Pension and Health Benefits Committee

# Agenda Item 8

**April 18, 2017**

**Item Name:** Health Care Combination Enrollments

**Program:** Health Benefits

**Item Type:** Information

**Executive Summary**

As a health benefits purchaser in the large group market, California Public Employees' Retirement System (CalPERS) is continually assessing innovative ways to provide high quality, accessible, and affordable health care to more than 1.4 million members in both Basic and Medicare health plans. The concept of allowing individuals enrolled in a combination plan to separately enroll in plans offered by different health carriers (also known as the multi-carrier combination plan concept) was one of many ideas the Health Policy Research Division (HPRD) considered over the past five years as a way to potentially optimize Medicare plan benefits for CalPERS members.

This agenda item reviews the history of the multi-carrier combination plan concept and the reasons HPRD did not act on this idea. If CalPERS were to implement a solution to allow combination plan enrollees to enroll in plans offered by different health carriers, such a change would benefit a relatively small CalPERS population and would deviate from current health industry data handling practices that safeguard health data privacy. It would also have a sweeping impact to CalPERS system processes, business processes, and to any external data systems linked to my|CalPERS. The cost of the change could be as high as $15 million for CalPERS alone and could take at least four years to implement.

**Strategic Plan**

This agenda item supports Goal A: "Improve long-term pension and health benefit sustainability by ensuring high quality, accessible and affordable health benefits."

**Background**

A combination plan is a family health plan in which some family members are eligible only for Basic health plans and some family members are eligible only for Medicare health plans. This can be a transitional or temporary phase in a family's health coverage experience. Families enroll in a combination plan when a family member becomes Medicare eligible (either by age or some other life event) and disenroll from a combination plan when all family members become either Medicare plan or Basic plan eligible.

A timeline of key events is contained in Attachment 1, but to summarize, beginning in 2012, HPRD proposed various amendments to statutes and regulations to allow the CalPERS Board of Administration (Board) to rapidly implement any Medicare plan options should the opportunity arise to provide Medicare-eligible retirees more diverse plan options that might best meet their needs while reducing health premiums and administrative costs.

The concept of allowing members in combination plans to separately enroll in plans offered by different health carriers was ultimately not needed because in 2015, a new Medicare strategy emerged: the selection of the UnitedHealthcare (UHC) Medicare Advantage (MA) plan as the single non-Kaiser MA plan. The primary benefit of UHC's MA plan is that it allowed plan members to access care – at the same benefit level – using UHC's comprehensive national network of contracted health care providers in California and across the country. In addition, this plan included benefits which were not available in some MA plans, such as the SilverSneakers and HouseCalls programs. Lastly, this plan provides members with the ability to purchase a vision and dental benefit if those benefits were not offered as part of their retiree benefit package. The UHC MA plan was implemented in 2016.

At the February 2017 Board meeting, the Board approved the submission of proposed California Code of Regulations (CCR) section 599.502(g)(4) to the Office of Administrative Law. This regulation clarifies that all family members in a combination plan must enroll into one Basic plan and one Medicare plan provided by the same carrier. Also during the February 2017 meeting, the Board directed the HPRD team to return with an analysis of potential costs and operational impacts that would result from allowing family members in combination plans to enroll in plans offered by different health insurance carriers.

**Analysis**

The discussion below provides the requested analysis of costs and operational impacts that would be encountered upon implementation of additional combination plan enrollment flexibility beyond what CalPERS currently offers, as well as an overview of the current budgetary and regulatory landscape. To fully understand the breadth and depth of the impacts, the HPRD team considered:

- Transition to single non-Kaiser MA Plan and Impacts
- Current industry practices
- Health data requirements
- CalPERS information system and operational impacts
- Budget and fiscal impacts, and
- Impacts to CalPERS health premiums.

