MONTGOMERY COUNTY & BI-COUNTY AGENCIES

POOLING STUDY PHASE 2

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Background

The Working Group on Retiree Group Insurance Benefits recommended a study to determine the effects of a multi-agency health benefits fund (pooling) on employee and retiree health care cost and choice.

In their October 1996 report, the Working Group on Retiree Group Insurance Benefits made recommendations for policy issues associated with the structure and funding of insurance benefits for the five major County and Bi-County Agencies. These Agencies are:

- Montgomery County Public Schools (MCPS),
- Montgomery County Government (MCGovt.),
- Maryland-National Capital Park and Planning Commission (M-NCPPC),
- Washington Suburban Sanitary Commission (WSSC); and
- Montgomery College (College).

The Working Group recommended that "retiree group insurance programs be designed to streamline operations and realize available economies of scale." In pursuit of this idea, the Group specifically recommended that the Agencies "examine collectively how creating a multi-agency health benefits fund (also known as pooling) would affect costs and the range of choices available to retirees."

In examining the effects of a multi-agency health benefits fund for retirees, it soon became apparent that most of the retiree programs are inter-woven with programs for active employees. As a result, the Working Group recommended a continuing study include the health insurance programs for both active *and* retired employees.

The health insurance programs offered by the Agencies currently cover approximately 35,000 employees and retirees. Including covered dependents, this represents over 70,000 individual participants. In February of 1997, the Council amended the Office of Legislative Oversight's Work Program to add a study on the feasibility of consolidated funding of inter-Agency health benefits.

The feasibility study include Phase 1 (a review of pooling) and Phase 2 (analysis of selected pooling scenarios).

The feasibility study has two phases:

Phase 1: This phase involved a general review of pooling arrangements and the development of pooling scenarios for consideration. This phase was completed and the results presented in a report to the Management and Fiscal Policy Committee in July, 1997. The report, dated June 30, 1997, was prepared by Aon Consulting.

Phase 2: Currently underway, this phase involves a detailed review and examination of selected scenarios from Phase 1. This review includes an actuarial analysis of the selected scenarios to determine the financial impact of a pooling arrangement on the Agencies.

Aon Consulting was retained to conduct a detailed review of two pooling scenarios for the County and Bi-County Agencies. The analysis results of pooling fully insured medical programs (the HMOs) are outlined in this report.

Aon Consulting was retained to complete a detailed analysis of two scenarios outlined in Phase 1. This report outlines the results of a detailed analysis for the following scenario: ***Pooling fully insured medical programs and reviewing alternate funding mechanisms for the plans***. The plans included in this analysis were the HMO programs. Each of the Agencies offers multiple HMO programs to employees and retirees. The HMO programs currently being offered by one or more of the Agencies were evaluated for pooling implications.

A separate report will outline the results for the second scenario: ***Pooling minimum premium and self-insured medical programs where possible.*** It is anticipated that this analysis will be complete in February 1998.

Pooling Agency Plans

Pooling health care plans could lead to economic and administrative savings for the five County and Bi-County Agencies.

Pooling is the consolidation of health care programs under one risk "umbrella." There are many areas in which the five County and Bi-County Agencies can take advantage of health care plan consolidation under pooling arrangements. For example, Agencies can:

- Share in the administration of programs;
- Share in the spreading of insurance risk;
- Share in the communication to employees; and
- Increase their leverage:
  - With vendors,
  - With network managers in the managed care environment, and
  - When demanding quality service and access to data.

However, there are issues to address in implementing a pooling arrangement. Actual savings may vary.

However, there are issues to address when considering pooling arrangements. For example:

- Consolidating plan designs and managed care networks ***may require employees to change benefits*** and possibly providers;
- Consolidating and coordinating multiple administrative functions and systems, including payroll, is a ***large undertaking***; and
- As plan pricing is based on averages for multiple employers or groups, a pooling arrangement ***may not be equally advantageous to all Agencies***.

In addition, potential savings under a pooled program may vary based on:

- ***The method of funding*** with insurance carriers and administrators (the five Agencies have an array of arrangements in place with their vendors, so potential savings will vary by Agency);
- ***The insurance premium*** under each of the Agency contracts with insurers and administrators. This varies by the size of the population insured and the method of program funding; and
- ***The type of plan design in place.*** "Savings from pooling" differs from "savings due to changes in plan design." Typically, savings due to changes in plan design are the result of consolidating programs. These savings are usually the result of cost-shifting to employees, and not pooling.

Findings

Overall savings can be achieved by pooling plans. However, pooling would require plan design changes for some Agencies, changes in funding, and consolidation of administrative duties. In addition, some Agencies would find their costs increasing and some savings may only be a one time savings.

The major findings of this report are as follows:

- **HMOs provided rates for consolidated programs that would result in estimated savings, due to pooling, of approximately $1.4 million.** This savings is being attributed to pooling, although there are other factors involved. For example:
  - **The majority of the estimated savings (about 1.1 million) comes from consolidating one HMO program, Optimum Choice**. The savings seem to reflect aggressive underwriting on the part of the HMO in order to maintain the business of the Agencies. These rates are for a one year period and if they are too low, the HMO may attempt to increase them at renewal. Therefore, this could reflect a one time savings only.
  - The savings estimate also reflects a **change in funding from minimum premium to fully-insured for MCPS and WSSC**.
- **Consolidation of separate HMO contracts under one contract would require plan design changes.** While the current HMO programs are very similar, consolidating the various HMO medical benefits into one program for all of the Agencies would require design changes for some of the Agencies. In most cases, the changes would involve slightly increasing the amounts patients pay for physician visits by $5 or $10 per visit, depending on the type of service and current plan provision. However, some of the changes would also involve slight *decreases* in patient payments. Even with the plan design changes, the Agencies' benefit programs would be within industry norms.
- **The financial impact of plan design changes is an estimated total savings of about $440,000.** Primarily, these savings represent the shifting of cost to employees through additional copayments. Reductions in premium, shared by employer and employees, are also reflected in these savings. These savings are not purely a result of pooling the programs.

- **The results on an overall basis reflect savings. However, individual Agencies have cost increases for some of the programs**. On an overall basis, each of the Agencies, except WSSC, have estimated savings from pooling. WSSC has an overall cost increase due to the fact that their claims experience is better than the average for most of the HMO plans.

- **Consolidating administrative procedures would also result in savings** for some of the Agencies. Identifiable savings come primarily from recommended changes in eligibility provisions. Savings due to changes in eligibility provisions come from reductions in the number of participants (dependents in this case) enrolled in the programs. However, the changes are limited by the internal system capabilities of each Agency. A review of internal systems is outside the scope of this report. Savings estimates from the limited changes identified were from $370,000 to $580,000.

- **The recommendations regarding data management and performance management do not translate into easily identifiable savings.** These areas are more long term in nature and would serve to help the Agencies identify and monitor health trends in the overall population. In doing so, the Agencies could develop focused programs and cost control strategies. A performance measurement system would ensure that the managed care programs are meeting employee and retiree needs and that the plans are delivering service effectively.

Recommended Next Steps

1. **Pursue pooling of the Optimum Choice programs**

- Total estimated pooling savings are about $1.1 million, to the benefit of all Agencies, except WSSC.
- Move toward consolidated plan designs which will produce additional savings of $175,000.
- Review the impact with out the inclusion of WSSC.
- Include the Optimum Choice program in the review of alternate funded plans.

2. **Pursue pooling of the Kaiser programs**

- Estimate pooling savings are about $162,000. However only MCGovt. benefits on a stand alone basis.
- Move toward a consolidated plan design which will produce an additional estimated savings of approximately $256,000.
- Review the impact without the inclusion of WSSC.

3. **Do not pursue pooling of the Freestate or NYLCare plans**

- Overall estimated pooling savings for the NYLCare plan are minimal ($25,000) with only one Agency benefiting.
- Overall estimated pooling savings for the Freestate plan are about $119,000. However the two Agencies that benefit, MCPS and M-NCPPC, have closed the program to new enrollment and are phasing out this plan.

4. **Pursue improving internal administrative procedures to allow for electronic data management to replace the manual procedures currently in place.**

- Current premium reconciliation and billing procedures are not effective for the size populations involved in the benefit plans. The Agencies are incurring costs for medical plans for ineligible participants since the current systems do not allow for accurate and timely transfer of eligibility data to the vendors. The current systems also do not allow the Agencies to verify eligibility data for each HMO plan on an ongoing basis.
- A study of the internal systems was outside the scope of this report, so estimates of savings from system improvements are not available. An analysis of the current systems should be pursued to determine net savings potential.

5. **Pursue streamlining eligibility provisions among the Agencies utilizing industry standard provisions.**

- This would result in estimated savings of $370,000 - $580,000.
- The ability to achieve this may depend on internal system improvements.

6. **Pursue the establishment of data management and performance management systems for pooled programs.**

- Agreements that meet the specific needs of the Agencies should be developed and established with vendors.
- If agreements are not currently in place on a stand alone basis, the Agencies should also pursue implementing these agreements for non-pooled programs where possible.

Pooling Fully Insured Medical Programs

Introduction

This report addresses the merits of combining HMO programs into a single contract with a universal plan design. The pooled programs were analyzed for their financial and administrative impact.

This report focuses on the HMO programs currently being offered through common vendors. While Agencies may share a common vendor, each Agency maintains it's own unique plan offerings on a stand alone basis.

This report addresses the merits of combining HMO programs into a single contract with a universal plan design. This report focuses on the following target areas:

- **Financial Impact**
  - Due to Plan Design Changes
  - Due to Pooling
- **Other Pooling Issues**
  - Eligibility Provisions
  - Premium Reconciliation & Billing Procedures
  - Data Management
  - Performance Management

Please note that this review includes active employees and non-medicare eligible retirees. Medicare eligible retirees have unique program needs in order to supplement their Medicare coverage. Medicare eligible retirees are the subject of a separate study and are not included in this report.

Also, the Optimum Choice program for WSSC and MCPS is currently funded under a minimum premium arrangement. These plans were included in this analysis to determine the impact of fully insured Optimum Choice programs for all Agencies.

The chart below outlines the HMOs, by Agency, that are included in this analysis.

	Kaiser HMO	NYLCare HMO	Optimum Choice HMO	Freestate HMO
MCPS	✓	✓	✓*	✓
MCGovt	✓		✓	
M-NCPPC	✓	✓	✓	✓
WSSC	✓	✓	✓*	✓
College	✓		✓	

**** Currently funded under minimum premium contracts.***

47.2% of the employee and retiree population participates in an HMO. The total cost of the HMO programs accounts for 42% of the total medical plan budget.

In 1997, there were approximately 16,400 employees and non-Medicare eligible retirees in these programs. This represents 47.2% of the total employee and retiree population with health care. There were about 18,300 employees and retirees, or 52.8% of the total population, in other health insurance programs offered by the Agencies. These figures represent employees and retirees, and not dependent spouses or children who may be enrolled in the programs.

The annual cost of these programs is approximately $63 million, or 42% of total medical plan costs (the total cost being about $150 million). These estimates reflect the projected costs for calendar year 1997.

Description of Fully Insured Funding Arrangements

Insurance carriers assume all financial risk under a fully insured funding arrangement. They base premiums on a number of factors, including the demographics of the group, plan design, and overall group claims performance.

