County of Los Angeles
CHIEF EXECUTIVE OFFICE
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WILLIAM T FUJIOKA
Chief Executive Officer

September 11, 2007

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

MEDICAL, DENTAL, LIFE INSURANCE, AND DISABILITY PLANS FOR 2008 (3 VOTES)

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve proposed premium rates for County sponsored plans as follows: (a) medical and dental rates for represented employees for the period January 1, 2008 through December 31, 2008, as shown in Exhibit I; (b) medical and dental rates for non-represented employees for the period January 1, 2008 through December 31, 2008, as shown in Exhibit II; (c) basic life and accidental death and dismemberment (AD&D) insurance rates, and for represented employees, optional term life and dependent life insurance rates for the period January 1, 2008 through December 31, 2010, as shown in Exhibit III; (d) supplemental group variable universal life (GVUL), dependent term life and survivor income benefit (SIB) rates for non-represented employees for the period January 1, 2008 through December 31, 2010, as shown in Exhibit III; and (e) rates for short-term disability (STD), long-term disability (LTD) and LTD Health Insurance plans as shown in Exhibit IV.

2. Approve Kaiser Mid-Atlantic HMO rates and plan design as detailed in Exhibit II.

3. Instruct the County Counsel to review and approve as to form the appropriate agreements with Blue Cross of California and Blue Cross Life and Health Insurance Company (Blue Cross), Connecticut General Life Insurance Company and CIGNA Healthcare of California, Inc. (CIGNA), Kaiser Foundation Health

Plan, Inc. (Kaiser), Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and Mid-Atlantic Medical Group (Kaiser Mid-Atlantic), PacifiCare of California and PacifiCare Life & Health (PacifiCare), and Delta Dental Plan (Delta Dental) and their successors or affiliates, as necessary, for the period January 1, 2008 through December 31, 2008; agreements with SafeGuard Health Plans, Inc. (SafeGuard), Metropolitan Life Insurance Company (MetLife), and Life Insurance of North America (LINA) and their successors and affiliates, as necessary, for the period January 1, 2008 through December 31, 2010, and instruct the Chairman to sign such agreements.

4. Approve proposed premium rates and benefit coverage changes for the following Union sponsored plans, as shown in Exhibit V, for the period from January 1, 2008 through December 31, 2008: The Association for Los Angeles Deputy Sheriffs, Inc. (ALADS); the California Association of Professional Employees (CAPE); and the Los Angeles County Fire Fighters Local 1014 Health and Welfare Plan.

5. Approve an adjustment in the minimum County contribution under the MegaFlex and Flexible Benefit Plans from $918 and $678 per month, respectively, to $987 and $735 per month, respectively, to be initially reflected on the January 15, 2008 pay warrants.

6. Approve an expenditure cap of $1.23 million per year for the Dependent Care Spending Account subsidy program for non-represented employees beginning on January 1, 2008.

7. Instruct the Auditor-Controller to make all payroll system changes necessary to implement the changes recommended herein to ensure that all changes in premium rates are first reflected on pay warrants issued on January 15, 2008.

8. Instruct the County Counsel to prepare the ordinances necessary to amend Title 5 of the Los Angeles County Code to implement the recommended changes.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Purpose

The County maintains employee health, dental, group life, and other insurance programs to provide benefits that promote the effectiveness, health, and welfare of its workforce. The current agreements for all County and Union sponsored medical, dental and life insurance plans end on December 31, 2007. The purpose of the

recommendations contained in this letter is to implement negotiated agreements with carriers to continue existing benefits and to adopt benefit changes for the 2008 calendar year.

Justification

Overall Premium Negotiation Process and Results

County Sponsored Plans in General. The recommendations in Exhibits I, II, III, and IV regarding the County sponsored plans are the result of intensive negotiations between the health, dental, and life insurance carriers and the County negotiating team consisting of representatives of the Chief Executive Office (CEO), Director of Personnel (DOP), and the County's group insurance consultant, Mercer Human Resource Consulting (Mercer). For County sponsored plans whose benefits are governed by Fringe Benefit Memoranda of Understanding (MOU) with SEIU Local 721 (Local 721) and the Coalition of County Unions (CCU), the unions' own benefit consultants have had input into the insurance carrier negotiation process.

Mercer's opinion is that the County sponsored plan carriers' final negotiated rates and offered terms are justified for represented and non-represented employee medical, dental and life insurance plans, but Mercer has expressed reservations about some Kaiser underwriting issues (discussed later in this letter and in Mercer's opinion letters). Mercer's opinion and the supporting due diligence is documented in Attachments A and B.

In general, County health (medical and dental) plans are rated by carriers based on the cost of claims, claims trend and administration costs, taking into account the health risk of, and the utilization of health care by County employees and their covered dependents. In 2007 nationally, there continues to be an ongoing pattern of increases in hospital and pharmaceutical costs. This will drive medical insurance costs for 2008 upwards at a rate estimated by Mercer at 9% in Southern California.

The County sponsored medical plan rates recommended in this letter, averaging 2.7% for represented employees and 12% for non-represented employees, are 6.3% lower and 3% higher respectively than the projected Southern California average. The underlying dental trend is more moderate. Life insurance carriers have offered to guarantee no increase through 2010.

County Approved Union Sponsored Plans in General. The premium and benefit recommendations in Exhibit V regarding County approved Union sponsored health plans were negotiated by the sponsoring unions and evaluated by the CEO and DOP

pursuant to the relevant provisions of the CCU Fringe MOU and County Code. The joint CEO and DOP recommendations are provided later in this report.

Renewal Policy and Process. In accordance with the Board of Supervisors' policy, the County negotiating team requires all carriers to justify rates fully and support proposed contract terms for the upcoming plan year. The rate renewal process for 2008 (documented in Attachments A and B) is designed to encourage full involvement and transparency among all County, Union and carrier stakeholders. The process involves production of data by carriers as needed, identification, in depth analysis and evaluation of all material underwriting issues in carrier proposals and documentation of due diligence and financial results.

With the exception of Kaiser, all parties fully complied with the process. Kaiser implemented a new rating methodology (NPS) in 2006 for 2007 rates and continues to use the new rating methodology for the 2008 renewal. In some respects, Kaiser is less able to provide timely supporting information (for example, health care utilization data with NPS), than they were under their old pricing mechanism. Kaiser assures us that this will be corrected in the next year or two.

Overall Results. Attachment C is a high level summary of carrier negotiation results that compares the estimated actual total premiums from initial carrier premium quotes for 2008 with the final result after performance guarantee review, challenges to carrier underwriting, benefit changes, and negotiation. Summary reasons for the negotiated reductions are given.

Total 2008 premiums to be paid to health, dental, group life and other insurance plan carriers are estimated to be $647 million for County sponsored plans and $123 million for Union sponsored plans, a total of $770 million. This is an increase of $29.2 million or 3.9% over 2007.

Total savings from initial carrier proposals is $23.8 million. Of that, $10.1 million are negotiated savings from 2008 carrier proposals, $13.1 million is from benefit design changes agreed to by County unions, and $0.6 million is from performance guarantee refunds and rate credits.

Attachment C also shows the percentage increase for each carrier by cafeteria plan as well as the total increase for County sponsored health, dental, group life, and other insurance programs. The increase in medical plan premiums estimated to be paid to health carriers during 2008 will range from -0.6% to 15.1% for an average of 4.1%, which is much lower than the expected average projected Southern California increase of 9%. Due to rate guarantees for Delta Dental and DeltaCare plans, the overall

increase for Dental plans will be 0.2%. Life insurance rates for 2008 will remain at current 2007 rate levels.

2008 Premium Rates Recommended for Adoption:

Recommended Rates. County and Union sponsored health, dental, group life and other insurance rates recommended for adoption are shown in Exhibits I through V. Unless otherwise noted in this letter, the rates support existing benefits enabled by the applicable Fringe MOU, or County Code provision. The rates shown in these Exhibits are the monthly prices that employees will pay from County cafeteria plan contributions from their own resources after County subsidies are subtracted from negotiated carrier premiums rates paid to carriers. For this reason, percentage increases in premium rates to be charged to employees as shown in the Exhibits, in many cases, may differ from the negotiated increases in premium to be paid to carriers as reported in the body of this letter and in Attachment C.

Union Concurrence. Local 721 and management representatives voted in the Labor-Management Benefit Administration Committee (BAC) to recommend the premium rates for employees represented by Local 721. The CCU and management representatives in the Labor-Management Employee Benefits Administration Committee (EBAC) voted to recommend the premium rates with the exception of Kaiser, for employees represented by the CCU. The CCU position regarding Kaiser is set forth in full in the enclosed letter (Attachment D) from the Coalition Chair and EBAC labor Chair, Blaine Meek, to the EBAC management Vice Chair, Frank Frazier.

Implementation of Strategic Plan Goals

The recommended actions are consistent with the principles of the Countywide Strategic Plan by promoting the well being of County employees and their families by offering comprehensive employee benefits.

FISCAL IMPACT/FINANCING

Each cafeteria plan, including represented employee plans provided by MOUs with County unions, provides for a County contribution and, in some cases, an additional subsidy to help pay the cost of insurance benefits. The current County contributions and applicable subsidies for employee benefits mentioned in this letter, or changed contributions, or subsidies recommended herein are included in the Fiscal Year 2007-2008 budget. Employees pay for additional costs above and beyond the County contributions and subsidies through payroll deduction.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The general facts concerning 2008 premium rate and benefit adjustments for County sponsored plans affecting both represented and non-represented employees are stated in this section. The details of each carrier's County sponsored medical, dental, group life, and other insurance plan proposal, Mercer's evaluation, and Mercer's opinion concerning their justification and term of offer are given in Attachments A and B. Unless otherwise specified, the term of offer is one year.

Represented Employees

Medical Plan Benefit Changes Affecting Represented Employees

As provided in the Local 721 and CCU fringe benefit MOUs, the following changes were agreed to take place for County sponsored medical plans beginning in 2008:

- $10 office visit co-payment for all HMOs.
- $5 generic/$20 name brand prescription drug co-payment.
- $0 co-payment for children up to age 5 (Kaiser and PacifiCare only; CIGNA can not administer this change due to system limitations).

In addition, an increase in the pharmacy co-payment to $5 generic/$20 name brand/$35 non-formulary will be implemented in the PacifiCare PPO at the request of Local 721.

Medical Plan Rates Affecting Represented Employees

CIGNA Rates for 2008: Consistent with the fringe benefit agreement with the CCU, the CIGNA PPO plan will be discontinued in 2008. CIGNA will continue to provide two different plans to employees represented by the CCU: an HMO and a Point of Service plan (POS). The 2008 negotiated contract rates for all CIGNA plans will decrease -0.6% after excessive reserves in the CIGNA Plan Stabilization Reserve (PSR) are applied to premium.

Mercer's opinion certifying the CIGNA rates are justified and supporting a transfer of excessive reserves from the PSR to reduce premium, is included in Attachment A.

Kaiser Rates for 2008: Based on Kaiser's last best offer, Kaiser's 2008 rates will increase by 0.2% for the Local 721 plan and 2.2% for the CCU plan. The low rate increases are partially due to plan design changes. Kaiser also claims significant decreases in inpatient hospital utilization, as a factor, but to date has not produced evidence to support this view. A credit for an error in large claim pooling that was

discovered in Mercer's audit of Kaiser, and a credit for a 2005 performance penalty are lesser factors.

Both premium level and rate increases are different for the Local 721 and CCU plans. The substantially higher cost of the CCU plan is attributable mainly to larger family size. The CCU plan has a higher number of dependents in its plan, which increases individual subscriber costs.

The difference in the year-to-year plan increase favoring Local 721 over the CCU in 2008 is mostly because Kaiser has levied a 1.5% load on the CCU plan. Kaiser says the load is needed due to: (1) its assumption that risk will increase due to declining plan enrollment, and (2) alleged failure by the County and CCU to engage Kaiser on cost mitigation goals and objectives. The facts are in dispute. Mercer does not agree with the added load but has reached an impasse with Kaiser.

Our Office and Mercer is concerned by the large unsupported fluctuation in Kaiser's rate increase from year-to-year. In contrast to the low proposed 2008 rate increases, the 2007 rate increases for both Choices and Options were in double digits, while 2006 increases were in the high single digits. The odds are small that such large year to year changes could occur in the very large Union plan population.

Mercer's opinion on Kaiser's proposed rates is included in Attachment A.

PacifiCare Rates for 2008: PacifiCare provides two fully insured plans to employees represented by Local 721: An HMO and a preferred provider plan (PPO). The 2008 negotiated contract premium rates for the HMO plan will increase 8.3% and the PPO plan will increase 13.8%, an average of 8.6%.

