KEEPING LAwell
City of Los Angeles Employee Benefits

Joint Labor-Management Benefits Committee (JLMBC)
COMMITTEE REPORT 24-05

JLMBC MEMBERS:
Employee Organizations
David Sanders, Chairperson
Marleen Fonseca, First Prov. Chairperson
Chad Boggio
Esteban Lizardo
Lisa Palombi

Management
Dana Brown**, **Vice-Chairperson
Tony Royster, Second Prov. Chairperson
Matthew Rudnick
Matthew Szabo
Holly Wolcott

Date: January 4, 2024

To: JLMBC

From: Staff

Subject: **Medical Plans Survey**

DISCUSSION

A. Background

At its July 6, 2023 meeting, the JLMBC heard report 23-27 regarding Medical Insurance Plan Options for Plan Year 2025 which outlined multiple options for either continuing current health plan agreements or executing a Request For Proposals (RFP). The JLMBC approved a recommendation to create a new Ad-Hoc Medical Plan Subcommittee for development of a recommendation. The overall objective of the ad hoc is to look at the large array of rising cost factors and to weigh the possible changes which may have an impact in reducing health plan premiums. The ad hoc was ultimately tasked with making a recommendation to the full JLMBC on whether to issue a new Medical RFP or to continue the existing contract.

At its November 2, 2023 meeting, the JLMBC heard report 23-39 (**Attachment A**) regarding a Recommendation to Begin Drafting a Medical Plans RFP. The report outlined the discussion that the Ad-Hoc Medical Plan Subcommittee had and the items and options the subcommittee reviewed. The report also recommended the JLMBC approve of the Ad-Hoc Medical Plan Subcommittee to perform surveys and outreach as necessary with City employees and their dependents to develop a Request For Proposals for Medical Plans requesting multiple plan design options and alternative medical plan types. The JLMBC approved the recommendation of the report.

B. Medical Plans Survey

Following the November 2, 2023 meeting, staff and the LAwell Programs consultant Keenan, began work on developing a survey. In order to determine the main focus of the survey, focus groups were held to gather general feedback from LAwell members. A focus group is a meeting of, typically, a small number of people led by a moderator where open-ended questions are posed to the group. Keenan moderated these conversations and held six (6) different focus group sessions; three (3) virtually and three (3) in person at City worksites. The virtual focus group sessions were very well attended with approximately 15-20 persons in each session. The in-person focus group sessions had one (1) to five (5) persons attend each session. All six (6) sessions were held during the first week of December 2023.

Keenan noted that the overwhelming theme from these focus groups was that the participants were very satisfied with their current health plan coverage and not interested in any change at all. Very few participants noted a desire to experience any changes, and out of those who did, they generally noted wanting to receive more benefit without any increased costs.

The results of the focus group feedback helped shape the survey questions to focus more on identifying how employees would react and adjust to small changes in their medical plan options. These questions also strive to better assess the education of members in regards to their current health plan. The survey questions are included in **Attachment B**. This survey was released City-wide via email on December 28, 2023. Employees who take the survey will be required to answer every question. However, the majority of questions have an '*unsure*' or '*decline to answer*' option. These two options were included so members would be required to provide answers to all questions, but not deter completion of the survey if they did not want to answer a question for whatever reason. The goal of this strategy is to obtain survey results comprising the most honest answers possible and satisfying survey participation experience. Through testing, the online survey took between five (5) and 10 minutes to complete. The survey is completely anonymous. Members who complete the online survey will see a link at the end of the survey taking them to a separate webpage where they can enter a raffle to win a gift card as a reward for their completion of the survey. However, the value of the gift card would need to be reported as taxable income on the winners W-2 and the winners would need to sign an acknowledgement of this tax reporting requirement before receiving their prize.

In addition to the City-wide email notification, staff mailed a postcard to all 26,000 LAwell members (**Attachment C**) to reach employees who may not have a working email address. In addition to the online survey, members can request a paper survey by calling 213-978-1621 and leaving a voicemail requesting the paper survey mailed to their provided mailing address. The paper survey format is included in Attachment B, which can also be provided directly to any member. Staff has asked labor unions and associations to assist in notifying their members about this survey.

The survey will be open through Wednesday, January 17, 2024. Online surveys must be completed and submitted by that date and paper surveys should be mailed with a postmark by that date. All received responses to the survey will be compiled and reported to the JLMBC at its February 1, 2024 meeting along with the Ad-Hoc Medical Plan Subcommittee recommendation regarding a Medical Plan RFP.

Submitted by: ______________________________________

Paul Makowski, Chief Benefits Analyst

ATTACHMENT A

Joint Labor-Management Benefits Committee (JLMBC)
COMMITTEE REPORT 23-39

JLMBC MEMBERS:
Employee Organizations
David Sanders, Chairperson
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Lisa Palombi

Management
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Tony Royster, Second Prov. Chairperson
Matthew Rudnick
Matthew Szabo
Holly Wolcott

Date: November 2, 2023

To: JLMBC

From: Medical Plan Ad-Hoc Subcommittee and Staff

Subject: **Recommendation to Begin Drafting a Medical Plans RFP**

RECOMMENDATION

That the JLMBC approve the recommendation from the Medical Plans Ad-Hoc Subcommittee to (a) perform surveys and outreach as necessary with City employees and their dependents and to (b) develop a Request For Proposals for Medical Plans requesting multiple plan design options and alternative medical plan types.

DISCUSSION

A. Background

At its July 6, 2023 meeting, the JLMBC heard report 23-27 regarding Medical Insurance Plan Options for Plan Year 2025 which outlined multiple options for either continuing current health plan agreements or executing a Request For Proposals (RFP). The JLMBC approved a recommendation to create a new Ad-Hoc Medical Plan Subcommittee for development of a recommendation. The overall objective of the ad hoc is to look at the large array of rising cost factors and to weigh the importance of changes which may have an impact in reducing health plan premiums. The ad hoc was ultimately tasked with making a recommendation to the full JLMBC on whether to issue a new Medical RFP or to continue the existing contract. Report 23-27 is attached for reference as **Attachment A**.

B. Ad-Hoc Medical Plan Subcommittee Review Items

The Ad-Hoc Medical Plan Subcommittee consists of two members: David Sanders (Shauna Janeway as alternate) representing Labor and Matt Szabo (Paul Girard as alternate) representing Management. The Ad-Hoc Medical Plan Subcommittee met multiple times to discuss and identify a list of items for review which are in line with the objective of revising Medical Plan design. Through their discussions with staff and the LAwell Programs consultant Keenan and Associates, it was identified that a very large number of items can have an impact, directly or indirectly, on health plan premium rates.

The following items were identified as priorities by the Ad-Hoc Medical Plan Subcommittee to discuss further:

ITEM #	ITEM DESCRIPTION
	Overall enrollment and population size
1	- Perform a Dependent Eligibility Verification Audit
2	- Revise dependent Enrollment requirements
3	- Revise LAwell Eligibility rules *3a - Allow for coverage on "day one" of employment* *3b - Alter hours rule* *3c - Extend coverage to as-needed/intermittent employees* *3d - Remove "honor" system associated with Life Events* *3e - Change Life Event reporting window*
4	- Change Cash in Lieu incentive.
	Benefit Coverage/Plan Design changes
5	- Narrow Network vs Full Network
6	- Weigh the importance of provider loss
7	- Unbundle
8	- Change medical plan design *8a. - Consider adding (or increasing for PPO) a deductible* *8b - Consider increasing copay, or varying copay structure* *8c - Consider changing/applying co-insurance*
9	- Consider adding new plan options *9a - High Deductible Health Plan (HDHP)* *9b - Exclusive Provider Option (EPO) instead of PPO* *9c - Point of Service (POS) instead of PPO*
10	- Annual physical/preventative service use *10a - Requirement or incentive?*
11	- Changing Prescription Drug Benefits? *11a - Audit or Pharmacy Benefits Manager (PBM) oversight*
	Fiscal/Financial changes
12	- Participating Contract concept *12a - Reserve accumulation – Section 115 account*
13	- Pooling Point analysis
14	- Capitation Audits
15	- Discuss changing City subsidy maximum authority. *15a - Ad Code – Non-represented EE's* *15b - All other MOU's have the same language*
	Other changes
16	- Contractual changes to condition management performed by each carrier, perhaps rate guarantees/service level agreements.

These above items have different paths and options to consider when applying to the Ad-Hoc Medical Plan Subcommittee's objective of lowering premium costs. For the most part, the Ad-Hoc Medical Plan Subcommittee categorized the above list in the following way:

I. *RFP items*

The following items, as currently discussed and reviewed, would primarily require a RFP process to be executed in order to achieve any change.

- Item #5 : Narrow Network vs Full Network
- Item #6 : Weight Importance of provider loss
- Item #7 : Unbundle
- Item #8 : Change Medical Plan Design
- Item #9 : Consider adding new Plan options
- Item #10: Annual Physical/Preventive Service*
- Item #11: Changing Prescription Drug Benefits*

II. *Contract items*

These items can mainly occur through existing contract negotiation

- Item #12 : "Participating Contract" concept
- Item #13 : Pooling Point analysis
- Item #14 : Capitation Audits
- Item #16 : Changes to condition management

III. *Other Paths***

Finally, these items have a separate path outside of RFP/Contract processes**

- Item #1 : Dependent Eligibility Verification Audit
- Item #2 : Revise dependent Enrollment requirements
- Item #3 : Revise LAwell Eligibility rules
- Item #4 : Change Cash in Lieu incentive
- Item #15: Change City subsidy maximum

**These items have components which do not require a RFP.*
***Although these items do not require a RFP or Contract negotiation, their action may affect pricing and would need to be disclaimed in advance.*

A presentation deck with high-level overview of these discussion items was developed by Keenan and is included as **Attachment B**.

C. Discussion

The Ad-Hoc Medical Plan Subcommittee has reviewed a large amount of material to date, and still has many more items to discuss and explore further. However, through discussion, the Ad-Hoc Medical Plan Subcommittee, through material presented by Keenan and staff, identified one of the most potentially effective changes that could directly impact plan premiums would be to change Medical Plan Design (Item #8) and consider adding in a new Medical Plan Option (Item #9). Research executed by Keenan shows that even a somewhat modest plan design change or plan addition could result in a

multi-million dollar reduction in annual medical plan premiums. The current medical plans offered to City Employees have not changed at all in any manner in well over a decade. However, to that degree, the City and JLMBC will need to make some very important decisions on where to draw on line on what changes to consider. In order to do that, staff and Keenan – at the direction of Ad-Hoc Medical Plan Subcommittee and/or JLMBC – will need to embark on research of City employees. Surveys will need to be conducted to gather a better understanding of employee aptitude towards change and what items they are receptive to consider. Focus Groups will need to be held to dive deeper into understanding change options, and what barriers may exist with different employee sets in being able to accept change. A deeper dive analysis would need to be made into actual employee health plan use so that we can have a better understanding of the statistical data we routinely see about utilization.