Transition to Single non-Kaiser MA Plan and Impact

In any given year, there are approximately 62,000 individuals enrolled in combination plans available to CalPERS members, including plans offered by associations (CAHP, PORAC, CCPOA), HMOs, and PPOs. The overall population size remains fairly constant year to year. The following table shows combination plan enrollment totals prior to the implementation of the single non-Kaiser MA plan offered by UHC for plan year 2016:

| **Total Combination Plan Enrollments – December 2015** | | | |
|---|---|---|---|
| Health Plan Type | Subscribers | Dependents | Total Lives |
| PPOs | 9,930 | 12,652 | 22,582 |
| Kaiser | 9,298 | 12,260 | 21,588 |
| Sunsetting Non-Kaiser HMO* | 6,399 | 8,411 | 14,810 |
| Associations | 1,160 | 1,486 | 2,646 |
| UnitedHealthcare | 142 | 200 | 342 |
| **Total** | **26,929** | **35,009** | **61,938** |

* Anthem HMO, Blue Shield, Health Net, Sharp

Prior to plan year 2016, approximately 15,000 individuals were enrolled in the Anthem HMO, Blue Shield, Health Net, and Sharp combination plans that would no longer be offered after the UHC MA plan implementation.[1] These individuals needed to make a plan change for plan year 2016. In 2015, this population accounted for approximately 1.1 percent of CalPERS' approximately 1.4 million health program members.

The families enrolled in Anthem HMO, Blue Shield, Health Net, and Sharp combination health plans were notified by CalPERS to change their health plan during the plan year 2016 Open Enrollment period because their Medicare/Basic HMO combination plan would no longer be available.[2] The notification stated that if no action was taken by the subscriber, the family would be administratively transferred to UHC (if available in their area) or PERS Choice (if a UHC Basic plan was not available in their area) effective January 1, 2016.

CalPERS team members estimate that each month approximately 900 covered individuals transition into a combination plan enrollment status. Of those, approximately 200 individuals will be required to change health plans to one of the available health plans with a Medicare plan (Kaiser, UHC, or PPO).

Current Health Industry Practices

Although combination plan families must make different choices than they did prior to plan year 2016 due to the reduced number of plans available to them, the need for enrollees to transition to different plans due to changes in benefit design or network coverage is not unique to CalPERS' health benefits program, nor is the enrollment requirement that subscribers and dependents enroll with a single health insurance carrier.

HPRD conducted a market scan of industry associations representing large group health insurance purchasers and asked if they knew of any employers or large group health plans that allowed covered family members to enroll in Medicare and non-Medicare health plans offered by different carriers. The respondents said that this type of arrangement is practically unheard of and:

- Is likely prohibited by health insurance carriers, which would in turn prevent employers from providing employees with this option, and,
- Would create an administrative problem when tracking family deductibles and out-of-pocket expenses.

Other public purchasers that prohibit multi-carrier combination enrollments include:

- University of California[3]
- State of Washington[4]
- State of Illinois[5]

[1] CalPERS Agenda Item 8: *2016 Medicare Plan Approaches*. May 19, 2015. https://www.calpers.ca.gov/docs/board-agendas/201505/pension/item-8.pdf

[2] Members enrolled in Kaiser and UHC combination plans were not notified because they could stay in their plans.

[3] University of California. 2017: *A Complete Guide to Your UC Health Benefit*. http://ucnet.universityofcalifornia.edu/forms/pdf/complete-health-benefits-guide-for-employees.pdf

[4] Washington State Health Care Authority. *Public Employee Benefits: Plan Change Requirements*. https://www.hca.wa.gov/public-employee-benefits/employees/change-your-coverage#Plan-change-requirements

[5] Illinois Department of Central Management Services. *State Employee Benefits: Dependent Coverage*. https://www.illinois.gov/cms/Employees/benefits/StateEmployee/Pages/State-Dependent-Enrollment.aspx

These prohibitions and constraints are driven primarily by health data rules and regulations, and subsequently reinforced by information system standards.

Health Data Requirements

CalPERS and the multiple business partners it contracts with to administer health benefits use standard health industry enrollment and data handling practices to ensure families enroll in combination plans offered by the same carrier in order to help safeguard health data privacy for CalPERS members.

Allowing multi-carrier combination plan enrollments could expose CalPERS and its contracting health plan partners to the risk of violating Health Insurance Portability and Accountability Act (HIPAA) rules[6]. HIPAA provisions support the electronic exchange of administrative and financial health care information between health care providers, health plans, and employers. HIPAA requires that a health plan use a standardized health enrollment format, and the American National Standards Institute (ANSI) is the national standard for electronic enrollment and maintenance.