Last year, we recommended to the Board of Supervisors (Board) exploring alternative funding arrangements with PacifiCare as a result of significant surpluses retained by PacifiCare over the three years ending in 2005. In 2006, a much smaller surplus resulted and was considered by Mercer to be at an acceptable variance of 0.5% of premium. However, based on our request, PacifiCare offered two non-traditional alternative funding arrangements that share risk and surpluses. Both arrangements increased exposure for the County and did not provide adequate levels of return to the County. Mercer recommends the County continue the current fully insured arrangement and monitor PacifiCare's financial results. If future surpluses are excessive or rating methodology has increased conservatism, we will revisit the shared risk alternative funding arrangement.

Mercer's opinion certifying that PacifiCare's 2008 rates are justified and examining the alternative funding arrangement is included in Attachment A.

Union Sponsored Plan Benefit Changes and Rates for 2008: Premiums for County approved Union sponsored plans will also increase for 2008. The estimated increase in premiums paid to carriers in 2008 on behalf of all Union sponsored medical plans is $6.2 million or 5.3%. Proposed 2008 premium increases to be paid to individual carriers and benefit changes for the ALADS, CAPE, and Local 1014 Fire Fighters Plans are summarized below:

Summary of Union Sponsored Plan Changes for 2008

Union Sponsor	Average Increase in Rates to be Paid to Carrier on Behalf of Plan Sponsor	Requested Benefit Changes
CAPE	5.6%	• Add hearing aid benefit up to $1,000 maximum every two years for HMO Classic and Lite plans.
		• Add 100% of out-of-network pharmacy purchase after co-payments for covered emergencies.
ALADS	6.0%	• No plan design changes.
Local 1014	2.5%	• Add coverage for organ transplants utilizing Blue Cross Centers of Expertise Program.
		• Reduce annual deductible from $300/$600 to $200/$600.
		• Remove $30,000 lifetime max. co-insurance for medically necessary gastric bypass, treat as other surgeries in plan.
		• Increase lifetime childhood immunization to $3,000.
		• Add reconstruction of teeth following accidents up to $10,000.
		• Improve VSP benefit to 12 month exams, 12 months lenses, and 24 month frames from 12 month exams, 24 month lenses, and 24 months frames.
		• Increase cancer screening office visit allowance to $200 from $100 maximum.
		• Change mental health benefits, as outlined in the Local 1014 letter attached to Exhibit V, Enclosure 3.
		• Eliminate certain exclusions to plan as outlined in the Local 1014 letter attached to Exhibit V, Enclosure 3.

The subsidized rates to be paid by members of Union sponsored plans are summarized in Exhibit V. The complete list of carrier benefit changes, upon which the 2008 rates are based, are documented in the Union request letters attached to Exhibit V. We have reviewed the changes for all three plans and support them.

Dental Plan Changes Affecting Represented Employees

The recommended employee contribution rates for County sponsored represented employee dental plans are summarized in Exhibit I. The 2008 dental rates shown in Exhibit I are the rates quoted by the carriers for represented employees, except that in the case of Delta Dental, the rates have been reduced by the 2008 subsidies previously negotiated with the unions and approved by your Board.

The Delta Dental indemnity plan rates and the prepaid dental plan DeltaCare USA's rates continue to be the same as 2007, due to rate guarantees through December 31, 2008.

SafeGuard's negotiated contract rates will increase by 3.3% for 2008, and are guaranteed through December 31, 2010. The actual rate increase for 2008 will differ slightly as it includes a credit for performance guarantees.

Life Insurance and Disability Programs for Represented Employees

Basic term life insurance, optional group life, dependent life and Accidental Death and Dismemberment (AD&D) rates are the same as during 2007 and are guaranteed through 2010.

Under the LTD Health Plan, as negotiated with County unions and previously approved by your Board, effective January 1, 2008, employees will have an option to elect 100% County payment of their monthly health premiums for County sponsored plans. We recommend extending the $3.00 per month fee currently paid by non-represented employees to represented employees for this benefit.

Non-Represented Employees

Medical Plan Changes Affecting Non-represented Employees

Non-represented employees who participate in the MegaFlex and Flexible Benefit Plans have a choice between Kaiser and four Blue Cross health plans, which include an HMO, POS, PPO, and a Catastrophic Plan. For 2008, there are no changes in benefits to the medical plan design. The negotiated contract rates for Kaiser will increase 15.1%, while the average increase in contract rates for the Blue Cross HMO and Blue Cross indemnity plans (POS, PPO, and Catastrophic) will be 10.2%.

Mercer has reviewed the proposed increases and given its opinion concerning their justification in Attachment B. Mercer believes that the Blue Cross increases are justified

but has reservations concerning the Kaiser rates due to lack of supporting patient utilization data and other issues reported in Attachment B. Kaiser has promised to provide, by August 31, 2007, requested utilization data, which was first requested four months ago. Since August 31, 2007 is after the required filing date of this letter, we will provide an update by the date your Board hears this matter.

We are recommending implementation of a Kaiser HMO plan for three non-represented CEO employees working in Washington, D.C. This Kaiser plan is a hybrid HMO developed for employer groups with a small number of employees in the Washington, D.C. area. The plan has standard benefits and requires a separate agreement. The members must receive care from Kaiser staff physicians, but will use private hospitals contracted by Kaiser. The premium rates are community rated and regionalized to the mid-Atlantic area.

We recommend that your Board continue the historical County practice of funding any difference between the negotiated contract cost of these plans and the contribution paid by the employees. The recommended employee contribution rates are summarized in Exhibit II.

Dental Plan Changes Affecting Non-represented Employees

The recommended employee contribution rates for County sponsored non-represented employee dental plans are summarized in Exhibit II. The Delta Dental rates have been reduced by the 2008 County subsidies previously approved by your Board.

The Delta Dental indemnity plan rates and the prepaid dental plan DeltaCare USA's rates continue to be the same as 2007, due to rate guarantees through December 31, 2008.

SafeGuard's negotiated contract rates will increase by 3.3% for 2008, and are guaranteed through December 31, 2010. The actual rate increase for 2008 will differ slightly as it includes a credit for performance guarantees.

Life Insurance and Disability Programs

MetLife's rates for Optional Group Universal Variable (GVUL) life insurance and the Dependent Life and Survivor Income Benefit (SIB) are guaranteed through 2010. There will be no changes in the cost of the Long Term Disability (LTD) and Short Term Disability (STD) benefits for 2008.

Basic term life insurance and Accidental Death and Dismemberment (AD&D) rates are the same as during 2007 and are guaranteed through 2010.

Changes to the Minimum County Contribution Under the MegaFlex and Flexible Benefit Plans

Currently, non-represented employees covered by the MegaFlex and Flexible Benefit Plans currently receive a County contribution expressed as a percentage of salary, but not less than a minimum "floor" contribution of $918 per month under MegaFlex, and $678 per month under the Flexible Benefit Plan. For 2008, we recommend that the minimum contributions be increased to $987 for the MegaFlex Plan and $735 for the Flexible Benefit Plan, due to increased employee health insurance costs for both Kaiser and Blue Cross. These adjustments would be initially reflected on the County pay warrants issued on January 15, 2008.

Dependent Care Spending Account for Non-Represented Employees (DCSA)

As previously approved by your Board, effective January 1, 2008, the County will provide a contribution to help pay for child and elder care costs. The amount of the tax-free contribution is based on salary and outlined in Exhibit VI. Your Board previously approved annual limits to the amount of the County contribution for represented employees. We are recommending an annual limit of $1.23 million be established for non-represented employees. If the annual limit is reached any time in 2008, the County contribution is stopped completely for the remainder of the year. If this event occurs, participating employees will have an opportunity to increase their own contribution.

Kaiser CMGO Progress Report

At its September 19, 2006 meeting, your Board instructed the CEO and DOP to prepare "a progress report on the Kaiser Health Plan's Cost Mitigation Goals and Objectives and an evaluation determining if they can be improved, expedited, or enhanced." Some recent successes in Kaiser's implementation of the County CMGO program are described in Attachment E.

Cost Mitigation Goals and Objectives (CMGO) is not a Kaiser program. It is a County joint labor-management program to limit inflationary increases in health insurance costs for represented County employees enrolled in all County sponsored medical plans (including Kaiser), and to improve the quality of care. Currently the County has CMGO agreements with both Local 721 and the CCU, and will extend the program to non-represented employees in 2008. The CMGO agreement, shown in full in Attachment F, seeks to control health costs through a variety of initiatives including for example:

- *Initiative:* Modify employee behavior through education to more effectively use health resources and, when necessary and agreed by the parties, through benefit changes to discourage inappropriate use of high cost health resources. *Result:* A combination of education and co-payment changes led to reduction of inappropriate emergency room use in the PacifiCare and Kaiser Plans.
- *Initiative:* Working with carriers, improve reporting and analysis to spot trends in employee health resource use, set targets for change and measure improvement. *Result:* Meetings with the carrier over the past six years have led to improved utilization reporting and targeting of problem utilization at PacifiCare. Development of similar reporting began at Kaiser in 2004 and is beginning to mature.
- *Initiative:* Through joint labor management negotiations with carriers, reduce cost increases per year to 5% or less. *Result:* First rolled out for all carriers in connection with the 2007 renewal, the 2008 renewal shows increases of less than 5% for four of the six County sponsored HMO plans including the Kaiser Union plans.
- *Initiative:* Increase participation in and the effectiveness of the County wellness program. *Result:* Working with Local 721 and leveraging Kaiser and PacifiCare resources, we are building a new program from the ground up to actively promote wide spread participation in and use of well developed carrier wellness programs in a standard County format. It is hoped that this initiative will improve employee health, and increase well being and productivity. A tracking mechanism is being created to measure results.

CMGO started over six years ago as a joint labor management pilot program with PacifiCare, which had the interest and capability to apply advanced reporting and analysis methods to solve problems of health service delivery and patient use of those services. Focusing on inpatient services initially, PacifiCare was able to save several million dollars through better management of admissions, and length of hospital stay while improving patient outcomes. In 2004, Kaiser joined the program, and since then both Kaiser and PacifiCare have made progress, particularly in chronic disease management and reporting, as the program evolved to its current form. We are confident based on the success of the joint Local 721 effort, that the addition of the CCU and non-represented employees, and the plans they are enrolled in, will lead to further successes.

Request for Proposal (RFP) for Kaiser Replacement

After Kaiser declined a renegotiation provision in its 2007 contract, your Board on December 19, 2006 instructed the Chief Executive Officer and Director of Personnel to work with Union representatives to explore the feasibility of replacing Kaiser through a

Request for Proposal (RFP). We have learned that both SEIU Local 721 and the Coalition of County Unions oppose marketing the Kaiser business. Since both Union fringe benefit MOU's contain provisions requiring Kaiser and all other County sponsored medical plans to be offered as an option through the September 30, 2009 termination of the MOUs, Union opposition bars replacement until 2010 at the earliest.

County policy requires that County business periodically be bid competitively to ensure first rate services at competitive prices. Group insurance has been treated as a special case. Health insurance has not been put out to bid except when there was a very compelling reason to do so. Kaiser has never been put out to bid and CIGNA has not been bid competitively for 16 years. PacifiCare and Blue Cross have been bid in the last seven years.

The County consultant, Mercer, advises that carrier business be put out to bid at 5 to 10 year intervals to strike a balance between creating business aversion to doing business with the County by too frequent carrier replacement, and marketing often enough to remind carriers that if prices drift too high, or services deteriorate, we will replace them.

Lack of competitive bidding is an important issue because without the occasional risk of replacement, carriers feel little pressure to hold down costs or improve services. In our annual rate renewal process, we focus more on the cost increase than the total cost of providing service. The fact is, that locally and nationally, health cost increases have averaged twice the CPI for over 20 years. Nationally, health costs are twice those of other advanced nations, but with poorer heath outcomes, and at 17% of Gross Domestic Income (GDI), health care is nearing the cost of the traditional necessities (food, clothing and shelter) combined. There is a real risk that health care will become unaffordable. It would be wise for the County to use all of the tools at its disposal to influence these costs.

As one measure to control high health prices, the CEO is considering exploring with other governmental agencies opportunities to work together as a large employer consortium to gain economies of scale in purchasing health care. This avenue may result in bidding all County HMO business, including Kaiser for 2010, if County unions drop opposition to marketing the plans.

Upon adoption of the recommendations contained herein, the County Counsel will prepare the ordinances, including benefit plan amendments and contracts, necessary to implement the recommendations.