D. Recommendation/Next Steps

The Ad-Hoc Medical Plan Subcommittee will need to complete these employee research and review further aspects of plan design options in order to draft a Medical Plan RFP. Only after the Medical Plan RFP is drafted would the Ad-Hoc Medical Plan Subcommittee be able to make a recommendation on if it should be issued. It is possible that, through the work to design and draft this completely different Medical Plan RFP, that the Ad-Hoc Medical Plan Subcommittee may determine that issuing a RFP is not the best path at this time and that extending the current contracts, with additional negotiations over select items, is a better option. Therefore, the Ad-Hoc Medical Plan Subcommittee will remain in place should the JLMBC adopt the recommendation identified in this report. The Ad-Hoc Medical Plan Subcommittee still has a lot of work left to perform. However, the Ad-Hoc Medical Plan Subcommittee wanted to gather consensus and feedback from the JLMBC in pursuing the next major steps in this process.

The proposed timeline for this action is as follows:

- November 2023 to January 2024 - the Ad-Hoc Medical Plan Subcommittee will commence in the following activities:
    - Design and execute surveys and focus groups to gain employee opinions/needs for Medical Plan services and perceptions.
    - Continue to research and review options for consideration to include in the draft RFP
    - Continue to review and discuss the additional items on the 16-item list for consideration of inclusion into the RFP or to be executed along a different path.
- **January 2024 - Ad-Hoc Medical Plan Subcommittee determines whether to recommend to JLMBC to issue the drafted RFP or to extend existing contracts**

  The following paths outline the two options that the ad-hoc could ultimately recommend to the JLMBC:

Dates	RFP Route	Contract Extension Route

February 8, 2024 *(JLMBC Meeting)*	JLMBC approves draft RFP for release	JLMBC directs staff to begin negotiation of contract extensions
March/April 2024	RFP Responses due	Negotiate
April/May 2024	Evaluate responses	Contract Proposals (aka Renewals) received
May/June 2024	Select winning bidders	Approve contract extension

Submitted by: ______________________________________
Paul Makowski, Chief Benefits Analyst

On behalf of the Ad-Hoc Medical Plan Subcommittee/Consultants/and City staff:
Shauna Janeway - Member Benefits & Employer Relations Coordinator/SEIU
Paul Girard - Senior Labor Relations Specialist III/CAO
Megan Gardner - Account Executive/Keenan
Bordan Darm - Assistant Vice-President/Keenan
Melissa King - Account Executive/Keenan
Alex Rabrenovich - Account Executive/Keenan
Paul Makowski - Chief of Employee Benefits/Personnel Department
Chuong Tran – Senior Benefits Analyst II/Personnel Department

ATTACHMENT A

JLMBC MEMBERS:
Employee Organizations
David Sanders, Chairperson
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Gary Glaze
Esteban Lizardo

Management
Dana Brown, Vice-Chairperson
Tony Royster, Second Prov. Chairperson
Matthew Rudnick
Matthew Szabo
Holly Wolcott

Date: July 6, 2023

To: JLMBC

From: Staff

Subject: **Medical Insurance Plan Options for Plan Year 2025**

RECOMMENDATION

That the JLMBC consider (a) creation of a new Ad-Hoc Medical Plan Subcommittee for development of a recommendation on medical plan coverage for Plan year 2025, (b) referral to the Ad-Hoc Plan Design Subcommittee for development of a recommendation on medical plan coverage for Plan year 2025, or (c) direct staff to return the full JLMBC with a detailed report and recommendation on medical plan coverage for Plan year 2025.

DISCUSSION

A. Background

The LAwell Program offers an array of benefit coverage options for its eligible members, and the benefits menu of available coverages has evolved over the years. At its May 17, 2019 meeting, the JLMBC created an Ad Hoc Plan Design Subcommittee to work with staff and LAwell Program consultants to (a) assess the current status of the LAwell Program plan and benefit menu design; (b) identify best practices in other comparable employer-sponsored programs; and (c) recommend strategies for design improvements consistent with the staffing and administrative resources available to support the LAwell Program. That subcommittee last convened in May 2020 to review an expansion to the cash in lieu program and considered options for Long Term Care Insurance. The recommendation from the Ad Hoc resulting from its May 2020 meeting were included in JLMBC report 20-13.

At its January 21, 2021 meeting, the JLMBC approved a Request for Proposals (RFP) for medical plan services for its 2022 plan year. The City received multiple bids from prospective insurance providers. However, due to multiple factors, the JLMBC/Personnel Department were forced to cancel the RFP. As a result, the City extended its current contracts for a 6th service year, subject to City Council approval.

On August 5, 2021, the JLMBC established an Ad Hoc Health Procurement, Procurement Planning, and Plan Design Subcommittee (Subcommittee) for the purpose of developing recommendations for the JLMBC with respect to (a) the design of the next Health Services Request for Proposal (2022 Health Services RFP); (b) defining an updated procurement calendar for other benefit services, and (c) any additional related plan design changes.

On September 25, 2021, and January 4, 2022, the Subcommittee met to consider and advance staff recommendations with respect to a new proposal of revised Health Plan Services RFP development concepts. The proposed recommendations included the following changes from the prior procurement effort:

- Dividing the Health Plan Services RFP into two separate procurements: Staff Model HMO & Network Plans
- Streamlining and simplifying the questionnaire which reduced the total number of questions
- Requiring bundled proposals for full network plan replacement (as opposed to partial or "a la carte" network plan replacement) to protect member and City interests by minimizing potential negative employee or employer price impacts
- Minimizing disruption to LAwell Program members
- Eliminating Best and Final Offer and engagement exercises to reduce process risks and increase accountability

At its January 27, 2022 meeting, the JLMBC approved two new RFPs for medical plan services, in alignment with the recommendation from the Subcommittee. The new RFP was revised to reduce the risk of reasons to cancel the RFP. However, this time around, the City only received a few bids from prospective insurance providers.

Under the RFP's issues in 2021 and 2022, the City did not pursue changes to its benefit design. Instead, the City asked for full replacement options of its current plans matching or enhancing their current design.

As a result of its 2022 RFPs, on June 2, 2022, the JLMBC recommended awarding a contract with Kaiser and Anthem for two-years of services from January 2023 to December 2024, with an option to extend one-year contractual agreement extensions in 2025, 2026, and 2027 is at the City's sole discretion.

Since awarding a contract for 2023 & 2024 services, and since medical plan premiums are traditionally and typically only guaranteed for one 12-month period, the LAwell program entered into its first renewal process since 2021. And at its June 1, 2023 meeting, the JLMBC adopted a renewal for Plan Year 2024 that included a 9.9% increase for Anthem and a 10.4% increase for Kaiser. A large amount of discussion was held by the JLMBC around how to address premium rate increases in the future. This report provides some options for consideration to attempt to address the larger and long-term problem of growing health care costs.

B. Timelines for RFP and Contract extension

The JLMBC has two main paths to consider in determining how to approach receiving proposals for premiums and plans for 2025. The JLMBC can choose to continue the current contract agreements with Anthem and Kaiser – which would provide an options for both providers to participate in another renewal process for the same services currently being provided - , or the JLMBC could decide to go back out to competitive bidding – which would allow for the City to potentially alter the services being provided and allow other medical providers the option to submit competitive pricing for those services.

For a LAwell Plan Year 2025 implementation, a final medical provider service rate proposal would need to be adopted by the JLMBC no later than May 2024. The paths for either a contract extension or a RFP are very similar.

Although the final implementation date of May 2024 cannot be moved, some of the dates and items leading up to May 2024 are not as fixed and could be adjusted.

RFP Execution Timeline	Month	Contract Extension Timeline
Approve Proposal/Select Winning Bidder for 2025	May 2024	Accept renewal rates for 2025
Evaluate Proposals	April 2024	
	March 2024	
	February 2024	
Release RFP	January 2024	Target contract execution
	December 2023	
Design RFP	November 2023	Award contract extension
	October 2023	Discuss/negotiate contract extension terms
	September 2023	
	August 2023	

C. Items to Consider

Since the primarily identified concern is cost, there are a wide array of aspects that the JLMBC can consider which, one way or another, can potentially impact the overall cost of premiums. In considering whether to pursue a RFP or a contract extension, a number of items should be considered for discussion. However, not all items to be considered can apply to both the RFP or contract extension options.

Overall enrollment and population size. The JLMBC can consider options and activities which can directly impact the size of the population and the number of individuals covered by the plan. These consideration items could range from enrollment eligibility audits to plan rule changes in eligibility and/or how coverage for members and their dependents are added.

Since changes in population are fully within the control of the City, any option to consider changes to the overall population are perceived as being able to equally apply to either a RFP or contract extension. However, timing of implementation of any change would be crucial to seeing any potential impact of the change. Arguably, any proposed change should be implemented as early as possible so that any impact can be applicably included in the pricing data used by a medical provider to set rates for plan year 2025 by the May 2024 deadline.

Benefit Coverage/Plan Design changes. The JLMBC could consider making plan design changes which could result in premium pricing changes. Such changes could include a change in plan type offerings, such as the addition of a High-Deductible Health Plan (HDHP) option, and changes to the benefit coverage levels and payments, including the amount of deductibles and copayments.

Since any benefit/plan design change would be a distinct difference and deviation from the services requested through the last RFP, they can only be explored through a new RFP. No option here could be perceivably acted through a contract extension. Should the JLMBC want to entertain exploration of any benefit/plan design change, multiple actions would need to take place before a final determination to proceed could be made. Such actions may include surveys and focus groups of city employees, and deeper reviews of peer groups and case studies. Any such action would need to be completed in the next few months to lead up to a RFP release.

Fiscal changes. The JLMBC could consider reviewing potential changes to its subsidy structure and how the City determines its maximum subsidy cost. Medical subsidy for the LAwell program is tied, via Memorandums of

Understanding (MOU) and Los Angeles Administrative Code (LAAC), to the Kaiser family rate. This setting may have a perceived impact in how medical providers underwrite their premiums and may reduce the incentive for employees to switch insurance plans.

Since changes in subsidy structure are fully within the power of the City to implement through legislative action and collective bargaining, this option is perceived to equally apply to either a RFP or contract extension. However, implementation of any change, if desired, may not perceivably occur within a timeframe which could result in any practical impact for a 2025 implementation.

Other changes. The JLMBC could consider other changes which may have less of a direct impact to any pricing structure and less control over any timely implementation. Such options may include actions to address the impact of the main cost drivers identified by health plan providers in their recent proposal of rate increases. These options may include actions such as further and deeper review into the reasons behind health plan providers increase to rates. It may also include actions to attempt to change employee behavior and ultimately reduce the quantity of high cost claim occurrences.

Any action, or desire to pursue any other change could equally apply to either a RFP or Contract Extension.

D. Options to Proceed

The JLMBC can proceed with determining whether to issue a new RFP or to award a contract extension in one of three ways:

(a) *Create a new Ad Hoc Medical Plans Subcommittee*
The JLMBC may create an Ad Hoc Subcommittee on Medical Plans which would be narrowly tasked with only reviewing all relevant options for consideration to determine how to proceed. The ad hoc would ultimately be tasked with making a recommendation to the full JLMBC on whether to issue a new Medical RFP or to continue the existing contract.

