AGENDA
Task Force on Employee Wellness and Consolidation of Agency Group Insurance

Tuesday, September 6, 2011
8:00 to 9:30 a.m.
Department of Health and Human Services' TAN (1st Floor)
Conference Room
401 Hungerford Drive, Rockville

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

8:05 Presentation and Discussion: Office of Legislation Oversight
Overview of County Budget Challenges (emphasis group insurance)
Summary of Recent Agency Actions re: group insurance

8:25 Presentation and Discussion: Wes Girling, Montgomery County Government, Office of Human Resources
Overview of County Government insurance participant demographics, plan offerings, and wellness/disease management efforts

8:50 Presentation and Discussion: Jan Lahr-Prock,
Maryland-National Capital Park and Planning Commission
Overview of M-NCPPC insurance participant demographics,
plan offerings, and wellness/disease management efforts

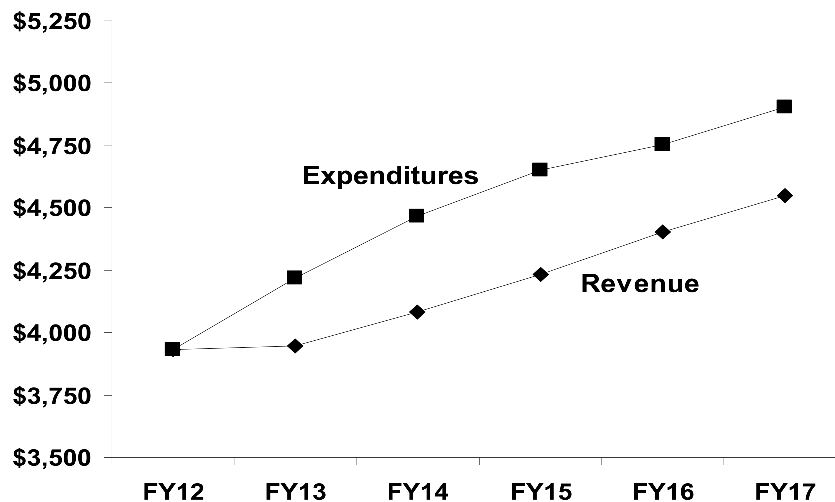
9:15 New Business
Public/Visitor Comments

9:30 Adjourn

Office of Legislative Oversight
Presentation to

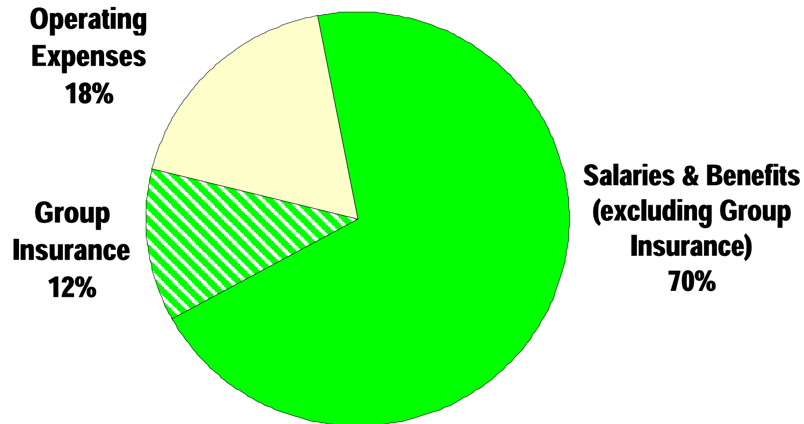
Task Force on Employee Wellness and Consolidation of Agency Group Insurance

September 6, 2011



FY11 Approved Tax Supported Agency Operating Budgets

(excluding debt service)



Total = $3.4 billion

Group Insurance Costs

County Government

	FY02	FY11	% Change
Active Employees	$36m	$80m	+120%
Retirees *	$13m	$31m	+131%
Workyears (FTE)	7,347	7,374	+0.4%

MCPS

	FY02	FY11	% Change
Active Employee	$87m	$216m	+147%
Retirees *	$14m	$43m	+198%
Workyears (FTE)	17,085	19,439	+14%

* Annual pay-as-you-go contribution only.

FY12 Budget

Actions taken by County Executive, County Council, and/or Agency Governing Bodies included:

- Program Cuts
- Elimination of Positions
- Salary Freeze
- Changes to Employee Benefits

FY12 Group Insurance Changes

County Government

- Increased active employee share of annual premium costs
- Changed prescription drug plan design
- Changed eligibility and cost share for retiree health benefits

MCPS

- Changed eligibility and cost share for retiree health benefits

Montgomery College

- Changed eligibility and cost share for retiree health benefits

Glossary of Terms

Actuary: A person qualified to calculate pension and insurance premiums, reserves, and dividends using probabilities based on statistical records.

COBRA plan: A health insurance plan created under the Consolidated Omnibus Budget Reconciliation Act of 1985. A COBRA plan offers an employee who leaves an employer (under certain conditions) the right to continue health insurance coverage at the employee's cost for a limited period of time.

Copayment: A medical insurance cost sharing arrangement that requires a plan participant to pay a fixed dollar amount when a medical service is received.

Cost share: The allocation of benefit costs (such as annual health insurance premiums) between the employer and the employee.

Deductible: A fixed dollar amount during the benefit period that an insurance plan participant pays before the insurance provider will pay for covered expenses.

Fiscal year: The 12-month period to which annual operating budget appropriations apply. For County agencies, the fiscal year starts on July 1 and ends on June 30.

Flexible spending account: A spending account allows an employee to set aside money for eligible health care (and dependent day care) expenses on a pre-tax basis.

Fully insured plan: A health insurance plan offered to employees where a contracted vendor establishes premiums and pays all claims under the plan. In a fully insured plan, the vendor offers agencies insurance products with pre-determined plan designs.

Group insurance: Insurance that is purchased for a group (such as the employees of a government or private company) usually at a reduced rate for the benefit of individual members of the group. County agency group insurance offerings include health, prescription drug, dental, vision, life, and long-term disability plans. County agencies offer group insurance benefits to active and retired personnel.