Under fully insured funding arrangements, insurance carriers assume all financial risk under the plan. Premium rates are set based on certain risk assumptions:

- The size of the group;
- The group's age and sex distribution;
- The group's industry classification; and
- Location.

Another major factor in establishing a group's premium rates is the plan design.

Fully insured funding arrangements are priced prospectively with premiums submitted throughout the plan year. Claims do not affect the fixed premiums paid during the current plan year. Instead, the plan year's performance is taken into account and applied to new assumptions and pricing approaches when setting plan premiums for the following year.

Pooling: The Power of Economies of Scale

Larger groups have cost advantages when it comes to pricing, administration, and claims fluctuations.

Pooling smaller groups together to form one large group has several distinct advantages, all of which typically result in a lower overall insurance cost with a single carrier. Pricing mechanisms favor larger groups in the following areas:

- ***Administration*** — Reducing or eliminating duplicate administrative tasks has a significant impact on insurance costs. The cost of administration usually represents 10% to 15% of a total premium rate. Depending on how efficiently administrative duties can be combined, administrative charges may be reduced by 2% to 5%. This reduction is dependent on streamlining and achieving common administrative practices for the pooled plans.

- ***Margin For Fluctuation In Claims*** — Margins are established to support business goals and hedge against potential underfunding. As groups get larger, their performance is easier to predict. This predictability margin typically ranges from 2% to 10%, depending on the size of the group. The larger the group size and subsequent claims base, the less impact large individual claims or utilization changes have on the overall expected volume. Thus, the insurance carrier is better able to predict future liability and can reduce margin factors as risk exposure becomes more predictable.

- ***Demographic/Experience Rating*** — As group size increases and therefore, predictability of claims, carriers begin to price plans on the merits of the group itself, rather than using community averages, and age and sex rate adjustments.

- ***Designing Funding Arrangements*** — A larger group also has more flexibility in designing a fully insured funding arrangement. A pooled group may be able to reduce premiums up front or receive a year-end reimbursement when favorable claims experience occurs.

Summary of Focus Areas

Information was gathered from the various HMOs and Agencies in the following areas:

Financial Impact

Current HMO plans were adjusted to reflect only core medical benefits (no dental, vision, etc.). These core plans were then assigned relative dollar values. These values were compared to rate quotations of pooled programs, provided by HMO vendors. This analysis also included a comparison of funding methods.

Due to Plan Design Changes and Due to Pooling

To determine the financial impact of a pooled program, the current HMO programs for each Agency were reviewed by vendor. Some of the Agencies currently include prescription drugs and supplemental programs such as dental, vision, and hearing, in addition to core medical coverage. These programs were excluded, where possible, so that they could be compared to a model, consolidated program that only included core medical benefits. (Other differences in plan design were also noted in the design of a model, consolidated program.) After plans were adjusted to reflect core medical benefits only, each of the core HMO programs was assigned a relative dollar value.

To measure the effects of plan design changes and pooling, each HMO vendor was asked to provide rate quotations for a model, consolidated program (for all Agencies currently insured through the vendor). The "consolidated" rates were then compared to the current, separate rates for each of the Agencies. The savings resulting from having a uniform plan design was figured into the total savings of pooling the programs.

In addition to the financial analysis, the methods of funding and rate setting were reviewed on a stand-alone basis and on a pooled basis. The HMOs were asked to provide current rate methodologies, pooled, fully-insured rate methodologies, and any alternate funding arrangements available on a pooled basis.

Other Pooling Issues

The stand alone plans were also compared to pooled programs for savings and efficiencies in administration, data, and performance management.

- **Administrative Process** — Each of the Agencies currently have different policies in place and methods for administering the insurance programs. Basic administrative parameters were reviewed by vendor and Agency to identify areas where consolidation would be possible and cost effective.
- **Data Management** — The review of data reporting included a recommended approach to securing meaningful data in the future. On a pooled basis, consistent data reporting would allow the Agencies to analyze health trends in their overall population. On a stand alone basis, reporting is often inconsistent and trends may not be apparent.

- **Performance Management** — The final area of review supports installing an agreement between the vendors and the Agencies for quality performance benchmarks. On a pooled basis, the combined Agencies have leverage to negotiate a performance measurement process with vendors to ensure quality service to employees and financial remuneration to the Agencies when benchmarks are not met or exceeded. Performance monitoring would also help alleviate ongoing administrative problems.

Summary of Estimated Savings

Annual estimated savings results for each Agency and for each HMO were broken down into the following components:

- Impact of pooling all plans
- Impact of plan design streamlining
- Total cost impact

In some situations, the HMO quotations resulted in additional cost for individual Agencies. Additional cost is shown as negative savings, indicated by ( ), in the following chart.

HMO	Savings	MCPS	MCGovt.	College	M-NCPPC	WSSC	Total
Kaiser	**Pooling**	**($206,700)**	**$435,800**	**($20,300)**	**$5,700**	**($52,400)**	**$162,100**
	Plan Design	$183,100	$57,400	$15,700	N/A[1]	N/A[1]	$256,200
	Total	($23,600)	$493,200	($4,600)	$5,700	($52,400)	$418,300
Freestate	**Pooling**	**$54,100**			**$99,700**	**($34,400)**	**$119,300**
	Plan Design	$10,600			$200	N/A[1]	$10,800
	Total	$64,700	N/A[2]	N/A[2]	$99,900	($34,400)	$130,100
NYLCare	**Pooling**	**$29,500**			**($26,000)**	**$21,300**	**$24,700**
	Plan Design	N/A[1]			N/A[1]	N/A[1]	
	Total	$29,500	N/A[2]	N/A[2]	($26,000)	$21,300	$24,700
Optimum Choice	**Pooling**	**$273,100**	**$526,800**	**$256,600**	**$110,000**	**($71,700)**	**$1,093,800**
	Plan Design	$175,000	($8,400)	($5,500)	($2,600)	$16,700	$175,200
	Total	$448,100	$518,400	$251,100	$107,400	($55,000)	$1,269,000
All Agencies	**Pooling**	**$150,000**	~~**$1,011,600**~~	**$236,300**	**$189,400**	**($137,200)**	**$1,401,100**
	Plan Design	$368,700	$49,000	$10,200	~~($3,000)~~	$16,700	$442,200
	Total	$518,700	~~$962,900~~	$246,500	$187,000	($120,500)	$1,401,100

[1] *Pooled quotations reflect no change in current core medical plan design.*
[2] *MCGovt. and College do not offer Freestate and NYLCare HMOs.*

Financial Impact

Summary of Estimated Savings

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	Plan Design	N/A[1]			N/A[1]	N/A[1]	
	Total	$29,500	N/A[2]	N/A[2]	($26,000)	$21,300	$24,700
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[1] *Pooled quotations reflect no change in current core medical plan design.*
[2] *MCGovt. and College do not offer Freestate and NYLCare HMOs.*

Pooling savings are due to consolidating the programs and improved premium rates due to larger group size. However, pooling results in additional cost for some Agencies if the Agency has more favorable claims experience than the combined Agency average.

The above chart assumes a consolidated plan design. The model plan was used in order that the HMOs would be able to provide quotations for a pooled program. In consolidating the plan design, some benefit changes were assumed for the Agencies. The plan design saving estimates represent the value of the benefit changes. In some cases, benefits cost more for individual Agencies. Additional cost is indicated by ( ).

The pooling savings are due to consolidating the programs under one contract and improved premium rating as the result of larger group size. In some cases, pooling results in additional cost for individual Agencies. This is primarily due to the fact that an individual Agency may have more favorable claims experience than the average of the combined Agencies.

The next section of this report outlines, in detail, the process and methods used for developing these savings, as well as issues specific to Agency and HMO.

Estimated Savings Due to Plan Design Changes

The programs included in this analysis were all HMO plans that have similar basic benefits. The Agencies' HMO programs differed in the amount patients pay (copayments) for physician visits and how supplemental benefits are treated.

Supplemental benefits usually include prescription drugs, dental, and vision. Since the Agencies' prescription drug, dental and vision programs are the subjects of separate studies, costs and benefits for these programs were not included in this report.

Common Plan Features

The Agency programs all cover the same types of medical services, including:

- Inpatient and outpatient hospital,
- Surgery, Lab and X Ray,
- Primary Care and Specialist Physician visits,
- Maternity Care,
- Preventative Care (Physicals, Well Child, Immunizations, Mammography, etc.),
- Emergency Care,
- Mental Health Care,
- Physical Rehabilitation, Chiropractic, Skilled Nursing and Home Health Care, and
- Organ Transplants.

The amount the Agencies pay for treatment in each of these areas is very similar. Detailed outlines of the current plan parameters by HMO and Agency can be found in Appendix A.

Plan Design Differences

Plan designs differed in copayments and the types of transplants covered.

Current plan designs differ primarily in:

- The amount patients are required to pay for:
  - certain types of office visits (some programs do not require a copayment, while others require a $5 or $10 copayment per visit),
  - emergency room visits, and
  - surgical visits.
- The types of transplants covered.

Consolidated Plan Designs

Only core medical benefits were analyzed in this report. The consolidated plan design increased or decreased copayments for some services in some HMOs.

To accurately compare the current HMO programs to a pooled program, it was necessary to have a comparable, consistent plan design. In developing a consolidated program, all supplemental programs were excluded (such as drug, vision, and dental). Only core medical benefits were included. The consolidated plan design, which represented a combination of current plan features for the Agencies, was outlined for each vendor.

The plan design changes included in the consolidated model were changes in employee copayments for certain types of visits. These were increases in some cases and decreases in others. The plan design utilized for each vendor represented a combination of common plan features that would not increase overall benefits or costs.

While the consolidated plan design may represent a slight reduction in benefits for some employees, the designs used reflect industry standards, or better than industry standards. For example, a $5 office visit copayment is assumed for the consolidated Kaiser program. This is a reduction in benefits for employees that currently have no copayment for office visits. However, the industry standard for this service is a $10 copayment.

Changing plan designs would result in savings of approximately $442,000.

The overall savings due to plan design changes was approximately $442,000. This reflects total savings through reduced premium rates for the employers and employees. By Agency, the savings estimates range from about $369,000 for MCPS to a cost of $3,000 for M-NCPPC.

An outline of the consolidated plan utilized for each vendor can be found in Appendix B. We have provided a brief highlight of the similarities and differences by vendor in the next several pages of this report, along with the financial impact of the changes.

Kaiser

- All five Agencies currently have fully insured HMO programs with Kaiser.
- The Agencies have one of two programs, Plan A (MCPS, MCGovt. and College) or Plan L (M-NCPPC, WSSC).
- The primary difference between the plans is that Plan A has no copayment for office visits while Plan L requires a $5 copayment. In addition, Plan A has an emergency room visit copayment that is $10 higher than Plan L's.
- Plan L was used for the consolidated plan.

Plan	MCPS	MCGovt.	College	M-NCPPC	WSSC	Total
Design Savings	$183,100	$57,400	$15,700	$0	$0	$256,200

For MCPS, MCGovt. and the College, plan design changes would require a $5 office visit copayment (where before they had none), but a reduction of $10 in emergency room copayments.

The major impact of a plan design change under a consolidated program for Kaiser is the introduction of a $5 copayment for office visits (MCPS, MCGovt. and the College). This is a minimal copayment amount and is comparable to copayment requirements under some of the other HMO plans these Agencies offer.