Should the JLMBC wish to create this new Ad Hoc Medical Plans Subcommittee, it would need to be created in accordance with the provisions of the current bylaws.

(b) *Refer to existing Ad Hoc Plan Design Subcommittee*
The JLMBC may refer the recommendation to its current Ad Hoc Plan Design Subcommittee. This committee can discuss the RFP but may be limited to discuss some of the items of concern noted above. As the Ad Hoc Plan Design Subcommittee was formed to (a) assess the current status of the LAwell Program plan and benefit menu design; (b) identify best practices in other comparable employer-sponsored programs; and (c) recommend strategies for design improvements consistent with the staffing and administrative resources available to support the LAwell Program, it may be out of scope for this committee to address the “other changes” category or to widely look at options that may fall out of the Plan Design function but may otherwise be related to Medical Plans. However, if the primary intent of referral is to look at the first three items of consideration: (i) Enrollment/Population size, (ii) Coverage/Plan Design, and (iii) Fiscal items, those may very easily align with the original intent of the already established Ad Hoc Plan Design Subcommittee.

Should the JLMBC choose this option, the JLMBC may want to address or revise its members serving the Ad Hoc Plan Design Subcommittee. The current members are:

- Marleen Fonseca
- David Sanders
- Matthew Szabo

A fourth Management seat is vacant. One additional Labor seat previously sat on this subcommittee for a total of five members. Under the bylaws, a subcommittee can be composed of no less than two (2) members and no more than five (5) members as the membership cannot be comprised of a quorum of the full JLMBC.

Lastly, since this Ad Hoc was created for a larger purpose, the ad hoc would not yet dissolve once a recommendation was made. However, the JLMBC can choose to dissolve it through action.

(c) *Staff/consultant proposal*
The JLMBC may direct staff and its consultant to compose a recommendation which would be brought to the full JLMBC at a later meeting.

Submitted by: ____
Paul Makowski, Chief Benefits Analyst

ATTACHMENT B

City of Los Angeles

JLMBC Ad Hoc Committee Priorities

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JLMBC Adhoc Committee Priorities

Overall Enrollment/Demographics
Perform a Dependent Eligibility Verification Audit
Revise dependent Enrollment requirements" - Change rules to require documentation first. - Remove “honor” system with dependent additions and bill or remove coverage for non-compliance - Expand dependent options to include new dependent types
Revise LAwell Eligibility rules - Allow for coverage on "day one" of employment - Alter hours rule - Extend coverage to as-needed/intermittent employees - Remove "honor" system associated with Life Events - Change Life Event reporting window
Change Cash in Lieu incentive.

JLMBC Adhoc Committee Priorities

Benefit Coverage/Plan Design changes
Analysis on Narrow Network vs Full Network - does it make sense to have both?
Weigh the importance of provider loss
Bundling/Unbundling of Non-Staff Model plans
Change medical plan design - Consider adding (or increasing for PPO) a deductible - Consider increasing copay, or varying copay structure - Consider changing/applying co-insurance
Consider adding new plan options - High Deductible Health Plan (HDHP) - Exclusive Provider Option (EPO) instead of PPO - Point of Service (POS) instead of PPO
Annual physical mandate? - Preventative service use mandate or ?
Changing Prescription Drug Benefits? - Audit or Pharmacy Benefits Manager (PBM) oversight

JLMBC Adhoc Committee Priorities

Fiscal/Financial
"Participating Contract" concept - Reserve accumulation – Section 115 account
Pooling Point analysis
Capitation Audits
Discuss changing City subsidy maximum authority. - Ag Code – Non-represented EE's - All other MOU's have the same language

Other
Contractual changes to condition management performed by each carrier, perhaps rate guarantees/service level agreements.

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Medical Plans Enrollment

Health Plan	2023 Members	
	Enrolled	**% of Total**
Anthem Narrow Network (Select) HMO	3,894	15.25%
Anthem Full Network HMO	114	0.45%
Anthem Vivity HMO	1,938	7.59%
Anthem PPO	2,607	10.21%
Kaiser Permanente HMO	15,799	61.89%
Cash-in-Lieu	1,177	4.61%
Total	**25,529**	**100.00%**

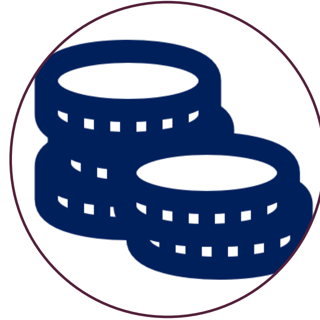
Source: JLMBC Presentation from LifeWorks, Thursday March 2, 2023

OBJECTIVES

JLMBC Adhoc Committee Objectives

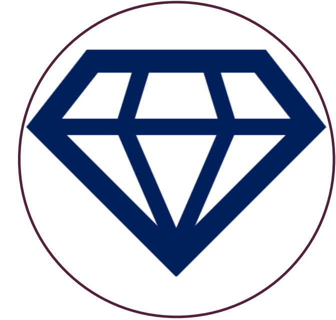
Achieving long-term stability in premiums, ensuring access, and fostering innovation and value is an ongoing process. It requires a commitment to adapt to changing circumstances and evolving healthcare technologies and practices. Additionally, involving key stakeholders, is crucial for the success of this multi-year strategy.

The City's commitment to this is demonstrated through the establishment and work of the JLMBC Ad-hic committee.



Stabilize Premiums

Ensure Access



Innovation and best value

OVERALL ENROLLMENT AND POPULATION SIZE

Dependent Enrollment and Verification

- Adding Dependents: Change Rules of Adding Dependents Due to Life Events
  - Employees are allowed to make a Life Event change outside of Open Enrollment and follow up with documentation
    - The dependent is added immediately upon request
    - Time to report change (30 days) and time to submit documentation (60 days) can be confusing to employees
    - Documentation may not come in on time or be sufficient to justify the change
      - Can become an administrative burden to correct
  - Possible Solutions:
    - Require documentation prior to making the change
      - Concern: Access to Care
    - Maintain current practice, but discontinue coverage and/or bill employee for non-compliance
      - Concern: Member complaints
- Consider expanding types of dependents allowed to enroll in a plan

Dependent Enrollment and Verification

- Perform Dependent Verification Audit
  - Such audits identify ineligible dependents who are then removed from coverage, potentially resulting in significant savings*
    - Utilize current TPA or perform an RFP?
    - One time audit or ongoing contract?
    - The last dependent verification audit was performed about 10 years ago
  - Concerns: Additional cost and administrative burden to administer
  - Recommendation: A listing of potential vendors has been identified; conduct an RFI to determine pricing and levels of staff contributions toward the effort.

*Estimated amount of ineligible dependents: 4% - 10% (BMI); 5% - 12% (BenefitFocus); 3% - 10% (Mercer)

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Health Coverage Eligibility Requirements for New Hires

- Consider changing the amount of hours needed before becoming eligible for health coverage.
  - Based on Segal survey, common practice appears to be that coverage starts the first of the month following the date of hire/first day of employment
  - Start on the first day of employment
    - Common in the private sector?
    - Attractive to potential new hires/strong talent
  - Concerns:
    - Cost increases
    - Systems and hiring practices would need to change Citywide
  - Recommendation: Survey other governmental agencies to determine if any offer coverage on first day of employment and how it works.

Eligibility for a Health Subsidy

- Employees must meet certain requirements regarding hours worked (40 hours or as established in MOU) to maintain a health subsidy.
  - A decrease in the hours requirement could assist approximately 500 employees
  - Is there a benefit in changing the criteria?
  - What are other organizations' requirements?

- Recommendation: Survey other organizations to understand what other options exist

Alternative coverage options

- Cash In-Lieu
  - Current practice is to provide $100 monthly to employees who elect to not enroll in an LAwell medical plan

- Alternative: Reimbursement Plan for Employees Who Can Access Medical Coverage Through Other Means
  - Employee selects reimbursement plan instead of LAwell plan
    - Premium is lower than employer plan (or any excess can be reimbursed to the employer through the plan)
    - Employee has no out-of-pocket costs for medical services (e.g. copays, deductibles, coinsurance, etc.)
    - The City and the employee both save money

BENEFIT COVERAGE/PLAN DESIGN CHANGES

Disclaimer

Information on some of the following slides contain ILLUSTRATIVE, non-binding scenarios for purposes of discussion and context only. Any change to plan design, new plan offerings, and associated premium rates would be subject to final underwriting and/or regulatory approval as applicable.

Network offerings – Narrow vs. Full Network

- Offering both a Full and Narrow network option is typically more expensive for an employer but provides greater flexibility of choice for employees
  - Both the Narrow and Vivity plans are considered 'Narrow Network' plans
  - Plan designs are the same across the plans
  - The majority of LAwell employees reside in Urban areas where access on a Narrow Network is more than adequate
  - **This makes cost a driving factor for enrollment**
    - The Narrow network is **29.18% less** than Full Network plan
    - The Vivity plan is **40.55% less** than the Full Network plan

2024 Premium Rates

Anthem Narrow		Anthem Full		$ Diff	% Diff
Employee Only	$780.80	Employee Only	$1,102.58	**-$321.78**	**-29.18%**
Employee + Spouse/DP	$1,717.86	Employee + Spouse/DP	$2,425.66	**-$707.80**	**-29.18%**
Employee + Child(ren)	$1,483.62	Employee + Child(ren)	$2,094.90	**-$611.28**	**-29.18%**
Family	$2,030.24	Family	$2,866.74	**-$836.50**	**-29.18%**

Anthem Vivity		Anthem Full		$ Diff	% Diff
Employee Only	$655.46	Employee Only	$1,102.58	**-$447.12**	**-40.55%**
Employee + Spouse/DP	$1,442.06	Employee + Spouse/DP	$2,425.66	**-$983.60**	**-40.55%**
Employee + Child(ren)	$1,245.40	Employee + Child(ren)	$2,094.90	**-$849.50**	**-40.55%**
Family	$1,704.24	Family	$2,866.74	**-$1,162.50**	**-40.55%**

Plan	Enrollment
Anthem Narrow Network (Select) HMO	3,894
Anthem Full Network HMO	114
Anthem Vivity HMO	1,938

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Network offerings – Narrow vs. Full Network

- The City's portion of cost does not change should the Full-Network option be eliminated
- The Employee share of cost would decrease significantly:

Enrollment Tier	Full HMO			Select HMO			Combined		
	Enrollment	Employee Share	City Share	Enrollment	Employee Share	City Share	Combined	Employee Share	City Share
Subscriber	48	$160.89	$390.40	1,349	$ -	$ 390.40	1,397	$ -	$ 390.40
Subscriber & Spouse/Dependent	15	$353.90	$858.93	706	$ -	$ 858.93	721	$ -	$ 858.93
Subscriber & Child/Children	13	$305.64	$741.81	478	$ -	$ 741.81	491	$ -	$ 741.81
Family	38	$424.67	$1,008.70	1,302	$ 6.42	$ 1,008.70	1,340	$ 6.42	$ 1,008.70
Total	**114**	**$33,142.00**	**$79,597.28**	**3,835**	**$8,358.84**	**$2,800,966.76**	**3,949**	**$8,602.80**	**$2,880,564.04**