Health maintenance organization (HMO): A health benefit plan that covers only services provided by in-network physicians or specialists.

In-network provider: A physician, hospital or other medical professional or facility that provides services that are identified by the insurance vendor as part of the plan's network of providers. In-network providers agree to charge lower copayments or deductibles than out-of-network providers.

Non-tax supported resources: Agency resources generated from non-tax sources that are earmarked for a specific purpose or use.

<u>Glossary of Terms</u> (continued)

Other post-employment benefits (OPEB): Benefits – other than pension benefits – that an employer provides to its retired employees, including healthcare coverage, life insurance, and deferred compensation. The Government Accountability Standards Board requires that public sector employers report future OPEB liabilities during the period of active service for employees and recognize unfunded OPEB costs as a liability.

Out-of-network provider: A physician, hospital or other medical professional or facility that does not participate in the insurance vendor's network. Out-of-network providers charge higher copayments or deductibles than in-network providers.

Out-of-pocket costs: Health care charges that are not covered by an insurance plan.

Pay-as-you-go (PAYGO) funding: Current year funding for financial obligations that continue for multiple years. In the context of retiree health benefits, PAYGO represents funding allocated to cover the current year costs of retiree insurance premiums and claims but excludes the cost of future year liabilities.

Point of service (POS) plan: A health plan in which beneficiaries receive services from a network of authorized providers. Beneficiaries have the option of accessing out-of-network providers by paying additional *out-of-pocket costs*.

Premium: Fees paid for insurance benefit coverage for a defined benefit period.

Self insured plan: A health insurance plan offered to employees where the agency sets aside funding and pays all claims from a self insurance fund. The agencies determine the design of self insured plans.

Stop-loss coverage: A form of reinsurance for employers with self-insured plans that limits the amount the employer will have to pay in the case of higher-than-expected claim(s).

Take Up Rate: The percentage of employees eligible for an optional group insurance benefit that chose to enroll for the benefit.

Tax supported resources: Agency resources generated from taxes and other sources of revenue that are not earmarked for a specific purpose or use.

Workyear: A standardized unit of measurement of personnel effort, similar to the term "full-time equivalents." For non-public safety employees of the County Government, a workyear equals 2,080 hours of service. For most MCPS employees (e.g., teachers), a workyear refers to a ten-month position.

Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs

County Government
Plan Overview
September 6, 2011

County Government Plan Overview

- Introduction
- Plan Offerings
- Projected Costs for 2012 Plan Year
- Demographics
- Wellness and Disease Management Initiatives
- Changes for 2012
- Questions

Introduction

- The administration of the employee benefit programs is an Executive branch function administered by the County Executive, with day to day administration delegated to the Office of Human Resources.
- The plans provide coverage for County employees, retirees, and their eligible dependents, as well as for employees of participating county agencies

Introduction

- Benefits levels, and employer/employee cost sharing arrangements are collectively bargained between the Executive Branch, and three bargaining units representing County employees:
  - UFCW Local 1994 MCGEO
  - IAFF Local 1664
  - Fraternal Order of Police Lodge 35

Plan Offerings

Medical

- Two Point-of-Service Plans administered by Carefirst BlueCross BlueShield
- Two Health Maintenance Organization options:
  - Kaiser Permanente
  - UnitedHealthcare

Prescription

- Three Prescription Drug Options administered by CVS/Caremark
- KaiserPermanente plan participants have prescription coverage as part of their medical plan election.

Plan Offerings (continued)

Plan Design

- HMO Co-pays KaiserPermanente - $5, UnitedHealthcare $5 Primary Care Physician, $10 Specialist
- POS Co-pays $10 High Option plan, $15 Standard Option Plan for Primary Care Physician and Specialist
- Prescription Plan Co-pays - Standard Option Plan
  - $10 for generic prescriptions
  - $20 for preferred brand name prescriptions
  - $35 for non-preferred brand name prescriptions
- Prescription Plan Co-pay – High Option Plans
  - MCGEO and IAFF $4 for generic prescriptions, $8 for brand name prescriptions
  - FOP, non-represented, and retirees $5 for generic prescriptions, $10 for brand name prescriptions.

NOTE: Co-pays are the same at retail pharmacies (generally a 30 day supply) and the mail order pharmacy (up to a 90 day supply)..

Plan Offerings (continued)

Current Cost Sharing

- Represented employees pay 20% of plan cost. The County pays 80%
- Non-Represented employees pay 24% of plan cost. The County pays 76%.
- The County contribution to the High Option prescription plan is limited to the amount the County pays toward the cost of the Standard Option plan. Employees and retirees pay the difference between the County's Standard Option plan cost and the total cost of the High Option plan. As a result, High Option Prescription Plan participants pay as much as 46% of plan cost in 2011.

Projected Costs for 2012 Plan Year

- Medical and Prescription Drug plans are self-insured, except for the Kaiser Permanente Health Maintenance Organization (HMO) which is a fully insured program.
- Rates are set through an annual underwriting process that:
  - Projects claims and administrative expenses by plan
  - Projects enrollment/demographics
  - Adjusts for plan design changes, large claims, etc

Projected Costs for 2012 (cont.)

2012 Plan Year Projected Claims and Administrative Expenses

- Medical plans - $124 million
- Prescription Drug plans - $41 million
- Dental and Vision plans - $12 million

Projected Costs for 2012 (cont.)