The change in emergency room copayment under the consolidated plan is a reduction of $10 for MCPS, MCGovt. and the College. Utilization of emergency room services should be relatively low in frequency under an HMO plan, and the emergency copayment is waived if the patient is admitted under both plan designs. As a result, this should not result in a cost increase for these Agencies.

NYLCare

There were no plan design changes in the consolidated NYLCare program.

- Three of the Agencies (MCPS, M-NCPPC and WSSC) currently have fully insured HMO programs with NYLCare.
- The plan design is the same for all three Agencies.
- NYLCare was asked to provide pooled quotations for the current plan design, so there are no plan design savings.

Optimum Choice

- An HMO program is offered through Optimum Choice by all five Agencies.
- The copayment amounts for preventive and specialist physician office visits differ for some Agencies ($5 versus $10).
- Outpatient surgical care requires a $25 copayment for all of the Agencies except WSSC, where no copayment is required.
- The transplant benefit is more restrictive for M-NCPPC and MCGovt. than for the other Agencies.
- The consolidated program used the $10 copayment program and the expanded transplant benefit.

Plan	MCPS	MCGovt.	College	M-NCPPC	WSSC	Total
Design Savings	$175,000	($8,400)	($5,500)	($2,600)	$16,700	$175,200

Under one program, MCPS and WSSC see copayments increase; McGovt. and M-NCPPC see better transplant benefits; and the College sees some copayments decrease.

The consolidated plan design has the most impact on MCPS and WSSC since specialist visits would require a $10 copayment instead of $5. This is a minimal increase in copayment for employees and retirees.

The expanded transplant definition is an increase in benefits for MCGovt and M-NCPPC. The College also has a slight increase in benefits under the consolidated plan since the copayment for physicals and well child care was reduced from $10 to $5.

Freestate

This program is currently frozen to new enrollees by MCPS and M-NCPPC. The consolidated program for WSSC would require a $5 copayment and does not include expanded transplant benefits.

- Three of the Agencies (MCPS, M-NCPPC, and WSSC) offer an HMO program through Freestate. This program is currently frozen to new enrollees by MCPS and M-NCPPC.
- The MCPS program currently requires no copayment for office visits (except mental health), while the other two Agencies require a $5 copayment.
- The transplant coverage under the M-NCPPC program is more expansive than the other two Agencies.
- The consolidated program incorporated the plan design currently in place for WSSC which requires a $5 copayment and does not include the expanded transplant benefits.

Plan	MCPS	M-NCPPC	WSSC	Total
Design Savings	$10,600	$200	$0	$10,800

Estimated Savings Due to Pooling

A pooled program assumes one contract for all Agencies with each HMO vendor. Savings depend on the claims experience or demographics of the group; and reductions in risk factors and margins included in premium rates by insurers.

The five County and Bi-County Agencies currently have separate contracts on a stand alone basis with each of the HMOs they offer. Each Agency's premium rates are established on a stand alone basis. In some cases, claims experience is utilized in establishing rates, while in other cases, community averages and demographics may be utilized. The larger groups typically are rated with more emphasis placed on the actual claims experience of the group.

Under a pooled program, it was assumed one contract would be established for all of the Agencies with each HMO vendor. In addition, the Agencies would be rated on a combined basis. This combined rating may be based on overall experience or overall demographics of the combined Agencies, depending on the size of the total population with each HMO.

Some of the Agencies would see reductions in estimated costs if the rating of the combined group produces better average cost than the group had on a stand alone basis. This would occur if the average claims experience or demographics for the combined Agencies are more favorable than the group on a stand alone basis. Some of the Agencies would see increases in cost under a pooled program for the opposite reasons, if their experience or demographics on a stand alone basis are more favorable than the average of the combined group.

Some savings also may result due to reductions in risk factors and margins included in premium rates by insurers. The larger the group size, the less risk of claims fluctuations, so these factors are reduced.

The overall estimated savings from pooling the programs are about $1.4 million. This represents about 2.3% of the current annual premium associated with these plans.

The results by Agency range from a savings of about $963,000 for McGovt. to a cost of $137,000 for WSSC. The cost increase for WSSC is primarily due to its' better claim utilization experience with three of the HMOs than the other Agencies.

Most of the pooling savings ($1,094,000 or 78%) are the result of quotations provided by the Optimum Choice HMO. This may be the result of aggressive underwriting in addition to the

benefits of pooling.

The savings from pooling, by HMO and Agency, are outlined in the next few pages of this report, along with associated issues and concerns.

Kaiser

Pooling	MCPS	MCGovt.	College	M-NCPPC	WSSC	Total
Savings Estimates	($206,700)	$435,800	($20,300)	$5,700	($52,400)	$162,100

Three of the Agencies experiences a cost increase while McGovt. and M-NCPPC experience savings. The cost differences are due to the individual Agency's claims experience.

The overall pooling savings are estimated to be about $162,000.

- Most of the savings accrue to McGovt., with M-NCPPC also experiencing slight savings.
- The other three Agencies experience a cost increase. This is because the claims experience for McGovt. has been less favorable than the other Agencies. When the experience of all Agencies is combined, the average produces a reduction for McGovt. and increases for MCPS, the College, and WSSC.
- The M-NCPPC experience on a stand alone basis was slightly less favorable than the average of the combined group.

Freestate

Pooling	MCPS	M-NCPPC	WSSC	Total
Savings Estimates	$54,100	$99,700	($34,400)	$119,300

MCPS and M-NCPPC experience savings, but not WSSC. The reason is again due to claims experience, as well as group demographics.

Total estimated savings due to pooling are approximately $119,000.

- The Freestate pooled quotations reflect savings for MCPS and M-NCPPC but not for WSSC. The average claim experience and demographic factors for WSSC were more favorable than the other two Agencies.

- Overall savings from pooling result under the Freestate program for several reasons:
  - Freestate weighed the groups' experience more than the community average in their pooled rating. On a stand alone basis, Freestate uses the community average more than the groups own claim experience.
  - The combined experience was better on average than the community, even though it resulted in an increase for WSSC.
  - Freestate assumed that the program would be open to new enrollment by MCPS and M-NCPPC.

NYLCare

Pooling	MCPS	M-NCPPC	WSSC	Total
Savings Estimates	$29,500	($26,000)	$21,300	$24,700

Total estimated savings due to pooling are approximately $25,000.

While pooling NYLCare results in overall savings, it also results in cost increases for M-NCPPC.

- Pooling the NYLCare programs results in savings of about $25,000 overall. However, it results in a cost increase for M-NCPPC and cost reductions for MCPS and WSSC. This is because M-NCPPC has better claim experience on a stand alone basis than the other two Agencies.

Optimum Choice

Pooling	MCPS	MCGovt.	College	M-NCPPC	WSSC	Total
Savings Estimates	~~$150,000~~	~~$962,600~~	~~$236,300~~	~~$189,400~~	~~($137,200)~~	~~$1,401,100~~

Three Agencies have significant savings as a result of pooling Optimum Choice plans.

Most of the savings attributable to pooling are due to the quotations provided by Optimum Choice (about $1.4 million).

- Three of the Agencies (McGovt., M-NCPPC, and the College) have significant savings relative to their premium volume with this HMO.

- Overall savings from pooling result under the Freestate program for several reasons:
  - Freestate weighed the groups' experience more than the community average in their pooled rating. On a stand alone basis, Freestate uses the community average more than the groups own claim experience.
  - The combined experience was better on average than the community, even though it resulted in an increase for WSSC.
  - Freestate assumed that the program would be open to new enrollment by MCPS and M-NCPPC.

NYLCare

Pooling	MCPS	M-NCPPC	WSSC	Total
Savings Estimates	$29,500	($26,000)	$21,300	$24,700

While pooling NYLCare results in overall savings, it also results in cost increases for M-NCPPC.

Total estimated savings due to pooling are approximately $25,000.

- Pooling the NYLCare programs results in savings of about $25,000 overall. However, it results in a cost increase for M-NCPPC and cost reductions for MCPS and WSSC. This is because M-NCPPC has better claim experience on a stand alone basis than the other two Agencies.

Optimum Choice

Pooling	MCPS	MCGovt.	College	M-NCPPC	WSSC	Total
Savings Estimates	$273,100	$526,800	$256,600	$110,000	($71,700)	$1,093,800

Three Agencies have significant savings as a result of pooling Optimum Choice plans.

Most of the savings attributable to pooling are due to the quotations provided by Optimum Choice (about $1.1 million).

- Three of the Agencies (McGovt., the College and M-NCPPC) have significant savings relative to their premium volume with this HMO (-7.5%, -24.8% and -4.9% respectively).

- MCPS has moderate savings and WSSC has a cost increase.
- The claim utilization factors for the three agencies with substantial savings (McGovt., M-NCPPC, and the College) significantly exceed that of the group average.
- The MCPS factor approximates the group average while WSSC's actual experience is better than the group average. Both of these Agencies currently have minimum premium arrangements in place under which they only pay actual claims and administrative expenses.
- The magnitude of the expected savings may be a function of aggressive underwriting in addition to the benefits of pooling.

Methodology for Calculating Savings

Since some of the benefits under current programs differ, the HMOs were requested to provide the component cost for prescription drugs and other supplemental benefits currently included in each Agency's plan. It was then possible to adjust the rates for the current programs to reflect basic medical coverage, excluding prescription drugs and supplemental benefits. A detailed outline of the current rates and component costs can be found in Appendix C.

The HMOs were also requested to provide rates based on the consolidated plan design for all Agencies they currently insure. The rates were utilized to develop annual per employee costs for each HMO. An outline of the pooled rates, enrollment assumptions and per employee costs can be found in Appendix D.

Total savings were calculated by subtracting the adjusted plan cost from the consolidated plan cost. Detailed calculations by HMO and Agency can be found in Appendix E.

The plan design relative value factors were utilized to estimate the amount of savings due to plan design. The remaining savings were attributed to pooling the programs. The plan design relative value factors can be found in Appendix F.

Other Pooling Issues

Administrative and management tasks can be streamlined to produce cost savings and greater efficiency.

Under consolidated or pooled programs, the Agencies should address the following areas:

- Eligibility,
- Premium reconciliation and billing procedures,
- Data management, and
- Performance management.

The review of each area involved individual Agency's procedures for external, ongoing HMO administration, as well as individual contract provisions. The practices in these areas should be streamlined to produce administrative and cost efficiencies, as well as successful quality plan management.

Eligibility

Eligibility policies vary across Agencies.

New Hires and Terminations

The eligibility date is the day an employee and dependent become eligible to participate in the plan. Conversely, at termination of employment, it is the date the employee and dependent are no longer eligible for plan benefits.

Currently, each Agency has its' own standards for when new hires are eligible to participate in the medical plan. The policies vary from date of hire (DOH) to requiring at least a one month wait. The benefit termination periods also vary by each Agency. Typically a policy that provides benefits on the date of hire ceases them on the date of termination. A policy that begins benefits on the first of the month following date of hire usually continues benefits through the end of the month of termination.

	MCPS	MCGovt	College	M-NCPPC	WSSC
Initial Benefit Eligibility	1st of month following DOH	DOH	1st of month following DOH	DOH	1st of month following DOH
Benefit Termination	Last day of the month of termination	Date of termination	Last day of the month of termination	Date of termination	Last day of the month of termination

Two of the Agencies (MCGovt. and M-NCPPC) provide benefits as of hire date, while the other three (MCPS, WSSC, and the College) require the new employee wait until the first of the following month.