Network offerings – Disruption

Geo Access

- A non-comparative look at the size and scale of a carrier's network in different geographic areas

Disruption

- A method of network analysis that measure which carriers have most of the providers an employee group uses

Provider Network Match

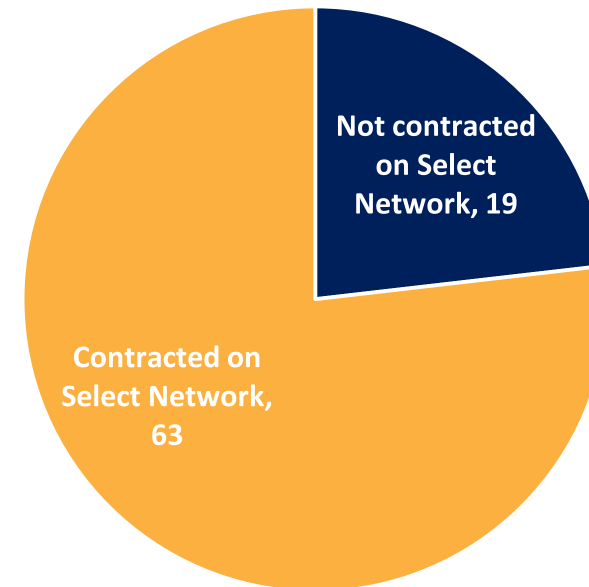
- Looks at the providers utilized in current network and compares it to the potential network at the individual provider level. This is the most accurate measure to determine if your members would be 'displaced' changing networks

- When considering a change to plan offerings or a change to medical carrier, network provider match and/or disruption becomes a large factor.
  - Tolerance is dependent upon the employer
  - 85% or greater is typically viewed as 'acceptable'
    - The higher the % match, the easier transition is for those enrolled

Network offerings – Disruption

- In looking at the Providers utilized on the Traditional and Narrow (Select) networks we found the following:
  - 82 Providers are designated/utilized on the Full/Traditional network
    - Of those 82 providers, 63 are also contracted on the Narrow (Select) network
    - 19 providers in the Full Network are not contracted on the Narrow/Select Network but some of those are contracted through the Regional Network (Vivity)

Full Network = 82 Total



Not contracted on Select Network   Contracted on Select Network

Plan offerings – Bundling vs. Unbundling

- Benefits of Bundling
  - Can produce rate concessions
  - Greater consideration for plans with lower, less credible enrollment
  - Administrative ease of utilizing one carrier
- Benefits of Unbundling
  - Encourages competition
  - Offers the opportunity to provide unique plan offerings
- This concept would apply to the non-Staff model, and there has been some resistance with the current provider to unbundling.

Plan offerings – Medical plan design

- Current state
  - The City's current HMO plans have the same plan design across the non-Staff Model plans (Anthem) and have parity - as close as possible plan design – with the Staff Model plan (Kaiser)
  - There are three (3) Anthem HMO plans and one (1) Kaiser plan offering

- Benchmarks
  - CalPERS plans – utilize a similar strategy in providing a single plan design, but with 6 carriers
  - Direct purchasers - strategy is mixed

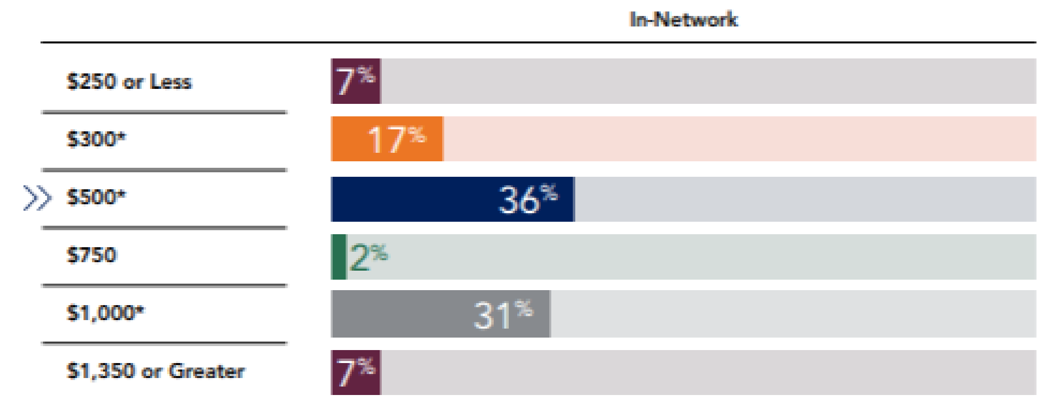
Plan offerings – Medical plan design

- Consider changing/applying co-insurance
  - Adding coinsurance/increasing co-insurance will typically lower premiums; those who only utilize preventive or routine care will pay less each month in premium and may not be as impacted by the change in plan design
  - There are a number of areas that could be changed that are impactful to rates:
    - Office Visit – Currently $15 on the HMO and $30 on the PPO
    - Emergency Room – Currently $100 on the HMO and $100 + 10% coinsurance on the PPO
    - Prescription Drug
    - Lab/X-Ray
    - Any change to a combination of the above, would provide exponential impact

Plan offerings – Medical plan design

- Consider adding (or increasing for PPO) a deductible
  - In most cases, the higher a plan's deductible, the lower the premium.
  - The City's current PPO plan deductible does incentivize utilizing In-Network providers

	Single		Family	
	In Network	Out of Network	In Network	Out of Network
City of LA	**$750**	**$1,250**	**$1,500**	**$2,500**
City of Long Beach	$150	$350	$300	$700
LA County - Prudent Buyer	$150	$400	$450	$800
County of San Bernardino	$250	$250	$500	$500
City of San Diego	$500	$500	$1,500	$1,500
CalPERS Platinum	$500	$2,000	$1,000	$4,000
OC - Wellwise	$500	$750	$1,000	$1,500
CalPERS Gold	$1,000	$2,500	$2,000	$5,000
LA County - Catastrophic	$2,000	$2,000	$4,000	$4,000
Ventura County	-	-	$3,000	$6,000
OC - Sharewell	-	-	$5,000	$5,000
Riverside County	See CalPERS PPO Plans			



Plan offerings – Medical plan design

Should the City decide to make plan designs, there could be potential premium savings. For the PPO plan, Anthem has provided the following illustrative look at the impact of changing certain plan design elements:

Benefit	Current PPO		Illustrative		Adjust Total (Med/Rx) Rate
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Annual Deductible in-network and out-of-network deductibles accumulate separately	$750 individual $1,500 family	$1250 individual $2,500 family	$1,200 individual $2,400 Family	$2,000 Individual $4,000 Family	-4.23%
Annual Maximum Out-of-Pocket in-network and out-of-network out of pocket accumulate together	$2,000 individual $4,000 family		$3,200 individual $6,400 Family		-1.06%
Office Visit	$30 copay	30% coinsurance	$30 copay	40% coinsurance	-1.77%
Medical Coinsurance	10% Coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	
			Total Impact to current rate		**-7.06%**

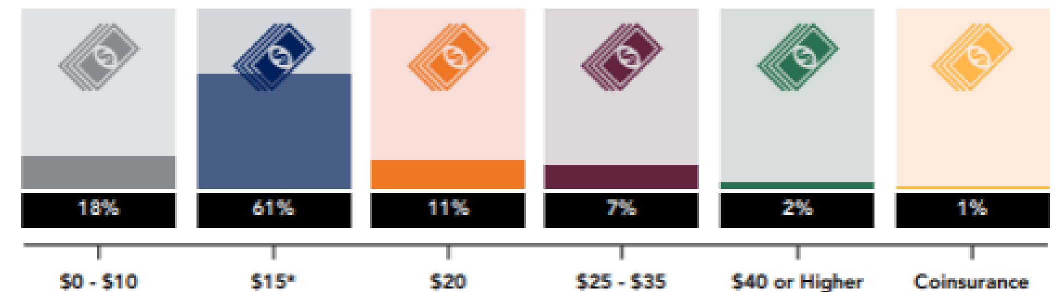
In the example provided above, the estimated savings provided based on the illustrative changes would result in an annual premium savings of $3,728,740.

ILLUSTRATIVE, non-binding information as per page 15

Plan offerings – Medical plan design

Agency	Plan	HMO Office Visit Copay
City of LA	**All**	**$15**
Orange County	Select HMO	$5
County of San Bernardino	Kaiser Traditional	$10
County of San Bernardino	Signature	Level 1 - $10; Level 2 - $30
County of Los Angeles	Kaiser	$15
County of Los Angeles	HMO	$15
CalPERS HMO Plans	All	$15
County of Ventura	VC Health Care HMO	$15
County of Ventura	Trio	$15
County of Los Angeles	POS - 3 Tier	$15/$25/30%
City of Long Beach	1 HMO plan, no Kaiser plan	$20
Orange County	Choice HMO	$20
Orange County	Kaiser	$20
City of San Diego	Kaiser Traditional	$20
City of San Diego	Cigna HMO	$20
City of San Diego	Cigna Scripps Select	$20
County of San Bernardino	Trio	$25
County of Ventura	Access+	$35
County of San Bernardino	Access+	$40
County of San Bernardino	Kaiser Choice	$40
City of San Diego	Kaiser Deductible HMO	$40
Riverside County	See CalPERS Plans	

- Consider increasing copay, or varying copay structure
  - Can apply to Staff model and non-Staff model plans



Plan offerings – Medical plan design

ILLUSTRATIVE, non-binding information as per page 15

- Staff Model option:

Benefit Plan Description		HMO $30; $500 IP; $100 Surg $15/$35/30% RX	HMO $30; $500 IP; $250 Surg $15/$35/30% RX	HMO X; $40/$50 OP; 30% IP; $40/$15/30% RX	$750 Ded; $25 OP; 20% IP; $30/$10/20%RX	$1000 Ded; $20 OP;20% IP; $30/$10/20%RX	$1600 Ded; $20 OP; $250 IP; $30/$10/20%RX	$1500 Ded; $30 OP; 20% IP; $30/$15/20%RX	$2000 Ded; $30 OP; 20% IP; $30/$15/20%RX	$2000 Ded; $30/50 OP; $250 IP; $30/10/20%RX
Plan ID		HMO 9982	HMO 9992	HMO 16035	DHMO 8783	DHMO 8785	HSA 16280	DHMO 16020	DHMO 13771	HSA 16266
Estimated Rate Change From 2024 Rates		-3.5%	-3.6%	-12.0%	-13.5%	-14.0%	-24.5%	-24.6%	-28.0%	-29.0%

* Decrements are based off 2024 rating factors and are subject to variation for 2025 rating.

