# CLARK COUNTY
# STAFF REPORT


**DEPARTMENT:** Human Resources

**DATE:** December 17, 2013

**REQUEST:** Approve contract renewal with Kaiser Permanente for Medical and Dental coverage

**CHECK ONE:** X Consent _____ CAO

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## BACKGROUND

The 2014 rates for the Kaiser Permanent HMO Plans came in very favorable with a 0% rate increase. There are no changes to the plan benefits for 2014. Enrollment in this plan is approximately 852 employees.

In addition to the HMO plan, we are implementing a new High Deductible Health Plan. This plan will help curb health care costs in the future and satisfies the Affordable Care Act requirement to offer an affordable health plan. The plan includes a $1,250 deductible or $2,500 for family; once met the plan pays 80% up to a $3,000 individual or $6,000 family out of pocket maximum. A copy of the Plan Summary is attached. The cost of this plan is approximately 32% less than the HMO plan.

The Kaiser Dental Plan received an increase of 3.5% due to utilization of the plan. There are no plan changes.

## COMMUNITY OUTREACH

Community outreach is not a consideration for this request.

## BUDGET AND POLICY IMPLICATIONS

Since the medical rates will not increase for 2014, any additional cost would result from enrollment changes. The dental plan will increase slightly, however due to enrollment changes the overall cost increase is approximately 1.3%. This cost increase has already been factored in to the 2013-2014 biennial budget.

## FISCAL IMPACTS

☐ **Yes (see attached form)** ☑ **No**

## ACTION REQUESTED

Approve Contract Amendment to renew the Kaiser Permanente HMO and add the High Deductible Health Plan for plan year 2014.

## DISTRIBUTION

Kathy Meyers, Benefits Manager

Francine Reis
Human Resources Director

Approved: _____
CLARK COUNTY
BOARD OF COMMISSIONERS

DEC. 17, 2013 SR 273-13

KAISER PERMANENTE®

## 2014 CLARK COUNTY RATE APPROVAL – Kaiser #01190 and #18959

**MEDICAL**

**MOU & Affiliated Groups & Custody Guild (non-MOU)**

| | Active - HMO<br>018, 031, 048, 065, 066, 071, 073, 074 | PERS Retirees<br>Under age 65<br>064 | PERS Retirees<br>Over age 65<br>064 Senior Adv. |
|---|---|---|---|
| **Single** | $547.84 | $804.84 | $230.04 |
| **Two Party** | $1,095.68 | $1,609.67 | $230.04 * |
| **Family** | $1,643.54 | $2,414.51 | $230.04 ** |

| | Active – HSA<br>MOU & Affiliated Groups |
|---|---|
| **Single** | $373.92 |
| **Two Party** | $747.84 |
| **Family** | $1,121.76 |

**Deputy Sheriffs Guild (Non-MOU)**

| | Active - HMO<br>051, 053, 067 | LEOFF 1 Retirees<br>Under age 65<br>042 | LEOFF 1 Retirees<br>Over age 65<br>061 Senior Adv. |
|---|---|---|---|
| **Single** | $579.36 | $579.36 | $270.99 |
| **Two Party** | $1,158.72 | $1,158.72 | $270.99 * |
| **Family** | $1,738.08 | $1,738.08 | $270.99 ** |

* plus whatever age group the spouse falls in

** plus whatever age group the spouse and child(ren) fall in

**PERS Retirees -064**

| | Retiree Over 65 / Spouse Under 65 | Retiree Under 65 / Spouse Over 65 |
|---|---|---|
| **Single** | $230.04 | $804.84 |
| **Two Party** | $230.04 + 804.84 = $1,034.88 | $804.84 + 230.04 = $1,034.88 |
| **Family** | $230.04 + 1,609.67 = $1,839.71 | $1,609.67 + 230.04 = $1,839.71 |

**LEOFF 1 Retirees -042 & -061**

| | Retiree Over 65 / Spouse Under 65 | Retiree Under 65 / Spouse Over 65 |
|---|---|---|
| **Single** | $270.99 | $579.36 |
| **Two Party** | $270.99 + 579.36 = $850.35 | $579.36 + 270.99 = $850.35 |
| **Family** | $270.99 + 1,158.72 = $1,429.71 | $579.36 + 850.35 = $1,429.71 |

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**DENTAL Plan P w/Orthodontia Plan E**

| **036, 045, 046, 057, 072-075** | |
|---|---|
| Single | $55.80 |
| Two Party | $111.58 |
| Family | $167.38 |

As an authorized representative of Clark County, I accept this contract approval for the contact period of 01/01/2014 – 12/31/2014. By signing below, I acknowledge agreement with the rates described.

Authorized Representative: _____

Signature: _____

Date: DEC. 17, 2013

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All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

# Summary of medical benefits

HIGH DEDUCTIBLE HEALTH PLAN

Clark County 1190-080
Washington High Deductible Health Plan (HSA-Qualified) 1420
January 1, 2014 through December 31, 2014

**Deductible** (All Services except preventive care are subject to the Deductible. You must pay Charges for the Services when you receive them, until you meet your Deductible. If you are the only Member in your Family, then you must meet the $1,250 Deductible. If you are a Member in a Family of two or more Members, you meet the Deductible when your entire Family meets the $2,500 Deductible amount. Every Member in your Family must pay Charges during the Calendar Year until the entire Family meets the $2,500 Deductible. After you meet the Deductible, you pay the applicable Copayments or Coinsurance for covered Services the remainder of the Calendar Year until you meet your Out-of-Pocket Maximum. Note: The Deductible and Out-of-Pocket Maximum amounts are subject to increase if the U.S. Department of Treasury changes the minimum Deductible and Out-of-Pocket Maximum amounts required in High Deductible Health Plans.)

