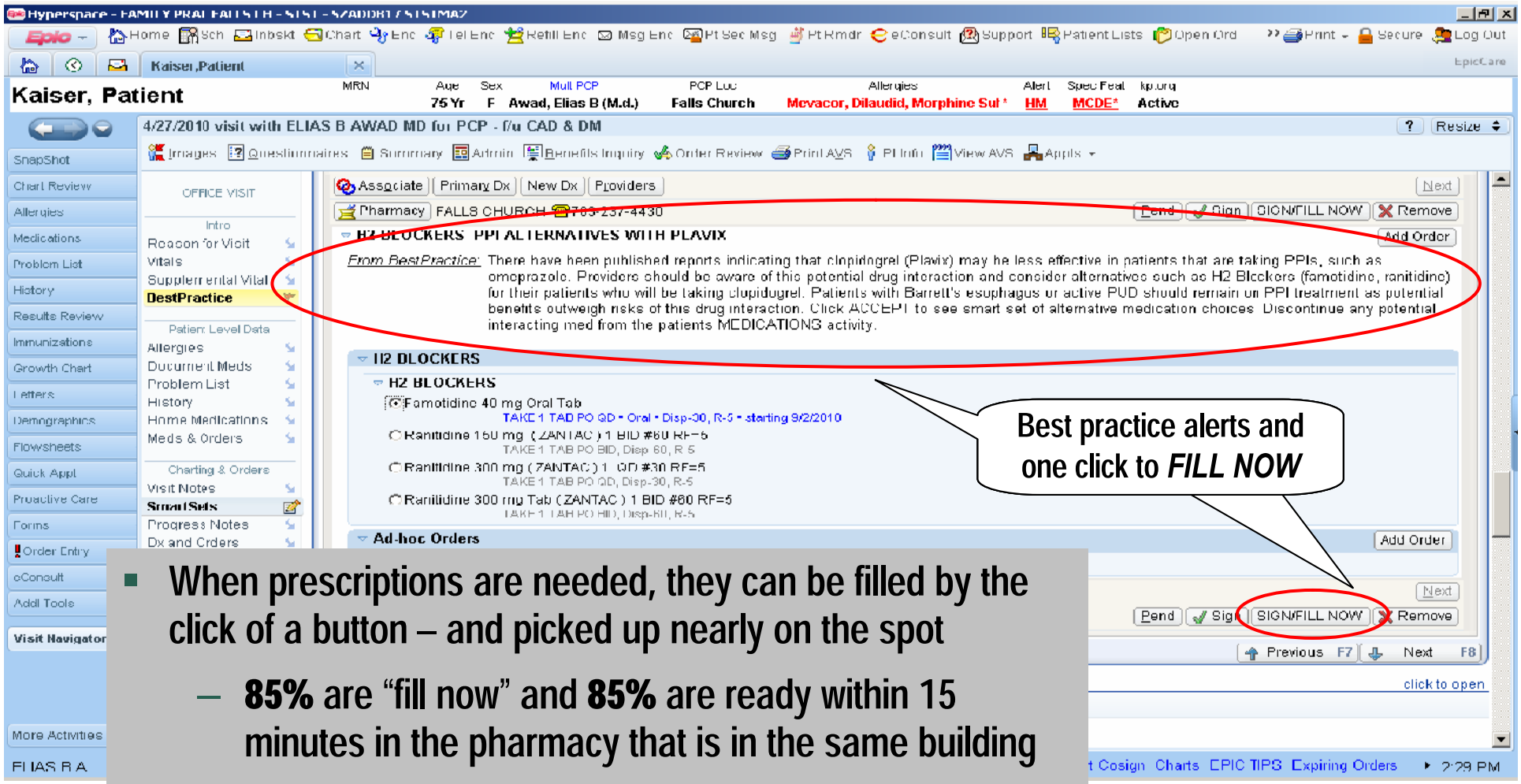
Systems built to drive in-reach



- When prescriptions are needed, they can be filled by the click of a button – and picked up nearly on the spot
  - **85%** are "fill now" and **85%** are ready within 15 minutes in the pharmacy that is in the same building
- That makes closing a care gap easy when Rx is required

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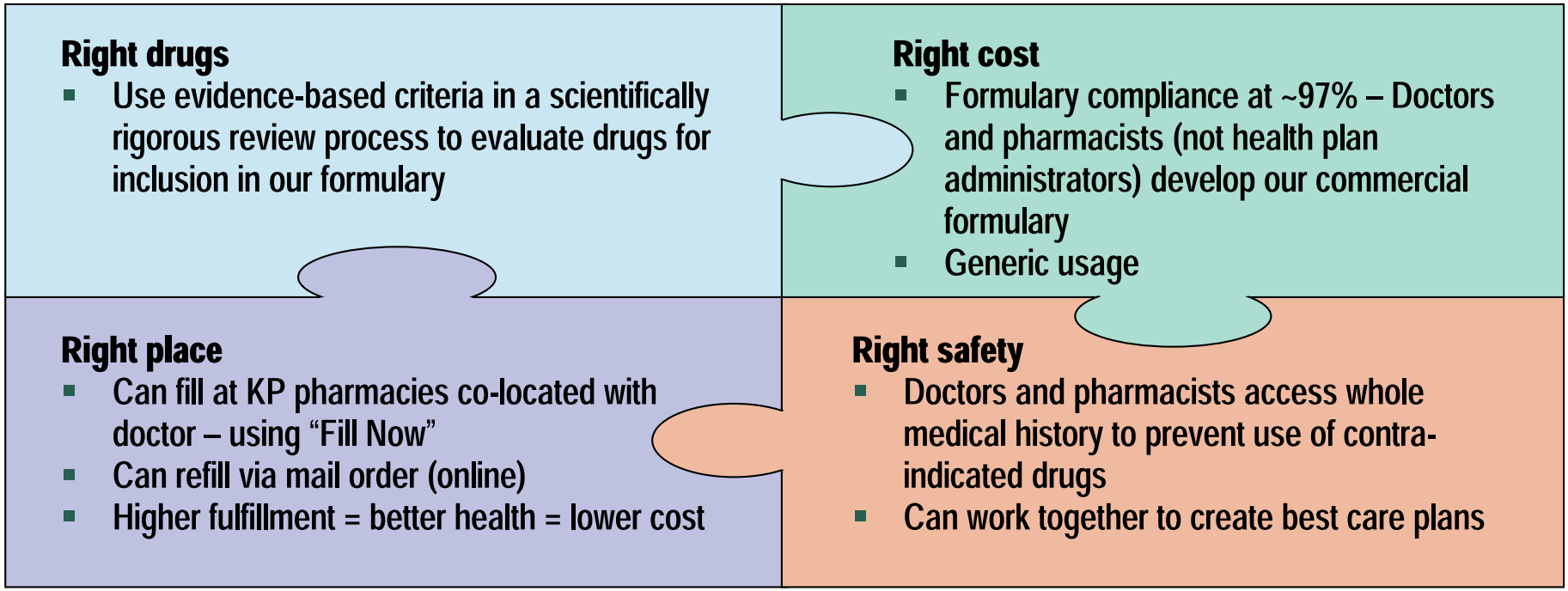
Pharmacy deep dive: Better pharmacy management mitigates costs & improves quality

- At Kaiser Permanente, we **own and operate** facility and mail-order pharmacy services
- Our physicians and pharmacists **work together** in our integrated system
- We use **comprehensive strategies** to maintain a clinically effective, cost-efficient program
- We provide employers with **competitive pharmacy benefit rates**



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Systems built for patient engagement

- Secure e-mail
- Test results
- Book appointments
- Online refills
- Print records
- Care reminders

The most powerful online tools in the industry…

all for free

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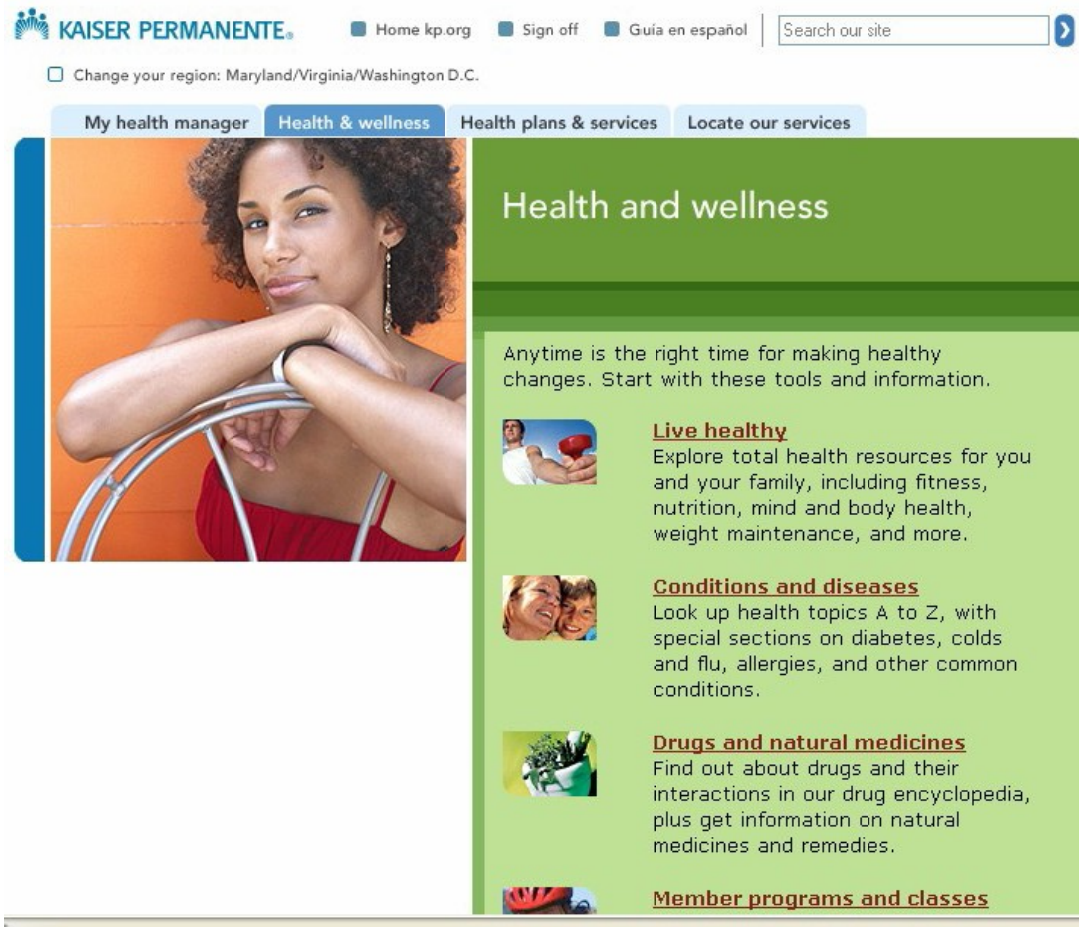
Not just engagement, but wellness tools too