- For context, a complete replacement of the current Kaiser program to the HMO $30 plan, on an illustrative basis, would provide an annual premium savings amount of $9,072,184
- Offered on a side-by-side basis, with a 5% migration from the current enrollment to the HMO $30 plan, on an illustrative basis, there would be an annual premium savings of $454,287.07

Adding new plan options - HDHP

High Deductible Health Plan (HDHP)

- Lower premiums but higher upfront out-of-pocket costs
  - Services are paid 100% until annual deductible is met
  - Services are feed to participants at the health plan provider's lower contracted fee rates
- Can be an HMO, POS, PPO, or EPO plan
- Can offer a HDHP with copays, but removes HSA eligibility
- Employee education with example utilization cost comparisons between a HDHP and a low deductible plan mode
  - Reduced out of pocket cost for health premium contribution combined with medical insurance provider's lower negotiated fees for services can cost less than low deductible plan annual premium contribution alone.
  - Typical savings for HDHP enrollees amounts to $500 a year according to the Nation Bureau of Economic Research.

Adding new plan options – HDHP – Illustrative Cost Examples

Anthem Illustrative - Plan Design Modification Costs	Grandfather Current PPO		New			New		
	In-Network	Out-of-Network	In-Network	Out-of-Network	Adjust Total (Med/Rx) Rate	In-Network	Out-of-Network	Adjust Total (Med/Rx) Rate
Annual Deductible in-network and out-of-network deductibles accumulate separately	$750 individual $1,500 family	$1250 individual $2,500 family	$1,600 ee only $3,200 member / $3,400 family	$4,800 ee only $4,800 member / $10,200 family	-8.53%	$2,500 ee only $3,200 member/ $5,300 family	$7,500 ee only $7,500 member/ $15,000 family	-14.08%
Annual Maximum Out-of-Pocket in-network and out-of-network out of pocket accumulate together	$2,000 individual $4,000 family		$3,400 ee only $3,400 member / $6,800 family	$10,200 ee only $10,200 member / $20,400 family	-1.46%	$5,300 ee only $5,300 member/ $10,600 family	$16,000 ee only $16,000 member/ $32,000	-2.87%
Office Visit	$30 copay	30% coinsurance	20% coinsurance after deductible is met	40% coinsurance after deductible is met	-2.28%	20% coinsurance after deductible is met	40% coinsurance after deductible is met	-2.28%
Medical Coinsurance	10% Coinsurance	30% coinsurance	20% coinsurance after deductible is met	40% coinsurance after deductible is met		20% coinsurance after deductible is met	40% coinsurance after deductible is met	
Current Costs	**Monthly Premium**	**Employee Monthly Premium Cost**	**Illustrative Monthly Premium**	**Illustrative Employee Monthly Premium Cost**	**Plan Design Savings**	**Illustrative Monthly Premium**	**Illustrative Employee Monthly Premium Cost**	**Plan Design Savings**
Full Network - Single	$ 1,298.12	$ -	$ 1,134.17	$ -	-12.63%	$ 1,038.11	$ -	-20.03%
Employee + Spouse/DP	$ 2,855.84	$ 685.44	$ 2,495.15	$ 477.75		$ 2,283.82	$ 266.42	
Employee + Child(ren)	$ 2,466.38	$ 295.98	$ 2,154.88	$ 137.48		$ 1,972.36	$ -	
Family	$ 3,375.08	$ 1,204.68	$ 2,948.81	$ 931.41		$ 2,699.05	$ 681.65	
Select Network - Single	$ 780.80	$ -	$ 682.18	$ -		$ 624.41	$ -	
Employee + Spouse/DP	$ 1,717.86	$ -	$ 1,500.89	$ -		$ 1,373.77	$ -	
Employee + Child(ren)	$ 1,483.62	$ -	$ 1,296.24	$ -		$ 1,186.45	$ -	
Family	$ 2,030.24	$ 12.84	$ 1,773.82	$ -		$ 1,623.58	$ -	

ILLUSTRATIVE, non-binding information as per page 15

HDHP 1600

Anthem Illustrative - Plan Design Modification Costs	Grandfather Current PPO		New		
	In-Network	Out-of-Network	In-Network	Out-of-Network	Adjust Total (Med/Rx) Rate
Annual Deductible in-network and out-of-network deductibles accumulate separately	$750 individual $1,500 family	$1250 individual $2,500 family	$1,600 ee only $3,200 member / $3,400 family	$4,800 ee only $4,800 member / $10,200 family	-8.53%
Annual Maximum Out-of-Pocket in-network and out-of-network out of pocket accumulate together	$2,000 individual $4,000 family		$3,400 ee only $3,400 member / $6,800 family	$10,200 ee only $10,200 member / $20,400 family	-1.46%
Office Visit	$30 copay	30% coinsurance	20% coinsurance after deductible is met	40% coinsurance after deductible is met	-2.28%
Medical Coinsurance	10% Coinsurance	30% coinsurance	20% coinsurance after deductible is met	40% coinsurance after deductible is met	
Current Costs	**Monthly Premium**	**Employee Monthly Premium Cost**	**Illustrative Monthly Premium**	**Illustrative Employee Monthly Premium Cost**	**Plan Design Savings**
Select Network - Single	$ 780.80	$ -	$ 682.18	$ -	-12.63%
Employee + Spouse/DP	$ 1,717.86	$ -	$ 1,500.89	$ -	
Employee + Child(ren)	$ 1,483.62	$ -	$ 1,296.24	$ -	
Family	$ 2,030.24	$ 12.84	$ 1,773.82	$ -	

Sample HSA Funding with Savings

Select Network	Monthly City Premium Cost Savings	Annualized City Premium Cost Savings	City Contribution to HSA	City Savings after HSA Contribution
Single	$ 98.62	$ 1,183.38	$ 750.00	$ 433.38
Employee + Spouse/DP	$ 216.97	$ 2,603.59	$ 750.00	$ 1,853.59
Employee + Child(ren)	$ 187.38	$ 2,248.57	$ 750.00	$ 1,498.57
Family	$ 256.42	$ 3,077.03	$ 750.00	$ 2,327.03

- Employer contributions can be place into an HSA and employees can contribute up to the combined employer/employee annual maximum
- Employer contributions can otherwise be placed into HRA, allowing employees the ability to contribute up to max in HSA, allowing for maximum tax-advantaged savings.

ILLUSTRATIVE, non-binding information as per page 15

HDP 2500

Anthem Illustrative - Plan Design Modification Costs	Grandfather Current PPO		New		
	In-Network	Out-of-Network	In-Network	Out-of-Network	Adjust Total (Med/Rx) Rate
Annual Deductible in-network and out-of-network deductibles accumulate separately	$750 individual $1,500 family	$1250 individual $2,500 family	$2,500 ee only $3,200 member/ $5,300 family	$7,500 ee only $7,500 member/ $15,000 family	-14.08%
Annual Maximum Out-of-Pocket in-network and out-of-network out of pocket accumulate together	$2,000 individual $4,000 family		$5,300 ee only $5,300 member/ $10,600 family	$16,000 ee only $16,000 member/ $32,000	-2.87%
Office Visit	$30 copay	30% coinsurance	20% coinsurance after deductible is met	40% coinsurance after deductible is met	-2.28%
Medical Coinsurance	10% Coinsurance	30% coinsurance	20% coinsurance after deductible is met	40% coinsurance after deductible is met	
Current Costs	**Monthly Premium**	**Employee Monthly Premium Cost**	**Illustrative Monthly Premium**	**Illustrative Employee Monthly Premium Cost**	**Plan Design Savings**
Select Network - Single	$ 780.80	$ -	$ 624.41	$ -	-20.03%
Employee + Spouse/DP	$ 1,717.86	$ -	$ 1,373.77	$ -	
Employee + Child(ren)	$ 1,483.62	$ -	$ 1,186.45	$ -	
Family	$ 2,030.24	$ 12.84	$ 1,623.58	$ -	

Sample HSA Funding with Savings

Select Network	Monthly City Premium Cost Savings	Annualized City Premium Cost Savings	City Contribution to HSA	City Savings after HSA Contribution
Single	$ 156.39	$ 1,876.73	$ 1,500.00	$ 376.73
Employee + Spouse/DP	$ 344.09	$ 4,129.05	$ 1,500.00	$ 2,629.05
Employee + Child(ren)	$ 297.17	$ 3,566.03	$ 1,500.00	$ 2,066.03
Family	$ 406.66	$ 4,879.88	$ 1,500.00	$ 3,379.88

- Employer contributions can be place into an HSA and employees can contribute up to the combined employer/employee annual maximum
- Employer contributions can otherwise be placed into HRA, allowing employees the ability to contribute up to max in HSA, allowing for maximum tax-advantaged savings.

ILLUSTRATIVE, non-binding information as per page 15

Adding new plan options – HDHP/HSA

High Deductible Health Plan (HDHP)

- Can offer a Health Savings Account (HSA) with a HDHP if the plan does not offer copays
  - Pre-tax employee contributions to provide 30% savings on medical spend
  - Funds can be invested and grow triple-tax free
  - Allows for employer contribution which can help incentivize employees to select a lower cost health plan and create cost savings for the employer
  - Allows for better consumerism and overall employee savings
  - More options and access to types of care
    - IE services that are not covered by the health plan can be more readily access via HSA plan funds
  - The only voluntary retiree health savings financial tool

Adding new plan options - HSA

HSA Trends

- Interest in HSA accounts is high. One-quarter of adults with private health insurance were extremely interested, 28% were very interested, and another 28% were somewhat interested. Only 17% were not interested.
- Increase in employers offering HDHP with a savings option (HSA or HRA) has increased from 6% in 2006 to 25% in 2022. This number increases when looking at employers by size.
  - 55% of firms with 200-999 employees offer HDHP/SO
  - 66% of firms with 1,000+ employees offer HDHP/SO

Source and additional data:

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HRA High Deductible Plan with Copays

Benefit	Grandfather Current PPO		Add		
	In-Network	Out-of-Network	In-Network	Out-of-Network	Adjust Total (Med/Rx) Rate
HRA Fund	N/A		Individual: $1,000 Family: $2,000		+7.1%
Annual Deductible in-network and out-of-network deductibles accumulate separately	$750 individual $1,500 family	$1250 individual $2,500 family	$2,500 Individual $5,000 Family		-10.40%
Annual Maximum Out-of-Pocket in-network and out-of-network out of pocket accumulate together	$2,000 individual $4,000 family		$5,300 Individual $10,600 Family		-1.97%
Office Visit	$30 copay	30% coinsurance	$30 copay	40% coinsurance	
Medical Coinsurance	10% Coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	-1.77%
Current Costs	**Monthly Premium**	**Employee Monthly Premium Cost**	**Illustrative Monthly Premium**	**Illustrative Employee Monthly Premium Cost**	**Plan Design Savings**
Select Network - Single	$ 780.80	$ -	$ 714.43	$ -	-8.50%
Employee + Spouse/DP	$ 1,717.86	$ -	$ 1,571.84	$ -	
Employee + Child(ren)	$ 1,483.62	$ -	$ 1,357.51	$ -	
Family	$ 2,030.24	$ 12.84	$ 1,857.67	$ -	

Health Reimbursement can be a tool used by Employers to off-set a HDHP with copays (non-HSA compliant plan design)