Respectfully submitted,

WILLIAM T FUJIOKA
Chief Executive Officer

WTF:SRH:DL
WGL:FF:MLH:meg:df

Attachments (15)

c: Executive Officer, Board of Supervisors
Auditor-Controller
County Counsel
Department of Human Resources
SEIU Local 721
Coalition of County Unions
Mercer

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COUNTY-SPONSORED
MEDICAL AND DENTAL INSURANCE PLANS
FOR REPRESENTED EMPLOYEES
CURRENT 2007 RATES AND PROPOSED 2008 RATES

Plan	Option	Coverage Category[a]	Current 2007 Rates[b]	Proposed 2008 Rates[b]	Percentage Change
CIGNA Choices	Network HMO	1	$ 349.14	$ 346.95	-0.6%
		2	$ 694.01	$ 689.62	-0.6%
		3	$ 799.34	$ 794.28	-0.6%
	Network POS	1	$ 626.50	$ 622.56	-0.6%
		2	$ 1,111.87	$ 1,104.85	-0.6%
		3	$ 1,166.44	$ 1,159.08	-0.6%
KAISER Choices		1	$ 406.76	$ 415.85	2.2%
		2	$ 808.08	$ 826.26	2.2%
		3	$ 938.25	$ 959.33	2.2%
KAISER Options		1	$ 386.92	$ 387.68	0.2%
		2	$ 776.83	$ 778.36	0.2%
		3	$ 900.57	$ 902.34	0.2%
PACIFICARE Options	HMO	1	$ 312.39	$ 338.86	8.5%
		2	$ 634.19	$ 687.65	8.4%
		3	$ 734.08	$ 796.01	8.4%
	PPO	1	$ 785.86	$ 894.80	13.9%
		2	$ 1,590.84	$ 1,810.13	13.8%
		3	$ 1,841.90	$ 2,096.82	13.8%

[a] 1 = Employee only
2 = Employee + 1 Dependent
3 = Employee + 2 or more Dependents

[b] Rates reflect current negotiated County subsidies

COUNTY-SPONSORED
MEDICAL AND DENTAL INSURANCE PLANS
FOR REPRESENTED EMPLOYEES
CURRENT 2007 RATES AND PROPOSED 2008 RATES

Plan	Option	Coverage Category[a]	Current 2007 Rates[b]	Proposed 2008 Rates[b]	Percentage Change
DELTA DENTAL[b]		1	$ 21.09	$ 21.09	0.0%
Choices		2	$ 35.20	$ 35.20	0.0%
		3	$ 52.62	$ 52.62	0.0%
DELTA DENTAL[b]		1	$ 31.66	$ 31.66	0.0%
Options		2	$ 52.80	$ 52.80	0.0%
		3	$ 79.29	$ 79.29	0.0%
DELTACARE USA		1	$ 13.83	$ 13.83	0.0%
Choices & Options		2	$ 22.81	$ 22.81	0.0%
		3	$ 33.74	$ 33.74	0.0%
SAFEGUARD[c]		1	$ 9.83	$ 10.19	3.7%
Choices & Options		2	$ 19.04	$ 19.70	3.5%
		3	$ 24.85	$ 25.70	3.4%

[a] 1 = Employee only
2 = Employee + 1 Dependent
3 = Employee + 2 or more Dependents

[b] Rates reflect current negotiated County subsidy.

[c] SafeGuard rates for 2008 reflect a 0.38% credit adjustment for 2006 performance guarantee penalties. Rates are guaranteed through 12/31/2010.

COUNTY-SPONSORED
MEDICAL AND DENTAL INSURANCE PLANS
FOR NON-REPRESENTED EMPLOYEES
CURRENT 2007 RATES AND PROPOSED 2008 RATES

Plan	Option	Coverage Category[a]	Current 2007 Rates[b]	Proposed 2008 Rates[b]	Percentage Change
BLUE CROSS	CaliforniaCare HMO	1	$ 206.76	$ 227.85	10.2%
		2	$ 404.41	$ 445.66	10.2%
		3	$ 424.21	$ 467.48	10.2%
		4	$ 479.74	$ 528.67	10.2%
	PLUS POS	1	$ 312.42	$ 344.29	10.2%
		2	$ 627.28	$ 691.26	10.2%
		3	$ 642.01	$ 707.50	10.2%
		4	$ 716.11	$ 789.15	10.2%
	Catastrophic	1	$ 159.92	$ 176.23	10.2%
		2	$ 320.87	$ 353.60	10.2%
		3	$ 325.83	$ 359.06	10.2%
		4	$ 376.85	$ 415.29	10.2%
	Prudent Buyer PPO	1	$ 398.47	$ 439.11	10.2%
		2	$ 731.57	$ 806.19	10.2%
		3	$ 759.70	$ 837.19	10.2%
		4	$ 880.18	$ 969.96	10.2%
KAISER Flex/Megaflex		1	$ 206.76	$ 227.85	10.2%
		2	$ 404.41	$ 445.66	10.2%
		3	$ 424.21	$ 467.48	10.2%
		4	$ 479.74	$ 528.67	10.2%
KAISER - MID-ATLANTIC		1	N/A	$ 227.85	N/A
		2	N/A	$ 445.66	N/A
		3	N/A	$ 467.48	N/A
		4	N/A	$ 528.67	N/A
DELTA DENTAL[c] Flex/Megaflex		1	$ 21.10	$ 21.10	0.0%
		2	$ 31.04	$ 31.04	0.0%
		3	$ 35.25	$ 35.25	0.0%
		4	$ 52.68	$ 52.68	0.0%
DELTACARE USA Flex/Megaflex		1	$ 13.83	$ 13.83	0.0%
		2	$ 23.89	$ 23.89	0.0%
		3	$ 23.72	$ 23.72	0.0%
		4	$ 34.43	$ 34.43	0.0%
SAFEGUARD[d] Flex/Megaflex		1	$ 9.83	$ 10.19	3.7%
		2	$ 18.48	$ 19.12	3.5%
		3	$ 20.84	$ 21.56	3.5%
		4	$ 27.23	$ 28.16	3.4%

[a] 1 = Employee only
2 = Employee + Child(ren)
3 = Employee + Spouse
4 = Employee + Spouse + Chil(ren)

[b] Rates, where applicable, are net of County subsidy; except that the premium charged to an employee whose benefits are subject to COBRA is the carrier quoted rate plus an administrative charge as prescribed by COBRA.

[c] Delta Dental rates for 2008 reflect County subsidies.

[d] SafeGuard rates for 2008 reflect a 0.32% credit adjustment for 2006 performance guarantee penalties. Rates are guaranteed through 12/31/2010.

KAISER HMO PLAN
MID ATLANTIC STATES BENEFIT PLANS 2008

	Standard Benefit Plan
Benefit Type	***Standard***
Basic Member Costs	
Copayments	$15
Deductibles	None
Coinsurance	None
Annual Out-of-Pocket Maximum	$3,500/$9,400
Lifetime Maximum	None
Office Visits and Other Outpatient Care	
Office Visits	$15
Well-Child Care to Age 3	No Charge
X-ray, Laboratory and Special Procedures[A]	No Charge
Outpatient Surgery - Surgery Center or Outpatient Hospital	$100
Physical, Occupational and Speech Therapy (outpatient)[3]	$15
Prenatal Care	No Charge
Home Health Care/Hospice	No Charge
Infertility Diagnosis/Treatment[1]	50% of AC
Vision Exam	$15
Inpatient Services	
Hospital Inpatient Care (per admit)	$250
Skilled Nursing Facility (100 days/calendar year)	No Charge
Emergency Services and After Hours Urgent Care	
Emergency Services	$100
After Hours Urgent care	$15
Ambulance	$100
Mental Health services	
Mental Health Outpatient (unlimited)	$20 individual therapy and $10 group therapy
Mental Health Inpatient (unlimited; per admit)	$250
Chemical Dependency Services	
Chemical Dependency Outpatient (unlimited)	$20 individual therapy and $10 group therapy
Chemical Dependency Inpatient (Detox only; per admit; unlimited)	$250
Prescription Drugs	
Presription Drug (30 days dispensing supply @ 1 copay) (Infertility Drugs excluded)	$15 Generic / $30 Brand
Maintenance Medication - Mail Order[2] (Infertility Drugs excluded)	$15 Generic / $30 Brand
Additional Benefits	
Durable Medical Equipment	20% of AC
Prosthetics/Orthotics	20% of AC

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT AND SURVIVOR INCOME BENEFIT PROGRAMS CURRENT 2007 RATES AND PROPOSED 2008 RATES

	Monthly Cost per $1,000 of Insurance	
	2007[a]	2008[a]
COUNTY-PAID BASIC GROUP TERM-LIFE INSURANCE	$0.275	$0.275

OPTIONAL GROUP TERM LIFE INSURANCE FOR REPRESENTED EMPLOYEES

Employee: The monthly premium per $1,000 of insurance is based on the employee's age as shown in the following table:

Age	2007[a,b]	2008[a,b]
Less than 30	$0.047	$0.047
30-34	$0.080	$0.080
35-39	$0.090	$0.090
40-44	$0.100	$0.100
45-49	$0.150	$0.150
50-54	$0.230	$0.230
55-59	$0.430	$0.430
60-64	$0.660	$0.660
65-69	$0.942	$0.942
70 and over	$1.813	$1.813

Dependent Term Life Insurance:	2007[a]	2008[a]
Cost per month per $5,000 of coverage, no matter how many eligible dependents employee may have. Coverage is offered in increments of $5,000 up to $20,000. Dependent care coverage premium is charged to the employee.	$1.091	$1.091

[a] Rates are guaranteed through 12/31/2010.

[b] The County subsidizes 15% of the monthly premium.

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT AND SURVIVOR INCOME BENEFIT PROGRAMS CURRENT 2007 RATES AND PROPOSED 2008 RATES

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE - Cost per Month

	Current 2007 Rates*		Proposed 2008 Rates*	
Employee Coverage	Employee Only Plan G	Employee & Dependents Plan H	Employee Only Plan G	Employee & Dependents Plan H
$ 10,000	$0.21	$0.41	$0.21	$0.41
$ 25,000	$0.52	$1.02	$0.52	$1.02
$ 50,000	$1.05	$2.05	$1.05	$2.05
$100,000	$2.10	$4.10	$2.10	$4.10
$150,000	$3.15	$6.15	$3.15	$6.15
$200,000	$4.20	$8.20	$4.20	$8.20
$250,000	$5.25	$10.25	$5.25	$10.25
$300,000	$6.30	$12.30	$6.30	$12.30
$350,000	$7.35	$14.35	$7.35	$14.35

These figures apply regardless of employee's age. If Plan H is selected, all eligible dependents will be insured automatically.

* Rates are guaranteed through 12/31/2010.

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT AND SURVIVOR INCOME BENEFIT PROGRAMS CURRENT 2007 RATES AND PROPOSED 2008 RATES

OPTIONAL GROUP VARIABLE UNIVERSAL LIFE INSURANCE FOR FLEX/MEGAFLEX PARTICIPANTS

Employee: The monthly premium per $1,000 of insurance is based on the employee's age as shown in the following table:

Age	2008 Rate*	Age	2008 Rate*	Age	2008 Rate*
20-24	$0.045	57	$0.338	77**	$2.476
25-29	$0.056	58	$0.381	78**	$2.794
30-34	$0.065	59	$0.425	79**	$3.148
35-39	$0.067	60	$0.478	80**	$4.064
40	$0.078	61	$0.538	81**	$4.690
41-42	$0.079	62	$0.594	82**	$5.116
43	$0.088	63	$0.639	83**	$5.579
44	$0.100	64	$0.708	84**	$6.078
45	$0.111	65	$0.736	85**	$6.631
46	$0.121	66	$0.826	86**	$7.211
47	$0.132	67	$0.879	87**	$7.846
48	$0.154	68	$0.979	88**	$8.526
49	$0.164	69	$1.088	89**	$9.225
50	$0.175	70	$1.197	90**	$9.941
51	$0.197	71	$1.323	91**	$10.694
52	$0.207	72	$1.469	92**	$11.465
53	$0.228	73	$1.613	93**	$12.263
54	$0.251	74	$1.786	94**	$13.071
55	$0.284	75	$1.968		
56	$0.305	76**	$2.186		

* Rates are guaranteed through 12/31/2010.
Employee cost for Megaflex employees is half of actual premium. The County pays the other 50%.

** For employees age 76-94 who remain in County service, County will subsidize the difference between the employee's cost of coverage using the premiums for the employee's actual age and cost of coverage using age 75 rate.