- **Online classes & education**
- **Link to member programs (Health Ed classes and more)**

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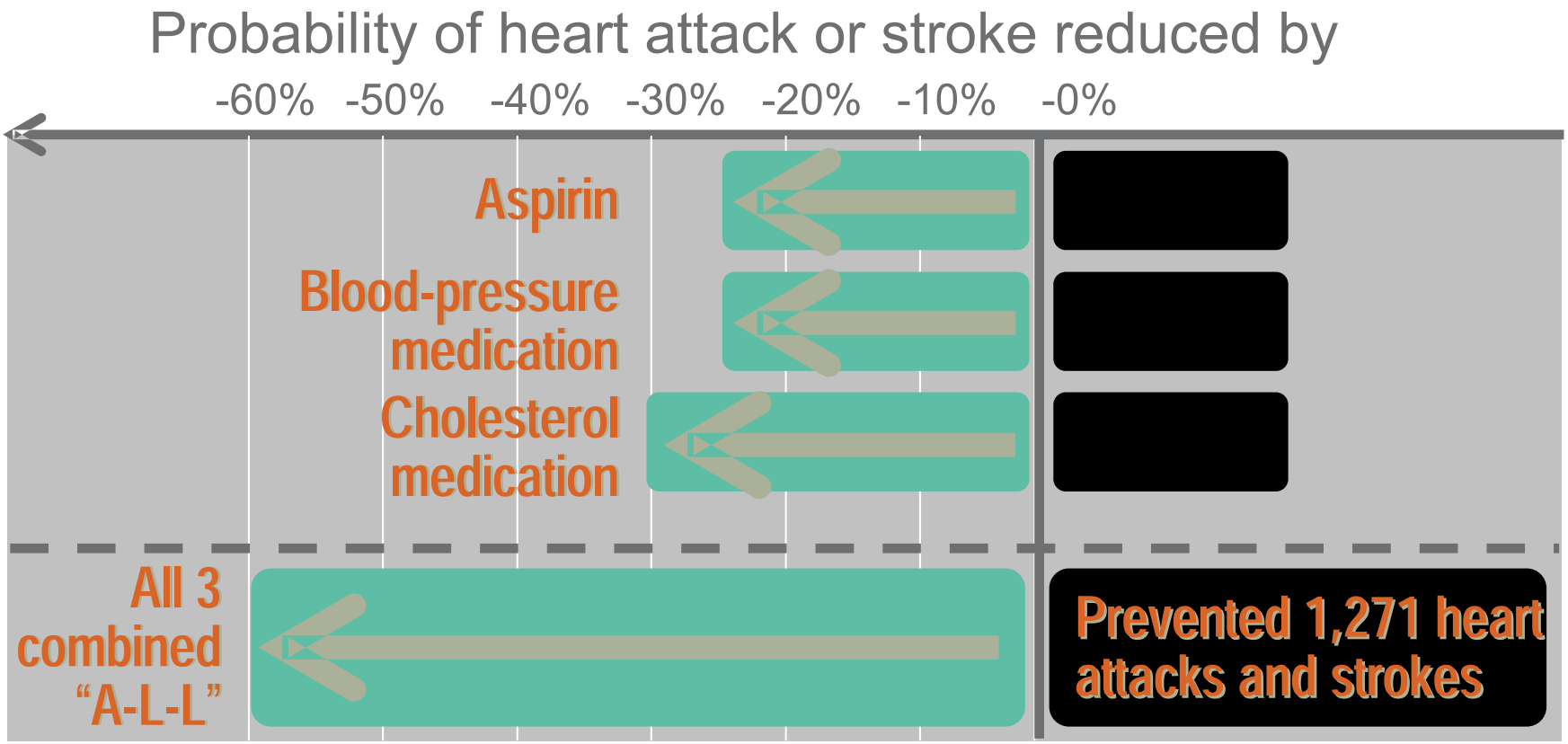
"So What?" – institutionalizing best practices to achieve best health and best cost



Source: James Dudl, MD, et al., "Preventing Myocardial Infarction and Stroke with a Simplified Bundle of Cardioprotective Medications," *American Journal of Managed Care*, October 2009.

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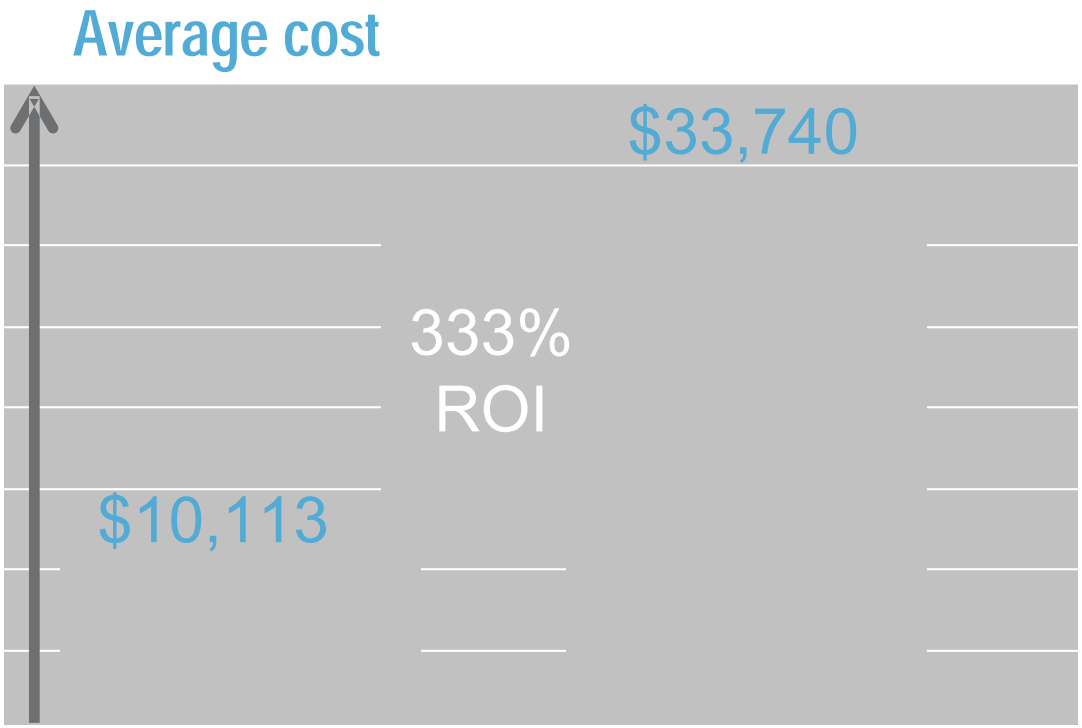
"So What?" – institutionalizing best practices to achieve best health and best cost



30,000 employees

10% on "A-L-L"

45 fewer heart attacks

1,800 days saved

Your productivity savings

Source: Kaiser Permanente data. The numbers on this slide were derived from internal Kaiser Permanente study of A-L-L, including Care Management Institute (CMI) analysis of unpublished data, the CMI business plan, and Department of Social Services data.

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"So What?" – More cost-efficient than competitor plans four years running

Better health for members who email

Patients with diabetes HEDIS® measure	Healthier outcomes (percentage points)
Blood sugar control	
HbA1c screening	↑ 6.9
HbA1c less than 9%	↑ 11.1
Cholesterol	
LDL-C screening	↑ 7.2
LDL-C less than 100 mg/dl	↑ 10.5
Blood pressure	
BP less than 140/90	↑ 6.6

Source: Yi Yvonne Zhou et al., "Improved Quality at Kaiser Permanente Through E-mail Between Physicians and Patients," *Health Affairs*, July 2010, pp. 1,370–1,375

- Kaiser Permanente recently studied more than 35,000 members with diabetes, hypertension, or both for two months—comparing the health status of those who used email against those who did not.
- The group who communicated with their doctors via email had higher screening rates and better health outcomes in blood sugar, cholesterol, and blood pressure control.

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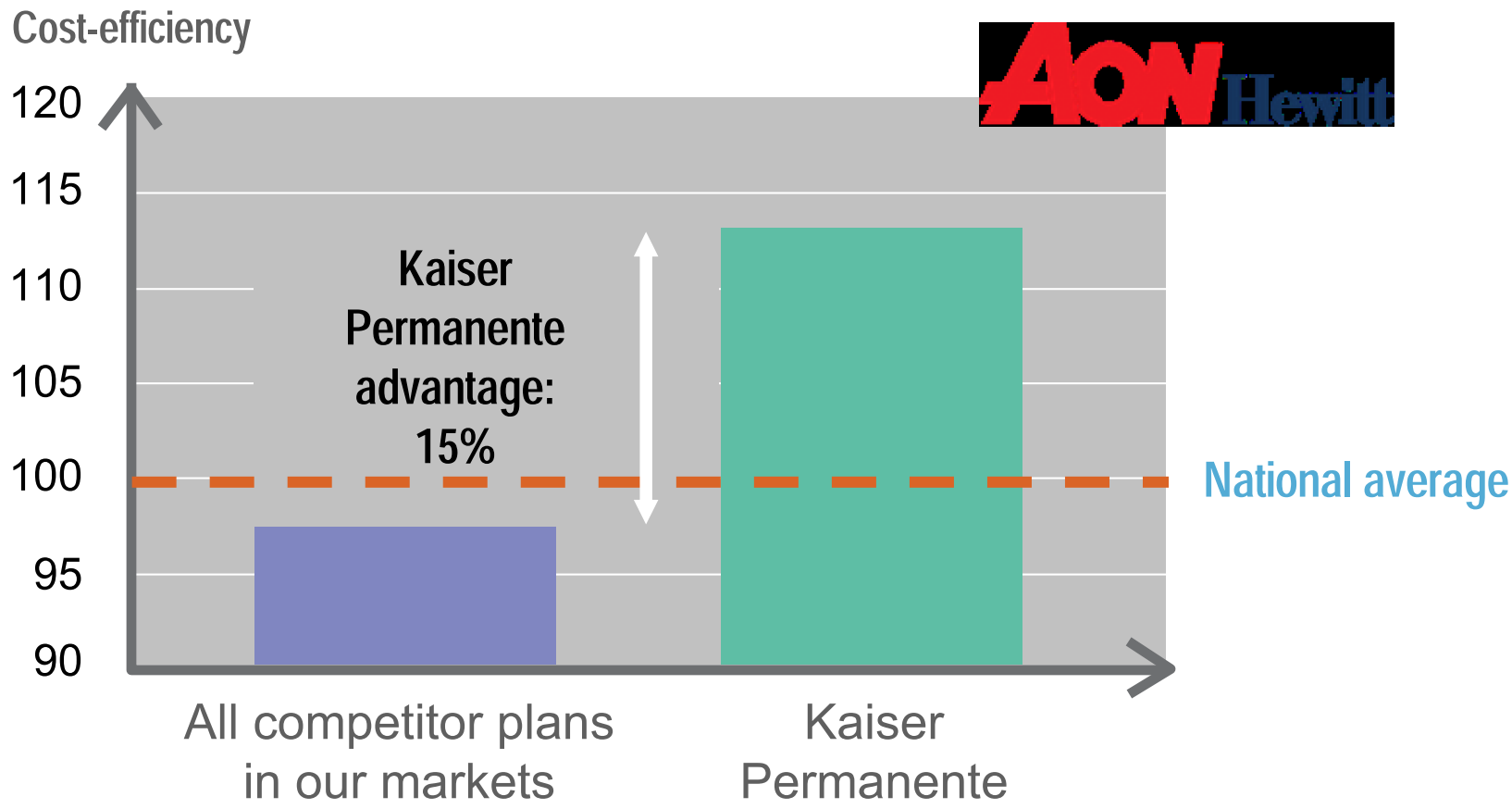
"So What?" – More cost-efficient than competitor plans four years running



Note: Aon Hewitt analyzes plan data after adjusting for demographics of the covered population, plan design, and geographic cost differences to establish an equitable, apples-to-apples comparison.