CalPERS and its contracted health plan partners all use the ANSI 834 file transfer specification to perform the initial enrollment and subsequent maintenance of individuals who are enrolled in health.[7] ANSI 834 standardized transactions and code sets must be implemented consistently by all organizations involved in the electronic exchange of data, and HIPAA sets limits on what health data can be shared between entities.

ANSI defines the terms “member”, “subscriber”, and “dependent” as follows[8]:

- Member is a subscriber or dependent who has been enrolled for coverage under an insurance plan.
- Subscriber is an individual eligible for coverage because of his or her association with a sponsor.
- Dependent is an individual who is eligible for coverage because of his or her association with a subscriber.

Through these definitions, ANSI standardizes and constrains the transmission of enrollment data between systems. According to HIPAA guidelines, an entity must agree to not[9]:

- Modify the definition, condition, or use of a data element or segment within an ANSI 834 standard transaction;
- Add any additional data elements or segments;
- Use any code or data values which are not valid in the current version of ANSI 834; or,
- Change the meaning or intent of the ANSI 834 transaction.

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[6] HHS.gov. *Summary of the HIPAA Privacy Rule*. https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/

[7] *CalPERS HIPAA Transaction Set Standard and Health Companion Guide*. *Version 4.1.* https://www.calpers.ca.gov/docs/hipaa-health-companion.pdf

[8] Supremus Group (2014). *HIPAA Certification Training Official Guide: CHPSE, CHSE, CHPE.* https://books.google.com/books?id=rVHOAwAAQBAJ&pg=PT79#v=onepage&q&f=false

[9] U.S. Department of Health and Human Services (2000). *Should Health Plans Publish Companion Documents That Augment the Information in the Standard Implementation Guides for Electronic Transactions?* https://aspe.hhs.gov/report/frequently-asked-questions-about-electronic-transaction-standards-adopted-under-hipaa/should-health-plans-publish-companion-documents-augment-information-standard-implementation-guides

Therefore, under ANSI standards, health insurers can receive only subscriber data and dependents are tied to subscribers. ANSI guidelines would preclude CalPERS from implementing an electronic placeholder subscriber scenario or some other type of workaround to allow dependents to act as subscribers in the selection of individual health plans.

Information System and Operational Impacts

If ANSI requirements were ever modified to allow separate subscriber and dependent enrollments, separating the combination plan enrollments would require extensive my|CalPERS changes. my|CalPERS is the centralized Information Technology (IT) system for all health program enrollment administrative data and functions, and the my|CalPERS platform was designed and built to meet specific requirements under Government Code section 22830:

> An employee or annuitant, under eligibility rules prescribed, may enroll in a health plan approved by the board either as an individual or for self and family.[10]

All health data components anchor primarily to the concept of an eligible subscriber and secondarily to associated dependents comprising a single account eligible for health care.

Separating combination plan enrollments would require making changes to my|CalPERS to allow each member of a family plan to independently enroll in a health plan, essentially creating separate health subscriber accounts for each individual. Moving to a model where individual health enrollees each have an account will have a sweeping impact on CalPERS system processes, business processes, and any data systems linked to my|CalPERS, such as those maintained by the Office of the State Controller (SCO), health insurance plan partners, and systems used by employers who offer CalPERS health benefits to their employees (e.g., California Department of Human Resources, California State University, and contracting public agencies) to track health enrollment and eligibility and calculate payroll.

A preliminary assessment of high-level impacts to my|CalPERS processes and systems by CalPERS Information Systems Technology Branch reveals that multiple subsystems would be impacted, including those that handle carrier rates, employer contribution formulas, member share of premium, ANSI interfaces, data architecture, and member self-service enrollment. The estimate of the time required to implement necessary my|CalPERS system changes indicated that it could take up to 100,000 hours. From a budgeting perspective, this is the equivalent of up to 56 full-time resources for a full year or up to 28 resources full-time for two years assuming all work is linear and can be done sequentially. To engage a vendor, this level of effort would have a cost estimate ranging from $12 million to $15 million. Attachment 2 shows the level of impact to all identified my|CalPERS processes and systems in greater detail.