- Does not allow for an elective employee contribution like the HSA
- Dollars in HRA plan are subject to employer rules
    - Can allow dollars to only be accessed during the current plan year
    - Can allow dollars to accumulate, but only be accessible upon separation if the employee retirees or meets a years of service requirement

ILLUSTRATIVE, non-binding information as per page 15

Adding new plan options - EPO

Exclusive Provider Option (EPO) instead of Preferred Provide Option (PPO)

- Only provides coverage for services in-network, only out-of-network care that is covered is for emergency medical care
- Need to ensure the EPO network you provide is regionally appropriate to employee households. Popular lower cost option in rural areas where HMO networks are limited.
- Second most popular, behind HMO, plan design selected in the ACA marketplace, comprising of 31% of ACA enrollment
- No referral required for specialist
- Pre-authorization may be required for certain medical procedures and treatments

Adding new plan options - POS

Point of Service (POS) instead of Preferred Provide Option (PPO)

- POS plans, the least common plan type, are a hybrid between a PPO and HMO plan. Only 9% of employees covered by an employer-sponsored health plan had a POS plan in 2021, according to the Kaiser Family Foundation.
- Must work with a primary care provider and, typically, referrals are required to see a specialist.
- POS plan will cover of out-of-network provider, like a PPO
- Compared to an EPO plan, POS plans typically have smaller networks with fewer doctors and facilities. This is the key driver in the lower premium cost when compared to EPOs.
- For most effective medical plan rate performance, its best to ensure the POS network you provide is regionally appropriate to employee households

Adding new plan options – Summary Chart

Feature	PPO	EPO	POS	HMO
Cost	$$$$	$$$	$$	$
Referrals?	No	No	Yes	Yes
Out-of-network care covered?	Yes	No	Yes	No
Most popular employer-sponsored offering	1	3	4	2
Most popular on ACA marketplace	3	2	4	1

Keenan Benefits Survey Results

Organizations try to offer as much choice as possible in their plan offerings. The figures below are based on enrollment by plan type.

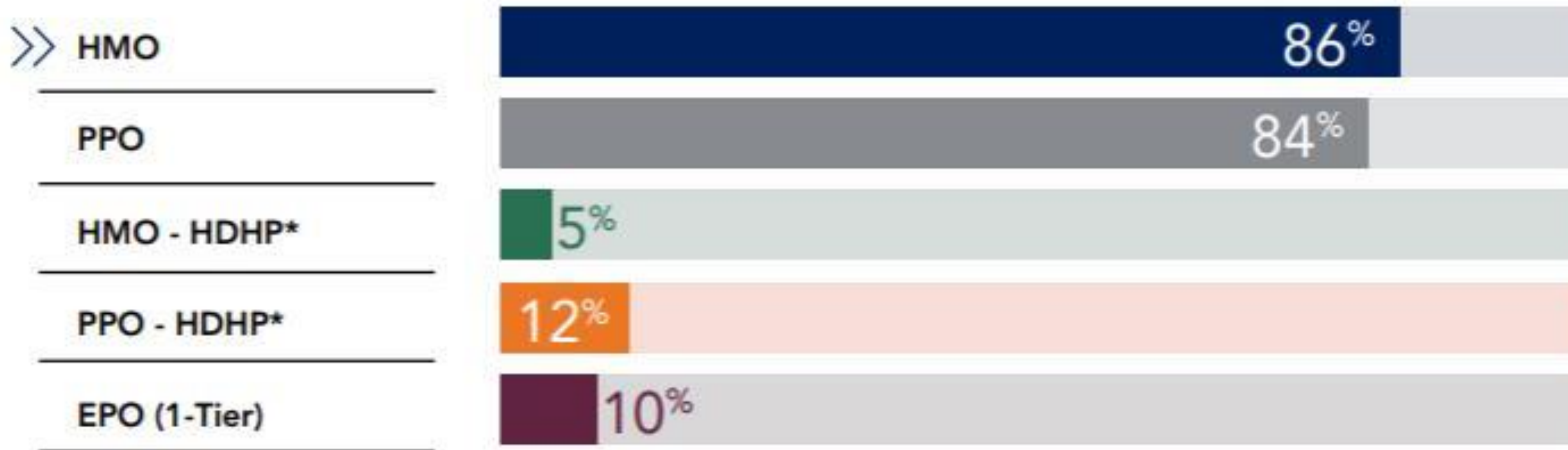
FIGURE 1.5

	Statewide	Nor Cal	So Cal
EPO	8%	25%	1%
HMO	73%	33%	90%
HMO - HDHP*	6%	21%	0%
PPO	12%	19%	9%
PPO - HDHP*	1%	2%	0%

*May include HSA or HRA

Note: the low utilization of HDHPs and EPOs in South California is driven by these options not being made available by CalPERS Medical.

Keenan Benefits Survey Results



Note: data is highly reflective of the plan offerings made available by CalPERS Medical due to the large number of public agency participation in CalPERS medical in our 2023 Survey.

Annual Physical Mandate or Incentive

- Can employers require employees to utilize annual preventative medical screenings/physicals?
  - Unless the medical examination is job-related and consistent with business necessity and is required of all persons in the same position in the same job category, an employer cannot require annual physicals for their employees.
- Recommendations to encourage employees to utilize their annual medical screening benefits:
  - Internal communication channels to promote annual check-ups and screenings
  - Provide structured calendar time (block on calendars) for employees to schedule appointments annually
  - Protect PTO and sick leave time, provide employees with additional leave allowance for annual physical and screenings

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Annual Physical Mandate or Incentive

- Recommendations to encourage employees to utilize their annual medical screening benefits (continued)
  - Provide incentives having employees submit confirmation of appointment utilization using the honor system, doctor’s note, or form signed by the doctor to be eligible for screening incentives:
    - Financial incentive for all who complete wellness activities
    - Entering employees into a larger giveaway with drawings quarterly or semi-annually, like a paid vacation, to create buzz and lower overall incentive spend
    - Additional wellness benefits, gym memberships or app-based fitness subscriptions
    - Health observance campaigns with interdepartmental challenges, luncheon or special outing for the department with the highest health screening completion rate

Annual Physical Mandate or Incentive

- Recommendations to encourage employees to utilize their annual medical screening benefits (continued)
  - Enhance the annual screening experience by adding Executive Physicals to your benefits package and strongly advertise the specialty of this benefit offering during on-boarding
    - More comprehensive examination can help catch conditions earlier, better for the health of employees and the medical plan overall
    - High employee satisfaction with experience shared with peers to drive utilization
    - Lower frequency (IE every 3-5 years) for employees under the age of 40 and annually or biennially available to those 40+

FISCAL/FINANCIAL CHANGES

Participating Contract

A health plan contract is either a participating contract or a non-participating contract

- Participating contracts are a hybrid between fully-insured and self-insured plans
  - Participating contracts are dividend eligible, non-participating contracts are not.
  - A dividend is paid through a year-end accounting process which looks at premium remitted compared to actual expenses paid.
    - If there is a positive balance, the excess funds would be returned to the City.
    - If there is a negative balance, the shortfall would be applied to the renewal.
- A participating contract typically has the same claim projections, expense loads, and fee components, and the carrier sets the premium as with a fully-insured plan
  - The difference is in the margin; participating contracts typically have higher margin requirements, which if not used are returned in the year-end accounting

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Participating Contract

Here's how it works:

- Carrier sets premium rate
  - Premium includes the cost of a Claims Stabilization Reserve (CSR), an account in which a pre-paid amount determined by the carrier is set aside to cover claims costs that exceed total premiums paid
- A year-end accounting is performed
  - Once the plan year ends and all claims have been paid, an accounting is performed to determine if there was a premium surplus or deficit
  - If a deficit, funds will be taken from the CSR to cover the difference
  - If a surplus, funds can be retained in a Premium Stabilization Reserve for future use

Participating Contract

- Premium Stabilization Reserve
  - An interest-earning account administered by the carrier that holds premium surpluses after the year-end accounting is performed and any remaining funds have been applied to the CSR for the next plan year
    - Funds in the PSR belong to the client and can be requested at any time or directed toward plan benefits/costs
    - It is not a requirement that premium surpluses be held in a PSR
    - Usually, the interest rate is set at based on index (was LIBOR, transitioning to SOFR)

A Premium Stabilization Reserve account is also a good intermediary or ‘steppingstone’ for Self-Funding Dental/Vision while the City looks to set up a Section 115 Trust.

Pooling Point Analysis

For fully-insured, experience-rated coverage, a pool charge and pooling point apply.

- All City of Los Angeles medical coverage is experience-rated, meaning rates are developed based on the plans' claim experience.
- The pooling point (level) is the point at which high-cost claimants no longer apply to the plan's experience but are transferred to a community pool.
- The pool charge is the fee charged to each plan to transfer the claims above the pooling point to the community pool.
- Over time, the claims above the pooling point should represent at least 65% to 70% of the pool charge.
- When these loss ratios are off, a review of pooling points and fees should be done.

Pooling Point Analysis - Anthem

Over the past three years, the City's Anthem program has amounted an 85.9% loss ratio.

- The Vivity program has had the highest loss ratio at 155.9%.
- The PPO plan has had an 81.3% loss ratio.
- The Traditional and Select HMO combined have had a 42.3% loss ratio.

HMO - Traditional / Select	2021	2022	2023	Total
Pooling Point	$300,000	$300,000	$300,000	$300,000
Pooled Amount	$457,097	$383,473	$1,943,623	$2,784,192
Pool Charge	$1,817,194	$1,341,497	$3,420,740	$6,579,431
Loss Ratio	25.2%	28.6%	56.8%	42.3%
HMO - Vivity	**2021**	**2022**	**2023**	**Total**
Pooling Point	$300,000	$300,000	$300,000	$300,000
Pooled Amount	$2,274,175	$1,166,864	$4,017,896	$7,458,935
Pool Charge	$1,184,853	$1,341,497	$2,259,052	$4,785,402
Loss Ratio	191.9%	87.0%	177.9%	155.9%
PPO	**2021**	**2022**	**2023**	**Total**
Pooling Point	$300,000	$300,000	$300,000	$300,000
Pooled Amount	$3,028,422	$1,329,631	$4,152,549	$8,510,602
Pool Charge	$2,942,812	$3,098,403	$4,431,348	$10,472,563
Loss Ratio	102.9%	42.9%	93.7%	81.3%
Total Anthem	**2021**	**2022**	**2023**	**Total**
Pooling Point	$300,000	$300,000	$300,000	$300,000
Pooled Amount	$5,759,693	$2,879,968	$10,114,067	$18,753,729
Pool Charge	$5,944,859	$5,781,397	$10,111,141	$21,837,397
Loss Ratio	96.9%	49.8%	100.0%	85.9%

Pooling Point Analysis - Kaiser

Keenan was able to review Kaiser data back to 2013.

- Over time the pooling point has increased from $500,000 to $825,000 for 2024.
- The overall loss ratio is 83.5%.
- However, 2018 and 2019 had loss ratios of 355.6% and 225.1% respectively.
- If we look from 2020 to 2023, the loss ratio is 48.4%.