| | |
|---|---|
| For a Family of one Member | $1,250 per Calendar Year |
| For a Family of two or more Members | $2,500 per Calendar Year |

**Out-Of-Pocket Maximum** (All Deductible, Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum unless otherwise noted.)

| | |
|---|---|
| For a Family of one Member | $3,000 per Calendar Year |
| For a Family of two or more Members | $6,000 per Calendar Year |

| **Preventive Care Services** | **You pay** |
|---|---|
| Routine preventive physical exam (includes adult, well baby, and well child) | $0 |
| Scheduled prenatal care and first postpartum visit | $0 |
| Immunizations | $0 |
| Preventive tests | $0 |
| **Outpatient Services** | |
| Primary care visit | 20% Coinsurance after Deductible |
| Specialty care visit | 20% Coinsurance after Deductible |
| Urgent care visit | 20% Coinsurance after Deductible |
| Emergency department visit | 20% Coinsurance after Deductible |
| Outpatient surgery visit | 20% Coinsurance after Deductible |
| Chemotherapy/radiation therapy visit | 20% Coinsurance after Deductible |
| Laboratory, X-ray, imaging, and special diagnostic procedures | 20% Coinsurance after Deductible |
| CT, MRI, PET scans | 20% Coinsurance after Deductible |
| Routine eye exam | 20% Coinsurance after Deductible |
| Nurse treatment room visits to receive injections | $10 after Deductible |
| Administered medications, including injections (all outpatient settings) | 20% Coinsurance after Deductible |
| Outpatient durable medical equipment, external prosthetic devices, and orthotic devices | 20% Coinsurance after Deductible |
| Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year) | 20% Coinsurance after Deductible |
| Spinal and extremity manipulation therapy visit (after 12 visits, prior authorization needed) | 20% Coinsurance after Deductible |
| **Inpatient Hospital Services** | 20% Coinsurance after Deductible |
| **Ambulance Services** (per transport) | 20% Coinsurance after Deductible |

| | |
|---|---|
| **Skilled Nursing Facility Services** (up to 100 days per Calendar Year) | 20% Coinsurance after Deductible |
| **Chemical Dependency Services** | |
| Outpatient Services | 20% Coinsurance after Deductible |
| Inpatient hospital & residential Services | 20% Coinsurance after Deductible |
| **Mental Health Services** | |
| Outpatient Services | 20% Coinsurance after Deductible |
| Inpatient hospital & residential Services | 20% Coinsurance after Deductible |
| **Student Out-of-Area Coverage** Routine, continuing, and follow-up Services (up to $1,200 per Calendar Year; amounts count toward the maximum) | 20% after deductible of the actual fee the provider, facility, or vendor charged for the Service |
| **Optional Benefits** | |
| Alternative care (self-referred) | Not covered |
| Hearing aids | After Deductible has been met, a $1,500 allowance is provided per aid per ear every three years towards the purchase of hearing aids |
| Outpatient prescription drugs | $15 generic/$30 brand after Deductible. $0 for formulary contraceptives, not subject to Deductible. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two Copayments. |
| Vision hardware and optical Services (ages 18 years and younger) | No charge for one pair standard frames and lenses or 6-month supply contact lenses every 24 months. |
| Vision hardware and optical Services (ages 19 years and older) | Balance after $200 allowance every 24 months |

## Exclusions and Limitations

The Services listed below are either completely excluded from coverage or partially limited. This applies to all Services that would otherwise be covered and is in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in the *Evidence of Coverage (EOC)*.

**Certain exams and Services; Cosmetic Services; Custodial Services; Dental Services.** Except when Medically Necessary for Members who have a medical condition that would place undue risk if performed in a dental office. The procedure is subject to Utilization Review.; **Designated blood donations; Detained or confined members; Employer responsibility; Experimental or investigational Services; Eye surgery.** Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures.; **Family Services.** Services provided by a member of your immediate family.; **Genetic testing; Government agency responsibility; Hearing aids.** Unless the Hearing Aid rider has been purchased.; **Hypnotherapy; Non-Medically Necessary Services; Nonreusable medical supplies; Outpatient Prescription Drugs.** Unless the Outpatient Prescription Drug rider has been purchased. Our formulary applies. We cover non-formulary drugs only when you meet exception criteria unless specifically covered by your prescription drug plan.; **Professional Services for fitting and follow-up Services for contact lenses; Services performed by unlicensed people; Services related to a non-covered Service; Services that are not health care Services, supplies, or items; Sexual reassignment surgery; Supportive care and other Services; Travel and lodging.** Limited to: (a) Medically Necessary ambulance Services, and (b) certain expenses that we preauthorize.; **Travel Services.** All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless the Travel Services rider has been purchased.; **Vision hardware and optical Services (ages 18 and younger).** Unless the Pediatric Vision Hardware and Optical Services rider has been purchased.; **Vision hardware and optical Services (ages 19 and older).** Unless the Adult Vision Hardware and Optical Services rider has been purchased.; **Vision therapy and orthoptics or eye exercises.**

**Questions? Call Membership Services** (M-F, 8 am-6 pm) or visit **kp.org**
Portland area..503-813-2000. All other areas..1-800-813-2000. TTY..1-800-735-2900.
Language Interpretation Services, all areas..1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your *EOC* or call Membership Services. In the case of conflict between this summary and the *EOC*, the *EOC* will prevail.