Efficient internal electronic systems are necessary to administer eligibility properly and control costs.

The industry standard for eligibility is the date of hire. Termination procedures should be consistent. An employer's ability to administer date of hire eligibility is dictated by internal administrative systems. Employers with electronic capabilities are best able to administer date of hire additions and date of termination deletions. These systems help alleviate adverse selection that may exist under programs that continue benefits after termination.

If electronic systems are not in place to accomplish immediate eligibility and terminations, the industry standard is first of the month following the event. This is the method currently being used by MCPS and WSSC.

Streamlining dependent eligibility provisions to industry standards would reduce costs.

Dependent/Student Eligibility

The dependent age limit dictates when dependent child coverage terminates. This age limit has two maximums. The first is the age at which a non-student dependent child may remain under the employee coverage. If the dependent is a qualified student then he/she may remain in the plan until they reach the student age limit.

The College allows a non-student dependent to remain on HMO plans the longest, until age 22. The other four Agencies require non-student coverage termination at age 19, which is the industry standard. WSSC has one exception to this under the Kaiser HMO plan, non-students are allowed to stay in the plan until age 23. The student age limit ranges from age 22 for the College to unlimited for MCPS. Age 23 is the industry standard.

Under a pooled program, recommended dependent eligibility would be age 19 for non-students and age 23 for students. The estimates provided by the HMO vendors for the cost of the current student extensions range from $370,000 -$580,000. This is primarily attributable to the MCPS program that doesn't have a student age limit.

Eligibility maintenance is important to control costs, especially in an HMO program.

Eligibility Maintenance

The maintenance of eligibility is the process of providing the health care carriers with an accurate list of employees and dependents participating in the plan. This is very important in controlling costs under the fully insured HMO programs. If eligibility is not accurate, the Agencies may pay premium for ineligible participants. In a managed care environment, HMOs often make monthly payments to physicians based on enrollment. If the enrollment is incorrect, it is difficult or impossible, for HMO's to retroactively reimburse the Agencies since they have already made payments to physicians. The chart below indicates the current eligibility monitoring process.

	Employee Eligibility	Dependent Eligibility
Kaiser	Determined by the Agency	HMO reviews annually on birthday
NYLCare	Determined by the Agency	HMO reviews annually in August
Freestate	MCPS determines eligibility Freestate determines eligibility for M-NCPPC and WSSC	MCPS determines eligibility Freestate reviews twice each year at the beginning of each semester
Optimum Choice	Determined by the Agency	HMO reviews annually on birthday

The Agencies are responsible for monitoring employee eligibility except for the M-NCPPC Freestate plan. Dependent eligibility is monitored by the HMO plans in most cases since it is based on age and is easily determined. The exception is for dependent student eligibility which requires manual intervention to ensure ongoing student status. The Agencies need effective systems in place to ensure accurate eligibility maintenance.

Premium Reconciliation & Billing Procedures

Agencies currently use three methods of premium reconciliation and billing. These methods involve manual adjustment of census and premium, as well as electronic means.

There are three methods of premium reconciliation and billing currently in practice.

1. The Agency receives a premium bill and current employee census. The Agency goes through the census and makes changes by way of additions and deletions. They pay premium based on the adjusted census and return the census to the HMO along with the premium payment. The HMO goes through the process a second time making changes to their system and reconciling the enrollment to the premium. This is a manual process.

2. The Agency is self billed. The Agency creates an electronic computer file and sends it to the vendor along with the premium check. The HMO vendor must read the file, update their records, and reconcile the premium submitted. This is an electronic process.

3. The Agency receives a premium bill. The Agency pays the requested amount, and submits that month's additions and deletions. The HMO makes the additions and deletions to their system and then adjusts the next month's bill to reflect the changes. M-NCPPC uses this method with Freestate. This is a manual process.

Premium Payment and Reconciliation					
	MCPS	**MCGovt**	**College**	**M-NCPPC**	**WSSC**
Kaiser	Electronic	Electronic[1]	Manual	Manual	Manual
NYLCare	Electronic	N/A	N/A	Manual	Manual
Freestate	Electronic	N/A	N/A	Manual	Manual
Optimum Choice	Manual	Manual	Manual	Manual	Manual

[1]MCGovt is to begin electronic payment in January, 1998.

Currently, Agencies are using manual processes to manage data. Manual processes are unreliable and may result in additional expense.

Most of the current data management is being done on a manual basis. Although MCPS has electronic methods in place, the process has not been effective due to internal system data issues and has required manual reconciliation procedures.

Manual management of data for the significant populations involved is unreliable and may result in major additional expense for the Agencies. The possible result of inaccurate data is that health benefits are continued for terminated employees and/or improper premium may be remitted to the insurers.

The recommended approach is electronic.

The recommended approach is electronic. However, this can not be accomplished until internal systems have the capacity to provide clean data. The review of internal administrative systems was outside the scope of the analysis for this report.

Data Management

Detailed reporting can help monitor use of preventive care and help identify adverse health trends. Reports should include data regarding demographics, cost and utilization, hospitalization statistics, utilization review and disease management initiatives, as well as patient satisfaction information.

The reporting process is an important tool for evaluating many features of the medical programs. Detailed reporting will help enable the Agencies to monitor the quality of care and cost efficiency of providing services. In a managed care environment, detailed reporting can help monitor utilization of preventive care and help identify any adverse health trends in the employee population.

Currently, the Agencies are receiving minimal data from the HMO vendors. On a stand alone basis, most of the populations are not large enough to support reporting of credible data. On a pooled basis, enrollment in the Kaiser and Optimum choice programs should be large enough to produce credible data.

Reports should include data regarding demographics, cost and utilization, hospitalization statistics, utilization review and disease management initiatives, as well as patient satisfaction information.

Typical reports that provide this information are outlined below:

- **Demographic Reports** provide information on the employees and dependents by age and sex. This report assists with the assessment of quality between carriers and groups of similar patients, as well as serving as a check on eligibility reporting.
- **Cost and Utilization Reports** provide a breakout for utilization between inpatient, outpatient, mental health and substance abuse, and other medical care costs. This report typically includes amounts paid by month and year-to-date, as well as comparisons to the previous year. This report should also highlight trends and averages compared to the insurers' norms.
- **Hospitalization Reports** will provide admission information based on a per diem per 1,000 members, admissions per 1,000 members and average length of stay. The top surgical procedures should also be outlined by cost and frequency.

- **Utilization Review and Disease Management Reports** will outline interventions in high cost claim situations, as well as health care initiatives being pursued by the vendors.
- **Employee satisfaction survey reports** give the employer insight on the needs of the employees and the issues of concern regarding the quality of the patient care delivery system.
- **The Health Plan Employer Data and Information Set (HEDIS)** reports provide the employer with managed care results on childhood immunizations and diagnostic screenings for mammography, cervical cancer and prenatal care, along with other statistics important for monitoring managed care effectiveness.

Performance Management

Performance agreements are established with vendors to ensure they maintain service in key areas. On a pooled basis, the Agencies should develop a single agreement that will meet all their needs and ensure consistent, superior, performance for all Agency employees. Areas to monitor include implementation, network maintenance, member services, and account management.

Performance agreements are established with vendors to ensure they maintain service in key areas. The performance measures are typically based on industry benchmarks which reflect the standard expected service in the market place. Measures may also be determined based on best practices which reflect the best performance available in the market place.

Vendor performance guarantees typically require the vendor to place a portion of administrative fees at risk. If the vendor fails to meet performance standards they are penalized. The goal of the performance agreement is not to recoup penalties from the vendor but to establish a measurement system for performance and ensure continuous monitoring of that performance.

A performance measurement system is important to ensure that quality service is being delivered to employees and retirees by the HMO and ensure employee satisfaction with that service. In addition, performance measures help ensure that satisfactory access to providers is maintained and that administrative services are accurate.

The Agencies should identify key areas that are important for the HMO vendors. On a pooled basis, a single agreement should be developed that will meet the needs of all the Agencies and ensure consistent, superior, performance for all Agency employees.

The following are typical key areas for performance monitoring:

- **Implementation** — This area usually involves ensuring that current up-to-date provider directories (as appropriate), along with accurate ID cards, are distributed to employees in a timely manner. When introducing new programs, it is particularly important that vendors are held to superior implementation service guarantees. In a new program situation, the implementation guarantee would be much broader in scope than for a current vendor. Usually, implementation performance also includes delivery of contracts and plan documents in a timely manner.

- **Network Maintenance**— Maintenance of provider networks should be outlined. Any major or minor changes to the network should be communicated to the employer and/or the employee in a manner acceptable to the employer. Expectations regarding communication of changes are established, as well as physician access standards.
- **Member Services** — Claims processing and responses to member questions should be accurate and timely. Industry benchmarks or best practices are used as target goals for the vendors.
- **Account Management** — Ongoing account management needs should be outlined along with expectations of the employer. Production and delivery of approved management reports should also be guaranteed.

A recommended performance agreement is outlined on the following pages.

Performance Standards

Performance standards are set forth below. At a minimum, performance standards must comply with these standards. Performance standards must include meaningful measurement criteria.

PERFORMANCE STANDARD	PENALTY $
IMPLEMENTATION	
☐ Production and distribution of current up-to-date provider directories to Montgomery County Agencies ***prior*** to the enrollment period	$3,000
☐ Production and distribution ID cards 14 days ***prior*** to effective date with accuracy equal to data provided by Montgomery County Agencies	$3,000
☐ Appropriate members of account team to perform a service and operational audit for Montgomery County Agencies within the first three months of the program	$3,000
☐ Provide Montgomery County Agencies with a benefits and financial contract 30 days prior to the effective date	$3,000
NETWORK MAINTENANCE	
☐ Maintenance of satisfactory number of providers (hospitals and physicians) in all implemented locations. "Satisfactory" is defined as a minimum of two Primary Care Physicians with open practices, within 8 miles of employee's home for 95% of Montgomery County Agencies' employees. ☐ Physician Board Certification - 85% Primary Care	$5,000

PERFORMANCE STANDARDS

PERFORMANCE STANDARD	PENALTY $
NETWORK MAINTENANCE (cont'd)	
☐ In the event of major changes to a network defined as effecting 10% or more of Montgomery County Agencies' enrolled participants in each network, you will comply with the following at no expense to Montgomery County Agencies: • Notification to Montgomery County Agencies of changes in make-up of the provider network within 90 days prior to the change. • Communication drafts for employees prepared at your expense and forwarded to Montgomery County Agencies for review within 60 days of the change. • Representatives will meet with Montgomery County Agency employees and management, if determined necessary by MCA. • Communication of changes to employees within 30 days of the change.	$5,000
☐ Minor network changes (changes effecting less than 10% of Montgomery County Agencies' participants in a network location) • Notification to affected participants at their homes within 30 days prior to date of change. Information regarding transition options to be provided with notification.	$5,000
☐ Production and distribution of directory updates on a quarterly basis to MCA administrators.	$3,000
MEMBER SERVICES	
☐ At least 85% of surveyed members will be satisfied or very satisfied as detailed results in a Montgomery County Agencies specific employee satisfaction survey. Survey will be at no cost to Montgomery County Agencies.	$5,000