Renewal	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total
Pooling Point	$550,000	$550,000	$600,000	$625,000	$650,000	$650,000	$675,000	$700,000	$725,000	$750,000	$800,000	
Pooled Amount	$665,142	$123,414	$178,925	$103,123	$895,888	$4,424,967	$3,012,464	$919,755	$1,661,435	$112,662	$304,180	$12,401,955
Pool Charge	$1,130,741	$1,241,851	$1,252,477	$1,229,834	$1,217,199	$1,244,401	$1,337,993	$1,381,676	$1,443,612	$1,658,385	$1,711,012	$14,849,181
Loss Ratio	58.8%	9.9%	14.3%	8.4%	73.6%	355.6%	225.1%	66.6%	115.1%	6.8%	17.8%	83.5%

Capitation Audit

- A capitation fee is realized in HMO coverage.
- It provides your primary care physician and your affiliated hospital a monthly income from the carrier whether or not you are seen by your PCP or your hospital.
- The capitation fee covers certain services for which your PCP and your hospital will not file a claim but is compensated in the capitation fee.
- Anthem provides the capitation fee for each line of HMO coverage in the renewal proposal.
- The audit compares covered services covered under capitation, to the cost of these services on a fee for service basis.

Capitation Audit – Anthem HMOs

- The Traditional HMO and Select HMO are bundled and show an annual capitation fee of $8,249 per subscriber.
- The Vivity HMO has a much lower annual capitation fee of $3,954 per subscriber.
- In total for 2024, The City will spend $41,054,773 for capitation ($6,845 per subscriber per year).
- The next step is to get the list of services covered by the capitation fee – which has been requested.

HMO - Traditional / Select	2022	2023	2024
Capitation	$36,422,493	$33,118,227	$33,300,352
Subscribers	4,830	4,179	4,037
Capitation/Sub.	$7,541	$7,925	$8,249
YOY % Change		5.1%	4.1%
HMO - Vivity	**2022**	**2023**	**2024**
Capitation	$6,798,775	$7,175,204	$7,754,421
Subscribers	1,912	1,865	1,961
Capitation/Sub.	$3,556	$3,847	$3,954
YOY % Change		8.2%	2.8%
HMO - Total	**2022**	**2023**	**2024**
Capitation	$43,221,268	$40,293,431	$41,054,773
Subscribers	6,742	6,044	5,998
Capitation/Sub.	$6,411	$6,667	$6,845
YOY % Change		4.0%	2.7%

Changing City subsidy maximum authority.

- Ad Code – Non-represented EE's
- All other MOU's have the same language

OTHER CHANGES

Condition Management

Kaiser: all condition management programs are already integrated into their services/healthcare delivery system and are not customizable offerings. PGs are not able to be supported due to HIPAA, condition management reports are affiliated with people. Condition management services include:

- Overall disease management
- Chronic condition management
  - Chronic Care Coordination
  - Diabetes Care Management
  - Heart Failure Program
  - HIV Case Management
  - Cardiovascular Disease Program aka PHASE (Prevent Heart Attacks and Strokes Everyday)
  - Palliative Care
- Maternity / gestational diabetes programs

Condition Management

Anthem: Under the City's fully insured contract, all available programs are included by default. There are no new programs for consideration.

- Condition Care program is reference in the Care Management PGs and include: Asthma, Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disorder (COPD), Diabetes, Heart Failure
- Additional programs included under condition support include: Austin Spectrum Disorder (ASD) V2, Behavioral Health Resource V3, Diabetes Prevention Outreach, End Stage Renal Disease Case Management, Maternity Management Program, MyHealth Advantage Gold V2, Virtual Second Opinion through Alight- PPO Only

Outside of what is included in the 2024 Case Management and Care Management PGs, Anthem does not typically offer additional PGs.

MEDICAL PLANS: CONTRACT EXTENSION VS PROCUREMENT

Background

History of Medical RFP’s:

- 2016 – Conducted RFP
- 2021 – Conducted RFP, ultimately withdrawn
- 2022 – Conducted RFP, feedback included: lack of competition in the process

Observations

- Bundling vs. Unbundling is a cornerstone issue
- Disruption is a key element to consider
- RFP Leverage
- Timing for RFP
- Contract Extension

THANK YOU

ATTACHMENT B

Medical Plans Survey. *Please return completed survey to:*

LAwell Benefits Program
200 N. Spring Street, City Hall Room 867
Los Angeles, CA 90012

Returned surveys must be postmarked no later than January 17, 2024.

The LAwell Civilian Employee Benefits Program is evaluating its medical plan offerings, and we want your input.

LAwell currently offers a Preferred Provider Option (PPO) medical plan through Anthem Blue Cross and multiple Health Maintenance Option (HMO) medical plans through Anthem Blue Cross and Kaiser Permanente. We'd like to know about your experiences with these plans and any possible changes you'd like to see.

Please complete the following survey, which asks a few questions and provides opportunities for you to provide your open feedback regarding LAwell Medical Plans.

Completing this survey should take less than ten (10) minutes.

DEMOGRAPHIC QUESTIONS

#1 – What is your home zip code?

☐ ________________

#2 – What is your worksite zip code?

☐ ________________

#3 – How long have you worked for the City?

- ☐ Less than one year
- ☐ 1–4 years
- ☐ 5–9 years
- ☐ 10–14 years
- ☐ 15–19 years
- ☐ 20 or more years

#4 – What is your age group?

- ☐ 25 or under
- ☐ 26–40
- ☐ 41–55
- ☐ 56–65
- ☐ 66–74
- ☐ 75 or older
- ☐ Decline to answer

#5 – What is your gender?

- ☐ Male
- ☐ Female
- ☐ Non-Binary
- ☐ I prefer not to answer

#6 – What City Department do you work for?

- ☐ Airports, Los Angeles World
- ☐ Board of Public Works
- ☐ Building and Safety
- ☐ Chief Legislative Analyst, Office of the
- ☐ City Administrative Officer, Office of the
- ☐ City Attorney, Office of the
- ☐ City Clerk, Office of the
- ☐ Contract Administration, Bureau of Public Works
- ☐ Controller, Office of the
- ☐ Council District
- ☐ Cultural Affairs Department
- ☐ Engineering, Bureau of Public Works
- ☐ Fire Department
- ☐ General Services Department
- ☐ Harbor Department
- ☐ Information Technology Agency
- ☐ Library
- ☐ Mayor
- ☐ Pensions, Fire and Police
- ☐ Personnel Department
- ☐ Planning Department
- ☐ Police Department
- ☐ Recreation & Parks
- ☐ Sanitation, Bureau of Public Works
- ☐ Street Lighting, Bureau of Public Works
- ☐ Street Services, Bureau of Public Works
- ☐ Transportation, Department of
- ☐ Other (includes smaller departments, such as Cannabis, Civil, Human Rights, and Equity, Ethics Commission, etc.)

#7 – What Job category?

- ☐ Clerical *(e.g. Administrative Clerk, Office Services Assistant, Secretary, etc.)*
- ☐ Paraprofessional *(e.g. Legal Secretary, Personnel Records Supervisor, etc.)*
- ☐ Administrative Professional *(e.g. Accountant, Management Assistant, Analyst, etc.)*
- ☐ Technical/Professional *(e.g. Attorney, Civil Engineer, Librarian, City Planner, etc.)*
- ☐ Skilled Craft *(e.g. Equipment Mechanic, Electrician, Refuse Collection Truck Operator, etc.)*
- ☐ Service & Maintenance *(e.g. Recreation Assistant, Maintenance Laborer, Custodian, Gardener, etc)*
- ☐ Management *(e.g. Senior Management Analyst, Assistant General Manager, etc.)*
- ☐ Sworn–Police *(e.g. Police Officer, Firefighter, etc.)*
- ☐ Protective Services *(e.g. Security Officer, Traffic Officer, Crossing Guard, etc.)*
- ☐ Unsure
- ☐ Decline to Answer

#8 – What Labor Organization represents you?

- ☐ AFSCME American Federation of State, County, & Municipal Employees (MOU's 3,6,7,10,11,16,37)
- ☐ SEIU Service Employees International Union (MOUs 4, 8, 14, 15, 17, 18)
- ☐ EAA Engineers & Architects Assoc. (MOU's 1, 19, 20, 21)
- ☐ Non-represented (MOU 00)
- ☐ Airport Police Command Officers Association (MOU 40)
- ☐ LA County Building & Construction Trades Council (MOU 2, 13)
- ☐ Municipal Construction Inspector Assoc. (MOU 5)
- ☐ IUOE International Union of Operating Engineers (MOU's 9, 31)
- ☐ LACSSA/LIUNA (MOU 12)
- ☐ LA City Attorney's Assoc. (MOU 29)
- ☐ Management Attorneys (MOU 32)
- ☐ LAPMA LA Professional Managers Assoc. (MOU's 36, 63, 64)
- ☐ LAPPA LA Port Police Assoc. (MOU 38)
- ☐ Los Angeles Manager's Association (MOU 63)
- ☐ Los Angeles Peace Officers Association (MOUs 39, 65)
- ☐ LOS ANGELES PORT PILOTS ASSOCIATION (MOU 26)
- ☐ Other
- ☐ Unsure
- ☐ Decline to Answer

Medical Plan Questions

Q9. Which City of Los Angeles medical plan are you enrolled in?

- ☐ Anthem Vivity
- ☐ Anthem Narrow Network
- ☐ Anthem Full Network
- ☐ Anthem PPO
- ☐ Kaiser
- ☐ N/A - I have Cash In Lieu
- ☐ N/A - I am not currently enrolled/eligible for LAwell plans
- ☐ Other: ___

If you selected Anthem PPO please answer Q9A; If your selected Anthem Full Network please answer Q9B; Otherwise skip to Q10

Q9A. (*For Anthem PPO)* When utilizing your medical PPO plan, how often do you receive out-of-network benefits?

- ☐ Regularly
- ☐ Sometimes
- ☐ Never
- ☐ Unsure

Q9B. (*For Anthem Full Network)* Which of the following most closely matches your reason for selecting the Full Network?

- ☐ My preferred doctor is in-network in the Full plan, but is not in-network for another HMO.
- ☐ I like the large selections of doctors available
- ☐ The Full Network plan is familiar to me and I don't want to change.
- ☐ Other: [fill in blank]

Q10: Which of the following applies to you:

- ☐ A) I am enrolled in LAwell & My current medical premium is fully covered by the City subsidy.
- ☐ B) I am enrolled in LAwell & I pay a portion of the premium via payroll deduction
- ☐ C) I am enrolled in LAwell as the dependent of another City employee
- ☐ D) I am not enrolled in LAwell; I have coverage outside the City

If you selected A above, then please answer Q10A below; otherwise skip to Q11

***Q10A.* If the City Subsidy no longer fully covered your current plan, how likely are you to consider changing plans?**

- ☐ Not likely – I really like my current plan and would be willing to pay a portion of the premium to keep it.
- ☐ Somewhat likely – I like my current plan, but I would consider changing depending on the cost increase
- ☐ Very Likely – the main reason I picked my coverage is because the City pays 100% of the premium. I would want to change to whatever option was free to me.
- ☐ Unsure/Decline to state

Q11: How many dependents are you covering?