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT AND SURVIVOR INCOME BENEFIT PROGRAMS CURRENT 2007 RATES AND PROPOSED 2008 RATES

Dependent Term Life Insurance for Flex and Megaflex Participants

	2008 Rate*
Cost per month per $5,000 of dependent life coverage, up to $20,000.	1.24**

SURVIVOR INCOME BENEFIT - For Megaflex participants enrolled in Retirement Plan E

	Current 2007 Rates*		Proposed 2008 Rates*	
Employee Age	Employee Cost** (25% Option)	Employee Cost** (50% Option)	Employee Cost** (25% Option)	Employee Cost** (50% Option)
Under 30	0.156%	0.300%	0.156%	0.300%
30 to 34	0.192%	0.396%	0.192%	0.396%
35 to 39	0.252%	0.516%	0.252%	0.516%
40 to 44	0.360%	0.708%	0.360%	0.708%
45 to 49	0.480%	0.960%	0.480%	0.960%
50 to 54	0.636%	1.272%	0.636%	1.272%
55 to 59	0.912%	1.836%	0.912%	1.836%
60 to 64	1.248%	2.496%	1.248%	2.496%
65 to 69	1.716%	3.432%	1.716%	3.432%
70 and over	3.048%	6.096%	3.048%	6.096%

* Rates are guaranteed through 12/31/2010.
** Employee Cost for Megaflex is half of the actual premium. The County pays the other 50%.

SHORT-TERM DISABILITY, LONG-TERM DISABILITY AND LONG-TERM DISABILITY HEALTH INSURANCE CURRENT 2007 RATES AND PROPOSED 2008 RATES

MEGAFLEX SHORT-TERM DISABILITY PLAN

Employee Cost as a Percentage of Monthly Salary:

Current 2007 Rates			Proposed 2008 Rates		
Income Replacement	Waiting Period	Cost	Income Replacement	Waiting Period	Cost
70%	14 Days	0.000%	70%	14 Days	0.000%
100%*	7 Days	0.934%	100%*	7 Days	0.934%

* Reduced to 80% after 21 days

MEGAFLEX LONG-TERM DISABILITY PLAN

Employee Cost as a Percentage of Monthly Salary:

	Current 2007 Rates		Proposed 2008 Rates	
Income Replacement	Plan E + * Retirement Plan	All Other Plans	Plan E + * Retirement Plan	All Other Plans
40%	0.000%	0.040%	0.000%	0.040%
60%	0.117%	0.157%	0.117%	0.157%

* Plan E plus 5 more years of continuous service

SHORT-TERM DISABILITY, LONG-TERM DISABILITY AND LONG-TERM DISABILITY HEALTH INSURANCE CURRENT 2007 RATES AND PROPOSED 2008 RATES

LONG-TERM DISABILITY HEALTH INSURANCE - Cost per month

For Flex/MegaFlex Employees

Current 2007 Rate		Proposed 2008 Rate	
75 % Premium Payment	100 % Premium Payment	75 % Premium Payment	100 % Premium Payment
$0.00	$3.00	$0.00	$3.00

For Represented Employees

Current 2007 Rate	Proposed 2008 Rate	
75 % Premium Payment	75 % Premium Payment	100 % Premium Payment
$4.25	$0.00	$3.00

UNION-SPONSORED
MEDICAL AND DENTAL INSURANCE PLANS
CURRENT 2007 RATES AND PROPOSED 2008 RATES

Plan	Option	Coverage Category[a]	Current 2007 Rates[b]	Proposed 2008 Rates[b]	Percentage Change
ALADS	Prudent Buyer Plan	1	$ 536.45	$ 561.24	4.6%
Blue Cross	Under Age 50	2	$ 1,045.45	$ 1,094.81	4.7%
		3	$ 1,203.83	$ 1,257.21	4.4%
	Prudent Buyer Plan	1	$ 536.45	$ 561.24	4.6%
	Age 50 and Over	2	$ 1,045.45	$ 1,094.81	4.7%
		3	$ 1,203.83	$ 1,257.21	4.4%
	CaliforniaCare	1	$ 338.73	$ 360.68	6.5%
	Basic Plan	2	$ 649.98	$ 698.37	7.4%
	(All Ages)	3	$ 808.27	$ 868.17	7.4%
	Prudent Buyer Plan	1	$ 619.18	$ 643.97	4.0%
	Premier Plan	2	$ 1,128.18	$ 1,177.54	4.4%
	Under Age 50	3	$ 1,286.56	$ 1,339.94	4.1%
	Prudent Buyer Plan	1	$ 619.18	$ 643.97	4.0%
	Premier Plan	2	$ 1,128.18	$ 1,177.54	4.4%
	Age 50 and Over	3	$ 1,286.56	$ 1,339.94	4.1%
	CaliforniaCare	1	$ 421.46	$ 443.41	5.2%
	Premier Plan	2	$ 732.71	$ 781.10	6.6%
	(All Ages)	3	$ 891.00	$ 950.90	6.7%
CAPE	Classic	1	$ 464.00	$ 490.00	5.6%
Blue Shield		2	$ 932.56	$ 984.56	5.6%
		3	$ 1,157.56	$ 1,221.56	5.5%
	Lite	1	$ 299.00	$ 316.00	5.7%
		2	$ 600.56	$ 634.56	5.7%
		3	$ 770.56	$ 813.56	5.6%
	PPO	1	$ 459.17	$ 484.42	5.5%
	(Out-of-state only)	2	$ 922.42	$ 973.45	5.5%
		3	$ 1,189.50	$ 1,255.22	5.5%
FIREFIGHTERS LOCAL 1014		1	$ 446.00	$ 457.00	2.5%
		2	$ 847.56	$ 868.56	2.5%
		3	$ 1,005.56	$ 1,030.56	2.5%

[a] 1 = Employee only
2 = Employee + 1 Dependent
3 = Employee + 2 or more Dependents

[b] Rates reflect current negotiated County subsidies

ENCLOSURES TO EXHIBIT V

1. ALADS Request
2. CAPE Request
3. Los Angeles County Fire Fighters Local 1014 Request

ENCLOSURE 1

ALADS Insurance Trust

9500 Topanga Canyon Blvd. Chatsworth, CA 91311
Tel (213) 678-0040 (800) 842-6635 Fax (818)678-0030

August 3, 2007

Mr. Michael J. Henry, Director
County of Los Angeles
Hall of Administration, Room 579
500 West Temple Street
Los Angeles, California 90012

Attention: Ms. Marian Hall
Human Resources Manager
Employee Benefits – Deferred Income Division
Department of Human Resources
County of Los Angeles
3333 Wilshire Boulevard, Tenth Floor
Los Angeles, California 90010

RE: ALADS/BLUE CROSS 2008 HEALTHCARE PLAN PREMIUMS
Via U.S. Mail and E-Mail

Dear Ms. Hall:

Following are the monthly premium rates for the ALADS Blue Cross Prudent Buyer and CaliforniaCare medical and dental plans for the 2008 plan year:

Plan	Employee	Employee + 1	Employee + 2
Prudent Buyer Basic	$561.24	$1,100.25	$1,262.65
Prudent Buyer Premier	$643.97	$1,182.98	$1,345.38
CaliforniaCare Basic	$360.68	$703.81	$873.61
CaliforniaCare Premier	$443.41	$786.54	$956.34

Further, the ALADS plans do provide "Creditable Coverage" as defined in the Act.

Sincerely,

Bud Treece, Trust Administrator

(Computer generated and laser printed in-house)

ENCLOSURE 2

CAPE AFL-CIO
California Association of Professional Employees Benefit Trust

July 25, 2007

Marian Hall
Human Resources Manager
Employee Benefits-Deferred Income Division
County of Los Angeles
Department of Human Resources
3333 Wilshire Boulevard
Los Angeles, CA 90010

Re: 2008 RENEWAL – CAPE/BLUE SHIELD MEDICAL PLANS

Dear Ms. Hall:

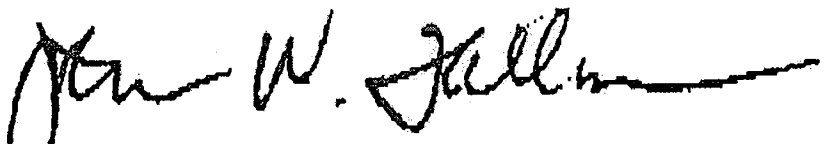
This letter is to advise you of the CAPE Benefit Trust Board of Trustees' approval of the renewal of Blue Shield's contracts for the year 2008 for the CAPE/Blue Shield Classic, Lite and PPO medical plans. Attached please find the benefit structures and rates for both plans.

We have added a new benefit to both the CAPE/Blue Shield Classic and Lite medical plans for the 2008 plan year. Beginning January 1, 2008, members will receive a $1,000 benefit every two years towards hearing aids under the HMO level of benefits for monaural or binaural including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. The benefit can be used all at once, or spread out over the two year period. The new benefit has been added beneath "Other Plan Benefits" on the enclosed benefit summaries. For the Classic, Lite and COBRA PPO plans, we have clarified the maximum lifetime benefit under the PPO Network and Out-of-Network tiers to reflect $4,000,000 combined for both tiers for the Lite and Classic plans and $6,000,000 for the COBRA PPO plan (this does not represent any change in benefits.) The Classic and Lite out-of-network pharmacy benefit has changed from a lesser of 75% of purchase price or reasonable charge after copayment to 100% of purchase price after applicable prescription copayment for covered emergencies. There are no other core benefit changes for 2008 other than any mandated regulatory changes.

We would appreciate your forwarding the 2008 CAPE/Blue Shield medical plans' information to the Board of Supervisors for their timely approval.

Sincerely,

CALIFORNIA ASSOCIATION OF
PROFESSIONAL EMPLOYEES BENEFIT TRUST



John W. Fallon
Chairman
CAPE Benefit Trust Board of Trustees

Attachments

2008 CAPE/Blue Shield
Classic Plan*

(800) 487-3092 www.blueshieldca.com

BENEFITS	PRIMARY CARE NETWORK	PPO NETWORK	OUT-OF-NETWORK (Reimbursements Based On Allowable Amount)
Type of Plan	A Point of Service Plan		
Who is Eligible	All Participants	All Participants	All Participants
Calendar Year Deductible	None	$300 per person; $600 per family maximum (combined-PPO Network and Out-of-Network)	$300 per person; $600 per family maximum (combined-PPO Network and Out-of-Network)
Maximum Annual Out-of-pocket Expenses	$2,000/person; $4,000/family	After deductible, $4,000/person; $8,000/family (combined - PPO Network and Out-of-Network)	After deductible, $6,000/person; $12,000/family (combined - PPO Network and Out-of-Network)
Lifetime Maximum Benefit	Unlimited	$4,000,000 (combined PPO Network/Out-of-Network)	$4,000,000 (combined PPO Network/Out-of-Network)
PREVENTIVE CARE			
Immunizations	100%; no copayment	Not covered	Not covered
Periodic Health Exams	100%; no copayment (including Well Woman Exam,	Routine physicals not covered. Well Woman Exam	Not covered
	Pap Smear, and Mammography)	100% after $20 copayment; tests 90% no deductible	
Vision Care	Up to age 18 screenings only; 100%; All members one eye	All members one eye exam per year- $10 copayment at	$10 Reimbursement for eye exam only
	exam per year- $10 copayment at MES providers only	MES providers only	
MEDICALLY NECESSARY CARE			
Ambulance	100% after $50 copayment	90% after deductible	90% after deductible
Doctor Office Visits	100% after $10 copayment	100% after $20 copayment for consultation only (not subject to deductible)	60% after deductible
Emergency Room	100% after $50 copayment (waived if admitted)	100% after $50 copayment (waived if admitted)	100% after $50 copayment (waived if admitted)
Hospital Care	100%; no copayment	90% after deductible	60% after deductible, carrier max payment $420 per day
Maternity	100%; no copayment	100% after $20 copayment for consultation only (not subject to deductible)	60% after deductible
Surgery	100%; no copayment (outpatient $50 copayment)	90% after deductible	60% after deductible, outpatient-carrier max pymt $420 per day
X-Ray & Lab Tests	100%; no copayment	90% after deductible	60% after deductible
Prescription Drugs	$10 (generic), $15 (brand name), $30 (nonformulary-requires	$10 (generic), $15 (brand name), $30 (nonformulary-requires	Covered emergencies only - copayment applies
	preapproval); Mail-Order- 90-day Supply: $20 (generic),	preapproval); Mail-Order- 90-day Supply: $20 (generic),	
	$30 (brand name), $60 (nonformulary-requires preapproval)	$30 (brand name), $60 (nonformulary-requires preapproval)	
MENTAL HEALTH CARE			
Mental Health-Outpatient	Non-severe psychiatric care: $10 copayment for initial visit;	Non-severe psychiatric care: $10 copayment for initial visit;	Non severe psychiatric care: 50% after deductible (up to 20 combined
	$50 copayment/visit thereafter (up to 20 combined visits	$50 copayment/visit thereafter (up to 20 combined visits	visits per calendar year)
	per calendar year)	per calendar year)	Severe mental illness: 60% (after deductible)
	Severe mental illness: $10 copayment/visit	Severe mental illness: $10 copayment/visit	
	----Provided by United Behavioral Health. Must be arranged through MHSA----		
Mental Health-Inpatient	100%	100%	60% (after deductible), up to $420 carrier max per day
	----Provided by United Behavioral Health. Must be arranged through MHSA----		
OTHER PLAN BENEFITS			
Chiropractic Care	100% after $10 copayment	100% after $10 copayment	Not covered
	----Includes acupuncture; up to 40 combined visits/calendar year (based on medical necessity)----		
	----Provided through American Specialty Health Plans----		
Hearing Aids	$1,000 maximum benefit every two years	Not covered	Not covered
Home Health Care	100% after $10 copayment	90% after deductible	60% after deductible
	(combined 100 visits per calendar year)	(combined 100 visits per calendar year)	(combined 100 visits per calendar year)
Hospice Care	100% when provided by authorized hospice agency	100% when provided by authorized hospice agency	Not covered unless authorized by Blue Shield
Physical Therapy	100% after $10 copayment	90% after deductible	60% after deductible
Skilled Nursing Facility	100%; no copayment (combined 100 days per calendar year)	90% after deductible (combined 100 days per calendar year)	60% after deductible (combined 100 days per calendar year)

*This is a limited benefit summary. Refer to the carrier summary for further details.