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Hewitt Health Value Initiative™ Described

- The Hewitt Health Value Initiative™ Financial Index is a measure of **health plan financial efficiency**.
  - A Financial Index Score *greater* than 100% indicates a plan that is *more cost efficient* than average
  - A Financial Index Score *less than* 100% indicates a plan that is *less cost efficient* than average

- Kaiser Permanente ranked **first** in *cost efficiency, clinical quality **and** overall plan performance* in the Mid-Atlantic States (MAS) market.
  - Kaiser Permanente MAS delivers **18% greater financial efficiency** compared to the average of our competitors
  - Kaiser Permanente's Plan Performance Index is the **highest in the Mid-Atlantic market.** It is **12%** above the HMO market average, and **51%** better than the all-plan average
  - For the Mid-Atlantic States region, Kaiser Permanente's **Clinical Quality Score is the highest in the market**. It is 14% above the HMO market average, and **125%** better than the all-plan average.

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Requested Items to Cover

- Wellness and disease management in delivery of care
- Programs for Kaiser Permanente employees
- **Capacity to serve new clients**
- Union partnerships
- Rate setting

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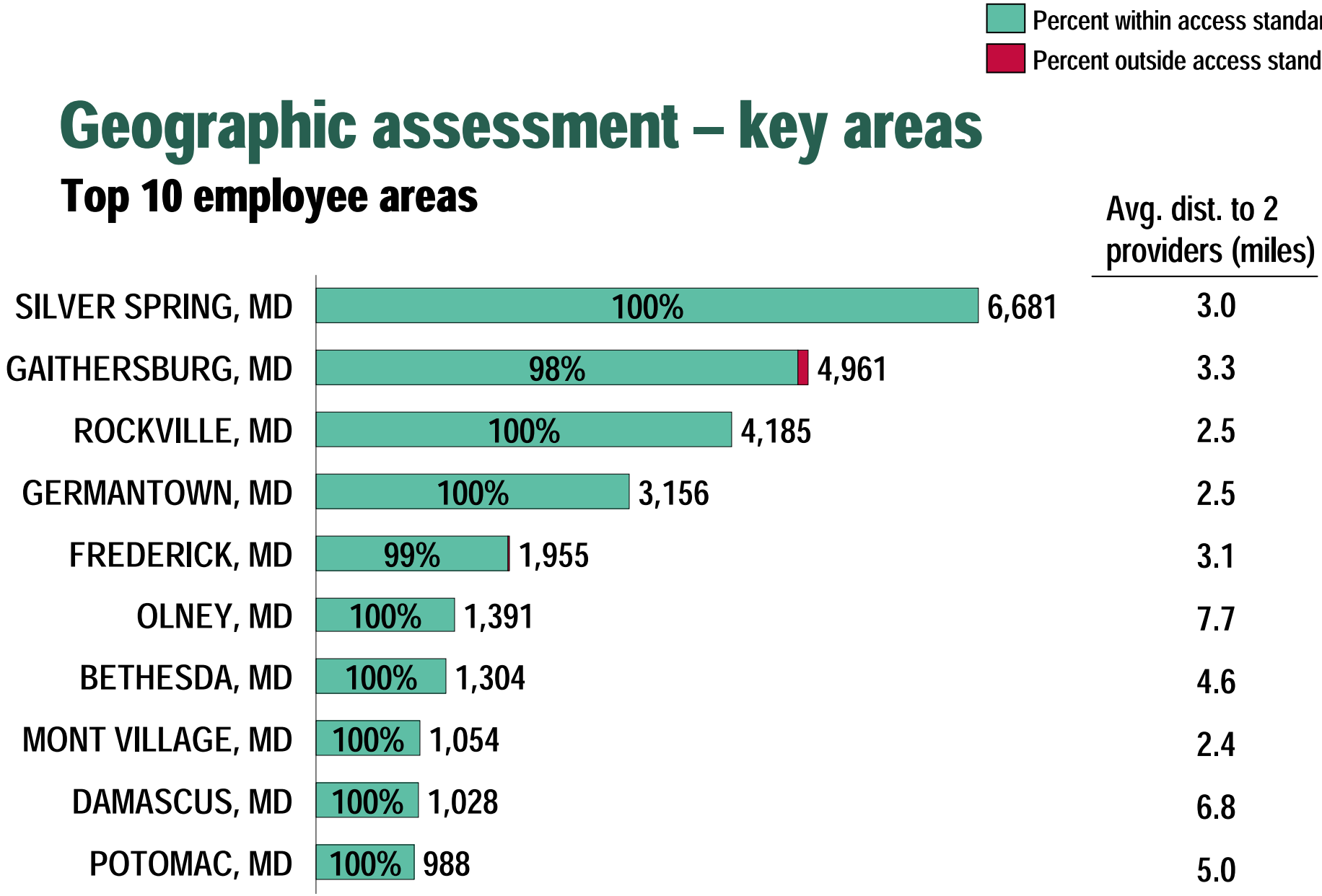
Geographic assessment – key areas

Top 10 employee areas



Bases on census from RFP

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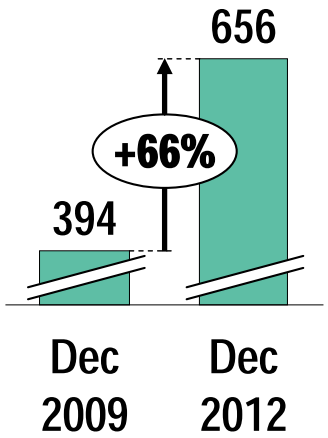
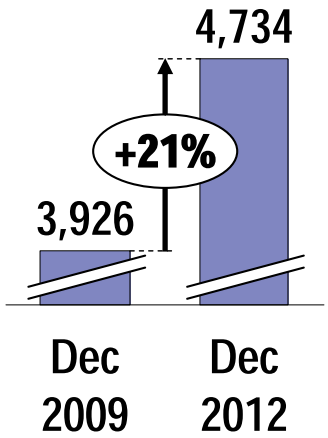
Expanding services

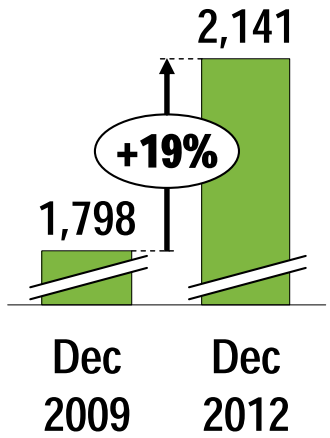
Urgent Care
Hours / wk



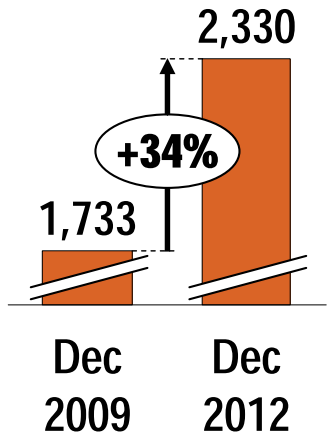
Radiology
Machine hours / wk



Lab
Hours / wk



Pharmacy
Hours / wk



- Almost 300 board-eligible/board-certified physicians have joined us since the beginning of 2009
  - We have over a dozen specialists in 19 different specialties

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Planned growth – 5 full service centers

Gaithersburg Medical Center
655 Watkins Mill Rd
Opening Spring, 2012

Southern Baltimore Medical Center
Opening 2013

Tyson's Corner Medical Center
8008 Westpark Dr
Opening Summer, 2012

Largo Medical Center
Expansion Completed
Spring, 2013

Capitol Hill Medical Center
Attached to Union Station
Opened January 24, 2011

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Gaithersburg: A huge array of services

- Comprehensive Primary and Specialty Care Services
- 72 Provider Offices (23 Primary Care and 49 Specialty Care)
- Clinical Decision Unit/Urgent Care (24 x 7 x 365)
- Ambulatory Surgery Center
- Comprehensive Imaging services (except for PET CT)
- Laboratory (including blood transfusion) and Pharmacy
- HIMS, Member Services, Health Education and Administrative Support

First Floor
- Cafe
- Clinical Technology
- EVS
- Facilities Services
- Health Education
- HIMS
- Imaging Services
- Laboratory/ Blood Transfusion/ Lab Service
- Member Services
- Pharmacy

Second floor
- Cardiology
- CDU/Urgent Care
- Orthopedic Surgery
- Nuclear Medicine
- Podiatry
- Pulmonary

Third Floor
- Allergy
- Blood Transfusion
- Dermatology
- Endocrinology
- Hematology
- Infectious Disease
- Infusion Center
- Infusion Pharmacy
- Nephrology
- Neurology
- Oncology
- Pain Management
- Physical Medicine
- Rheumatology
- Sleep Medicine

Fourth Floor
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Ophthalmology
- Optical Center
- Optometry

Fifth Floor
- Administration
- Adult Medicine
- Adolescent Medicine
- Conference Rooms
- OB/GYN
- Pediatrics
- Security
- Staff Lounge

Sixth Floor
- Ambulatory Surgery
- Audiology
- ENT
- General Surgery
- Plastic Surgery
- Presurgical Testing
- Urology
- Vascular Surgery
- Sterile Processing