An implementation of this scale would have a considerable cost and resource impact to any external partner receiving CalPERS health data. For example, the SCO estimates that if it were necessary to modify multiple systems, tables, and reports, these modifications could take 9-18 months and could exceed budgeted maintenance and operations in which case a budget augmentation might be required. In the case of some contracting agencies in which the employer contributes a specified dollar amount based on the carrier with which the employee enrolls, CalPERS would be required to request new contract resolutions containing revised contribution methods (methods that were likely negotiated with their employee groups). Both CalPERS and

[10] The Public Employees' Medical and Hospital Care Act section 22830. https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=GOV&division=5.&title=2.&part=5.&chapter=1.&article=5.

the contracting agencies would need to build the capability to determine what contributions are paid for all permutations of separate carrier enrollments.

Additionally, separating a family combination plan enrollment would require a complete departure from the current family tiering scheme CalPERS uses for negotiating insurance rates and determining the employer and employee split of premiums. This scheme would need to be revised. Also, to adapt to my|CalPERS systems changes, CalPERS would incur additional operational impacts and could experience a potential decrease in member account customer service responsiveness as well as a need for additional resources to meet Open Enrollment processing timeframes and service level agreements.

CalPERS Budget and Impact to Timeline

Implementing the separation of combination plan enrollments would introduce new state operations costs for CalPERS. If the my|CalPERS system changes necessary to separate combination plan enrollments require substantial funding, CalPERS may have a challenge obtaining it. In 2016, the CalPERS health program lost the ability to use the CalPERS Formal Budget Request (FBR) process as it has done in the past to request funding for health-related administrative expenditures.

Language contained in the FY2016/2017 budget trailer bill conditions administrative expenditures from the CalPERS' Health Care Fund (HCF) and Contingency Reserve Fund (CRF) upon approval in the annual state legislative budget process[11], thereby discontinuing the CalPERS' Board use of monies in the HCF to pay for other costs as determined by the Board. Therefore, CalPERS must request spending authority from the Department of Finance (DOF) using their Budget Change Proposal (BCP) process, and recent DOF Budget Letters have cautioned departments to control costs and warn that a department's ability to submit a BCP is limited.[12]

The BCP process is time-consuming. For example, if CalPERS were to begin developing an initiative today, the earliest we could submit a BCP would be August 2018 for the 2019-20 legislative budget process. Assuming the BCP was approved without delay, and the IT implementation took two years, the separation of combination plan enrollments could be completed by 2022. The table below illustrates the sequence of steps and timeline required:

| **BCP Timeline** | | |
|---|---|---|
| Phase | Begin | End |
| Submit BCP to Agency | **August 2018** | - |
| Agency approval | - | September 2018 |
| Submit BCP to DOF | September 2018 | June 2019 |
| DOF approval | July 2019 | - |
| IT Implementation | January 2020 | **January 2022** |

Any other California departments affected by the my|CalPERS system change would also likely be required to launch their own BCP initiatives in order to comply with the changes.

[11] SB 836 (2015-2016) *State government*. See Legislative Counsel's Digest section 17: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB836

[12] See *Department of Finance 2017-2018 Budget Letter 17-01* (http://www.dof.ca.gov/budget/Budget_Letters/documents/BL17-01.pdf) and *2017-2018 Budget Letter 16-15* (http://www.dof.ca.gov/budget/budget_letters/documents/BL16-15.pdf).

**Budget and Fiscal Impacts**
Implementing the separation of combination plan enrollments would introduce new state operations costs for CalPERS, and costs would also be incurred outside CalPERS. Because of changes to contracting health plan systems, the contracting health plans would likely seek reimbursement through increased administrative fees and increased premiums. All external state departments receiving CalPERS health data would also incur new operations costs as they work to comply with any new data requirements.

**Benefits and Risks**
Allowing each member in a combination plan enrollment to select the health plan and carrier of their choice would give these members flexibility when making enrollment choices.

The risks of implementing such a choice might result in:

- Variance from established data handling practices that help ensure compliance with HIPAA health data privacy laws;
- Redesign and reprogramming of many my|CalPERS system processes and data interfaces with external partners;
- Revision of family tiering methods, which would affect the calculation of employer and employee contributions in my|CalPERS, employer resolutions, employee-bargained MOUs, and any external data systems (like SCO); and
- Increased administrative costs, leading to higher health premiums.

**Attachments**
Attachment 1 – Medicare Optimization History
Attachment 2 – Impacts to my|CalPERS Processes and Systems
Attachment 3 – Presentation Slides

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