In case of discrepancies, the carrier's summary takes precedence.

2008 Premium Rates

Employee Only: $ 490.00

Employee + One: $ 990.00

Employee + Family: $1,227.00

2008 CAPE/Blue Shield
Lite Plan*

(800) 487-3092 www.blueshieldca.com

BENEFITS	PRIMARY CARE NETWORK	PPO NETWORK	OUT-OF-NETWORK (Reimbursements Based On Allowable Amount)
Type of Plan	A Point of Service Plan		
Who is Eligible	All Participants	All Participants	All Participants
Calendar Year Deductible	None	$500 per person; $1,000 per family maximum (combined-PPO Network and Out-of-Network)	$500 per person; $1,000 per family maximum (combined-PPO Network and Out-of-Network)
Maximum Annual Out-of-pocket Expenses	$2,000/person; $4,000/family	After deductible, $4,000/person; $8,000/family (combined - PPO Network and Out-of-Network)	After deductible, $6,000/person; $12,000/family (combined - PPO Network and Out-of-Network)
Lifetime Maximum Benefit	Unlimited	$4,000,000 (combined PPO Network/Out-of-Network)	$4,000,000 (combined PPO Network/Out-of-Network)
PREVENTIVE CARE			
Immunizations	100%; no copayment	Not covered	Not covered
Periodic Health Exams	100%; no copayment (including Well Woman Exam,	Routine physicals not covered. Well Woman Exam	Not covered
	Pap Smear, and Mammography)	100% after $25 copayment; tests 80% no deductible	
Vision Care	Up to age 18 screenings only; 100%; All members one eye	All members one eye exam per year- $10 copayment at	$10 Reimbursement for eye exam only
	exam per year- $10 copayment at MES providers only	MES providers only	
MEDICALLY NECESSARY CARE			
Ambulance	100% after $50 copayment	80% after deductible	80% after deductible
Doctor Office Visits	100% after $10 copayment	100% after $25 copayment for consultation only (not subject to deductible)	60% after deductible
Emergency Room	100% after $50 copayment (waived if admitted)	100% after $50 copayment (waived if admitted)	100% after $50 copayment (waived if admitted)
Hospital Care	100%; no copayment	80% after deductible	60% after deductible, carrier max payment $360 per day
Maternity	100%; no copayment	100% after $25 copayment for consultation only (not subject to deductible)	60% after deductible
Surgery	100%; no copayment (outpatient $75 copayment)	80% after deductible	60% after deductible, outpatient-carrier max pymt $360 per day
X-Ray & Lab Tests	100%; no copayment	80% after deductible	60% after deductible
Prescription Drugs	$10 (generic), $15 (brand name), $30 (nonformulary-requires	$10 (generic), $15 (brand name), $30 (nonformulary-requires	Covered emergencies only - copayment applies
	preapproval); Mail-Order- 90-day Supply: $20 (generic),	preapproval); Mail-Order- 90-day Supply: $20 (generic),	
	$30 (brand name), $60 (nonformulary-requires preapproval)	$30 (brand name), $60 (nonformulary-requires preapproval)	
MENTAL HEALTH CARE			
Mental Health-Outpatient	Non-severe psychiatric care: $10 copayment for initial visit;	Non-severe psychiatric care: $10 copayment for initial visit;	Non severe psychiatric care: 50% after deductible (up to 20 combined
	$50 copayment/visit thereafter (up to 20 combined visits	$50 copayment/visit thereafter (up to 20 combined visits	visits per calendar year)
	per calendar year)	per calendar year)	Severe mental illness: 60% (after deductible)
	Severe mental illness: $10 copayment/visit	Severe mental illness: $10 copayment/visit	
	----Provided by United Behavioral Health. Must be arranged through MHSA----		
Mental Health-Inpatient	100%	100%	60% (after deductible), up to $360 carrier max per day
	----Provided by United Behavioral Health. Must be arranged through MHSA----		
OTHER PLAN BENEFITS			
Chiropractic Care	100% after $15 copayment	100% after $15 copayment	Not covered
	----Includes acupuncture; up to 30 combined visits/calendar year (based on medical necessity)----		
	----Provided through American Specialty Health Plans----		
Hearing Aids	$1,000 maximum benefit every two years	Not covered	Not covered
Home Health Care	100% after $10 copayment	80% after deductible	60% after deductible
	(combined 100 visits per calendar year)	(combined 100 visits per calendar year)	(combined 100 visits per calendar year)
Hospice Care	100% when provided by authorized hospice agency	100% when provided by authorized hospice agency	Not covered unless authorized by Blue Shield
Physical Therapy	100% after $10 copayment	80% after deductible	60% after deductible
Skilled Nursing Facility	100%; no copayment (combined 100 days per calendar year)	80% after deductible (combined 100 days per calendar year)	60% after deductible (combined 100 days per calendar year)

*This is a limited benefit summary. Refer to the carrier summary for further details.

In case of discrepancies, the carrier's summary takes precedence.

2008 Premium Rates

Employee Only:	$316.00
Employee + One:	$640.00
Employee + Family:	$819.00

2008 CAPE/Blue Shield
COBRA PPO Plan*

(800) 487-3092 www.blueshieldca.com

BENEFITS	IN-NETWORK	OUT-OF-NETWORK (Reimbursements Based On Allowable Amount)
Type of Plan	A Preferred Provider Option Plan	
Who is Eligible	Participants residing outside the State of California	Participants residing outside the State of California
Calendar Year Deductible	$250 per person; $500 per family maximum (combined-In-Network and Out-of-Network)	$250 per person; $500 per family maximum (combined-In-Network and Out-of-Network)
Maximum Annual Out-of-pocket Expenses	After deductible, $3,000/person; $6,000/family (combined - In-Network and Out-of-Network)	After deductible, $10,000/person; $20,000/family (combined - In-Network and Out-of-Network)
Lifetime Maximum Benefit	$6,000,000 (combined PPO Network/Out-of-Network)	$6,000,000 (combined PPO Network/Out-of-Network)
PREVENTIVE CARE		
Immunizations	$25 copayment per visit	Not covered
Periodic Health Exams	$25 copayment per visit (Includes Well Woman/Baby Care)	Not covered
Vision Care		Not covered
MEDICALLY NECESSARY CARE		
Ambulance	80% after deductible	80% after deductible
Doctor Office Visits	$25 copayment for consultation only (not subject to deductible)	60% after deductible
Emergency Room	80% after $50 copayment (waived if admitted)	80% after $50 copayment (waived if admitted)
Hospital Care	80% after deductible	60% after deductible, carrier max payment $600 per day
Maternity	100% after $20 copayment for consultation only (not subject to deductible)	70% after deductible
Surgery	90% after deductible	70% after deductible, outpatient-carrier max pymt $420 per day
X-Ray & Lab Tests	90% after deductible	70% after deductible
Prescription Drugs	$10 (generic), $15 (brand name), $30 (nonformulary-requires preapproval)	Covered for emergencies only- 75% of lesser of actual price or
	Mail-Order 90-day Supply: $20 (generic), $30 (brand name),	reasonable charge, minus copayment
	$60 (nonformulary-requires preapproval)	
MENTAL HEALTH CARE		
Mental Health-Outpatient	Non-severe psychiatric care: $10 copayment for initial visit;	Non severe psychiatric care: 50% after deductible (up to 20 combined
	$50 copayment/visit thereafter (up to 20 combined visits	visits per calendar year)
	per calendar year)	Severe mental illness: 70% (after deductible)
	Severe mental illness: $10 copayment/visit	
	----Provided by United Behavioral Health. Must be arranged through MHSA----	
Mental Health-Inpatient	100%	70% (after deductible), up to $420 carrier max per day
	----Provided by United Behavioral Health. Must be arranged through MHSA----	
OTHER PLAN BENEFITS		
Home Health Care	90% after deductible	70% after deductible
	(combined 100 visits per calendar year)	(combined 100 visits per calendar year)
Hospice Care	100% when provided by authorized hospice agency	Not covered unless authorized by Blue Shield
Physical Therapy	90% after deductible	70% after deductible
Skilled Nursing Facility	90% after deductible (combined 100 days per calendar year)	70% after deductible (combined 100 days per calendar year)

*This is a limited benefit summary. Refer to the carrier summary for further details.
In case of discrepancies, the carrier's summary takes precedence.

2008 Premium Rates

Employee Only: $484.42
Employee + One: $978.89
Employee + Family: $1,260.66

ENCLOSURE 3

50th Anniversary

1949-1999

Celebrating a Half Century of Unity

LOS ANGELES COUNTY FIRE FIGHTERS
LOCAL 1014 HEALTH AND WELFARE PLAN

3460 FLETCHER AVENUE · EL MONTE, CALIFORNIA 91731
(310) 639-1014 (800) 660-1014 (within California)

July 24, 2007

Marian L. Hall
Senior Human Resources Manager
County of Los Angeles, Department of Human Resources
3333 Wilshire Blvd. Suite 1000
Los Angeles, CA 90010-4101

VIA FACISMILE 213-637-0832
Hard Copy US Mail

In re: Your letter of June 13, 2007 requesting plan year 2008 Employee Insurance Information

Dear Ms. Hall:

For the past several months, the Board of Trustees has been studying potential changes to the Los Angeles County Fire Fighters Local 1014 Health and Welfare Plan. This process has been conducted with the assistance of Mercer Health & Benefits, the Plan's consultant. The overall purpose of the project was updating the Plan's benefits so that they are competitive with other programs offered to Los Angeles County employees while maintaining appropriate financial reserves and making adequate allowance for the possibility that claims could be higher than projected.

The following benefit enhancements and rates have been approved by the Local 1014 Board of Trustees for implementation for the 2008 Plan year:

1. Cover organ transplants under the Blue Cross Centers of Expertise program.
2. Reduce the annual deductible from $300 per individual, $600 per family to $200 per individual, $600 per family
3. Remove the $30,000 lifetime maximum and 50% coinsurance for medically necessary gastric by-pass surgery; treat as any other surgery under the Plan.
4. Add the following covered services and eliminate specific exclusions:
    a. Cover medically necessary expenses for the pregnancy of a dependent child
    b. Cover medically necessary expenses for complications of cosmetic surgery
    c. Cover medically necessary expenses for vision therapy
5. Increase lifetime childhood immunization maximum from $2,000 to $3,000

6. Cover reconstruction of teeth following accidents up to $10,000
7. Change acupuncture and chiropractic benefit to allow 30 visits per calendar year combined
8. Remove the requirement of a physician referral for acupuncture
9. Change mental health/substance abuse benefit (MHN)
    a. Add severe mental health outpatient benefit - unlimited outpatient visits; in-network $0 copay for first six visits, $15 thereafter; out-of network $20 per visit
    b. Add severe mental health inpatient benefit - unlimited days in hospital or skilled nursing facility; $200 copay in-network, 80% out-of- network.
    c. Reduce out patient copay for non-severe to $15 from $20 for visits 6 through 50 in-network and change out-of network benefit from 50% co-insurance to $20 co-payment
    d. Add inpatient , out-of network benefit of 80%, max 30 days per year and improve in-network benefit to $200 copay
    e. Make substance abuse benefits the same as non-severe mental health; remove two episodes per lifetime maximum.
10. Improve VSP benefit waiting periods from 12 months exam, 24 months lenses and 24 months frames to 12 months exam, 12 months lenses and 24 months frames.
11. Increase office visit allowance in conjunction with cancer screening from a maximum of $100 to a maximum of $200.
12. Change physical therapy benefit from 30 visits per twelve month period to 30 visits per calendar year.
13. Make lancets a covered expense for insulin users

RATES

The Los Angeles County Fire Fighters Local 1014 Health and Welfare Plan Trustees approved a rate increase of 2.5% for Plan Year 2008. The proposed 2008 monthly rates are rounded to the nearest dollar:

Member only	$ 457.00
Member plus one dependent	$ 874.00
Family	$1,036.00

Please call me at (800) 660-1014 with any questions.