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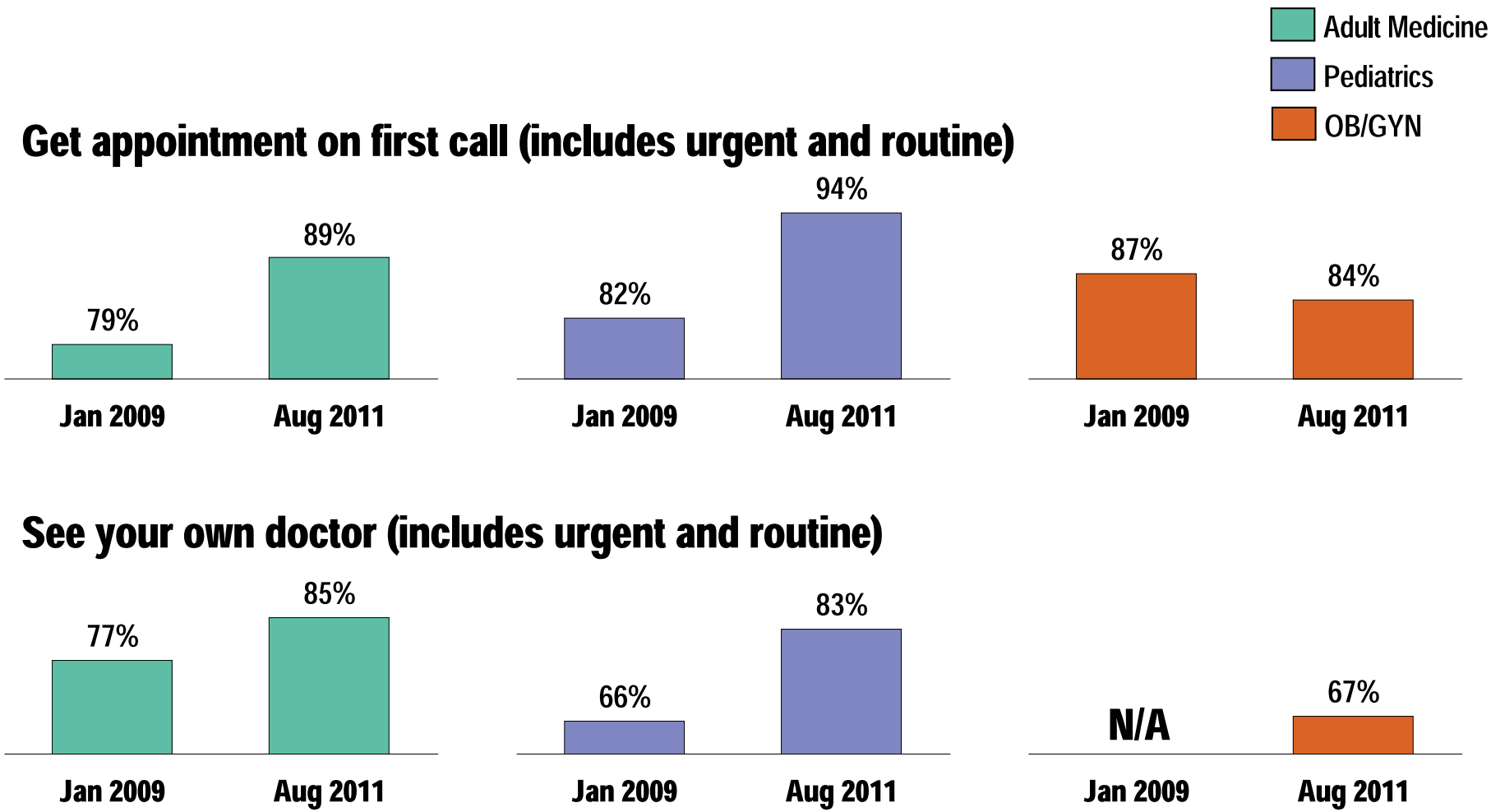
Access to care – primary care



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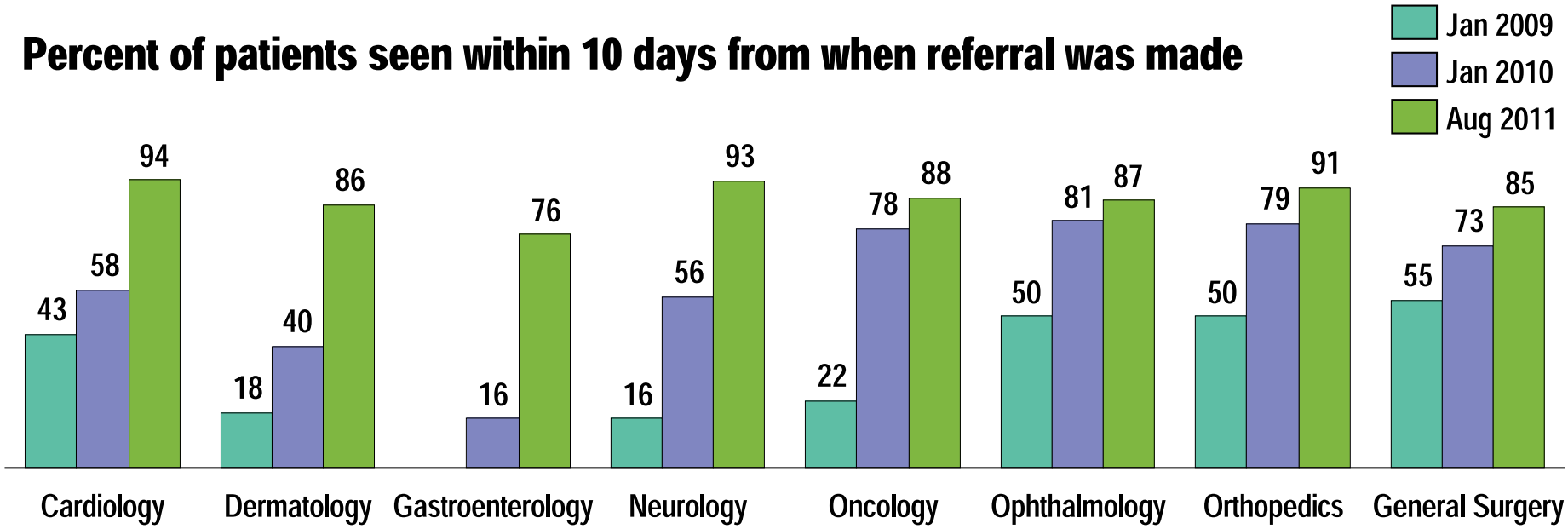
Access to care – specialty care



Across all specialties in 2011 our members have been seen, *on average*, 5-7 days after the referral

About 1 in 4 are seen same or next day

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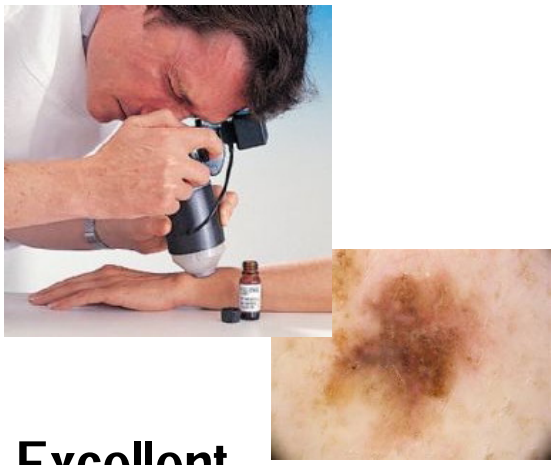
Adding innovations: Furthering patient access to care – the way you want it

Selected innovation examples

TeleDermatology



Excellent response time

pConsult

Live consultation

Telemedicine Pilots

vConsult (Ortho, Spine)
More to come

- Saves time
- Saves a visit
- Saves a copay
- Improves care

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Requested Items to Cover

- Wellness and disease management in delivery of care
- Programs for Kaiser Permanente employees
- Capacity to serve new clients
- **Union partnerships**
- Rate setting

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Our Labor Management Partnership

- Launched in 1997 to transform the relationship between KP and its unions
- Largest, most comprehensive partnership, covering 90,000 employees in 29 local unions
- Shared commitment to improve quality, service, affordability and the workplace guided by the KP Value Compass
- Unit-based teams lead patient-centered change at the front lines.

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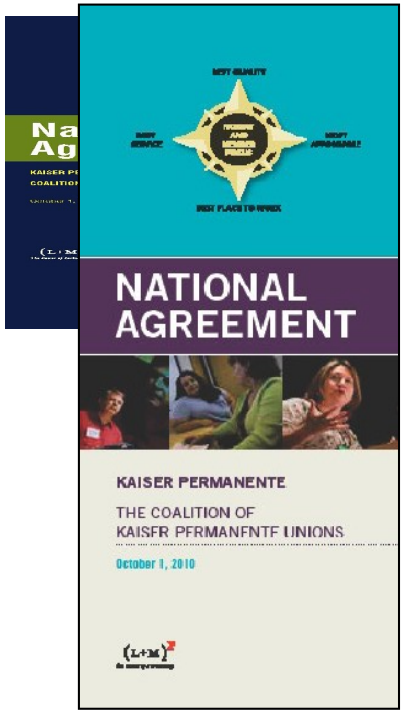
Founding principles of the Partnership

"Health care services and the institutions that provide them are undergoing rapid change. Now is the time to enter into a new way of doing business…to unite around our common purposes and work together to most effectively deliver high quality health care and prevail in our new, highly competitive environment."

- Partnership Founding Agreement, 1997



(L+M)P
The Power of Partnership
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Distinctive workplace strategy

- Nation's only union health plan
- Frontline voice in goal setting, decision making, and ongoing performance improvement
- Employer of choice in health care, providing superior care in a high-performance workplace
- Employment and income security
- Enhanced career opportunities for union workers, with innovative educational trust funds

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Public recognition

- Kaiser Permanente's industry-leading use of collaborative communities to improve organizational performance is featured in the *Harvard Business Review*.

- The article highlights Kaiser Permanente's Labor Management Partnership as a model collaborative community that fosters this kind of innovation, agility and efficiency. Kaiser Permanente's unit-based teams employ all of the key elements of collaborative communities, including a shared purpose, contribution and a strong infrastructure.

- The article authors, Paul Adler, Charles Hecksher and Laurence Prusak, use the Kaiser Permanente Value Compass to illustrate their point about the importance of defining and building a shared purpose. The Value Compass features the patient/member at the center of the compass, with four surrounding points: best quality, best service, most affordable and best place to work.