- On average rates for 2012 are expected to increase by about 2%.
- Prescription drug plan rates are expected to increase by 7.5% - slightly below the 7.7% the underwriting trend projection.
- Carefirst POS plan costs are flat.
- Kaiser Permanente premiums rates are up 3.4%.
- UnitedHealthcare HMO costs are up 2.2%

Demographics

Active eligibility as of 8/1/2012

• Non-represented employees	1,801
• MCGEO OPT/SLT	4,805
• FOP	1,125
• IAFF	1,050
• Participating Agencies	562
➢ Total eligible	9,343

Demographics (continued)

Active enrollment as of 8/1/2012

- Current active enrollment – 7,822 (excluding outside agencies)
- Dependents covered – 16,224
- Active Opt-outs - 1,205. Opt outs include:
  - Employees with coverage elsewhere
  - Employees covered by a spouse who is a county employee or retiree

Demographics (continued)

Active enrollment as of 8/1/2012 (not including outside agency employees)

- Carefirst BlueCross Blue Shield Plans
  - Individual – 1,561
  - 2-party – 1,225
  - Family – 2,397
- Kaiser Permanente
  - Individual – 397
  - 2-party – 240
  - Family – 438
- United Healthcare
  - Individual – 412
  - 2-party – 374
  - Family – 778

Demographics (continued)

Retiree enrollment as of 8/1/2012

• Retirees	4,189
• Surviving Spouses	414
• Total	4,603

Wellness and Disease Management

Prior to FY 2011, the County offered a Wellness program through a third party vendor. The program was not integrated with health plans and there was no correlation between the program and medical plan outcomes. As a result, the County discontinued it contract and began working with health plan vendors regarding Wellness and Disease Management opportunities.

Health plans have evaluated the County plan experience and have suggest strategies to be discussed in upcoming labor negotiations.

Wellness and Disease Management

Health plans have offered to provide a “wellness budget” to assist the County in developing wellness initiatives and targeting disease management opportunities, including:

- Interventions to manage the higher than average prevalence of diabetics among the covered population.
- A comprehensive smoking cessation program
- Weight/diet management programs to address obesity in the workforce

Changes for 2012

This past spring, the County Council approved the following changes to the employee health plans effective 2012:

- Employees enrolled in an HMO will pay 20% of plan cost
- Employees enrolled in a POS plan will pay 25% of plan cost
- Employees enrolled in medical, dental, vision and prescription (except except Kaiser) will pay 25% of plan cost. Employees in the High Option prescription plan also pay the difference between the employer cost of the Standard Plan and the High Option plan.

Changes for 2012 (continued)

- The prescription plans will require use of generic medications where available. Employees who purchase brand name drugs that have a generic equivalent will pay the generic co-pay PLUS the difference between the cost of the brand name drug and its generic equivalent.

- The penalty will be waived if a plan participants physician certifies that there is a medical reason the patient must use the brand name drug.

- A quantity limit (6 pills at a retail pharmacies and 18 pills at the mail order pharmacy) will be put in place for drugs used to treat Erectile Dysfunction.

Questions

Montgomery County Government

Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area	Indemnity Plan (closed to new members)
Allergy Testing	$5 copay.	$5 copay Primary Care Physician; $10 copay Specialist.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	80% after deductible.
Deductible	Copay where applicable.	No Annual Deductible.	**High Option** - In network: none; Out-of-network: $300 individual; $600 family. **Standard Option** - Same as High Option	**High Option -** In network: none; Out-of-network: $250 individual; $500 family. **Standard Option** - Same as High Option	$200 individual deductible; $400 family deductible.
Diagnostic/Lab/X-Ray	Covered in full.	Covered in full. No Copayment.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	100% up to $500 for services related to an illness in a calendar year (there is a separate limit of $500 for services related to an accident in a calendar year); 80% for services in excess of the $500 limit for either an illness or an accident in a calendar year.
Dr. Office Visits	$5 copay.	$5 copay Primary Care Physician; $10 copay Specialist.	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible. **Standard Option -** In network: $15 copay; Out-of-network: same as High Option.	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible. **Standard Option -** In network: $15 copay; Out-of-network: same as High Option.	80% after deductible.
Emergency Room	$50 copay – waived if admitted to hospital.	$25 copay (plan definition of emergency must be met) – waived if admitted to hospital; $15 copay for Urgent Care Centers.	**High Option -** In network: $25 copay waived if admitted to hospital; Out-of-network: 80% after deductible. **Standard Option** – In network: $35 copay waived if admitted to hospital; Out-of-network: same as High Option.	**High Option -** In network: $50 copay, waived if admitted; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	Covered in full if life-threatening or accidental injury; 80% after deductible for illness.

Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area	Indemnity Plan (closed to new members)
Hearing Aids	Under age 18. Up to $1,400 per hearing aid for each hearing impaired ear every 36 months.	Under age 19 up to $1,400 per hearing aid for each hearing impaired ear every 36 months.	For minor children. One hearing aid for each hearing impaired ear once every 36 months. Up to $1,400 for each ear.	For minor children. One hearing aid for each hearing impaired ear once every 36 months. Up to $1,400 for each ear.	For minor children. One hearing aid for each hearing impaired ear once every 36 months. Up to $1,400 for each ear.
Hearing Screening	$5 copay for hearing exam (hearing aids are excluded).	$5 copay Primary Care Physician; $10 copay Specialist.	**High Option -** In network: childhood hearing screening covered in full; Out-of-network: childhood hearing screening, 80% not subject to deductible. **Standard Option** – Same as High Option.	**High Option -** In network: childhood hearing screening covered in full; Out-of-network: childhood hearing screening, 80% not subject to deductible. **Standard Option** – Same as High Option.	Not covered.
Home Health Care Services	Covered in full if medically necessary.	Covered in full. No copayment; 60 visit maximum for skilled care services per calendar year.	**High Option -** In network: covered in full (90 visits max/calendar year); Out-of-network: 80% after deductible (90 visits max/calendar year). **Standard Option** – Same as High Option.	**High Option -** In network: covered in full (40 visits per calendar year); Out-of-network: 80% after deductible (40 visits per calendar year). **Standard Option** – Same as High Option.	Covered in full; 40 visits maximum/calendar year.
Hospice	Covered in full.	Covered in full. (See coverage booklet for eligibility information.)	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	Covered in full; $5,000 maximum.
Hospital	Covered in full.	Covered in full.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – In network: covered in full after $150 copay per admission; Out-of-network: same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – In network: covered in full after $150 copay per admission; Out-of-network: same as High Option.	Covered in full; 180 day maximum per confinement.
Immunizations	$5 copay. Included in well child care visits up to age 5 at no charge.	$5 copay Primary Care Physician	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full when billed with office visit; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	Maximum $15 per immunization ($45 per calendar year maximum per member); balance paid at 80% after deductible.

Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	**POS High and Standard Option Plans Out of Area**	**Indemnity Plan (closed to new members)**
In vitro Fertilization	Limited to 3 attempts per live birth. Lifetime maximum of $100,000.	Limited to 3 attempts per live birth. Lifetime maximum of $100,000.	Limited to 3 attempts per live birth. Lifetime maximum of $100,000.	Limited to 3 attempts per live birth. Lifetime maximum of $100,000.	Limited to 3 attempts per live birth. Lifetime maximum of $100,000.
Mammography - Preventive Screening Schedule	Schedule consistent with the current recommendations of the American College of Physicians.	Covered in full. Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year.	**High Option** – Covered in full. Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year. **Standard Option** - Same as High Option	**High Option** – Covered in full. Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year. **Standard Option** - Same as High Option	Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year.
Maternity	Covered in full once pregnancy is diagnosed.	No copayment applies after the first visit.	**High Option** - In network: first visit 100% after $10 copay; other visits 100%; Out-of-network: 80% after deductible. **Standard Option** – In network: first visit 100% after $30 copay; other visits 100%; Out-of-network: same as High Option.	**High Option** - In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – In network: first visit 100% after $30 copay; other visits 100%; Out-of-network - Same as High Option.	100% up to amount allowed by plan.
Maximum Lifetime Benefit	Unlimited Maximum.	Unlimited Maximum.	**High Option** - Unlimited Maximum. **Standard Option** - Same as High Option	**High Option** - Unlimited Maximum. **Standard Option** - Same as High Option	Individual: Unlimited Maximum for major medical services.
Out-of-Pocket Annual Maximum	N/A	$1,100 per individual up to a cap of $3,600 for a family	**High Option** - Per Individual: $1,000 plus the annual deductible. **Standard Option** - Same as High Option	**High Option** - In network: Individual: $1,000 plus the annual deductible; Family: $2,000 plus the annual deductible; Out-of-network: Individual: $2,000 plus the annual deductible; Family: $4,000 plus the annual deductible. **Standard Option** - Same as High Option	Individual: $1,000 plus the annual deductible; Family: $2,000 plus the annual deductible

Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area	Indemnity Plan (closed to new members)
Physical	$5 copay.	$5 copay Primary Care Physician;	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible (limit 1/calendar year). **Standard Option -** In network: $15 copay Primary Care Physician; $30 copay Specialist; Out-of-network: same as High Option.	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible (limit 1/calendar year). **Standard Option -** In network: $15 copay Primary Care Physician; $30 copay Specialist; Out-of-network: same as High Option.	Up to $75/exam every 2 years - employee and spouse only; balance is paid at 80% after deductible.
Prescriptions	**Kaiser Rx Plan (included with Kaiser HMO medical plan):** $5 at on-site pharmacies and for mail order; $15 at participating community pharmacies.	**No Rx Plan included; diabetic supplies covered under a pharmacy rider.**	**High and Standard Option – No Rx Plan included; diabetic supplies covered under a pharmacy rider.**	**High and Standard Option – No Rx Plan included; diabetic supplies covered under a pharmacy rider.**	80% after deductible. Prescription discount program included with mail order feature.
Rehabilitation Services	Inpatient: Covered in full (Unlimited). Outpatient: $5 copay; outpatient services for physical therapy are limited to up to 30 visits; occupational and speech therapy per injury, incident or condition are covered for a period not to exceed 90 days.	$10 copay/visit. 60 combined visits per year (short-term non-chronic conditions only).	**High Option -** In network: 100%; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	80% after deductible.

Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area	Indemnity Plan (closed to new members)
Skilled Nursing Facility	Covered in full; 100 days maximum.	Covered in full 60 days per calendar year maximum.	**High Option -** In network: covered in full (100 days max/calendar year); Out-of-network: 80% after deductible (100 days max/calendar year). **Standard Option -** Same as High Option	**High Option -** In network: covered in full (60 days max/calendar year); **Standard Option** – Same as High Option.	$30/day, up to 360 days per calendar year; $10,800 calendar year maximum.
Specialists	$5 copay.	$10 copay.	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible. **Standard Option -** In network: $30 copay; Out-of-network: same as High Option.	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible. **Standard Option -** In network: $30 copay; Out-of-network: same as High Option.	80% after deductible.
Substance Abuse/Mental Health	Inpatient: Covered in full; Outpatient/ individual visits: $20 copay per visit; group visits: $10 copay per visit.	Inpatient: Covered in full; Outpatient visits: 1-5 20% copay; 6-30 35% copay; 31+ 50% copay. $10 copay per visit for Medication management office visit. $25 copay up to 60 days per calendar year for Partial Hospitalization	**High Option -** In network: Inpatient- covered in full; Outpatient- visits 1-5 100%; 70% thereafter; Out-of-network: Inpatient- 80% after deductible; Outpatient- 80% first 5 visits; 65% next 25 visits; 50% each thereafter (all outpatient visits subject to deductible). **Standard Option** – Same as High Option.	**High Option -** In network: Inpatient – covered in full; Outpatient- visits 1-5 100%; visits 6-30 80%; 31+ 50%; Out-of-network: Inpatient- 80% after deductible; Outpatient- visits 1-5 80%; visits 6-30 65%; visits 31+ 50% (all outpatient visits subject to deductible). **Standard Option** – Same as High Option.	Inpatient- 100% to 180 days (lifetime maximum does not apply); Outpatient- 80% after deductible.
Surgery	Covered in full.	Inpatient: covered in full; Outpatient: $25 copay.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	100% up to amount allowed by plan.

Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area	Indemnity Plan (closed to new members)
Vision (Routine)	$5 copay for exams; 25% discount on lenses/frames at Kaiser centers; 15% discount off the cost of contact lenses.	$25 copay/exam; 15%-20% discount through participating optical centers.	**High Option -** In network: refraction not covered; (pediatric visual screening - covered in full under well child care). Out-of-network: refraction not covered (pediatric visual screening - 80% not subject to deductible under well child care). **Standard Option** - Same as High Option	**High Option -** In network: refraction not covered (pediatric visual screening – covered in full under well child care); Out-of-network: refraction not covered (pediatric visual screening – 80% not subject to deductible under well childcare). **Standard Option** - Same as High Option	None.
Well Child Care	Well baby/well child covered in full up to age 5.	$5 copay Primary Care Physician	**High Option -** In network: $10 copay; Out-of-network: 80% not subject to deductible (up to age 18). **Standard Option** - In network: $15 copay; Out-of-network: same as High Option.	**High Option -** In network: $10 copay; Out-of-network: 80% not subject to deductible (up to age 18). **Standard Option** - In network: $15 copay; Out-of-network: same as High Option.	100% for child wellness (including related lab tests and X-rays) up to age 18.

Note: This comparison is to be used as a guide only and not as the benefits offered. Consult the individual plan booklets for complete information. *(Rev. 9/10)*

The Maryland-National Capital Park and Planning Commission
September 6, 2011

Agency Mission / Responsibilities / Governance Structure

The Commission is a corporate body of the State of Maryland established by the Maryland General Assembly in 1927 under Article 28 of the Maryland Code. The Commission is a bi-county agency serving both Montgomery and Prince George's Counties. It is empowered to acquire, develop, maintain and administer a regional system of parks in the defined Metropolitan District in Montgomery and Prince George's Counties, and to prepare and administer a general plan for the physical development of a defined Regional District for the two Counties. The Commission also conducts the recreation program for Prince George's County.

There are 7 Departments:

1. Planning – Montgomery County
2. Parks – Montgomery County
3. Planning – Prince George's County
4. Parks & Recreation – Prince George's County
5. Finance (bi-county)
6. Legal (bi-county)
7. Human Resources (HR) (bi-county) – the Executive Director also serves as the HR Department Head

Employee & Retiree Population

TYPE	Eligible EEs	Enrolled in Medical	% Enrl	Enrolled in Prescription	% Enrl
Actives	2036	1827	68%	1298	49%
MCGEO				485	18%
FOP - Represented	162				
NonRepresented & MCGEO	1874				
Retirees <Age 65		383	14%	392	15%
Retirees – Medicare Eligible		442	17%	476	18%
COBRA		12	0%	10	0%
LTD EEs Eligible for Medicare		13	0%	9	0%
TOTAL	2036	2677	99%	2670	100%
% of the employees not enrolled in the plan			10%		13%

EEs = employees
MCGEO is only separated in the prescription plan due to slightly different plan designs
These numbers are taken from M-NCPPC system generated reports.

Dependents Covered
The Human Resources information system does not allow easy access to the number of dependents who are enrolled in the medical and prescription plans. However, the medical and prescription vendors have been able to provide the following enrollment numbers for their plans:

Employee Group Enrollment	Care-mark Rx	CIGNA EPO	UHC EPO	UHC POS	UHC Medi-care	Total Medical
Employees & Retirees	2,683	403	670	1,275	357	2,705
Spouses	1,417	206	180	279	145	810
Dependents	1,629	262	623	1,381	4	2,270
Total Members	5,729	871	1,473	2,935	506	5,785

Medical Plans
M-NCPPC offers the following medical plans:
UHC POS (Point of Service)
UHC EPO (Exclusive Provider Organization)
CIGNA EPO (Exclusive Provider Organization)

All three medical plan are 'open access' which means that a participant is not required to have a referral from the primary care physician (PCP) to seek the services of a provider specialist (a doctor who focuses on a limited area of expertise such as a cardiologist or pulmonologist).

None of the medical plans has a prescription benefit in the plan. There is a separate prescription plan.

The MCGEO collective bargaining agreement (CBA) includes an agreement that the Commission will offer a POS and two HMOs. Since the EPOs are basically HMOs without the need for referrals, the Commission currently meets the CBA requirements.

There are some differences in some copays between the plans and some coverages, such as the following brief summary of similarities and differences:

	UHC POS	UHC EPO	CIGNA EPO
COPAYS			
General Copay	$10	$10	$10
Specialist Copay	$10	$10	$10
Emergency Room	$35	$25	$35
Urgent Care	$10	$10	$35
DEDUCTIBLES			
In-network	None	None	None
Out-of-network	Ind $250 2 Mbr $500 Fam $600	N/A	N/A
OUT OF POCKET (OOP) MAXIMUMS	Ind $600 2 Mbr $1,200 Fam $1,800 Combined both in & out of network	Ind $1,100 Fam $3,600	Ind $1,500 Fam $3,000

Prescription Plan
The Commission's prescription plan is administered by Caremark, a third party vendor. Employees and retirees can choose to have medical only, prescription only or both. There are several management programs that are currently offered in the M-NCPPC prescription plan to include:

#	Program	Program Goal / Brief Description
1	Point of Sale Safety Review and concurrent Plan Design Edits	To check for serious drug interactions
2	Safety & Monitoring Solutions	a) to identify patterns of potential overuse and misuse including multiple prescribers &/or multiple pharmacies & notify prescribers by mail; b) to evaluate potential fraud, waste or abuse and take appropriate steps
3	Enhanced Safety & Monitoring Solution	Provides continued monitoring, prescriber & participant intervention, special investigation, case mgt and consultative services. Estimated ROI is 1:1, but all facets of the program have not been adopted by M-NCPPC at this point. Other levels include hourly consult of visit features.