- ☐ None
- ☐ One
- ☐ Two
- ☐ Three or more

Q12. Answer the following questions regarding your average use of health care coverage:

How often do you and/or your dependents…	Very rarely	1 - 4 times a year	5 – 8 times per year	9 – 12 times per year	More than 12 times per year	Unsure/ Decline to answer
…visit a doctor's office for a regular visit?	☐	☐	☐	☐	☐	☐
…seek an urgent care service?	☐	☐	☐	☐	☐	☐
…seek emergency room services?	☐	☐	☐	☐	☐	☐
…seek services while traveling (includes any services sought outside of CA)?	☐	☐	☐	☐	☐	☐
…fill a prescription?	☐	☐	☐	☐	☐	☐

Q13. What about your medical plan is the most important to you?

- ☐ Carrier (Anthem/Kaiser, etc)
- ☐ Provider Access (ability to seek services)
- ☐ Proximity of doctor/hospital to home
- ☐ Proximity of doctor/hospital to work
- ☐ Cost
- ☐ Type (HMO, PPO, etc.)
- ☐ Unsure
- ☐ Decline to Answer
- ☐ Other. (please specify)____

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Q13A. If your current carrier was not available in the future, what option below would help you adjust to the change? (check all that apply)

- ☐ Customized/Personalized educational materials that outline all of my options
- ☐ Personalized suggestions of coverage options which most closely match my current plan
- ☐ Automatic application for "Continuity of Care". This is when your new plan will allow you to continue treatment of an existing condition as it was preapproved under your previous health plan and doctor regardless of whether your doctor is in-network.
- ☐ Increased Opt Out/Waive option (aka higher Cash In Lieu)
- ☐ Other. (please specify)____

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Q13B. If your current doctor was no longer part of your network, what option below would help you identify a new doctor? (check all that apply)

- ☐ Automatic re-assignment to a doctor in the same vicinity/region as my current doctor
- ☐ Customized/Personalized list of doctors
- ☐ One-on-one direct assistance in located a new doctor
- ☐ Other. (please specify)____

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Q14. Are you satisfied with your plan's customer service?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Decline to answer

If No, please provide any additional information regarding your No answer (Optional)

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Q15. Please answer this question based on the below statement:

"I feel that I am well educated on all the benefits my medical plan offers. I understand what services are covered and what is not covered, and I understand how much I may need to pay for services."

- ☐ Yes
- ☐ No
- ☐ Unsure

If No or Unsure, please provide any additional information regarding your answer (Optional)

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Q.16 Are you satisfied with your medical plan?

- ☐ Yes
- ☐ No
- ☐ Neither satisfied nor dissatisfied

If No or Neither satisfied nor dissatisfied, please provide any additional information regarding your answer (Optional)

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Q17. Do you feel your medical plan is a good value?

1. Yes
2. No
3. Unsure
4. Decline to answer

If No, please provide any additional information regarding your answer (Optional)

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Q18. Please answer the following two questions

Important Terms regarding the following questions:

A Co-Payment is the fee that you pay to seek services, such as a visit to a doctor's office or the cost to fill a prescription. The current LAwell Plan co-payment structure for its HMO and PPO plans has been unchanged since 2011.

A Deductible is the amount that you will pay for medical services before your insurance starts to kick in. The current LAwell Plan structure holds a $0 deductible for it HMO plans and its PPO Plans has different in-network vs out-of-network deductibles.

An Out of Pocket Limit is the maximum amount that an employee will pay for services within the plan year. The limit is higher than your deductible and your deductible spending counts towards this annual maximum.

- **I would accept a small increase (*i.e. an increase of $5-$10*) in my Co-payment if:**
  - ☐ I get improved benefit coverage
  - ☐ I get a lower premium
  - ☐ The number of times I pay a co-payment is reduced
  - ☐ I get better prescription drug benefits
  - ☐ I have a lower Out of Pocket Limit
  - ☐ N/A: No change can offset the proposed increase.
  - ☐ Unsure
  - ☐ Decline to answer
  - ☐ Other. (please specify)____

  ____

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- **I would accept a small increase (*i.e. an increase of $100-$500*) in my calendar year deductible**
  - ☐ I get improved benefit coverage
  - ☐ I get a lower premium
  - ☐ I have a lower Out of Pocket Limit
  - ☐ I get better prescription drug benefits
  - ☐ N/A: No change can offset the proposed increase.
  - ☐ Unsure
  - ☐ Decline to Answer
  - ☐ Other. (please specify)____

  ____

  ____

Q19. For the next question, assume the current LAwell health plans continue to be offered, but an additional plan is introduced. How interested are to try a different kind of health plan?

- ☐ Very Interested
- ☐ Somewhat interested
- ☐ Somewhat disinterested
- ☐ Very disinterested
- ☐ Unsure
- ☐ Uncertain – It would depend on what the new plan looks like
- ☐ N/A – I never want to change under any circumstance.

If either disinterested, unsure, or uncertain answers were selected, do any of the following factors interest you (check all that apply):

- ☐ Having a larger network of doctors available to you
- ☐ Accessing a new facility that is currently unavailable to you
- ☐ Having a better condition management services – An improvement to education and experience in managing treatment options.
- ☐ Getting personalized healthcare assistance; Having someone lead you through and navigate the health system
- ☐ Getting better wellness and preventative services
- ☐ Other: ____

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Q20. Please answer the following two questions regarding a High Deductible Health Plan (HDHP).

Important Information regarding HDHPs:

A HDHP is a type of health plan where the deductible is higher than traditional health plans and is at an amount set by the Internal Revenue Service (IRS). For 2024, the minimum HDHP deductible amount for a single party plan is $1,600.

Per the IRS, enrollment in a HDHP provides eligibility for participation in a Health Savings Account (HSA). The HSA is a health personal savings account that is 100% immediately vested, meaning you own the account balance. The HSA allows for an employer contribution; and employees can also choose to contribute pre-tax dollars to their HSA in addition to what the employer contributed up to the IRS set annual combined maximum contribution limit. For 2024, the HSA maximum contribution limit for individuals is $4,150 and families $8,300, with an additional $1,000 catch-up contribution for those age 55 and older.

The money contributed to the HSA can be saved and used to pay for qualified medical expenses, such as deductibles, copayments, and coinsurances at any time; additionally, the balance in a HSA can be used towards monthly COBRA premiums and Medicare premiums in retirement. There is no limitation period to use your HSA account balance or submit claims. As long as your medical expenses were incurred after your HSA was established, the medical expenses are eligible for reimbursement.

The HSA concept is fundamentally different from the City's current Healthcare Flexible Spending Account (HCFSA), which can only be used to cover medical expenses during your active employment. A HSA can only be offered with a HDHP.

Would you be interested in learning more about HDHP and HSA?

- ☐ Yes
- ☐ No
- ☐ Unsure

Would you be interested in seeing alternative plan options such as a HDHP with HSA implemented with the City of Los Angeles?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Other: ______________________________

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Q21. What changes would you like to see in your medical plan?

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Q22. Is there anything else you would like to tell us about your experience with LAwell Medical Plans?

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Thank you for completing the LAwell Medical Plans survey. This completed survey must be returned to the Employee Benefits Division. Please return your completed survey to:

LAwell Benefits Program
200 N. Spring Street, City Hall Room 867
Los Angeles, CA 90012

Returned surveys must be postmarked no later than January 17, 2024.

THANK YOU FOR COMPLETING THE MEDICAL PLANS SURVEY.

If you would like to be entered into a drawing for a gift card for your completion of this anonymous survey, please provide your name, email (optional), and phone below and return – separately from your completed survey – to the Employee Benefits Division.

Please note: The winner(s) of the gift card(s) will be asked to sign an acknowledgement that the value of their gift card will be reported as taxable income on their W-2.

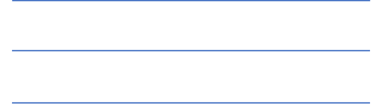
1. Name: ______________________________
2. Email address (optional): ____
3. Phone: ____________

Please return completed survey to:

LAwell Benefits Program
200 N. Spring Street, City Hall Room 867
Los Angeles, CA 90012

(Follow instructions on back of this page to send this page as a self-addressed letter/envelope)

Gift Card entries must be postmarked no later than January 17, 2024 to be eligible



Postage
Required

LAwell Benefits Program
200 N. Spring Street, City Hall Room 867
Los Angeles, CA 90012

Fold on dotted line

Fold on dotted line

Apply glue or tape to seal

Apply glue or tape to seal

ATTACHMENT C

We want to hear from you!

Your LAwell Civilian Employee Benefits Program (LAwell) is evaluating its medical plan offerings, and we want your input.

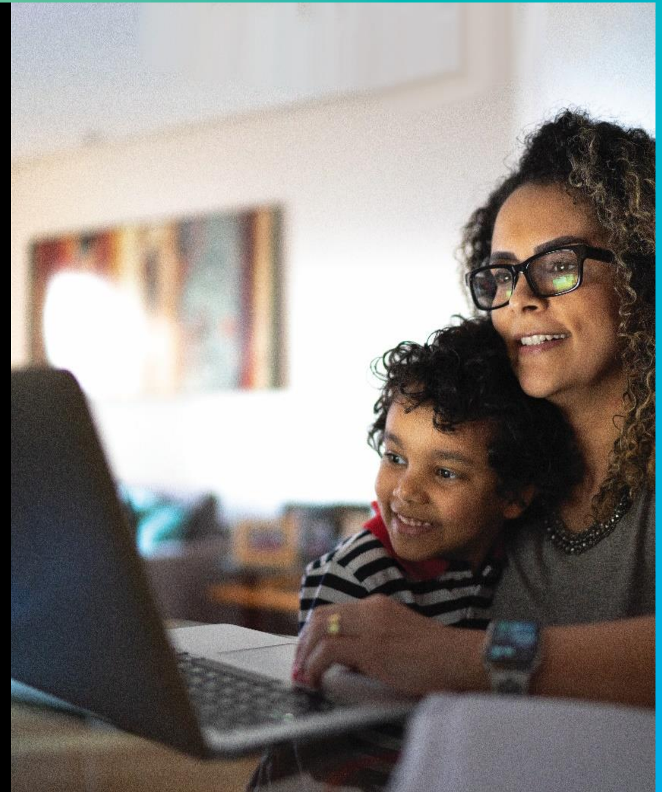
TAKE OUR SURVEY:

KeepingLAwell.com/survey

The survey will be open from December 28, 2023 to January 17, 2024.

Those who participate in the anonymous survey may opt in to be entered into a raffle to win a gift card.

To request a paper survey, please call 213-978-1621.



KEEPING LAwell
City of Los Angeles Employee Benefits

We want to hear from you!

City of Los Angeles – Personnel Department
LAwell Benefits Program
200 N. Spring Street, City Hall Room 867
Los Angeles, CA 90012

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