PERFORMANCE STANDARDS

PERFORMANCE STANDARD	PENALTY $
ELIGIBILITY	
☐ Accuracy of ID cards - 99% of all cards are 100% accurate. ☐ Timeliness of ID card turnaround - 5 days from receipt of data. ☐ Timeliness of ongoing monthly eligibility updates - within 2 working days. ☐ Accuracy of ongoing eligibility updates - 99% of eligible are accurate.	$100 penalty for each denied/granted accessibility of eligible/ineligible employee
DATA REPORTING AND ANALYSIS	
☐ Production and delivery of approved management reports within 20 days of close of quarter/month and delivery of ad hoc reports by the agreed upon date(s). ☐ Analyze data and meet with Montgomery County Agencies on at least a semi-annual basis	$5,000
MEMBERSHIP SERVICES RESPONSE TIME	
☐ 100% of all telephone calls logged ☐ Waiting Times 95% of calls are answered within 20 seconds 100% of calls are answered within 45 seconds ☐ Abandoned calls: Less than 3% ☐ Telephone Response 95% within 24 hours with 98% accuracy 100% within 48 hours with 99% accuracy ☐ Written Response 90% within 48 hours with 99% accuracy 100% within 72 hours with 99% accuracy	$20,000

PERFORMANCE STANDARDS

PERFORMANCE STANDARD	PENALTY $
MEMBERSHIP SERVICES RESPONSE TIME (continued)	
☐ Responses to inquiries to customer service will be accurate. Documentation by Montgomery County Agencies regarding inaccurate responses will be included in determination of failure to meet membership services response performance standard. ☐ Membership services response times will be reported and submitted to Montgomery County Agencies on a quarterly basis.	
ACCOUNT MANAGEMENT	
☐ Guarantee ongoing services provided by the account management staff (field marketing staff, administrative, and customer support) will be acceptable to Montgomery County Agencies. Any consistent pattern of errors as identified by Montgomery County Agencies management through documented letters, phone calls, etc. will be included in the determination of failure to meet the account management guarantee. ☐ Return telephone inquires by Montgomery County Agencies personnel within 24 hours. ☐ Respond to written inquires within five working days of receipt.	$10,000

Glossary

Adjusted Community Rating	A form of community rating wherein group-specific demographics are considered.
Capitation	A capitation benefit program is one in which a health care provider contracts with the program's sponsor or administrator to provide all or most of the medical services covered under the program to subscribers in return for payment on a per capita basis.
Catastrophic Claim	A very expensive claim that is usually the result of a serious injury or illness.
Community Rating	The process of determining premium rates for a group based on the average claims experience for the general population instead of a particular employer.
Demographics	The study of the characteristics of a given population. May include such factors as birth rate, age, sex and family composition.
Demographic Rating	The process of determining the premium rates for a group based on that group's characteristics. This may include such factors as birth rate, age and sex composition, and urban/rural distribution.
Eligibility Maintenance	The process of updating and tracking insurance plan participants' eligibility, usually on a monthly basis, to insure that only eligible participants receive benefits.
Experience Rating	The process of determining the premium rates for a group based wholly or partially on the basis of that group's claims experience.
Fully Insured	A funding mechanism in which the insurance company is responsible for paying all claims and expenses. The carrier is also responsible for processing claims and the administrative services. The employer pays a set premium per month and is not at risk for excess claims and expenses above the pre-set premium. In non-participating contracts, the employer is not at risk for any deficits and also does not participate in any surplus.

HEDIS	The Health Plan Employer Data and Information Set (HEDIS) is self reported information gathered by the National Committee for Quality Assurance that measures 60 performance criteria for managed care plans.
Medicare	Administered by the Social Security Administration, Medicare is the U.S. federal government plan for paying certain hospital and medical expenses for those who qualify, primarily those over 65.
Minimum Premium	A funding mechanism in which the employer and the insurance company agree that the employer will be responsible for paying all claims up to an agreed upon aggregate level, with the carrier responsible for the excess. The carrier is responsible for processing claims and the administrative services. The employer pays the insurer a set monthly "minimum premium" to cover expense and administrative charges, and typically funds a bank account to cover claim payments.
Performance Standards	Measurements of the insurer or administrator's ability to perform as quantified by standards. The standards are typically based on industry norms, benchmarks, and best practices. The performance levels monitored usually include quality of care, plan implementation, open enrollment services, claim turnaround times, claim payment accuracy, claim payment financial and procedural accuracy, telephone and written inquiry response time, member satisfaction, network discounts, and account management.
Pooling	Refers to a number of small groups that are analyzed and rated as a single large group. Risk pools attempt to find the claims liability for a group with a common denominator.
Premium	The amount of money a policyholder agrees to pay an insurance company for an insurance policy, in consideration of which the insurance company guarantees the payment of specified benefits.
Premium Reconciliation	The reconciliation, usually at year end, of the actual premium and expenses, to those paid during the plan year.
Primary Care	Routine medical care, normally provided in a doctor's office. Professional and related services administered by an internist, family practitioner, obstetrician-gynecologist or pediatrician in an ambulatory setting, with referral to secondary care specialists as necessary.

Reinsurance The acceptance by one or more insurers, called reinsurers, for a portion of the risk underwritten by another insurer or by the employer.

Retention The portion of the premium that is used by an insurer to cover the cost of risk, expense charges, and profit or contribution to surplus.

Self-Insurance A self-insured plan is one in which no insurance company collects premiums and assumes risk. The employer acts as an insurance company — paying claims with money normally earmarked for premiums. This type of arrangement is often referred to as an Administrative Services Only (ASO) arrangement because administrative services are typically performed by an insurance company or third party administrator and the employer is totally at risk for the claims.

Appendix Descriptions

Appendix A: Current HMO Plan Designs

Highlights each vendor's current plan provisions and provides a side by side comparison by Agency

Appendix B: Consolidated Plan Designs

Represents the approach chosen for a consolidated plan design for the pooled Agencies.

Appendix C: Current Costs in a Level Playing Field

Establishes an "apples to apples" comparison of each Agency's current plan costs. This required adjusting premium rates by removing supplemental coverages.

Appendix D-1: Current & Consolidated Plan - Annual Cost Comparison

Reflects the average cost per employee for the adjusted core medical plans versus the consolidated pooled plan.

Appendix D-2: HMO Consolidated Insured Plan Cost

Identifies premium rates in a 3-tier format (Individual, Two Party, Family) as quoted by each vendor for a consolidated plan.

Appendix D-3: Enrollment by Plan

Outlines the current enrollment by plan.

Appendix D-4: Adjusted Enrollment by Plan

Illustrates the assumed three tier enrollment under a consolidated plan.

Appendix E: Cost Impact: Savings Analysis by HMO and Agency

Shows an Agency by Agency comparison of savings and costs associated with pooling the HMO programs. This comparison incorporates each vendors' savings and costs associated with a consolidated plan design.

Appendix F: Plan Design Relative Values

Provides the relative value matrix used for valuing the savings due to changes in medical plan design.

APPENDIX A

Kaiser HMO Plan Designs:

Benefit	MCPS	MCGovt.	College	M-NCPPC	WSSC
Benefit Schedule	Plan A	Plan A	Plan A	Plan L Copays waived for children up to age 3	Plan L Copays waived for children up to age 3
Inpatient Hospital Room and Board	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Outpatient Surgical	Covered in full	Covered in full	Covered in full	$5 Copay	$5 Copay
PCP Routine Office Visit	Covered in full	Covered in full	Covered in full	$5 Copay	$5 Copay
Routine Physical Exams	Covered in full	Covered in full	Covered in full	$5 Copay	$5 Copay
Well Child Care	Covered in full	Covered in full	Covered in full	$5 Copay	$5 Copay
Immunizations	Covered in full	Covered in full	Covered in full	$5 Copay	$5 Copay
Hearing Exams	Covered in full	Covered in full	Covered in full	$5 Copay	$5 Copay
Allergy testing & Injections	Covered in full	Covered in full	Covered in full	$5 Copay, Injections $5 Copay per visit	$5 Copay, Injections $5 Copay per visit
Annual GYN Visit without referral	Covered in full	Covered in full	Covered in full	$5 Copay	$5 Copay
Maternity - Inpatient Care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Maternity - Prenatal Care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Maternity - Postnatal care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Specialty Physician Visit	Covered in full	Covered in full	Covered in full	$5 Copay	$5 Copay
Lab, X-Ray Services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Annual Out-of-Pocket Maximum	N/A	N/A	N/A	N/A	N/A
Emergency Room Visit	$35 (waived if admitted)	Covered in full	$35 (waived if admitted)	$25 (waived if admitted)	$25 (waived if admitted)
Ambulance Copayment per transport	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full

Kaiser continued

Benefit	MCPS	MCGovt.	College	M-NCPPC	WSSC
Mental Health Inpatient	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Mental Health Outpatient Visit	Visit 1-5 covered in full; Visit 6-10 $10 copay Visit 11+ $35 copay (Group visits up to 10 - $5; 10+ visits - $10)	Visit 1-5 covered in full; Visit 6-10 $10 copay Visit 11+ $35 copay (Group visits up to 10 - $5; 10+ visits - $10)	Visit 1-5 covered in full; Visit 6-10 $10 copay Visit 11+ $35 copay (Group visits up to 10 - $5; 10+ visits - $10)	Visit 1-5 covered in full; Visit 6-10 $10 copay Visit 11+ $35 copay (Group visits up to 10 - $5; 10+ visits - $10)	Visit 1-5 covered in full; Visit 6-10 $10 copay Visit 11+ $35 copay (Group visits up to 10 - $5; 10+ visits - $10)
Substance Abuse Inpatient	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Substance Abuse Outpatient Visit	Visit 1-5 covered in full; Visit 6-10 $10 copay Visit 11+ $35 copay (Group visits up to 10 - $5; 10+ visits - $10)	Visit 1-5 covered in full; Visit 6-10 $10 copay Visit 11+ $35 copay (Group visits up to 10 - $5; 10+ visits - $10)	Visit 1-5 covered in full; Visit 6-10 $10 copay Visit 11+ $35 copay (Group visits up to 10 - $5; 10+ visits - $10)	Visit 1-5 covered in full; Visit 6-10 $10 copay Visit 11+ $35 copay (Group visits up to 10 - $5; 10+ visits - $10)	Visit 1-5 covered in full; Visit 6-10 $10 copay Visit 11+ $35 copay (Group visits up to 10 - $5; 10+ visits - $10)
Physical Rehabilitation - Inpatient	Covered in full for up to 2 months per calendar year	Covered in full for up to 2 months per calendar year	Covered in full for up to 2 months per calendar year	Covered in full for up to 2 months per calendar year	Covered in full for up to 2 months per calendar year
Physical Rehabilitation - Outpatient	Covered in full for up to 2 months per calendar year and 20 visits per incident	Covered in full for up to 2 months per calendar year and 20 visits per incident	Covered in full for up to 2 months per calendar year and 20 visits per incident	$5 copay per visit - for up to 2 months per calendar year and 20 visits per incident	$5 copay per visit - for up to 2 months per calendar year and 20 visits per incident
Chiropractic per Visit	Not covered	Not covered	Not covered	Not covered	Not covered
Skilled Nursing Facility	Covered in full for up to 100 days per contract year	Covered in full for up to 100 days per contract year	Covered in full for up to 100 days per contract year	Covered in full for up to 100 days per contract year	Covered in full for up to 100 days per contract year
Home Health Care per Visit	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Durable Medical Equipment (DME)	Covered in full for up to 3 months use in home after confinement	Covered in full for up to 3 months use in home after confinement	Covered in full for up to 3 months use in home after confinement	Covered in full for up to 3 months use in home after confinement	Covered in full for up to 3 months use in home after confinement
Transplants	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full

[1]Cornea, heart, kidney, liver, heart/lung, pancreas/kidney, bone marrow.