#	Program	Program Goal / Brief Description
4	Comprehensive Generic Solutions	To determine generic substitutions and make notification that may have a negative impact on a participant
5	ExtraCare Health Card	Provide 20% discount on > 1,300 CVS store brand items eligible for FSA reimbursement
6	Specialty Guideline Mgt	Evaluate the appropriateness of drug therapy for specialty medications according to evidence based guidelines both before initiation or therapy and on an ongoing basis. Outreach is made to participants
7	Specialty Pharmacy	To optimize specialty therapy outcomes through personalized outreach & support for participants and prescribers. A pharmacist/nurse-led CareTeam is assigned to specialty patients
8	Drug Savings Review	To review long-term retail & mail drug histories of participants and identify situations in which CVS/Caremark pharmacists can assist prescribers in selecting the most appropriate medications
9	Prior Authorization / Appeals	To ensure safe, effective and appropriate use of selected drugs. Evidence-based criteria must be met for a drug override.
10	Enhanced Gaps in Care Pharmacy	Identifies potential high-risk plan participants, using pharmacy data through disease-specific clinical algorithms. A pharmacist reviews the participant profiles, monitors over- or under-utilization and contacts the prescriber if necessary. Estimated ROI is 1:1.

Most of these programs are what Caremark considers "Core" programs, which are included in the administrative fee charged by Caremark. The core programs do not have a return on investment.

The following sections on UnitedHealthCare and Caremark provide some information on the types of programs that are offered. Some of these programs require a signed contract before services can begin. For some programs the draft contracts are being reviewed.

CIGNA

CIGNA offers a number of programs at no cost to M-NCPPC such as:

- 24 hour health information line
- Well Aware Disease management programs

- Lifestyle Management Programs (stress, weight & quit smoking)
- Health assessments
- Online coaching programs
- Healthy Babies program
- Health Rewards Programs (some cost if cash incentives are used)

The low cost programs include:

- On-site lunch and learns
- On-site flu shots - $25 for non-CIGNA enrolled employees – Employees with CIGNA coverage would go through the CIGNA claim system
- On-site wellness seminars
- Offer pedometers to employees who might want to be in a walking club
- $25 gift cards to employees that take the Health Asseessment

UnitedHealthCare (UHC)

M-NCPPC's Total Population Management solution with UHC includes disease management, case management, inpatient care management, a NurseLine available 24/7, notification of complex medical conditions, and wellness.

UHC's disease management program focuses on the following:

- Coronary artery disease
- Diabetes
- Heart failure
- Asthma
- COPD
- Low back pain

The program provides a whole-person approach to disease management that includes behavioral health and co-morbidity management. The program is based on national guidelines and evidence-based medicine and is designed to improve the quality of care, lower cost of care, and ensure a personalized member experience and maximize purchasers' investments. The program strives to reduce variation in clinical quality and cost through improved patient self-management, and through guidance to quality and efficiency designated physicians, networks and clinical programs (and UnitedHealth Premium providers and facilities where appropriate).

The case management component provides access to collaborative and member-focused programs that leverage transitional case management, condition management and Complex Case Management to assist high-cost, high-risk members manage their conditions and care. These programs involve the process of identifying those at risk, assessing health care needs, planning and executing outcome-based care decision support that will ultimately change behavior to impact the quality and affordability of the health care experience. It focuses on engaging members who have a significant impact on medical spend through a wide array of methods, regardless of condition, including high-cost claimant triggers, and predictive modeling.

UHC also offers a suite of programs for Complex Case Management that identifies leading health care providers and guides members to them for care to promote better patient outcomes and significant cost savings for customers. Carefully chosen Centers of Excellence (COE) networks span across the nation bringing together the best physicians and clinics in areas such as organ transplantation, kidney disease, congenital heart, and cancer care. Specialty case managers work directly with members for transplantation, oncology, kidney disease, and bariatric surgery. COE facilities and UnitedHealth Premium providers, combined with case management, result in members being treated by experienced, knowledgeable physicians; and better care leads to shorter hospital stays, higher success rates, faster recoveries and lower costs.

NurseLine provides members with access to registered nurses to drive better health outcomes. Members receive access to symptom decision support, evidence-based health information, as well as education and medication information that improves care-seeking behavior, helps avoid unnecessary emergency room visits and reduces absenteeism. These nurses serve as a navigational hub, referring members to high-quality providers and other available care management programs as appropriate.

Caremark

Caremark has a variety of clinically based programs in place with M-NCPPC's Plan that are designed to generate cost savings for plan participants with several of the high cost conditions listed above. Caremark's programs to manage pharmacy costs, with a focus on high cost and chronic disease, include the following:

- **Utilization Management:** Programs involving real-time and retrospective comprehensive screening of prescriptions against patient history to help encourage adherence to basic safety protocols and to alert pharmacists, members and their physicians to important cost and safety issues that could ultimately avoid high cost drug events and hospitalizations. Caremark provides several levels of drug utilization review from concurrent review (such as, drug interactions, refill too soon, duplicate therapy, excessive dosing, under-utilization) to retrospective review. It also provides dose optimization services to promote single daily dose regimens in place of multiple daily dose regimens when clinically appropriate.
- **Specialty Guideline Management and Exclusive Specialty Network:** An evidence-based guideline program to evaluate the appropriateness of drug therapy for specialty medications before therapy is initiated, and on an ongoing basis. M-NCPPC has an exclusive specialty network that provides lower costs through better pricing and through waste/inventory/dose management. The controls in a specialty network environment also help to improve clinical outcomes through enhanced support and outcomes reporting. Some of the high cost conditions noted above fall under this program such as pulmonary arterial hypertension.
- **Generic Solutions:** M-NCPPC provides members targeted generic alternative messages informing those taking single source, non-preferred medications of less expensive generic alternatives. This promotes the use of generics and ultimately saves the plan and members money on the cost of treatment of many chronic conditions such as diabetes.

M-NCPPC also participated in Caremark's **AccordantCare™** program (now managed by Alere, a third party vendor). The disease management program focused on the following conditions, many of which are included on M-NCPPC's chronic/high list.