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LMP in action: Unit-based teams

Unit-based team: A natural work group of frontline workers, physicians and managers who solve problems and enhance quality for tangible results. UBTs work together to:

- Set goals
- Review and evaluate performance
- Identify and solve problems
- Contribute to decisions on budget, staffing and scheduling

UBTs drive organizational performance

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UBT success: Patient education & outreach

Woodlawn, MD, Internal Medicine team: Improving chronic care

WHAT THEY DID:

- Developed exam room questions to determine diabetes patients' compliance with prescribed preventive drug regimen, including aspirin.
- identified patients with gaps and referred them to RNs for education.
- Phone and letter outreach to diabetic patients to see if they are taking prescribed drugs.

RESULTS:

- Compliance more than doubled in 10 months, from 34.8% to 70.1%, for high-risk patients taking aspirin.

Dr. Nara Um, Woodlawn Medical Center

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Requested Items to Cover

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Kaiser Permanente Rating Methodology

- The KP methodology used for calculating renewal rates for mid and large groups is prospective experience rating.
- The credibility applied to each group's claims experience is based on the average membership during the utilization period.
  - Avg. Membership > 1,000 = 100% credible
  - Avg. Membership < 1,000 = Blend of Manual Rate, Risk and Groups Claims
- Montgomery County Government and Montgomery County Public Schools are both 100% credible.
- Montgomery County College and WSSC use a combination of risk and claims.
- The pooling level, pooling charges and retention are also based on membership. The larger the enrollment, the lower the charge.
- The revenue requirement will vary by group based on the group's unique utilization and costs associated with rendered services and influenced by benefit design, offering conditions, demographics, and contract size.

Appendix

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Kaiser Permanente Recognition: Highest employer satisfaction

- **"Highest Employer Satisfaction among Fully Insured Commercial Health Plans"**
- J.D. Power and Associates 2011 Employer Health Insurance Plan Study℠

Note: Kaiser Foundation Health Plan received the highest numerical score among fully insured commercial health plans in the proprietary J.D. Power and Associates 2011 Employer Health Insurance Plan Study℠. Study based on 7,024 employer responses measuring 6 plans. Proprietary study results are based on experiences and perceptions of employers surveyed in March–April 2011. Your experiences may vary. Visit jdpower.com.

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Kaiser Permanente Recognition: Time Magazine online


TIME Moneyland
Financial Insights from Your Wallet to Wall Street

Home | Saving & Spending | Planning | Investing | Real Estate & Homes | Careers

INSURANCE

Why Are Customers of This Health Insurer So Happy?

By MAGGIE MAHAR | October 18, 2011

Kaiser Permanente's stand out performance in *Consumer Reports'* national rankings of some 830 insurance plans raises an obvious question: What makes Kaiser so different? In a word: collaboration

http://moneyland.time.com/2011/10/18/why-are-customers-of-this-health-insurer-so-happy/


TIME Moneyland
Financial Insights from Your Wallet to Wall Street

Home | Saving & Spending | Planning | Investing | Real Estate & Homes | Careers & Wo

INSURANCE

Patients Prefer HMOs (And Other Healthcare Surprises)

By MAGGIE MAHAR | October 17, 2011

Are health insurance plans with big brand names better than smaller insurers that most people have never heard of? "Not usually," says Nancy Metcalf, senior program editor, at *Consumer Reports*. Unless that is, the plan's name is "Kaiser."

http://moneyland.time.com/2011/10/17/health-insurance-surprises-smaller-is-often-better-and-patients-prefer-hmos/

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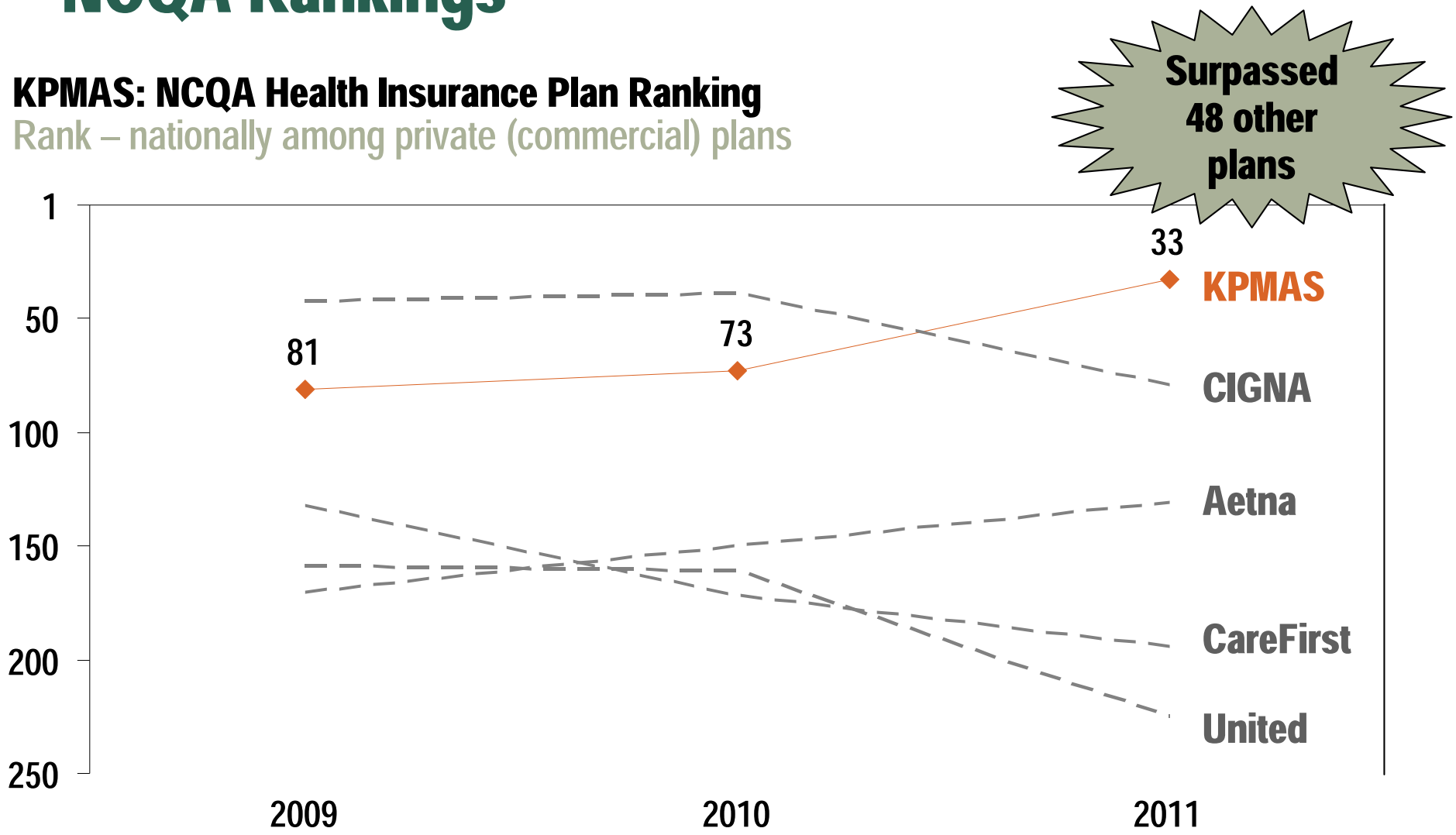
Kaiser Permanente Recognition: NCQA Rankings

KPMAS: NCQA Health Insurance Plan Ranking

Rank – nationally among private (commercial) plans



NOTE: NCQA (National Commission for Quality Assurance) plan rankings based on Consumer Satisfaction, Prevention, and Treatment metrics.

KAISER PERMANENTE® thrive

Kaiser Permanente Recognition: HEDIS Effectiveness of Care metrics

48 items measured

- Immunizations
- Condition management
- Screenings
- And more

Kaiser Permanente rank by State

				4th	5th
DC	48	0	0		
MD	18	13	12	3	2
VA	29	6	8	5	

All 48 metrics ranked 5th or better in each State

7 of 48 metrics not only local "gold," but top 10 nationally

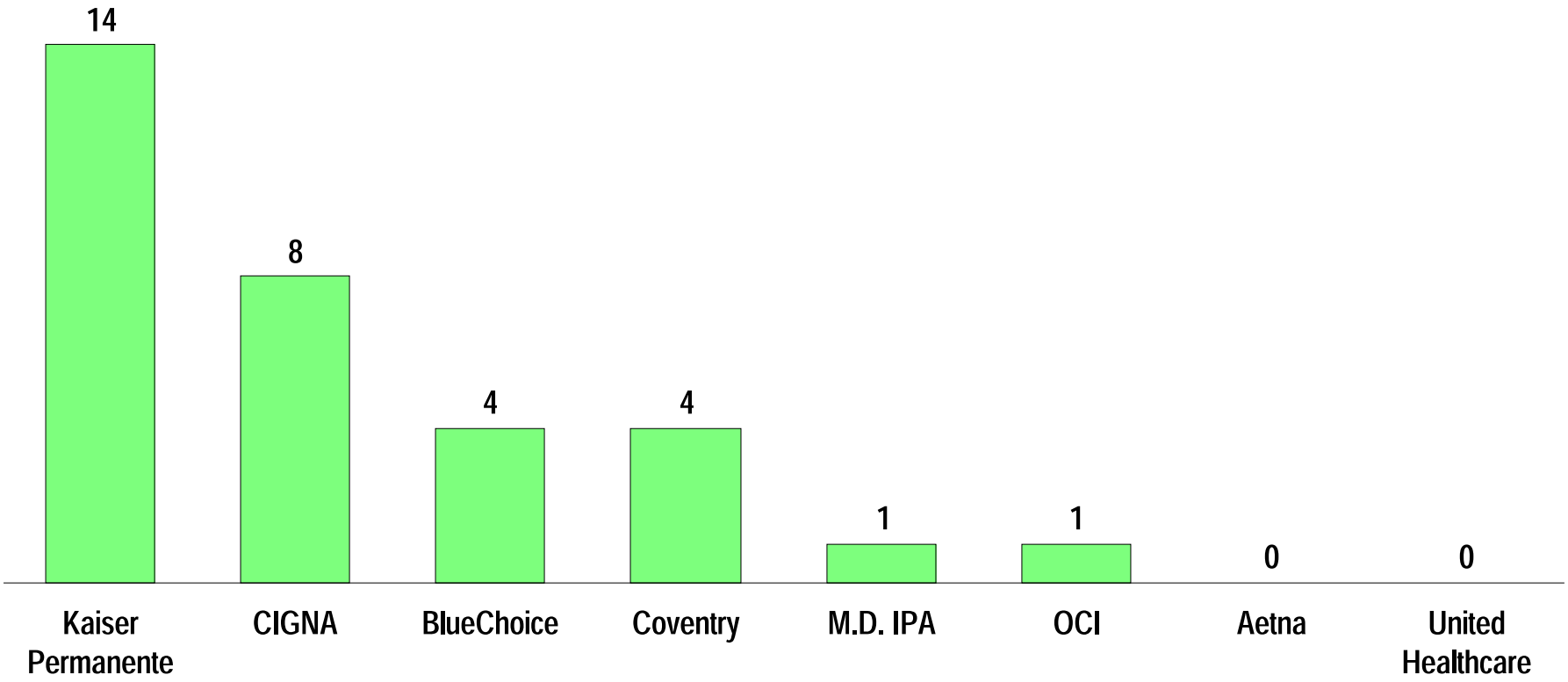
SOURCE: HEDIS 2011 Commercial EOC Top Performance; includes all non-PPO plans