Sincerely,

Alfred F. Cain, CEBS
Administrative Manager

EXHIBIT VI

DEPENDENT CARE SPENDING ACCOUNT
2008 EMPLOYER CONTRIBUTION

EMPLOYEE ANNUAL GROSS SALARY	EMPLOYER CONTRIBUTION PER MONTH
LESS THAN $29,999	$375
$30,000 - $34,999	$300
$35,000 - $39,999	$275
$40,000 - $44,999	$200
$45,000 - 49,999	$125
$50,000 OR MORE	$75

County contribution is subject to annual limits:

$3.33 million for Choices employees
$5.00 million for Options employees
$1.23 million for Flex/Megaflex employees

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August 23, 2007

Ms. Marian Hall
Chief of Employee Benefits
County of Los Angeles
3333 Wilshire Boulevard, Suite 1000
Los Angeles, CA 90010-4101

Subject:
Summary of 2008 Medical, Dental and Life Renewal Results and Recommendations (Represented Plans)

Dear Marian:

This letter summarizes the results of our analysis and negotiation of the 2008 renewal proposals for medical, dental, and life plans offered to the represented employees of the County of Los Angeles (County). In addition, it presents Mercer's recommendations for each plan.

The renewal request and negotiation process is outlined in the attached Addendum.

Medical Plans

Overview

For all represented medical plans, the total projected premium increase – for the final benefit designs is 2.7% or $12.7 million over 2007. This compares to an initial renewal increase, based on the current plan designs, of 7.5% or $35.1 million, representing a $22.5 million reduction in premium due to negotiations, benefit design changes and performance guarantee credits. The final renewals include the following plan design changes for 2008:

HMO

- $10 Office Visit/Urgent Care Copay (except, CIGNA urgent care copayment remains at $25)
- $0 Office Visit/Urgent Care Copay for children up to age 5 (Kaiser and PacifiCare only; CIGNA cannot administer)
- $5 generic/$20 brand Prescription Drug Copay

PacifiCare PPO
- $5 generic/$20 brand formulary/$35 brand non-formulary Prescription Drug Copay

After evaluation of the renewal proposals, Mercer recommends that the County accept the final 2008 renewal increases offered by CIGNA (-0.6% across all products), PacifiCare (8.6%) and Kaiser (Options 0.2%, Choices 2.2%). We believe the renewals are justified for all plans, with the exception of Kaiser. A summary of key issues, proposal terms and negotiation results are outlined below by carrier. Our position regarding Kaiser is explained in their section.

CIGNA

CIGNA initially proposed an overall 9.2% or $4.1 million increase on the Choices program. Because CIGNA met all 2006 performance guarantee measures, there was no penalty credit applied to the 2008 renewal.

CIGNA's rating requires the addition of a 4% claim fluctuation margin. CIGNA has been able to use the available premium stabilization reserve (PSR) to offset this rating requirement in the past – and this is the case again for the 2008 rating. In addition to satisfying the margin requirement, CIGNA was willing to further subsidize the rates with the PSR. The initial renewal included a minus 3% margin position for this reason. Without this reduction the increase would have been 12.6%.

For 2008, the County decided to eliminate the PPO plan. CIGNA assumed the PPO enrollment would move into the POS plan. The 2008 POS rates were based off of a combined POS/PPO 2007 rate.

Contrary to past years, the experience on the non-HMO plans resulted in a lower renewal increase than the HMO plan; however, given the low enrollment in the non-HMO programs, CIGNA proposed blending the rate increase across all programs. For 2008, the POS participants subsidize the HMO participants.

We reviewed the experience on the programs and negotiated with CIGNA on the following issues:

- As in past years, trend was higher than the County's actual experience

- The Premium Stabilization Reserve (PSR) is expected to grow to $6.5 million by the end of 2007 or approximately 14.8% of annual premium; we requested CIGNA use this PSR to further offset the required renewal

The final renewal position is -0.6%, or a decrease of $279,000 from 2007 rates. As outlined in further detail below, CIGNA's required contractual renewal position is a 4.6% increase, but they agreed to subsidize some of the renewal through the available funds in the PSR. We were successful in negotiating revisions to CIGNA's renewal through the following concessions.

- Reduction in trend factors applied to the renewal projection
- Subsidy from the stabilization reserve to offset 4.6% of the renewal increase in addition to offsetting the 4% margin requirement
- Negotiated plan design changes represent a 5.6% reduction in premiums

The County's financial agreement with CIGNA provides for a year-end reconciliation of premiums, claims and expenses associated with the plan. Surpluses are deposited to the PSR and any shortfall is withdrawn from the PSR to the extent funds are available. The PSR has grown significantly in recent years, as illustrated in the table below:

	2003 [1]	2004	2005	2006	2007 [2]	2008 [2]
Projected Premium	$32,529,078	$33,051,158	$33,133,340	$39,131,927	$43,927,832	$46,595,963 [3]
Beginning Premium Stabilization Reserve (PSR)	$648,469	$4,226,164	$4,445,614	$5,054,023	$6,519,885	$4,366,132
PSR % of Premium	2.0%	12.8%	13.4%	12.9%	14.8%	9.4%

[1] Stabilization reserve was used to subsidize rates and margin requirement; in other years, the PSR subsidized the margin requirement
[2] CIGNA projection; actual year-end balance will vary, based on policy year results
[3] Contract premium before 5.0% credit to reduce PSR; actual billed premium projected to be $44,442,212

The County and CIGNA have agreed to reduce the magnitude of the PSR over two years using portions of it to buy down indicated rate increases. The target reserve level at the end of two years is 6.0% of projected premium.

The County will be billed rates at a 0.6% decrease from 2007; if additional premium is needed, CIGNA will use the PSR to fund the plan. CIGNA projects the value of the PSR will be about $6.5 million at the end of 2007. In the unlikely event that the PSR is completely depleted, CIGNA could require the County to pay up to the 4.6% premium increase over 2007 rates. Given the historical experience, a catastrophic increase in claims would need to occur for the fund to be depleted by the end of 2007. While there is some small risk that the County will be required to pay additional funds, we believe this is unlikely. It is a prudent business decision for the County to accept CIGNA's offer to subsidize 5.0% of the 2008 rate action through the PSR.

It is our conclusion that CIGNA's final renewal position is justified based on the County's experience.

Kaiser

The County's enrollment in the Kaiser plans continues to be significantly greater than in the CIGNA and PacifiCare plans, with 61% of the County sponsored plan Represented employees enrolled with Kaiser.

Kaiser's initial renewal position was 1.9% for Options, based on the negotiated 2008 plan design (or 3.9% for the current plan design), and 4.4% for Choices for the current plan design.

Kaiser's initial renewal was based on the following factors:

- A 1.5% rate load to account for its perception of deteriorating risk of the population
- Significant decrease in inpatient hospital utilization by the plan members, which is highly unusual for a population as large as the Represented Kaiser enrollment
- Kaiser's commitment to continue working with the County and SEIU Local 721 on the cost mitigation goals and their interest in working on similar initiatives with the Choices population

The reasons for the inpatient utilization reduction are not fully understood. A change of the magnitude observed between the 2005 and 2006 results, that Kaiser used in its 2007 and 2008 ratings respectively, is unexpected for a population this large. Kaiser stated that the reduction was not attributable to a change in their rating system or due to a data or reporting error. While the decrease in utilization leads to a low renewal position, it is not known whether the positive trend will continue. We requested Kaiser's analysis for the 2006 change in utilization, but they delivered minimal information. We recommend that they continue to analyze the experience results and monitor and understand any changes emerging in the 2007 experience results.

Expanded access in the South Los Angeles area also continues to be an issue. Kaiser has not been able to find a suitable location for the South LA clinic, which they committed to in 2005 for 2006, and have asked for the County's assistance in finding a location.

After extensive negotiations, Kaiser agreed to remove the 1.5% risk load for the Options group, given their commitment to the CMGOs (Cost Mitigation Goals & Objectives); however, the load still applies to the Choices plan. In addition, the final renewal included the following adjustments to the Options and Choices plans:

- $170,000 to credit the final 2005 performance guarantee penalty payment (no penalty due on 2006 measures reported to date) – this amount in total was credited across the Represented and Non-represented renewals based on their respective enrolled membership
- Credit for a $821,642 large claim pooling error in the 2007 rating; this error was a finding in the Mercer Review of the 2007 Kaiser Rates – Kaiser agreed to the error and to credit it in the 2008 Represented plan rating

Total savings through negotiations and performance guarantee credits, not including benefit design changes, were $3.9 million.

The final renewal increases are 0.2% for Options and 2.2% for Choices, or 0.8% combined; an increase of $2.5 million over 2007. The final Choices renewal includes a credit of $1.8 million for benefit design changes to meet the negotiated plan design.

We do not believe the 1.5% risk load on the Choices plan is justified; however, Kaiser is unwilling to remove it. Additionally, Kaiser has not sufficiently explained the dramatic changes

in utilization over the past several years, so we are unable to adequately justify their renewal at this time. Further analysis of the County claims data is due from Kaiser by August 31.

PacifiCare

PacifiCare originally proposed an overall increase of 11.3%; 11.1% for the HMO and 21.1% for the PPO. The HMO renewal included credits for the 2008 negotiated plan design changes. Without the HMO plan changes, the original overall proposal was a 15.5% increase; 15.3% for the HMO.

Negotiations with PacifiCare produced a final offer of 8.3% increase on the HMO and 13.7% on the PPO after plan changes. This resulted in negotiated savings and performance guarantee credits of about $3.3 million and benefit design changes of $5.2 million from their original position.

PacifiCare's final renewal included the following adjustments:

- Removal of early quote load of 1.5%
- Updating of more current claims experience and reduced trend
- Reduction in the vision rider premium
- Application of preliminary 2006 Performance Guarantee penalties of $212,848. A final report including the HEDIS and CAHPS measures will be delivered in the fourth quarter 2007

As requested, PacifiCare offered an alternate funding arrangement. The County currently has a non-participating financial arrangement with PacifiCare. At the end of each policy year, PacifiCare retains any surpluses or deficits which result from a difference between the paid premium and the actual claims expenses and retention. In such an arrangement, it is expected that there will be a reasonable balance of gains and losses experienced by the carrier over time. PacifiCare retained significant surpluses during the 2003 through 2005 policy years. In 2006, a surplus resulted again, but it was within a more acceptable variance at 0.5% of premium.

The alternate funding arrangement included the following provisions:

- During 2008, PacifiCare would collect premium based on its cost projections (including medical and pharmacy claims, capitation payments, supplemental riders, and retention).

- In the second quarter of 2009 (between 6/1 – 7/1), PacifiCare would perform a financial reconciliation to compare the paid premiums to the actual claims and retention expenses for 2008.
- If a surplus resulted, it would be returned to the County (the surplus could be deposited in a premium stabilization reserve with PacifiCare to be used for future premium payments; however, this reserve limit is capped at 3% of premium).
- If a deficit resulted, the County would need to remit funds to PacifiCare to clear the deficit, within 30 days after PacifiCare delivered the reconciliation.
- A maximum risk sharing corridor of 20% applies. If the surplus were to exceed 20% of the premium (excluding retention), PacifiCare would keep the surplus in excess of 20%. Likewise, if a deficit exceeded 20% of the premium (excluding retention) PacifiCare, and not the County, would be responsible for the expenses above 20%. There would be no carry-forward of deficit amounts. PacifiCare also offered an option to share 50% of the results within the 20% corridor.
- PacifiCare would retain the liability and would continue to fund reserves for incurred but not reported claims.

Adopting the alternate funding proposal would require the County to:

- Make a long term commitment to a change in funding
- Prepare to manage excess funds (for example, managing surplus funds deposited into a stabilization reserve) and to fund shortfalls that could be payable to PacifiCare
- Consider increasing the budgeted renewal to fund a claims fluctuation margin to protect against adverse experience results during the policy year

PacifiCare did not offer a traditional participating arrangement in which they would carry-forward any deficits to future policy years, but instead would require the County to settle these funds within 30 days of their reconciliation. So, the County would face exposure to higher expenses if claims exceed projections. We recommend that the County continue to monitor PacifiCare's financial results and consider implementation of a shared risk arrangement if there appears to be a pattern of conservatism in their future rating. In any given year, the shared risk results can be positive or negative, but over time, we expect the County could benefit from sharing in the financial results.

We believe that PacifiCare has justified their renewal position and that the County should accept their offer.

Dental Plans

We believe the dental renewals are justified and should be accepted by the County.