Kaiser continued

Benefit	MCPS	MCGovt.	College	M-NCPPC	WSSC
Prescription Drugs	Not Covered	Covered	Covered	Not Covered	Covered
Retail		$3 per script at Kaiser pharmacy, otherwise $10 per script.	$3 per script at Kaiser pharmacy, otherwise $10 per script.		$5 per script at Kaiser pharmacy.
Mail Order		$3 per script at Kaiser pharmacy	$3 per script at Kaiser pharmacy		$3 per script at Kaiser pharmacy
Annual Deductible		No	No		No
Annual Maximum		No	No		No
Mandatory Generic		No	No		No
Vision Exam	Not Covered	Covered in full	Covered in full	$5 copay	$5 copay
Eyewear - Frames or Lenses	Discounts available	Discounts available	Discounts available	Discounts available	Discounts available
Dental Rider	Not Included	Included	Included	Included	Included
Dental	Covered in full for accidental only	Routine visits covered per schedule	Routine visits covered per schedule	Routine visits covered per schedule	Routine visits covered per schedule
EAP	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Optimum Choice HMO Plan Designs:

Benefit	MCPS	MCGovt.	College	M-NCPPC	WSSC
Benefit Schedule					
Inpatient Hospital Room and Board	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Outpatient Surgical	$25 copay	$25 copay	$25 copay	$25 copay	Covered in full
PCP Routine Office Visit	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay
Routine Physical Exams	$5 copay	$5 copay	$10 copay	$5 copay	$5 copay
Well Child Care	$5 copay	$5 copay	$10 copay	$5 copay	$5 copay
Immunizations	$5 copay	$10 copay	$10 copay	$10 copay	$5 copay
Hearing Exams	$5 copay	$10 copay	$10 copay	$10 copay	$5 copay
Allergy testing & Injections	$5 copay per testing and injection	$10 copay per testing and injection	$10 copay per testing and injection	$10 copay per testing and injection	$5 copay per testing and injection
Annual GYN Visit without referral	$5 copay	$10 copay	$10 copay	$10 copay	$5 copay
Maternity - Inpatient Care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Maternity - Prenatal Care	$5 copay ($50 max copay per pregnancy)	$10 copay ($100 max copay per pregnancy)	$10 copay	$10 copay ($100 max copay per pregnancy)	$5 copay
Maternity - Postnatal care	$5 copay	$10 copay	$10 copay	$10 copay	$5 copay
Specialty Physician Visit	$5 copay	$10 copay	$10 copay	$10 copay	$5 copay
Lab, X-Ray Services	$5 copay	$5 copay	Lab covered in full, $5 copay for X-ray	$5 copay	Lab covered in full, $5 copay for X-ray
Annual Out-of-Pocket Maximum	N/A	N/A	N/A	N/A	N/A
Emergency Room Visit	$25 copay (waived if admitted)	$25 copay (waived if admitted)	$25 copay (waived if admitted)	$25 copay (waived if admitted)	$25 copay (waived if admitted)
Ambulance Copayment per transport	Covered in full if medically necessary	Covered in full if medically necessary	Covered in full if medically necessary	Covered in full if medically necessary	Covered in full if medically necessary

Optimum Choice continued

Benefit	MCPS	MCGovt.	College	M-NCPPC	WSSC
Mental Health Inpatient	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Mental Health Outpatient Visit	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 31+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 31+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 31+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 31+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 31+ 50% copay;
Substance Abuse Inpatient	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Substance Abuse Outpatient Visit	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 31+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 31+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 31+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 31+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 31+ 50% copay;
Physical Rehabilitation - Inpatient	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Physical Rehabilitation - Outpatient	$5 copay - up to 60 visits per condition	$10 copay - up to 60 visits per condition	$10 copay - up to 60 visits per condition	$10 copay - up to 60 visits per condition	$5 copay - up to 60 visits per condition
Chiropractic per Visit	$5 copay - up to 60 visits per condition	$10 copay - up to 60 visits per condition	$10 copay - up to 60 visits per condition	$10 copay - up to 60 visits per condition	50% copay - up to 60 visits per condition
Skilled Nursing Facility	Covered in full for up to 60 days per contract year	Covered in full for up to 60 days per contract year	Covered in full for up to 60 days per contract year	Covered in full for up to 60 days per contract year	Covered in full for up to 60 days per contract year
Home Health Care per Visit	Covered in full if non physician otherwise copay applies	Covered in full if non physician otherwise copay applies	Covered in full if non physician otherwise copay applies	Covered in full if non physician otherwise copay applies	Covered in full if non physician otherwise copay applies
Durable Medical Equipment (DME)	50% Copay	50% Copay	50% Copay	50% Copay	50% Copay
Transplants	Covered in full[1]	Covered in full[2]	Covered in full[1]	Covered in full[2]	Covered in full[1]

[1]Transplants include heart, heart-lung, liver, pancreas, lung, kidney, cornea, and bone marrow.
[2]Cornea, kidney, and bone marrow

Optimum Choice Continued

Benefit	MCPS	MCGovt.	College	M-NCPPC	WSSC
Prescription Drugs	Not Covered	Covered	Covered	Not Covered	Covered
Retail		$2/$5 (G/B)	$2/$5 (G/B)		$5/$10 (G/B)
Mail Order		$2/$5 (G/B) 90 day supply	$2/$5 (G/B) 90 day supply		$5/$10 (G/B) 90 day supply
Annual Deductible					
Annual Maximum		$3,000	$3,000		$3,000
Mandatory Generic	No	No	No	No	No
Vision Rider	Core	Core	Core	Core	Core
Vision Exam	Excluded	$25 copay	$25 copay	$25 copay	$25 copay
Eyewear - Frames or Lenses	Discounts	Discounts	Discounts	Discounts	Discounts
Dental Rider	Not Covered	Covered	Covered	Covered	Covered
Dental Benefit	Schedule	Schedule	Schedule	Schedule	Schedule
Transplant Rider	Covered	Not Covered	Covered	Not Covered	Covered
EAP	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Freestate HMO Plan Designs:

Benefit	MCPS	M-NCPPC	WSSC
Benefit Schedule	Freestate Advantage II	Columbia Advantage II	Freestate Advantage III
Inpatient Hospital Room and Board	Covered in full	Covered in full	Covered in full
Outpatient Surgical	Covered in full	Covered in full	$5 copay
PCP Routine Office Visit	Covered in full	$5 copay	$5 copay
Routine Physical Exams	Covered in full	$5 copay	$5 copay
Well Child Care	Covered in full	$5 copay; under age 4 covered in full	$5 copay; under age 4 covered in full
Immunizations	Covered in full	$5 copay; under age 4 covered in full	$5 copay; under age 4 covered in full
Hearing Exams	Covered in full	$5 copay	$5 copay
Allergy testing & Injections	Covered in full	Covered in full	$5 copay - for testing and injections
Annual GYN Visit without referral	Covered in full	$5 copay	$5 copay
Maternity - Inpatient Care	Covered in full	Covered in full	Covered in full
Maternity - Prenatal Care	Covered in full	Covered in full	Covered in full
Maternity - Postnatal care	Covered in full	Covered in full	Covered in full
Specialty Physician Visit	Covered in full	$5 copay	$5 copay
Lab, X-Ray Services	Covered in full	$2 copay for lab; $5 copay for x-ray	Covered in full
Annual Out-of-Pocket Maximum	N/A	N/A	N/A
Emergency Room Visit	$25 copay (waived if admitted)	$25 copay (waived if admitted)	$25 copay (waived if admitted)
Ambulance Copayment per transport	Covered in full	Covered in full	Covered in full

Freestate continued

Benefit	MCPS	M-NCPPC	WSSC
Mental Health Inpatient	Covered in full	Covered in full	Covered in full
Mental Health Outpatient Visit	Visit 1-5 $15 copay; Visit 6-30 $25 copay; Visit 31+ $35 copay;	Visit 1-5 $15 copay; Visit 6-30 $25 copay; Visit 31+ $35 copay;	Visit 1-5 $15 copay; Visit 6-30 $25 copay; Visit 31+ $35 copay;
Substance Abuse Inpatient	Covered in full	Covered in full	Covered in full
Substance Abuse Outpatient Visit	Visit 1-5 $15 copay; Visit 6-30 $25 copay; Visit 31+ $35 copay;	Visit 1-5 $15 copay; Visit 6-30 $25 copay; Visit 31+ $35 copay;	Visit 1-5 $15 copay; Visit 6-30 $25 copay; Visit 31+ $35 copay;
Physical Rehabilitation - Inpatient	Covered in full up to 60 days per condition	Covered in full up to 60 days per condition	Covered in full up to 60 days per condition
Physical Rehabilitation - Outpatient	Covered in full up to 30 visits per condition per contract year	$5 copay - up to 30 visits per condition per contract year	$5 copay - up to 30 visits per condition per contract year
Chiropractic per Visit	Not covered	Not covered	Not covered
Skilled Nursing Facility	Covered in full up to 100 days per contract year	Covered in full up to 100 days per contract year	Covered in full up to 100 days per contract year
Home Health Care per Visit	Covered in full	Covered in full	Covered in full
Durable Medical Equipment (DME)	Covered in full	Covered in full	Covered in full
Transplants	Kidney, cornea and bone marrow covered	Kidney, cornea and bone marrow, heart-lung, pancreas covered	Kidney, cornea and bone marrow covered

Freestate continued

Benefit	MCPS	M-NCPPC	WSSC
Prescription Drugs	Not Included	Not Included	Not Included
Retail			$5
Mail Order			None
Annual Deductible			None
Annual Maximum			None
Mandatory Generic			Yes
Vision Rider	Core	Core	Included
Vision Exam	Covered in full	$5 copay	$5 copay
Eyewear - Frames or Lenses	Not Covered	Not Covered	Every 24 months
Dental Rider	Core	Included	Core
EAP	Not Covered	Not Covered	Not Covered

NYLCare HMO Plan Designs:

Benefit	MCPS	M-NCPPC	WSSC
Benefit Schedule	Plan N	Plan N	Plan N
Inpatient Hospital Room and Board	Covered in full	Covered in full	Covered in full
Outpatient Surgical	Covered in full	Covered in full	Covered in full
PCP Routine Office Visit	$ 5 copay	$ 5 copay	$ 5 copay
Routine Physical Exams	$ 5 copay	$ 5 copay	$ 5 copay
Well Child Care	$ 5 copay	$ 5 copay	$ 5 copay
Immunizations	Covered in full	Covered in full	Covered in full
Hearing Exams	$5 copay for children up to age 17	$5 copay for children up to age 17	$5 copay for children up to age 17
Allergy testing & Injections	$25 copay per testing & $5 per injection visit	$25 copay per testing & $5 per injection visit	$25 copay per testing & $5 per injection visit
Annual GYN Visit without referral	$ 5 copay	$ 5 copay	$ 5 copay
Maternity - Inpatient Care	$50 copay per day for each baby	$50 copay per day for each baby	Covered in full
Maternity - Prenatal Care	Covered in full	Covered in full One $5 copay	Covered in full
Maternity - Postnatal care	Covered in full	Covered in full	Covered in full
Specialty Physician Visit	$ 5 copay	$ 5 copay	$ 5 copay
Lab, X-Ray Services	Covered in full when part of office visit	Covered in full	Covered in full when part of office visit
Annual Out-of-Pocket Maximum	$650/$1,500 (s/f)	$650/$1,500 (s/f)	$650/$1,500 (s/f)
Emergency Room Visit	$40 copay (waived if admitted)	$40 copay (waived if admitted)	$40 copay (waived if admitted)
Ambulance Copayment per transport	Covered in full	Covered in full	Covered in full