- Adult asthma
- Coronary artery disease
- Chronic obstructive pulmonary
- Diabetes
- Heart Failure
- Peptic ulcer disease

AccordantCare™ provides disease management services for rare and chronic conditions. The program strives to motivate participants with chronic conditions to take a more proactive role in their healthcare to achieve optimum results through regular nurse-based counseling.

Real-time pharmacy data is incorporated into the disease management program to help enable reaching out to at-risk participants early in the process when they are more receptive to making lifestyle changes. This positively impacts the outcomes before participants develop costlier high-risk conditions. Real-time pharmacy access also provides for increased opportunities to improve medication adherence and lower drug costs by counseling members about prescription benefit design, and cost saving tips.

For 2009, the The AccordantCare™ program provided as estimate of approximately $300,000 in savings to the M-NCPPC plan. M-NCPPC has also experienced a significant decrease in hospitalizations and ER visits for members enrolled in Caremark's disease management programs, compared to pre-enrollment statistics. Reductions in these two areas lead to lower costs for treating conditions. There are no hard data constructs or return on investment to support the estimated savings.

This program was just recently discontinued because the new approach by Alere was to incorporate medical data with pharmacy data. Since M-NCPPC was not providing this data, the success of the program was significantly lowered. Additionally a separate contract was required between M-NCPPC and Alere and M-NCPPC needs sufficient time to review the feasibility of providing this scope of work to a vendor without the bidding process. Instead M-NCPPC has been pursuing contractual agreements with Caremark and the medical vendors, to provide prescription feeds to each of the medical vendors so case management can be handled by the medical plans. Although it is possible that M-NCPPC could provide medical feeds to Caremark, at this point there is not a strong economic reason to do so.

There are other clinical programs offered by Caremark that are currently under review to help manage utilization and appropriate care for participants.

Significant Changes for Calendar Year 2012

The Commission is anticipating rate increases this year in part due to some increased claims experience. Plan design is also being reviewed to determine if any programs offered by the

medical and prescription vendors can be implemented to help participants in the treatment and drug therapy programs. Currently nothing has been presented to the Department Heads and Commissioners for their review. The Commission will have a later than normal open enrollment season in order to more fully explore options on containing costs.

APPROVED SEPTEMBER 13, 2011

Minutes
Task Force on Employee Wellness and Consolidation of Agency Group Insurance

Tuesday, September 6, 2011
DHHS 401 Hungerford Road - Tan Conference Room

The meeting was called to order by Task Force Chair William (Bill) Mooney at 8:05 a.m.

Introductions

Chair Mooney asked those Task Force members not able to attend the July meeting to introduce themselves.

Approval of Minutes

The minutes from the July 21, 2011 meeting were approved without objection

Presentation – Office of Legislative Oversight (OLO)

Aron Trombka of OLO provided an overview of the trends in projected tax supported revenues and expenditures that are used to fund county agencies. The projections are based on current tax rates and economic conditions and no changes salaries and programs. The gap is driven by costs that are increasing faster than revenues such as pension and group insurance costs.

The OLO slides focus on two agencies: County Government and Montgomery County Public Schools (MCPS) because they account of the majority of expenditures. Average increases for group insurance for County Government and MCPS have been about 10% over the past decade. These increases have not been driven by increases in employees. Mr. Trombka noted that these increases are not unique to Montgomery County. The costs on chart #3 are employer costs only.

It was noted that the chart on slide #1 shows no gap between revenues and expenditures in FY12 because the county is required to approve a balanced budget.

Craig Howard of OLO reviewed some the changes that the agencies have made in order to balance the FY12 budget including program cuts, elimination of positions, salary and wage freezes, and changes to employee benefits. County Government increased the share of premium costs paid by active employees, changes to the prescription drug plan, and eligibility and cost share for retiree health benefits. MCPS changed eligibility and cost share for retiree health benefits as did Montgomery College.

Request for Comment from Guests

Chair Mooney asked if any of the visitors had comments. Councilmember Leventhal thanked everyone for serving on the Task Force and emphasized that he is interested in bringing down the cost of health insurance without harming employees. He clarified that while County Government has done some things, in this past budget, the action was to shift costs rather than reduce the cost of insurance.

Presentation – Montgomery County Government

Mr. Wes Girling, County Government Office of Human Resources provided the Task Force with an overview of health plan offerings and demographics. Two handouts were provided.

Mr. Girling noted that the agencies have bundled their RFPs for health care together to get bids that leverage economies of scale. This did not include creating a common plan but did try to lower the costs of administration.

Group insurance benefits are subject to collective bargaining for most County Government employees. Benefits are bargained separately with each of the three unions. Some of the differences in plan design are a function of collective bargaining.

The plan offerings across the agencies are similar but there are differences. County Government offers point of service plans from BlueCross BlueShield, two health maintenance organization (HMO) options – Kaiser Permanente and United Health Care. Three point of service prescription drug plans are offered through Caremark, with different premium costs, co-pays, and employee/employer share. Prescription is included in the Kaiser HMO. OHR wants to encourage employees to really look at which plan is best for them but there are probably many employees taking the high option plan that should be in the standard plan

All plans, with the exception of Kaiser Permanente, are self-insured. The County Government is at risk for the claims in the plans, although it does carry some catastrophic insurance. The County pays the companies an administrative fee.

The County Government expects group insurance to cost $124 million for medical, $41 million for prescription drugs, and $12 million for dental and vision this fiscal year. These are total expenses for both employer and employee (It includes administrative costs for the health care companies but not County Government staff.) Prescription drug costs are expected to continue to increase in part because of new bio-tech drugs that can be very helpful but very expensive. On average, the County Government is expecting rates for group insurance to increase by about 2% for 2012, in part because there has been a reduction in large claims.

To the extent that the agencies are offering the same vendors, by jointly bidding, the county is probably already getting the savings from economies of scale with regard to administration. If the new cost share structure changes which plans employees select, administrative costs may decrease for one plan and increase for another depending on the numbers that move into and out of the plans.