Delta Dental

The Delta Dental plans were renewed for 1/1/07 and both the contract and billed rates are guaranteed to 1/1/09. There were no performance guarantee credits due on the Delta plans for the 2006 policy year.

Safeguard Prepaid Dental

Safeguard initially proposed a 6% increase to the current contract rates for the County's 2008 plan. Negotiations with Safeguard based on the limited plan data provided resulted in a reduction of the renewal to 3.3% for contract rates or 3.5% for billed rates, an increase of about $106,000 over current billed rates. The contract rates are guaranteed through 12/31/10. Billed rates are slightly lower than the contract rates, as they include a credit for performance guarantee penalties. Billed rates may change from year to year, based on any applied performance guarantee penalty credit.

We believe the renewal is justified and support acceptance of a three-year contract rate guarantee on the Safeguard plans. A three-year rate guarantee requires a slightly higher increase than a single year increase because the premium will need to support utilization and price increases (trend) for a three-year period. However, the projected trend for the dental plans is relatively low. A three-year rate will lock in this projection, and does not preclude the County from reviewing other carrier options for 2009.

Basic/Voluntary Life and AD&D - CIGNA

Mercer recommends that the County accept the final 2008 renewal proposal offered by CIGNA.

Basic Life and AD&D rates will be continued for a three year guarantee period, through 12/31/10. The three year guarantee does not preclude the County from reviewing other vendors during this period.

Optional and Dependent Life rates are currently in a rate guarantee period and CIGNA agreed to extend it by one additional year, through 12/31/10. With this change, the rate guarantee periods for the Basic Life/AD&D and Optional/Dependent Life will be consistent.

CIGNA agreed to offer $5,000 towards the County's wellness initiatives.

If you have any questions or need additional information regarding any of the renewals, please let me know.

Sincerely,

Marci K. Burns
Principal

Enclosure

Copy:
Frank Frazier, County of Los Angeles
Bill Scott, Mercer Health & Benefits
Jeff Whitman, Mercer Health & Benefits
Ann Gillespie, Mercer Health & Benefits

Addendum

Process

The renewal request, analysis and negotiation are multi-step processes, conducted over a period of several months. A planning meeting with the County begins the process, in which objectives for the following plan year are established. Stakeholders include the County, Unions (Coalition of County Unions and SEIU-Local 721), Union consultants and Mercer.

Based on the planning meeting discussions, a Request for Renewal (RFR) is drafted and reviewed by all stakeholders. The RFR includes:

- Stated assumptions and requirements, including a submission letter to be signed by a company officer with the authority to bind their proposal
- Questionnaire encompassing carrier financial results, prescription drugs and provider issues, health and productivity management, administration, and quality issues
- Plan performance exhibits comparing the County's past plan results to the carriers' book of business results
- Rate quotation, rate development and projected cost exhibits
- Benefit design and contract changes
- Performance guarantees

All stakeholders submit requested changes to the draft. These are reviewed and incorporated into the final RFR, which is then released to the carriers.

Carrier proposals are submitted to all stakeholders at the same time. Following a review and analysis period, Mercer drafts negotiation letters for each plan. The drafts are reviewed by the County and the Union consultants, and their respective comments are incorporated before release

to the carriers. Weekly status conference calls are conducted between Mercer and the County to discuss the renewal results, negotiation process and any open issues.

Responses to the negotiation letters are due from the carriers prior to the renewal meetings. Again, the responses are delivered to all stakeholders concurrently. Final issues are reviewed and prepared for the renewal meetings.

Two-hour renewal meetings are conducted with each carrier. Due to the unique circumstances associated with the Kaiser renewal, several additional meetings were also held, including meetings with their senior management. Attendees include representatives from DHR, CEO, Union consultants, BAC and EBAC committees and Mercer, as well as the carrier representatives. The carrier representatives generally include account/sales management, financial, operations, and medical/provider relations personnel. Issues discussed during the meetings include: rate development/proposal rates, performance guarantees, RFP deviations, network contracting environment and quality initiatives. Outstanding issues and requests for reduced rates – where areas of opportunity exist – are identified for each carrier. Following the meeting, carriers must respond to all identified issues in writing to all stakeholders.

The review and negotiation process continues until all open issues are resolved or the carrier has presented their final offer. The negotiation does not always result in agreement on particular topics; however, it may result in overall business concessions from the carriers.

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August 23, 2007

Ms. Marian Hall
Chief of Employee Benefits
Department of Human Resources
County of Los Angeles
3333 Wilshire Boulevard
Los Angeles, CA 90010

Subject:
Summary of 2008 Medical, Dental, and Life Renewal Results and Recommendations (Non-represented Plans)

Dear Marian:

This letter summarizes the results of our analysis and negotiation of the 2008 renewal proposals for medical, dental, and life plans offered to the non-represented employees of the County of Los Angeles (County). In addition, it presents Mercer's recommendations for each plan.

The renewal request and negotiation process is outlined in the attached Addendum.

Medical Plans

Overview

For all medical plans, the total projected premium increase for the current benefit programs is 12.0% or $10.2 million. This compares to an initial increase of 13.2% or $11.2 million. Negotiated savings, including $18,000 for Kaiser performance guarantee credits, were $994,500. The Blue Cross program is self-funded and expected and maximum liability costs are projected. The Blue Cross expected costs are the basis for the renewals outlined in this letter.

After our analysis of the renewal proposals, Mercer recommends that the County accept the final 2008 renewal increase offered by Blue Cross, averaging to 10.1% across all products, which we believe is justified based on the plan experience. Kaiser's increase of 15.1%; however, has not been justified to our satisfaction, as critical analysis from Kaiser needed to complete our review is outstanding.

A summary of key issues, negotiation results and the proposal terms are outlined below by carrier.

Blue Cross

For the 2008 plan year, Blue Cross proposed an increase for all plans combined of approximately 12.0% or $6.3 million, before negotiations. The final renewal without any plan changes is 10.1%, an annual increase of $5.3 million.

All plans are funded through a minimum premium arrangement with specific stop loss of $300,000 per individual. The aggregate stop loss will continue to be set at 120% of projected claims for all plans. Projected 2008 maximum liability for the Blue Cross plans is $66.6 million, based on the current enrollment by product.

In reviewing Blue Cross' original renewal proposal, we identified several key issues:

- Higher than needed medical trend factors. Blue Cross utilizes book-of-business trend factors for this group. Actual experience for the County has shown a trend significantly lower
- Significant increases in stop loss charges
- Increase in the number and claim amount for large claims

Blue Cross' renewal proposal also included the cost of their disease management programs – 360 Degree Health – at a cost of about $3.97 per employee per month. The 2008 claims projection also included a claims credit equal to the cost of the programs, to reflect the reduction in claims expected by implementation of the disease management programs. The following disease management programs are included in 360 Degree Health:

- Future Moms (AKA: Maternity Management, Baby Connections, Baby Benefits)
- 24/7 NurseLine
- ConditionCare (AKA: Disease Management, Condition Management) – Includes Asthma, Diabetes, Coronary Artery Disease, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease
- ComplexCare (AKA: Advanced Care Management, ACM)
- Neonatal Intensive Care Unit

We understand that the County is in the process of implementing the 360 Degree Health program.

As a result of negotiations, Blue Cross updated their claim projections and their approach to the PPO projection, reducing the overall renewal. Blue Cross also agreed to hold the aggregate stop loss fee across all products to the same level as current.

The PPO renewal is significantly higher than trend, and experience reports throughout the year indicated that the actual PPO results were exceeding previous projections. If actual 2008 results are better than predicted by this renewal, the County will realize the difference via the self-funded arrangement. The PPO projection was impacted by the following:

- Given the relatively small enrollment in this plan (in comparison to other County sponsored plans) it is not unexpected to have sizable fluctuations in the results – particularly if driven by a change in the size or frequency of very large claims
- Benefits for PPO are significantly less managed than the HMO plans, and the benefits are not capitated
- High claimants were the primary driver of the renewal increase – there were 17 claimants in excess of $100,000 – including three that exceeded the $300,000 individual stop loss level ($393,000, $799,000 and $881,000)

Vision benefits for the HMO, POS, and PPO plans are offered on a non-participating insured basis through an arrangement between Blue Cross and VSP. The vision plan was renewed for 1/1/07 and is in a rate guarantee through 1/1/09. The cost of the vision plan is included in the Blue Cross rates mentioned above.

Blue Cross provided their 2006 performance guarantee report and applied the penalty of $265,147 to the County's May 2007 invoice.

We believe Blue Cross' most recent renewal proposal is justified and recommend that the County accept it.

Kaiser

Kaiser's renewal position is 15.1%, or an annual change of about $4.9 million, for the Non-represented plan. This result compares unfavorably to Kaiser's stated average Southern California increase of approximately 9.1%.

Key issues raised with Kaiser throughout the renewal process were:

- The necessity to provide a thorough understanding of the key renewal drivers
- Kaiser's analysis and supporting data for the significant reported increases in inpatient hospital utilization and pharmacy costs. The rate of change for hospital days per 1000 members and the number of admissions per 1000 members is highly unusual for a population of this size, unless driven by catastrophic claimants. Kaiser reviewed the high claimants and reported an increase, but they did not account for the significant change in hospital utilization

Kaiser was asked for their analysis of the plan utilization in the initial renewal request. In response, they provided their standard client renewal utilization reports and a very high level written summary noting the key utilization changes. However, their response did not address why inpatient utilization increased at such a high rate, even though the utilization was clearly inconsistent with recent years, and differed greatly from the Kaiser Health plan results.

Over the past three months, numerous written requests and face-to-face meetings with representatives from the County, Kaiser, and Mercer attempted to resolve the above issues. Since an understanding of the utilization changes was not forthcoming, we also vigorously pursued a reduction in the Non-represented plan renewal; however, Kaiser would not agree to change their renewal position.

During this time, Kaiser provided some limited additional data indicating that utilization for the Non-represented plan increased both in comparison to 2005 and at a faster rate than the Kaiser Health Plan. As a result, the renewal increase was higher than the Kaiser Southern California average. However, the reasons for the escalation in hospital admissions and increased length of stay still have not been determined.

Kaiser has committed to providing their full analysis of the Non-represented plan utilization changes by August 31, 2007. They have also committed to providing the County with quarterly updates regarding the Non-represented plan utilization, so that any unusual changes or trends can be explored and understood, prior to the rate setting process.

We are not able to justify the renewal positions until Kaiser provides the requested analysis.

Dental Plans

We believe the dental renewals are justified and should be accepted by the County.

Delta Dental

The Delta Dental plans were renewed for 1/1/07 and both the contract and billed rates are guaranteed to 1/1/09. There were no performance guarantee credits due on the Delta plans for the 2006 policy year.

Safeguard Prepaid Dental

Safeguard initially proposed a 6% increase to the current contract rates for the County's 2008 plan. Negotiations with Safeguard based on the limited plan data provided resulted in a reduction of the renewal to 3.3% for contract rates or 3.5% for billed rates, an increase of about $6,000 over current billed rates. The contract rates are guaranteed through 12/31/10. Billed rates are slightly lower than the contract rates, as they include a credit for performance guarantee penalties. Billed rates may change from year to year, based on any applied performance guarantee penalty credit.

We believe the renewal is justified and support acceptance of a three-year contract rate guarantee on the Safeguard plans. A three-year rate guarantee requires a slightly higher increase than a single year increase because the premium will need to support utilization and price increases (trend) for a three-year period. However, the projected trend for the dental plans is relatively low. A three-year rate will lock in this projection, and does not preclude the County from reviewing other carrier options for 2009.

Basic Life and AD&D - CIGNA

Mercer recommends that the County accept the final 2008 renewal proposal offered by CIGNA, which is a continuation of the current rates for both Basic Life and AD&D plans for a three year guarantee period, through 12/31/10. The three year guarantee does not preclude the County from reviewing other vendors during this period.

CIGNA agreed to offer $5,000 towards the County's wellness initiatives.

Sincerely,

Marci K. Burns
Principal

Enclosure

Copy:
Frank Frazier, County of Los Angeles
Bill Scott, Mercer Health & Benefits
Jeff Whitman, Mercer Health & Benefits
Ann Gillespie, Mercer Health & Benefits

Addendum

Process

The renewal request, analysis and negotiation are multi-step processes, conducted over a period of several months. A planning meeting with the County begins the process, in which objectives for the following plan year are established. Stakeholders for the Non-represented plan include the County and Mercer.

Based on the planning meeting discussions, a Request for Renewal (RFR) is drafted and reviewed by all stakeholders. The RFR includes:

- Stated assumptions and requirements, including a submission letter to be signed by a company officer with the authority to bind their proposal
- Questionnaire encompassing carrier financial results, prescription drugs and provider issues, health and productivity management, administration, and quality issues
- Plan performance exhibits comparing the County's past plan results to the carriers' book of business results
- Rate quotation, rate development and projected cost exhibits
- Benefit design and contract changes
- Performance guarantees

All stakeholders submit requested changes to the draft. These are reviewed and incorporated into the final RFR, which is then released to the carriers.