KAISER PERMANENTE® thrive

Kaiser Permanente Recognition: Maryland Healthcare Commission

Health Plan Quality Summary – Count of measures *above* MD State Average

HMO and HMO/POS Plans only: 22 total measures across 4 Performance Categories (Primary Care, Chronic Care, Behavioral Health Care, Member Satisfaction)



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KAISER PERMANENTE® thrive

Membership – Age and Gender Demographics

Group Name: MCPS
Group Number(s): 3029
Subgroup(s): 0002,0003,0012,0013,0021,0022,0029, 0030,0031
Quote Number(s): 7842876,7842877

Region: Mid-Atlantic States
Contract Period: 01/01/2012-12/31/2012

Members*

	Average Apr09-Mar10				Average Apr10-Mar11				Current as of Apr11			
Age	Male	Female	Total	Percent	Male	Female	Total	Percent	Male	Female	Total	Percent
0-0	43	29	72	0.8%	47	41	87	1.0%	33	36	69	0.8%
1-4	178	156	334	3.7%	177	151	328	3.7%	185	153	338	3.8%
5-9	258	245	503	5.6%	248	237	485	5.4%	246	237	483	5.5%
10-14	306	288	594	6.6%	297	268	565	6.3%	293	262	555	6.3%
15-19	384	427	811	9.0%	375	418	793	8.9%	359	415	774	8.7%
20-24	454	516	970	10.8%	451	506	957	10.8%	466	495	961	10.9%
25-29	155	259	414	4.6%	151	257	408	4.6%	165	283	448	5.1%
30-34	202	292	493	5.5%	195	279	474	5.3%	197	268	465	5.3%
35-39	230	325	555	6.2%	219	316	535	6.0%	209	307	516	5.8%
40-44	262	341	603	6.7%	252	336	588	6.6%	251	333	584	6.6%
45-49	300	399	699	7.7%	296	401	696	7.8%	295	406	701	7.9%
50-54	377	529	906	10.0%	368	494	862	9.7%	364	463	827	9.3%
55-59	449	533	982	10.9%	435	545	979	11.0%	407	530	937	10.6%
60-64	389	443	832	9.2%	405	460	865	9.7%	425	469	894	10.1%
65-69	110	72	182	2.0%	120	80	200	2.2%	121	90	211	2.4%
70-74	36	17	54	0.6%	43	17	60	0.7%	52	17	69	0.8%
75-79	7	6	13	0.1%	9	8	16	0.2%	8	7	15	0.2%
80-84	3	1	4	0.0%	2	0	2	0.0%	3	1	4	0.0%
85+	0	0	0	0.0%	1	0	1	0.0%	1	0	1	0.0%
Total Members	**4,143**	**4,878**	**9,021**	**100.0%**	**4,089**	**4,813**	**8,902**	**100.0%**	**4,080**	**4,772**	**8,852**	**100.0%**
Percentage	45.9%	54.1%			45.9%	54.1%			46.1%	53.9%		

Health Plan Average Age:	35.0	36.2	35.6		35.2	36.3	35.8		35.2	36.3	35.8	
Group Average Age:	35.4	36.5	36.0		35.7	36.7	36.2		35.8	36.7	36.3	
Average Contract Size:			2.36				2.37				2.41	
												%Change
Demographic Factor:							1.02639				1.03059	0.4%

Demographic Change: Current Demo Factor / Exp.Pd Demo Factor = 1.03059 / 1.02639 = **1.00409**

* Includes Actives and /or pre 65 Retirees only.

Membership – Age and Gender Demographics

Group Name: MONTGOMERY COUNTY GOVERNMENT
Group Number(s): 3012
Subgroup(s): 0000,0002,0008,0009,0010,0011,0012, 0013,0014,0015

Region: Mid-Atlantic States
Contract Period: 01/01/2012-12/31/2012

Members*

	Average Apr09-Mar10				Average Apr10-Mar11				Current as of Apr11			
Age	Male	Female	Total	Percent	Male	Female	Total	Percent	Male	Female	Total	Percent
0-0	6	8	15	0.5%	7	5	12	0.4%	4	7	11	0.4%
1-4	70	53	123	4.1%	66	46	112	3.7%	62	48	110	3.6%
5-9	98	93	191	6.4%	92	93	185	6.1%	95	94	189	6.2%
10-14	148	113	261	8.8%	144	108	252	8.3%	134	109	243	8.0%
15-19	165	142	307	10.3%	166	146	313	10.3%	178	142	320	10.5%
20-24	90	100	189	6.3%	126	124	249	8.2%	139	137	276	9.1%
25-29	70	62	132	4.4%	62	75	137	4.5%	66	84	150	4.9%
30-34	98	84	182	6.1%	86	73	159	5.2%	83	69	152	5.0%
35-39	101	114	216	7.2%	103	106	209	6.9%	105	104	209	6.9%
40-44	145	138	283	9.5%	130	132	262	8.6%	122	129	251	8.2%
45-49	136	165	301	10.1%	146	172	318	10.5%	157	172	329	10.8%
50-54	134	142	276	9.3%	139	146	285	9.4%	128	149	277	9.1%
55-59	138	137	275	9.2%	140	134	274	9.0%	133	122	255	8.4%
60-64	100	85	185	6.2%	110	99	209	6.9%	113	105	218	7.2%
65-69	24	16	40	1.3%	26	16	42	1.4%	28	15	43	1.4%
70-74	4	1	5	0.2%	5	2	7	0.2%	6	4	10	0.3%
75-79	1	0	1	0.0%	0	0	0	0.0%	0	0	0	0.0%
80-84	1	2	3	0.1%	1	2	3	0.1%	0	1	1	0.0%
85+	0	0	0	0.0%	2	0	2	0.1%	2	0	2	0.1%
Total Members	**1,528**	**1,455**	**2,983**	**100.0%**	**1,550**	**1,479**	**3,029**	**100.0%**	**1,555**	**1,491**	**3,046**	**100.0%**
Percentage	51.2%	48.8%			51.2%	48.8%			51.1%	48.9%		

Health Plan Average Age:	35.0	36.2	35.6		35.2	36.3	35.8		35.2	36.3	35.8	
Group Average Age:	33.9	34.8	34.3		34.3	35.1	34.7		34.2	34.8	34.5	
Average Contract Size:			2.21				2.27				2.31	
												%Change
Demographic Factor:							0.93957				0.93612	(0.4)%
Demographic Change:							**Current Demo Factor** / **Exp.Pd Demo Factor**		**0.93612** / **0.93957** =		**0.99633**	

* Includes Actives and /or pre 65 Retirees only.

Membership – Age and Gender Demographics

Group Name: Montgomery College
Group Number(s): 3189
Subgroup(s): 0000,0001,0002,0004,0005

Region: Mid-Atlantic States
Contract Period: 01/01/2012-12/31/2012

Members*

	Average Apr09-Mar10				Average Apr10-Mar11				Current as of Apr11			
Age	**Male**	**Female**	**Total**	**Percent**	**Male**	**Female**	**Total**	**Percent**	**Male**	**Female**	**Total**	**Percent**
0-0	2	3	5	0.5%	3	6	9	1.0%	0	4	4	0.4%
1-4	13	20	33	3.6%	12	15	27	2.9%	12	15	27	2.9%
5-9	33	22	55	5.9%	23	21	45	4.8%	21	24	45	4.8%
10-14	33	33	66	7.2%	39	34	73	7.9%	39	37	76	8.0%
15-19	43	28	71	7.7%	41	29	71	7.6%	44	31	75	7.9%
20-24	34	44	78	8.4%	46	42	87	9.4%	50	36	86	9.1%
25-29	14	21	34	3.7%	17	23	40	4.3%	18	27	45	4.8%
30-34	26	24	50	5.5%	21	26	47	5.1%	20	24	44	4.7%
35-39	26	38	65	7.0%	28	33	61	6.6%	32	31	63	6.7%
40-44	48	36	84	9.1%	46	39	86	9.2%	46	38	84	8.9%
45-49	39	50	89	9.7%	38	48	87	9.3%	41	50	91	9.6%
50-54	42	61	103	11.2%	41	58	99	10.7%	40	56	96	10.2%
55-59	41	50	91	9.9%	41	52	93	10.0%	46	57	103	10.9%
60-64	28	33	62	6.7%	34	40	73	7.9%	34	42	76	8.0%
65-69	15	14	29	3.1%	15	11	26	2.8%	15	8	23	2.4%
70-74	5	3	8	0.8%	2	3	5	0.5%	2	2	4	0.4%
75-79	0	0	0	0.0%	1	0	2	0.2%	2	1	3	0.3%
80-84	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
85+	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
Total Members	**443**	**479**	**923**	**100.0%**	**450**	**481**	**931**	**100.0%**	**462**	**483**	**945**	**100.0%**
Percentage	48.0%	52.0%			48.3%	51.7%			48.9%	51.1%		

Health Plan Average Age:	35.0	36.2	35.6		35.2	36.3	35.8		35.2	36.3	35.8	
Group Average Age:	35.8	37.3	36.6		35.8	37.4	36.6		36.3	37.4	36.8	
Average Contract Size:			2.05				2.07				2.08	
												%Change
Demographic Factor:							1.00772				1.00819	0.0%

Demographic Change: **Current Demo Factor** / **Exp.Pd Demo Factor** = 1.00819 / 1.00772 = **1.00047**

* Includes Actives and /or pre 65 Retirees only.