NYLCare continued

Benefit	MCPS	M-NCPPC	WSSC
Mental Health Inpatient	Covered in full	Covered in full	Covered in full
Mental Health Outpatient Visit	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 30+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 30+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 30+ 50% copay;
Substance Abuse Inpatient	Covered in full	Covered in full	Covered in full
Substance Abuse Outpatient Visit	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 30+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 30+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 30+ 50% copay;
Physical Rehabilitation - Inpatient	Covered in full	Covered in full	Covered in full
Physical Rehabilitation - Outpatient	$5 copay - up to 60 visits per condition	$5 copay - up to 60 visits per condition	$5 copay - up to 60 visits per condition
Chiropractic per Visit	Not Covered	Not Covered	Not Covered
Skilled Nursing Facility	Covered in full up to 60 days per illness or injury	Covered in full up to 60 days per illness or injury	Covered in full up to 60 days per illness or injury
Home Health Care per Visit	Covered in full; $5 copay for physician home services	Covered in full; $5 copay for physician home services	Covered in full; $5 copay for physician home services
Durable Medical Equipment (DME)	Not Covered	Not Covered	Not Covered
Transplants[1]	Covered	Covered	Covered

[1]Cornea, liver, kidney, heart, heart-lung, bone marrow and stem cell transplants.

NYLCare continued

Benefit	MCPS	M-NCPPC	WSSC
Prescription Drugs	Not Covered	Not Covered	Covered
Retail			$4/$8 (g/b)
Mail Order			$4/$8 (g/b)
Annual Deductible			None
Annual Maximum			$3,000
Mandatory Generic			
Vision Rider	Included	Included	Included
Vision Exam	$25 copay	$10 copay	$10 copay
Eyewear - Frames or Lenses	Per schedule	Per Schedule	Per schedule
Dental Rider	Core	Core	Core
EAP Rider	Covered	Covered	Covered

APPENDIX B

HMO Consolidated Plan Designs:

Benefit	Kaiser	NYLCare	Optimum Choice	Freestate
Benefit Schedule	Plan L Copays waived for children up to age 3	Plan N		Freestate Advantage III
Inpatient Hospital Room and Board	Covered in full	Covered in full	Covered in full	Covered in full
Outpatient Surgical	$5 Copay	Covered in full	$25 copay	$5 copay
PCP Routine Office Visit	$5 Copay	$ 5 copay	$5 copay	$5 copay
Routine Physical Exams	$5 Copay	$ 5 copay	$5 copay	$5 copay
Well Child Care	$5 Copay	$ 5 copay	$5 copay	$5 copay; under age 4 covered in full
Immunizations	$5 Copay	Covered in full	$10 copay	$5 copay; under age 4 covered in full
Hearing Exams	$5 Copay	$5 copay for children up to age 17	$10 copay	$5 copay
Allergy testing & Injections	$5 Copay, Injections $5 Copay per visit	$25 copay per testing & $5 per injection visit	$10 copay per testing and injection	$5 copay - for testing and injections
Annual GYN Visit without referral	$5 Copay	$ 5 copay	$10 copay	$5 copay
Maternity - Inpatient Care	Covered in full	$50 copay per day for each baby	Covered in full	Covered in full
Maternity - Prenatal Care	Covered in full	Covered in full	$10 copay ($100 max copay per pregnancy)	Covered in full
Maternity - Postnatal care	Covered in full	Covered in full	$10 copay	Covered in full
Specialty Physician Visit	$5 Copay	$ 5 copay	$10 copay	$5 copay
Lab, X-Ray Services	Covered in full	Covered in full when part of office visit	$5 copay	Covered in full
Annual Out-of-Pocket Maximum	N/A	$650/$1,500 (s/f)	N/A	N/A
Emergency Room Visit	$25 (waived if admitted)	$40 copay (waived if admitted)	$25 copay (waived if admitted)	$25 copay (waived if admitted)
Ambulance Copayment	Covered in full	Covered in full	Covered in full	Covered in full

HMO Consolidated Plan Designs (Cont):

Benefit	Kaiser	NYLCare	Optimum Choice	Freestate
Mental Health & Substance Abuse Inpatient	Covered in full	Covered in full	Covered in full	Covered in full
Mental Health Outpatient Visit & Substance Abuse Outpatient Visit	Visit 1-5 covered in full; Visit 6-10 $10 copay Visit 11+ $35 copay (Group visits up to 10 - $5; 10+ visits - $10)	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 30+ 50% copay;	Visit 1-5 20% copay; Visit 6-30 35% copay; Visit 31+ 50% copay;	Visit 1-5 $15 copay; Visit 6-30 $25 copay; Visit 31+ $35 copay;
Physical Rehabilitation - Inpatient	Covered in full for up to 2 months per calendar year	Covered in full	Covered in full	Covered in full up to 60 days per condition
Physical Rehabilitation - Outpatient	Covered in full for up to 2 months per calendar year and 20 visits per incident	$5 copay - up to 60 visits per condition	$10 copay - up to 60 visits per condition	$5 copay - up to 30 visits per condition per contract year
Chiropractic per Visit	Not covered	Not Covered	$10 copay - up to 60 visits per condition	Not covered
Skilled Nursing Facility	Covered in full for up to 100 days per contract year	Covered in full up to 60 days per illness or injury	Covered in full for up to 60 days per contract year	Covered in full up to 100 days per contract year
Home Health Care per Visit	Covered in full	Covered in full; $5 copay if physician	Covered in full; $10 copay if physician	Covered in full
Durable Medical Equipment (DME)	Covered in full for up to 3 months use in home after confinement	Not Covered	50% Copay	Covered in full
Transplants	Cornea, heart, kidney, liver, heart/lung, pancreas/kidney, bone marrow	Cornea, liver, kidney, heart, heart-lung, bone marrow and stem cell transplants	Heart, heart-lung, liver, pancreas, lung, kidney, cornea, and bone marrow.	Kidney, cornea and bone marrow covered

HMO Consolidated Plan Designs (Cont):

Benefit	Kaiser	NYLCare	Optimum Choice	Freestate
Prescription Drugs	Not Covered	Not Covered	Not Covered	Not Covered
Vision Exam	Not Covered	Core	Core	Core
Eyewear - Frames or Lenses	Discounts available			
Dental Rider	Not Covered	Core	Core	Not Covered
Dental	Covered in full for accidental only	Core	Core	Core
EAP Rider	Not Covered	Not Covered	Not Covered	Not Covered

Dependent coverage to age 19 or age 25 if a student

Appendix C
1998 HMO Premiums

	MCPS	MCGovt	MCGovt	College	M-NCPPC	WSSC
Kaiser						
Individual	**$131.99**	**$168.35**	**$168.35**	**$144.75**	**$133.92**	**$133.30**
Two Party	**$263.99**	**$335.21**	**N/A**	**N/A**	**$267.07**	**N/A**
Family	**$382.78**	**$485.38**	**$452.01**	**$389.56**	**$386.91**	**$358.65**
Kaiser - Net Riders						
Individual	$131.99	$152.01	$152.01	$128.41	$133.63	$123.66
Two Party	$263.99	$302.53	N/A	N/A	$266.49	N/A
Family	$382.78	$437.99	$407.89	$345.44	$386.07	$332.62
Annual Cost - Net Riders	**$11,811,110**	**$103,130**	**$3,175,710**	**$921,490**	**$766,354**	**$1,311,076**
Enrollment	**3,536**	**30**	**869**	**309**	**237**	**407**
Employee Per Capita	**$3,340**	**$3,438**	**$3,654**	**$2,982**	**$3,234**	**$3,221**
Composite Per Capita		**$3,647**				
Riders						
Prescription Drug	Not Included	Included	Included	Included[1]	Not Included	Included
Individual		$16.05	$16.05	*$16.05*		$9.35
Two Party		$32.10	N/A	*N/A*		N/A
Family		$46.55	$43.34	*$43.34*		$25.25
Dental Rider	Not Included	Included	Included	Included	Included	Included
Individual		$0.29	$0.29	$0.29	$0.29	$0.29
Two Party		$0.58	N/A	N/A	$0.58	N/A
Family		$0.84	$0.78	$0.78	$0.84	$0.78
Vision Rider	Excluded	Core	Core	Core	Core	Core
Dependent Age Rider	Included 19/99 No Charge	Not Included 19/26	Not Included 19/26	Not Included 22/22	Not Included 19/23	Not Included 23/23

[1] Estimate the College drug cost to be similar to the Government cost.

Appendix C
1998 HMO Premiums

	MCPS	MCGovt	MCGovt	College	M-NCPPC	WSSC
Freestate		Not Offered	Not Offered	Not Offered		
Individual	**$158.45**				**$211.80**	**$162.92**
Two Party	**$348.59**				**$465.96**	**N/A**
Family	**$475.35**				**$635.40**	**$472.46**
Freestate - Net Riders						
Individual	$158.45				$205.28	$126.79
Two Party	$348.59				$451.61	N/A
Family	$475.35				$615.83	$367.69
Annual Cost - Net Riders	**$528,589**				**$307,916**	**$777,018**
Enrollment	**122**				**53**	**220**
Employee Per Capita	**$4,333**				**$5,810**	**$3,532**
Riders						
Prescription Drug	Not Included				Not Included	Included
Individual						$30.82
Two Party						N/A
Family						$89.38
Dental Benefits	Not Included				Included	Not Included
Individual					$6.52	
Two Party					$14.35	
Family					$19.57	
Personal Injury Protection	Included[1]				Included[1]	Not Included
Individual	*$1.00*				*$1.00*	
Two Party	*$1.75*				*$1.75*	
Family	*$2.75*				*$2.75*	
Vision Four Benefit	Not Included				Not Included	Included
Individual						$5.31
Two Party						N/A
Family						$15.39

Appendix C
1998 HMO Premiums

	MCPS	MCGovt	MCGovt	College	M-NCPPC	WSSC
NLYCare		Not Offered	Not Offered	Not Offered		
Individual	$152.13				$142.51	$164.61
Two Party	$285.98				$297.86	N/A
Family	$468.53				$401.90	$432.14
NLYCare - Net Rider						
Individual	$149.64				$140.44	$142.34
Two Party	$280.64				$293.72	N/A
Family	$461.44				$395.69	$374.71
Annual Cost - Net Riders	**$523,427**				**$1,603,217**	**$1,328,852**
Enrollment	**158**				**471**	**347**
Employee Per Capita	**$3,313**				**$3,404**	**$3,830**
Riders						
Prescription Drug	Not Included				Not Included	Included
Individual						$19.76
Two Party						N/A
Family						$50.85
Vision	Included				Included[1]	Included
Individual	$0.25				*$2.07*	$2.07
Two Party	$0.53				*$4.14*	N/A
Family	$0.71				*$6.21*	$5.44
Waive Newborn Copay	Not Included				Not Included	Included
Individual						$0.44
Two Party						N/A
Family						$1.14
Extended Student Definition	Included				Not Included	Not Included
Individual	$2.24					
Two Party	$4.81					
Family	$6.38					

[1] Estimate M-NCPPC vision rider cost to be the same as WSSC.