As of August 2011, County Government had 7,822 active enrollees and 16,224 covered dependents. There are 1,205 potential enrollees who are active opt-outs. Most are enrolled in Carefirst BlueCross BlueShield. There are 4,189 retirees and 414 surviving spouses covered. Once a retiree is eligible for Medicare, it becomes the primary coverage.

Mr. Girling was asked how the cost of Medigap coverage compares to the cost of standard coverage. He responded that Medicare does bring down the cost but there is cross-subsidy in the setting of the rates. The Task Force asked for more information on the rates paid by non-Medicare eligible retirees and Medicare eligible retirees. If there was not a cross-subsidy, the rates for non-Medicare eligible retirees would go up and the rate for Medicare eligible retirees would go down. Councilmember Leventhal noted that the County Government has made a decision to have a cross subsidy; however, MCPS has said that they have lowered costs both by steering people to health maintenance organizations and employee wellness programs and because they do not have the same cross subsidy that County Government does. Mr. Girling noted that the County Government looked at this issue last year and there is about $7 million in cross subsidy, about 10% ($700,000) would be a cost to the county.

In response to a question about opting-out, Mr. Girling said that employees and retirees are allowed to opt-out but must show that they have continued health insurance that is similar to county coverage in order to opt back in.

County Government has not done a tremendous amount when it comes to wellness programs. County Government has a high prevalence of diabetics and need to address obesity in the workforce.

Mr. Girling reviewed the recent changes for 2012 which are included on slides #17 and #18.

Ms. Fidler asked whether the County Governments has looked at the cost of the Obama Healthcare Plan. Mr. Girling said that the inclusion of dependents up to age 26 increased the number of people covered by 700-800 people; however, this cohort is generally healthy so cost were not significant. The task Force discussed the issue of a “grandfathered” plan and that plans do not have to change certain things if they are “grandfathered.” Mr. Girling said that for 2011 the County Government is “grandfathered” and it is looking at whether it will be “grandfathered” for 2012. Ms. Riar asked whether the County can access any of the Federal money that has been awarded to the states. She also noted the State Health Quality and Cost Council that has been looking at wellness issues. Mr. Girling said the County did file a claim under the Federal

early retiree program but it is not clear whether the County will get a payment. Mr. McTigue said he would like to see some further work done on the issue of retiree cross-subsidy.

Presentation – Maryland-National Capital Park and Planning Commission

Ms. Jan Lahr-Prock, Office of Human Resources, Maryland-National Capital Park and Planning Commission (M-NCPPC) provided an overview presentation. A handout was provided.

M-NCPPC has 2,677 employees and retirees enrolled in medical and 2,670 enrolled in prescription. About 10% of employees have opt-ed out of medical and about 13% have opt-ed out of prescription. In regards to opting in and opting-out, M-NCPPC has a 36 month rule; a retiree or employee must show us that they have had coverage for the past 36 months similar to what M-NCPPC offers in order to opt back in.

With regards to Healthcare Reform, M-NCPPC did have some dependents come back into the system because of the age increasing to 26 but it was not significant.

M-NCPPC offers a United Healthcare point-of-service plan, and United Healthcare Exclusive Provider Organization (EPO), and a Cigna EPO. An EPO is like a HMO but without the need for a referral. There is also a Cigna Medicare supplemental plan. The cost of this plan has been flat for several years. This plan is separately cost out.

The current cost split is 85% paid by the employer and 15% paid by the employee.

Ms. Lahr-Prock described the prescription plan coverage and the different costs for co-pays for retail and mail order.

Ms. Lahr-Prock said that in 2014 insurance exchanges will have to be in place and employers are going to have to offer coverage. M-NCPPC may look at requiring spouses to take insurance through their employer. She noted that people generally think of cost-shifting as just between employee and agency but it can also be shifting to another employer or another program.

M-NCPPC is looking at all the programs offered by the carriers it uses, as it may not be taking full advantage of programs vendors have because M-NCPPC has to proactively say it wants them. Some programs are free and some have an additional charge.

M-NCPPC does penalize (monetarily) people if they get more than 3 refills at retail because it wants them to use mail order which has better prices. M-NCPPC is looking at reducing this to two refills.

M-NCPPC is going to give prescription data to its medical carriers so that medical carriers can better case manage patients to make sure they are taking medications.

It was clarified that the cost split is 85% 15% for both active employees and retirees. M-NCPPC is looking at changing this for retirees and possibly for active employees.

Comments from Chair/Discussion

Chair Mooney told the Task Force that they can provide follow-up questions by e-mail to the agencies or to staff. Mr. McTigue asked for some additional information regarding the request to AON Hewitt. At the next meeting their will be presentations from MCPS and Montgomery College. We will also be discussing splitting into the two committees to look at wellness and consolidation of agency plans.

Meeting adjourned at 9:25 a.m.

Attendees:

Task Force Members:

Sue DeGraba	Montgomery County Public Schools (MCPS)
Karen DeLong	AFSCME Local 2380
Joan Fidler	Public Member
Erick Genser	IAFF Local 1664
Denise Gill	FOP Lodge 35
Wes Girling	Montgomery County Government
Lee Goldberg	Public Member
Paul Heylman	Public Member
Tom Israel	MCEA
Rick Johnstone	MCPS
Jan Lahr-Prock	Maryland-National Capital Park and Planning Commission
Mark Lutes	Public Member
Brian McTigue	Public Member
Edye Miller	MCAAP
William Mooney	Public Member (Chair)
Richard Penn	AAUP
Farzaneh Riar	Public Member
Carole Silberhorn	Washington Suburban Sanitary Commission
Ulder Tillman	Montgomery County Government
Lynda von Bargen	Montgomery College
Michael Young	FOP Lodge 30

Alternates:
Amy Millar (for Gino Renne) MCGEO
Karen Bass (with Lynda von Bargen) Montgomery College

Guests:
Councilmember George Leventhal
Richard Romer, Staff to Council President Ervin
Patty Vitale, Chief of Staff to Councilmember Leventhal

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