Membership – Age and Gender Demographics

Group Name: Washington Suburban Sanitary Commission
Group Number(s): 4418
Subgroup(s): 0004,0007,0009,0012,0013

Region: Mid-Atlantic States
Contract Period: 01/01/2012-12/31/2012

Members*

Age	Average Jan10-Dec10 Male	Female	Total	Percent	Current as of Feb11 Male	Female	Total	Percent
0-0	3	4	8	1.0%	3	6	9	1.1%
1-4	17	11	28	3.6%	17	13	30	3.7%
5-9	32	21	52	6.7%	33	23	56	6.9%
10-14	33	39	73	9.3%	36	39	75	9.2%
15-19	44	32	76	9.8%	39	35	74	9.1%
20-24	38	36	74	9.4%	43	40	83	10.2%
25-29	14	9	23	3.0%	15	10	25	3.1%
30-34	17	14	31	4.0%	19	16	35	4.3%
35-39	25	19	44	5.6%	24	18	42	5.2%
40-44	29	28	56	7.2%	37	26	63	7.7%
45-49	41	31	72	9.2%	39	36	75	9.2%
50-54	42	44	86	11.0%	45	47	92	11.3%
55-59	49	38	86	11.1%	44	39	83	10.2%
60-64	37	21	59	7.5%	39	24	63	7.7%
65-69	6	4	10	1.3%	4	3	7	0.9%
70-74	2	0	2	0.2%	3	0	3	0.4%
75-79	0	0	0	0.0%	0	0	0	0.0%
80-84	0	0	0	0.0%	0	0	0	0.0%
85+	0	0	0	0.0%	0	0	0	0.0%
Total Members	**429**	**350**	**779**	**100.0%**	**440**	**375**	**815**	**100.0%**
Percentage	55.1%	44.9%			54.0%	46.0%		

Health Plan Average Age:	35.2	36.3	35.8		35.1	36.2	35.7	
Group Average Age:	35.2	34.3	34.8		34.9	34.0	34.5	
Average Contract Size:			2.41				2.43	
								%Change
Demographic Factor:			0.94529				0.93690	(0.9)%
Demographic Change:			**Current Demo Factor** / **Exp.Pd Demo Factor**		**0.93690** / **0.94529** =		**0.99112**	

* Includes Actives and /or pre 65 Retirees only.

Montgomery County Agencies
Doing business with Kaiser Permanente

•THE KAISER PERMANENTE ADVANTAGE

KAISER PERMANENTE®

Want to Save $27.4 Million Dollars in Health Care Costs with no Reduction in Benefits?

KAISER PERMANENTE®

Montgomery County Agencies 2011-2013 Best and Final Offer

Agency	Scenario I	Scenario V *
MCPS	6.0%	-2.04%
MCG	9.9%	1.45%
MC	0.3%	-7.67%
WSSC	2.6%	-5.24%
M-NCPPC	Prospective Business	

Scenario I: Each agency is rated on an individual experience basis, Yr 2 cap of 10%, Yr 3 cap of 14%

Scenario V: KP offered as Exclusive HMO to all agencies, Yr 2 cap of 8%, Yr 3 cap of 16%

*** $27.4 Million Annual Savings as Exclusive HMO Carrier**

Based on estimated incumbent renewal action (includes EPO coverage)

KAISER PERMANENTE®

Montgomery County Public Schools
2011 Renewal Cost Drivers
BAFO 6% Scenario I OR -2.04% Scenario V

www.montgomeryschoolsmd.org
Montgomery County Public Schools
ROCKVILLE, MARYLAND

- Decreased Enrollment yields worsening demographics
- Medical cost pmpm increased 8.6% from 2008 to 2009
- Increase in Inpatient and Outpatient cost
- Maternity and MHSA are key drivers
- Higher prevalence of depression, CAD, and asthma
- Scenario I offers 10% & 14% Renewal Caps for 2012 & 2013
- Scenario V offers 8% & 16% Renewal Caps for 2012 & 2013

KAISER PERMANENTE®

Montgomery County Government
2011 Renewal Cost Drivers
BAFO 9.9% Scenario I OR 1.45% Scenario V

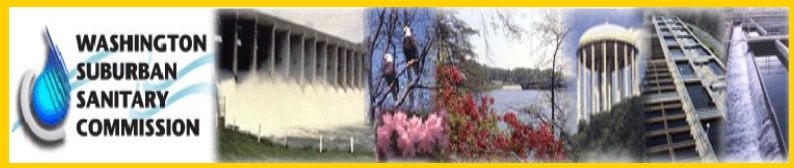
- Increased enrollment w/ age > 60 erodes demographics
- Medical cost pmpm increased 13.6% from 2008 to 2009
- 5 High cost claimants > $125,000
- Increase in Inpatient and Outpatient costs
- High prevalence of diabetes, depression and asthma
- Scenario I offers 10% & 14% Renewal Caps for 2012 & 2013
- Scenario V offers 8% & 16% Renewal Caps for 2012 & 2013

Montgomery College
2011 Renewal Cost Drivers

BAFO 0.3% Scenario I OR -7.67% Scenario V

- Medical costs decreased 2.4% from 2008 to 2009
- One High Cost Claimant exceeded $125K Pooling point
- Growth yields favorable demographic change of 0.3%
- Favorable Risk score compared Kaiser Permanente average
- Scenario I offers 10% & 14% Renewal Caps for 2012 & 2013
- Scenario V offers 8% & 16% Renewal Caps for 2012 & 2013

WSSC
2011 Renewal Cost Drivers
BAFO 0.3% Scenario I OR -7.67% Scenario V



- Medical costs increased 9.0% from 2008 to 2009
- Four claimants > $75K pooling point, 20.5% of claims
- Favorable demographic change of 2.2%
- Risk score slightly higher than Kaiser Permanente average
- Scenario I offers 10% & 14% Renewal Caps for 2012 & 2013
- Scenario V offers 8% & 16% Renewal Caps for 2012 & 2013

KAISER PERMANENTE®

The Maryland-National Capital Parks and Planning Commission

*** $1.7 Million**
Annual Savings
as
Exclusive HMO Offering

Scenario V
offers
8% & 16% Renewal Caps
for 2012 & 2013

*** Based on estimated incumbent renewal action**
If not exclusive HMO for Scenario I rates will be increased by 5%

KAISER PERMANENTE®

Follow-up Information from Kaiser Permanent to Task Force – Questions/Information Requests forwarded by Linda McMillan based on October 25, 2011 Task Force Discussion.

Responses from: Dawn Audia, Executive Director of Account Management for the Kaiser Foundation

1. Please provide information on access to mental health services in terms of how quickly an appointment can be made with different levels of mental health professionals. This question came after the part of the presentation that discussed access to specialists and how appointments can be made while the patient is in the office with the primary care physician.

Response - Kaiser Permanente (KP) has a goal to provide non urgent appointments within 2 weeks and urgent appointments within one day. This spans all provider types (Psychiatrist MDs, Therapists, etc.). Patients are allowed to self-refer to mental health. They are triaged to find the right type of care provider for them. Currently, our overall results are relatively dependent on the speed at which non-KP providers can offer visits (we externalize roughly 1/3 of care at present). Please note that Kaiser is in the process of expanding our behavioral health capacity. We are accelerating plans to hire >30 FTEs in behavioral health region wide so that we can bring most of the care inside and take our own responsibility for ensuring we completely meet our access targets (and offer the best care).

2. What is the cost share (employee/employer premium split) for Kaiser employees? (Information for the mid-Atlantic region that would be fine.)

Response - Kaiser Permanente funds benefit costs for our own employees with Flex Credits. Flex Credits are calculated based on a Flat $ plus a % of salary. If the benefits chosen cost more than the flex credits, the employee will pay the difference through pre-tax or after-tax payroll deductions (depending on the benefit selected). If the benefits cost less than the credits, the employee will receive those credits in their paycheck as taxable income.

3. I need to clarify the response to the question, "What percent of Kaiser employees are represented?" The response was 90% - was this 90% of those in eligible job classes (which would mean an employee could chose or not chose to be in the union) or 90% of non-doctors.

Response - Kaiser Permanente currently has 80% of our 164,000 (or roughly 131,000) non-physician and non-executive employees in a union.

4. Do you have data on client retention for the mid-Atlantic region?

Response - Our client retention in the Mid-Atlantic region is very good. For 2011, in our large group segment Kaiser only lost two customers. One was due

to a consolidation - the group was purchased by a national organization, and the other loss was due to political issues (a new, competing organization was added to the region). Year-to-date for Kaiser for all of our segments (small group, mid-market, large group, federal government and national accounts), we are at a 92% group retention, but a 98% member retention (we are growing in the groups we are retaining). In 2010 and 2011, our region has seen significant overall growth in Kaiser members and we anticipate this trend to continue based on our high quality, customer satisfaction scores and the opening of our new Medical Centers.

5. Do you have demographic information on age and gender for Kaiser members in county agencies (broken out by agency) so that it can be compared to the entire pool of agency employees?

Response - Demographic information by agency is attached.

6. Are you able to provide any more detail on your proposal to Montgomery County that would have resulted in $27 million in savings if the County agencies only used Kaiser as their HMO? Did the savings come from a reduction in the premium you would charge from serving a larger population or from the difference in the cost between United Healthcare/CareFirst/CIGNA HMOs + Caremark compared to the Kaiser premium that will be charged in 2012?

Response - The $27.4 million in savings assumed that Kaiser Permanente would still sit along side CareFirst and UHC, however, Kaiser would be the only HMO offering. The savings came from a reduction in administrative expenses due to economies of scale on the additional members, but more importantly, it came from an overall reduction in estimated claims costs based on our ability to control costs. I have attached the high level information we presented during the finalist presentation from the RFP in June of 2010. The assumptions that were made for the calculation were shared with AON at the time. We would be happy to provide an updated projection for you based on current information, but we anticipate very similar, if not greater savings.

We again, appreciate the opportunity to speak with the Task Force and welcome the opportunity to answer any additional questions or provide a tour of our Capitol Hill Medical Center.

Approved November 8, 2011

Minutes

Task Force on Employee Wellness and Consolidation of Agency Group Insurance

Tuesday, October 25, 2011

DHHS 401 Hungerford Road - Tan Conference Room

The meeting was called to order by Chair Bill Mooney at 8:05 a.m.

Approval of Minutes

Minutes from the October 11, 2011 and October 18, 2011 were approved without objection.

Request for Comments from Visitors

There were no visitor comments at this time.

Presentation – Kaiser Permanente

Ms. Dawn Audia, Executive Director of Account Management for the Kaiser Foundation Health Plan of the Mid Atlantic States, Dr. Jaewon Ryu, Associate Medical Director, and Patricia Nicholson, National Coordinator for the Coalition of Kaiser Permanente Unions, provided a presentation to the Task Force about the staff-model HMO used by Kaiser. A handout of the presentation slides was provided to the Task Force.

With regards to wellness and disease management and what is offered to Kaiser employees and clients, Ms. Audia said that Kaiser does not offer anything different to its employees than it offers to its members. However, Kaiser might pilot some programs first with employees. Wellness and disease management is at the core of Kaiser's operations because everything is integrated. Because doctors are salaried they have an incentive to take care of prevention.