Appendix C
1998 HMO Premiums

	MCPS	MCGovt	MCGovt	College	M-NCPPC	WSSC
Optimum Choice	Min Prem[1]					Min Prem[1]
Individual	$140.55	$157.44	$157.44	$218.55	$139.47	$137.55
Two Party	$264.19	$299.05	N/A	N/A	$281.12	N/A
Family	$432.83	$472.45	$429.62	$545.22	$424.40	$370.54
Optimum Choice - Net Riders						
Individual	$137.39	$140.35	$140.35	$186.64	$137.97	$127.89
Two Party	$258.25	$266.45	N/A	N/A	$278.12	N/A
Family	$423.10	$420.70	$382.16	$464.54	$419.40	$343.61
Annual Cost - Net Riders	**$23,470,463**	**$223,359**	**$6,765,221**	**$1,013,099**	**$2,128,183**	**$1,794,847**
Enrollment	**6,326**	**73**	**1,815**	**229**	**619**	**537**
Employee Per Capita	**$3,710**	**$3,060**	**$3,727**	**$4,424**	**$3,438**	**$3,342**
Composite Per Capita		**$3,702**				
Adjusted Annual Cost[2]	**$23,732,169**	**$223,359**	**$6,839,527**	**$1,036,542**	**$2,231,474**	**$1,820,913**
Adjusted Enrollment[2]	**6,607**	**73**	**1,838**	**235**	**657**	**558**
Adjusted Per Capita[2]	**$3,592**	**$3,696**		**$4,411**	**$3,396**	**$3,263**
Riders						
Dental	Not Included	Included	Included	Included	Included	Included
Individual		$1.50	$1.50	$1.50	$1.50	$1.50
Two Party		$3.00	N/A	N/A	$3.00	N/A
Family		$5.00	$5.00	$5.00	$5.00	$5.00
Prescription Drugs	Not Included	Included	Included	Included	Not Included	Included
Individual		$15.59	$15.59	$30.41		$8.16
Two Party		$29.60	N/A	N/A		N/A
Family		$46.75	$42.46	$75.68		$21.93
Expanded Student Definition						
Individual	$3.16					
Two Party	$5.94					
Family	$9.73					

[1] Reflects the premium rate equivalent.

[2] Adjustments reflect costs with Retiree Over Age 65 retirees. Optimum Choice does not track Medicare costs separately.

Appendix D-1

Current and Consolidated Plan Annual Cost Comparison

Current Plan Per Capita Cost[1]	MCPS	MCGovt	College	M-NCPPC	WSSC	Total
Kaiser	$3,340	$3,647	$2,982	$3,234	$3,221	$3,357
Freestate	$4,333	N/A	N/A	$5,810	$3,532	$4,085
NYLCare	$3,313	N/A	N/A	$3,404	$3,830	$3,540
Optimum Choice	$3,592	$3,696	$4,411	$3,396	$3,263	$3,600
Total Annual Premium	$35,586,000	$10,256,700	$1,931,600	$4,779,900	$5,169,300	$57,723,500
Consolidated Plan Per Capita Cost						
Kaiser	$3,347	$3,099	$2,997	$3,210	$3,350	$3,280
Freestate	$3,802	N/A	N/A	$3,926	$3,688	$3,756
NYLCare	$3,126	N/A	N/A	$3,459	$3,768	$3,515
Optimum Choice	$3,521	$3,421	$3,314	$3,223	$3,366	$3,469
Total Annual Premium	$35,067,300	$9,245,100	$1,685,000	$4,593,100	$5,289,800	$55,880,300
Savings / (Cost)	$518,700	$1,011,600	$246,600	$186,800	($120,500)	$1,843,200

[1]Adjusted to exclude prescription drugs and supplemental benefits.

Appendix D-2
HMO Consolidated Insured Plan Cost

Fully Insured	Kaiser	Freestate	NYLCare	Optimum Choice
Individual	**$132.26**	**$139.05**	**$140.69**	**$132.18**
Two Party	**$264.52**	**$278.11**	**$302.48**	**$264.36**
Family	**$383.54**	**$431.07**	**$400.97**	**$396.54**

Appendix D-3
Current HMO Enrollment

Current Enrollment	MCPS	MCGovt	College	M-NCPPC	WSSC	Total
Kaiser						
Employee	1,083	365	138	82	125	1,793
Empolyee + One	822	4	0	58	0	884
Family	1,631	530	171	97	282	2,711
Freestate						
Employee	32	0	0	11	67	110
Empolyee + One	30	0	0	15	0	45
Family	60	0	0	27	153	240
NYLCare						
Employee	69	0	0	154	83	306
Empolyee + One	43	0	0	132	0	175
Family	46	0	0	185	264	495
Optimum Choice[1]						
Employee	1,568	573	79	219	162	2,601
Empolyee + One	1,654	13	0	146	0	1,813
Family	3,104	1,302	150	254	375	5,185
Total						
Employee	2,752	938	217	466	437	4,810
Empolyee + One	2,549	17	0	351	0	2,917
Family	4,841	1,832	321	563	1,074	8,631
						16,358

Enrollment for MCPS is from the renewal. Other enrollment numbers are as provided by Agency in Phase I of this study (6/30/97).

[1]Optimum Choice includes Medicare enrollees.

Appendix D-4
Assumed Three Tier HMO Enrollment

Assumed Three Tier Enrollment	MCPS	MCGovt	College	M-NCPPC	WSSC	Total
Kaiser						
Employee	1,083	365	138	82	125	1,793
Empolyee + One	822	176	56	58	93	1,205
Family	1,631	358	115	97	189	2,390
	3,536	899	309	237	407	5,388
Freestate						
Employee	32	0	0	11	67	110
Empolyee + One	30	0	0	15	50	95
Family	60	0	0	27	103	190
	122	0	0	53	220	395
NYLCare						
Employee	69	0	0	154	83	306
Empolyee + One	43	0	0	132	87	262
Family	46	0	0	185	177	408
	158	0	0	471	347	976
Optimum Choice						
Employee	1,568	573	79	219	162	2,601
Empolyee + One	1,654	434	50	146	124	2,408
Family	3,104	881	100	254	251	4,590
	6,326	1,888	229	619	537	9,599
Total						
Employee	2,752	938	217	466	437	4,810
Empolyee + One	2,549	610	106	351	354	3,970
Family	4,841	1,239	215	563	720	7,578
	10,142	2,787	538	1,380	1,511	16,358

Employee + One is assumed to be 33% of the family group for the MCGovt, the College and WSSC.

Appendix E
Savings Analysis by HMO and Agency

	MCPS	MCGovt	College	M-NCPPC	WSSC	Total
KAISER						
Adjusted Current per Capita	$3,340	$3,647	$2,982	$3,234	$3,221	$3,357
Annual Premium	$11,811,200	$3,278,900	$921,500	$766,400	$1,311,100	$18,088,900
Consolidated Plan per Capita	$3,347	$3,099	$2,997	$3,210	$3,350	$3,280
Annual Premium	$11,834,800	$2,785,700	$926,100	$760,700	$1,363,500	$17,670,600
Total Savings/(Cost)	($23,600)	$493,200	($4,600)	$5,700	($52,400)	$418,300
Plan Design	$183,100	$57,400	$15,700	$0	$0	$256,200
Pooling	($206,700)	$435,800	($20,300)	$5,700	($52,400)	$162,100
FREESTATE						
Adjusted Current per Capita	$4,333	N/A	N/A	$5,810	$3,532	$4,085
Annual Premium	$528,600			$308,000	$777,100	$1,613,600
Consolidated Plan per Capita	$3,802	N/A	N/A	$3,926	$3,688	$3,756
Annual Premium	$463,900			$208,100	$811,500	$1,483,500
Total Savings/(Cost)	$64,700			$99,900	($34,400)	$130,100
Plan Design	$10,600			$200	$0	$10,800
Pooling	$54,100			$99,700	($34,400)	$119,300
NYLCARE						
Adjusted Current per Capita	$3,313	N/A	N/A	$3,404	$3,830	$3,540
Annual Premium	$523,500			$1,603,300	$1,328,900	$3,455,500
Consolidated Plan per Capita	$3,126	N/A	N/A	$3,459	$3,768	$3,515
Annual Premium	$494,000			$1,629,300	$1,307,600	$3,430,800
Total Savings/(Cost)	$29,500			($26,000)	$21,300	$24,700
Plan Design	$0			$0	$0	$0
Pooling	$29,500			($26,000)	$21,300	$24,700
OPTIMUM CHOICE						
Adjusted Current per Capita	$3,592	$3,696	$4,411	$3,396	$3,263	$3,600
Annual Premium	$22,722,900	$6,977,900	$1,010,100	$2,102,500	$1,752,400	$34,565,800
Consolidated Plan per Capita	$3,521	$3,421	$3,314	$3,223	$3,366	$3,469
Annual Premium	$22,274,800	$6,459,500	$759,000	$1,995,100	$1,807,400	$33,296,800
Total Savings/(Cost)	$448,100	$518,400	$251,100	$107,400	($55,000)	$1,269,000
Plan Design	$175,000	($8,400)	($5,500)	($2,600)	$16,700	$175,200
Pooling	$273,100	$526,800	$256,600	$110,000	($71,700)	$1,093,800
Grand Total Savings/(Cost)	$518,700	$1,011,600	$246,500	$187,000	($120,500)	$1,843,300
Plan Design	$368,700	$49,000	$10,200	($2,400)	$16,700	$442,200
Pooling	$150,000	$962,600	$236,300	$189,400	($137,200)	$1,401,100

Appendix F

Plan Design — Relative Values

Each current plan design was adjusted to reflect core medical benefits only (excluding prescription drugs and supplemental benefit riders) and was compared to the consolidated program. Relative values were established to compare current core programs to the consolidated program.

The chart below outlines the relative values by Agency and vendor. These relative values were developed by utilizing factors and rates provided by the HMOs as well as an actuarial manual rating system. The relative values were utilized to provide estimates of savings that are due to changes in plan design. In some cases the consolidated plan design results in slightly better benefits for an individual Agency which may result in additional cost for that particular Agency.

Relative Value Matrix	MCPS	MCGovt.	College	M-NCPPC	WSSC	Consolidated
Kaiser	.9845	.9825	.9830	1.0	1.0	1.0
NYLCare	1.0	N/A	N/A	1.0	1.0	1.0
Optimum Choice	.9923	1.0012	1.0054	1.0012	.9905	1.0
Freestate	.9800	N/A	N/A	.9996	1.0	1.0

There was not much difference in plan design between the Agencies once prescription drugs and supplemental riders were excluded. The relative values show that plan design relationships had, at most, a 2% difference. The consolidated design utilized for the pooled program reflects only slight changes in benefits for each of the Agencies.