Kaiser is the second largest purchaser of pharmaceuticals after the Federal government. Kaiser passes back its lower cost of pharmacy right away in its rates not through rebates. Kaiser has the highest rate of generic use in the country.

Ms. Audia said that in the typical fee-for-service world the patient has to coordinate their own care because specialists and pharmacists may not know what other providers are doing. Kaiser has member-centered care with one medical record. Everyone in the medical center uses the exact same medical record

Dr. Ryu said that while more practitioners are using electronic medical records, many are on different platforms and cannot share information. At Kaiser, records for everything are put into one medical record.

Dr. Ryu described patient in-reach and outreach. When Kaiser is with the patient doctors can remind the patient that they are due for a mammogram or due for a colorectal screening. Not many systems are able to do this because they are not able to pull from all records. Outreach is a different. The patient is not in front of the doctor but the system can identify for the doctor patients who are in need of screenings and clinic assistants follow-up. Dr. Ryu explained the medical record screens that are available to doctors to show what tests have been done and how the doctor has complied with standards for patients completing required tests. There are incentive payments associated with doctors meeting targets for compliance for preventive care.

The electronic records system also provides up-to-date alerts and best practices that are integrated into the medical record system. Dr. Ryu noted that the medical field doubles in knowledge every seven years and it would be almost impossible for any one doctor to keep up with the new information.

The Kaiser medical record and the scheduling software are integrated so that appointments for specialists can be made when the patient is with their primary doctor. It recycles cancelled appoints so they can be used for patients who come in and need to see a specialist on the same day.

Kaiser has pharmacies at each of its clinics. Studies show that patients fill their prescriptions only 80% of the time and if antibiotics are removed, the rate drops to 70% to 75%. At Kaiser the rate is 95% and the reason is that the pharmacy is located in the same building and the convenience makes the difference. This was especially true for drug prescribed for things with no symptoms, such as chronic conditions like diabetes.

Patients can access their records and review results from lab tests or physicals. Patients can contact doctors by e-mail. This can save people time and the cost (co-pay) of an office visit. This is the power of having salaried physicians; doctors don't have to see a patient to bill.

There are on-line classes and support groups such as smoking cessation and weight loss.

Dr. Ryu discussed the studies showing the best practice treatment of prescribing aspirin, blood pressure medication, and cholesterol medication to prevent heart attack and stroke. The studies show that it costs $10,113 to treat 57 people with these medications, but this would prevent one heart attack that costs $33,740; a return on investment of 333%. It was clarified later that this protocol was for people with diabetes, not just people older than 55.

With regard to capacity, the Mid-Atlantic region is in the process of building and expanding medical hubs that can include radiology, urgent care, lab work, and pharmacy. Kaiser has also hired almost 300 physicians since 2009. Kaiser is

completing a new facility in Gaithersburg. Kaiser envisions no problems with absorbing a larger membership. Most people can see a doctor on the first call and the time for seeing a specialist has improved.

A question was asked about the time it takes to see a mental health specialist. Dr. Ryu said he would provide follow-up information.

Ms Nicholson addressed the question, what is the labor-management partnership? Kaiser is the nation's only unionized health plan. In 1997 Kaiser launched a labor partnership through a national agreement that is founded on a shared commitment for service, quality, and affordability and is focused on the patient. It is implemented through local unit-based teams. It is very empowering for nurses and front-line staff. Kaiser wants to be the choice place to work for healthcare workers. Frontline staff has an equal investment in the success of the organization. Kaiser has educational programs to allow people who come in to move up; for example, someone who started as a receptionist might become a nurse.

The Task Force was given a link to a Harvard Business Review article about the first five years of the partnership.

Ms. Audia addressed the issue of how the county agencies are rated for premiums. Right now all the agencies are rated separately.

A question was asked about what percent of dollars are spent what percent of members. Dr. Ryu responded that he didn't have the hard dollars expected that Kaiser is similar to the 80%/20% that is seen nationwide. He said there are cases were expensive care is needed such as a baby who needs care in a NICU and this is expensive, but appropriate and needed care. He said it is important to note that Kaiser focuses on getting good prenatal care to prevent this. Another example of the focus on prevention is that Kaiser doesn't employ a surgeon for coronary artery bypass surgery. Kaiser has patients who need this and it is provided, but Kaiser views this as a failure as doctors should be working to prevent this condition. If someone did need this surgery, Kaiser has contracts in place to provide it. A follow-up question was asked about whether a patient has a say in what doctor they could use. Dr. Ryu said that if there is not a doctor on staff, then a doctor or hospital that is in the contracted network is used.

A question was asked about what percentage of people in large agencies decide to use Kaiser. Ms. Audia responded probably about 25%, but at one school system in Alexandria Kaiser has 65%. Some of this depends on location and employee contribution.

It was noted by some members of the Task Force that choice is very important to many employees. When Kaiser determines that it has to outsource a procedure what is the process that is used for selecting the provider? Dr. Ryu said that first Kaiser uses it employee doctors, then Kaiser uses contract doctors, and then Kaiser uses non-participating doctors. Using non-participating doctors would be very rare and in that case the patient would have a say is who is used.

What happens if a patient wants to use a protocol that is not the Kaiser approved protocol? Also, what happens for chronic care? Dr. Ryu said one of the advantages of having almost 9 million members is that Kaiser has a lot of data and evaluation. One of the things Kaiser is able to do is determine what is evidenced based. Dr. Ru noted that the concern about VIOXX first came to light through Kaiser and the FDA asked for Kaiser's data. Kaiser has a lot of evidence about radiation oncology that shows better outcomes. With regards to the ability for patients to participate in experimental treatment, Dr. Ryu said if it is an active medical trial it would be covered but, if not, then it would not be covered. This is typical of most health insurance. With regards to chronic care, Kaiser does have nursing and hospice care.

A question was asked about Kaiser's employee cost share for health insurance for its own employees. Ms. Audia said she would get the information.

In response to a question about why more people don't select Kaiser, Ms. Audia noted that in the past there was concern about access and the availability of doctors. Now the Mid-Atlantic region has merged with Northern California region and has greatly expanded.

A question was asked about why the State of Maryland does not have Kaiser as an option, given that the Maryland Health Care Commission gives Kaiser high ratings. Ms. Audia noted that Maryland was looking at a self-funded option that Kaiser could not provide. Since that time Kaiser has been working with Maryland to try to become an option again.

A follow-up question was asked about why Kaiser would spend 80% on 20% of members, same as the national average, when Kaiser has so much disease management and wellness. Dr. Ryu said it probably it is close to 75% spent on 25% but there are uneven costs, for example there are a lot of costs for end of life care.

A question was asked about what percent of Kaiser employees are represented by a bargaining agreement. Ms Nicholson said probably 90%, but she would provide some follow-up.

A question was asked about whether Kaiser has a defined benefit retirement plan for all its employees. The response was yes it does after a certain waiting period.

A question was asked about whether the primary care physician acts as a gate keeper in Kaiser; you can't get to a specialist without seeing and being referred by a primary care physician. Dr. Ryu said there is open access to some specialists like optometrists or gynecologists and Kaiser is moving more to open access because patients who really want to see a specialist aren't going to be convinced that they don't need to see one. The primary care doctor can also phone consult with the patient and then book the specialist.

A question was asked whether there are monetary incentives for employees to participate in wellness programs. Ms. Nicholson said there is a labor-management wellness committee that determines incentives and the regional team puts together

rewards for results that have specific metrics that are in both management and labor interest. The reward for results is determined ahead of time. Kaiser also has a very robust healthy worker group around "zero trends" from the University of Michigan.

Mr. Renne noted that all three County Government unions have had health improvement committees in their agreements but have struggled to get the County Government to engage and invest in doing what needs to be done.

It was emphasized that in the past the reality was that people couldn't get to see a specialist and this was a concern to people. Dr. Ryu responded there is much more capacity now and there are phone consults that have taken away barriers to making appointments. Task Force members noted this is an ongoing perception.

Questions were asked about the kind of retention data Kaiser has and what Kaiser does if it is not retained. Ms. Audia said Kaiser has some of the highest retention rates in the industry. The biggest reason Kaiser sees for change is when there is a change to a self insured plan.

Mr. Girling said that he has taken a back-stage tour of the Capitol Hill facility and it is very impressive. He asked if the Task Force could take a tour. Ms. Audia said they could arrange a tour.

A question was asked about plan price compared to other plan prices and risk selection. Ms. Audia said that once the cost of prescription drugs is added to the cost of other medical plans, Kaiser tends to have lower rates. If Kaiser were the only HMO for all the county agencies but the county kept its POS/PPO plans, Kaiser estimated that the county would save $27 million a year. Kaiser is staffing-up for 250,000 member growth over the next 15 years. As hubs come up, Kaiser will be over-staffed for a period of time. It was clarified that the $27 million was an annual savings.

A question was asked about whether there is information on how to adjust for risk factors, age, and gender so the county can really compare whether Kaiser is cheaper or whether there is a selection issue. Ms. Audia said that what Kaiser has found in other large groups is that a lot of members never leave so Kaiser actually has a lot of older members.

The Task Force adjourned at 9:30 a.m. The Task Force did not meet in committees as expected on the original agenda.

Attendees:
Task Force Members:

Sue DeGraba	Montgomery County Public Schools (MCPS)
Joan Fidler	Public Member
Erick Genser	IAFF Local 1664
Denise Gill	FOP Lodge 35
Wes Girling	Montgomery County Government

Lee Goldberg	Public Member
Paul Heylman	Public Member
Tom Israel	MCEA
Rick Johnstone	MCPS
Jan Lahr-Prock	M-NCPPC
Mark Lutes	Public Member
Tom McNutt	Public Member
Brian McTigue	Public Member
Edye Miller	MCAAP
William Mooney	Public Member
Richard Penn	AAUP
Gino Renne	MCGEO Local 1994
Farzaneh Riar	Public Member
David Rodich	SEIU Local 500
Carole Silberhorn	WSSC
Arthur Spengler	Public Member
Lynda von Bargen	Montgomery College
Michael Young	FOP Lodge 30

Alternates:

Karen Bass (for Lynda von Bargen)	Montgomery College
Paul Brown (for Jan Lahr-Prock)	M-NCPPC

Guests:

Stan Damas, MCPS, Department of Association Relations
Councilmember George Leventhal
Carolyn McCalvin, Beltway Benefits
Lori O'Brien, Office of Management and Budget (County Government)
Patty Vitale, Chief of Staff to Councilmember Leventhal

Staff:

Craig Howard, Office of Legislative Oversight
Kristen Latham, Office of Legislative Oversight
Linda McMillan, Council Staff
Aron Trombka, Office of Legislative Oversight