Carrier proposals are submitted to all stakeholders at the same time. Following a review and analysis period, Mercer drafts negotiation letters for each plan. The drafts are reviewed by the County, and their comments are incorporated before release to the carriers. Weekly status

conference calls are conducted between Mercer and the County to discuss the renewal results, negotiation process and any open issues.

Responses to the negotiation letters are due from the carriers prior to the renewal meetings. Again, the responses are delivered to all stakeholders concurrently. Final issues are reviewed and prepared for the renewal meetings.

Two-hour renewal meetings are conducted with each carrier. Due to the unique circumstances associated with the Kaiser renewal, several additional meetings were also held, including meetings with their senior management. Attendees include representatives from DHR, CEO and Mercer, as well as the carrier representatives. The carrier representatives generally include account/sales management, financial, operations, and medical/provider relations personnel. Issues discussed during the meetings include: rate development/proposal rates, performance guarantees, RFR deviations, network contracting environment and quality initiatives. Outstanding issues and requests for reduced rates – where areas of opportunity exist – are identified for each carrier. Following the meeting, carriers must respond to all identified issues in writing to all stakeholders.

The review and negotiation process continues until all open issues are resolved or the carrier has presented their final offer. The negotiation does not always result in agreement on particular topics; however, it may result in overall business concessions from the carriers.

ATTACHMENT C

COUNTY OF LOS ANGELES
2008 Renewal Results

	2007	2008 Original renewal - current plan	2008 Negotiated renewal - final plan	Percent Change	Negotiated Savings	Benefit design change savings	Performance Guarantee Credits	Total Savings [1]	Savings Comments
Flex/MegaFlex									
Kaiser	$32,359,178	$37,259,433	$37,241,499	15.1%	$0	$0	$17,935	$17,935	Negotiation, 2005 PG credit of $170,000 for Choices, Options & Flex/MegaFlex
Blue Cross [2] Expected Costs	$52,669,867	$58,967,181	$57,990,591	10.1%	$976,590	$0	$0	$976,590	Negotiation
Options									
Kaiser [3]	$205,495,440	$213,449,691	$205,894,465	0.2%	$3,481,648	$3,968,030	$105,548	$7,555,226	Negotiation, 2005 PG credit, pooled claim credit for 2007 rates, removal of 1.5% load, benefit change
PacifiCare	$122,158,009	$141,114,853	$132,609,773	8.6%	$3,068,799	$5,223,433	$212,848	$8,505,079	Negotiation, benefit changes for HMO & PPO
Choices									
Kaiser	$94,250,901	$98,386,820	$96,356,659	2.2%	$222,520	$1,761,124	$46,517	$2,030,161	Negotiation, 2005 PG credit, pooled claim credit for 2007 rates, benefit change
CIGNA [4]	$44,463,234	$48,568,761	$44,183,892	-0.6%	$2,276,985	$2,107,884	$0	$4,384,869	Negotiation, HMO benefit change
Total Medical	$551,396,629	$597,746,738	$574,276,878	4.1%	$10,026,541	$13,060,471	$382,848	$23,469,860	
Delta [4]									
Flex	$7,762,096	$7,762,096	$7,762,096	0.0%	$0	$0	$0	$0	Rate guarantee through 12/31/2008
Options	$30,842,979	$30,842,979	$30,842,979	0.0%	$0	$0	$0	$0	
Choices	$16,754,429	$16,754,429	$16,754,429	0.0%	$0	$0	$0	$0	
Safeguard [5]									
Flex	$184,314	$195,715	$190,733	3.5%	$4,432	$0	$550	$4,981	Negotiation, 2006 PG credit of $9,518 applied
Choices/Options	$3,059,185	$3,233,432	$3,165,510	3.5%	$58,954	$0	$8,968	$67,922	to 2008 rates across all plans
Total Dental	$58,603,003	$58,788,650	$58,715,747	0.2%	$63,385	$0	$9,518	$72,903	
CIGNA Basic Life [6]									
Flex/MegaFlex	$41,639	$41,639	$41,639	0.0%	$0	$0	$0	$0	
Choices/Options	$1,174,239	$1,174,239	$1,174,239	0.0%	$0	$0	$0	$0	
CIGNA Optional Life [6]									
Choices/Options	$12,765,836	$12,765,836	$12,765,836	0.0%	$0	$0	$0	$0	
Total Life [7]	$13,981,715	$13,981,715	$13,981,715	0.0%	$0	$0	$0	$0	
TOTAL	$623,981,347	$670,517,104	$646,974,340	3.7%	$10,089,927	$13,060,471	$392,366	$23,542,763	

[1] Reflects changes in total cost due to negotiations, benefit changes and performance guarantee credits
[2] Blue Cross' Performance Guarantee credits were paid directly to the County: $265,147 $265,147
[3] Kaiser Options original renewal premium is estimated based on the credit given for negotiated benefit changes.
[4] CIGNA and Delta Dental Negotiated Renewals are based on the billed, subsidized rates
[5] Safeguard's premiums are based on billed rates
[6] Basic Life rates are guaranteed through 12/31/2010; Optional Life rates are guaranteed through 12/31/2010
[7] Life premiums do not include AD&D, Dependent Life or Survivor Life plans through CIGNA or the MetLife Optional Life plan for Flex/MegaFlex

Total, including Blue Cross PG credit					$10,089,927	$13,060,471	$657,512	$23,807,910

ATTACHMENT D

1. Coalition of County Unions Rate Position
2. Kaiser's August 16, 2007 Letter to Whitman
3. Mercer's August 13, 2007 Letter to Kaiser Representative Mr. Till

COALITION OF COUNTY UNIONS

ATTACHMENT D

Los Angeles County Federation of Labor, AFL-CIO

Sent Via FAX and U.S. Postal Service

August 22, 2007

Mr. Frank Frazier
CEO Compensation Policy
County of Los Angeles
Hahn Hall of Administration, Room 526
500 West Temple Street
Los Angeles, California 90012

RE: COALITION'S POSITION REGARDING PROPOSED 2008 RATES FOR COUNTY-SPONSORED BENEFIT PLANS

Dear Mr. Frazier:

The Coalition has reviewed the proposed 2008 rates for the County-sponsored benefit plans and accepts all the proposed 2008 rates for these plans with the exception of the Kaiser Plan.

The renewal rates for the Kaiser Plan have been volatile for the past several years without justification being provided by Kaiser in support of its rates. The 2008 rate demanded by Kaiser for its Plan continues this pattern even though it is only a modest rate increase. This rate increase includes 1.5% load which the County's own consultant, Mercer, agrees is not justified.

Kaiser represents that this load is due to a "deterioration of risk" expected in 2008. Yet Kaiser also argues that it is a result of the Coalition failing to actively engage with Kaiser on Cost Mitigation Goals and Objectives (CMGO). [See Kaiser's August 16, 2007 letter to Whitman]

The Coalition and County Management agreed to specific CMGO initiatives with each of the County sponsored health plans as part of our current Fringe Benefits agreement. The Coalition will fulfill its commitment to work with County Management on the specific CMGO initiatives. The Coalition has given ample indication of cooperation and its willingness to consider with County Management any suggestions by Kaiser in pursuing these CMGO initiatives but Kaiser has not taken advantage of this opportunity to date. [See Mercer's August 13, 2007 letter to Kaiser Representative Mr. Till] Thus, the Coalition does not accept Kaiser imposing this penalty load on the County employees represented by it.

Respectfully,

Blaine J. Meek

Blaine J. Meek, Chair

BD411 015 FF

KAISER PERMANENTE®

August 16, 2007

Jeffrey Whitman
Principal
Mercer Human Resource Consulting
777 South Figueroa Street, Suite 2000
Los Angeles, Ca 90017

Re: Coalition of County Unions CMGOs - Response to Mercer's August 13th letter

Dear Jeff,

I am in receipt of your correspondence dated August 13th, 2007 and I am encouraged by the Coalition of County Union's interest in engaging with Kaiser Permanente in regards to the CMGOs. It is believed that active engagement in the areas of risk selection and wellness are part of the solution in addressing the adverse risk issue as reported in the recently published Mercer study.

As discussed and documented on numerous occasions, the medical trend in both Options and Choices is escalating at a faster pace then our standard pricing methodology reflects. As such, Kaiser Permanente requires an additional load in the renewal. This additional load was estimated to be 4% in both 2007 & 2008, but reduced to 2% in 2007 and 1.5% in 2008. The removal of the 2% load from the 2007 renewal assumed active engagement by the Coalition of County Unions. We, unfortunately, saw no evidence of such engagement. It was not until March 8th, 2008, that the parties met to review Kaiser Permanente's full engagement proposal using many of the same tools currently employed in the Options program. This proposal included a detailed description of our new reporting capabilities such as the *Periodic Utilization Report* and *Partnership in Health* report. Although pursued by Kaiser Permanente, no CMGO meetings were ever held with Coalition representatives. The May 17th meeting focused on the 2008 renewal.

The formal 2008 renewal meeting was held on June 22nd, 2007, with Kaiser Permanente, Mercer, County of LA and SEIU Local 721 representatives meeting to discuss the 2008 renewal and the analysis supporting the 1.5% risk load. Unfortunately, the Coalition of County Unions was not present to participate in these discussions. The application of a risk load (or credit) may not be frequently seen, although it is not unusual for this to be applied when risk selection exists within a specific population. In our June 22nd renewal meeting, we discussed how a risk load (or credit) has been applied in other groups where the use of past utilization to determine premium levels for a future coverage period cannot accurately account for the risk in a population when a risk selection is present. Kaiser Permanente has provided an extensive analysis of the rationale for the risk load, both the underlying theory and the numerical derivation. We believe that the 1.5% additional load in the 2008 renewal is both warranted and justified.

We look forward to meeting with the County of LA and the Coalition of County Unions on September 13, 2007, to engage in the CMGOs and review additional utilization data.

Sincerely,

William B. Caswell

William B. Caswell
Sr. Vice President, Operations
Health Plan, Southern California

CC:
Frank Frazier, County of Los Angeles
Marian Hall, County of Los Angeles
Blaine Meek, CAPE and Chair of EBAC
Marci Burns, Mercer
Anne Clifford, Fickewirth & Associates
Cindy Striegel, Kaiser Permanente
Christopher Till, Kaiser Permanente

MERCER
Human Resource Consulting

777 South Figueroa Street, Suite 1900
Los Angeles, CA 90017-5818
213 346 2311 Fax 213 346 2680
www.mercerHR.com

August 13, 2007

Mr. Christopher Till
Executive Account Manager
Kaiser Permanente
393 East Walnut Street, Fifth Floor
Pasadena, CA 91188

Subject:
Coalition of County Union CMGOs

Dear Chris:

As you know, in 2006 the Coalition of County Unions and County Management agreed to support the Cost Mitigation Goals and Objectives (CMGO) initiatives with each of the County sponsored health plans. To that end Kaiser was invited to present its capabilities to meet these goals, and the first meeting was held with EBAC on March 8, 2007. Kaiser outlined its programs that would support the County CMGO initiative, and the Coalition emphasized its commitment to the CMGOs. During the course of that meeting, EBAC learned that Kaiser would be able to develop experience utilization statistics that would be useful for developing CMGO strategies. The Coalition suggested quarterly meetings be set up to review this data. Kaiser next met with EBAC on May 17, at the Coalition's request, to present information on potential design changes to reduce plan costs, some of which were later implemented by EBAC.

Subsequent to this effort Kaiser delivered its renewal proposal to the County and the Coalition. That proposal contained a charge of 1.5% due to Kaiser's perception of "deterioration of risk" expected in 2008. In his July 25 response to our request to remove the 1.5% load for the Choices Plan, William Caswell, Senior Vice President Operations, stated "The 1.5% load for the Choices population will remain as there has been no significant engagement by the Coalition of County Unions in implementing the CMGOs even after the 2% load being removed in 2007." The County and the Coalition are perplexed by Kaiser's position given the Coalition's ample indication of cooperation and the lack of Kaiser initiative to move the program. Instead Kaiser wants to impose a penalty on County employees represented by the Coalition through this unacceptable charge.

The County and the Coalition want to get the CMGO process back on track. To that end the following meeting dates have been set aside for Kaiser to reengage with EBAC:

August 23, 2007, from 9:00 to 12:00

September 13, 2007, from 9:00 to 12:00.

We hope that Kaiser will come prepared to review the Coalition utilization information and reignite the CMGO process. Furthermore, the County and the Coalition expect Kaiser to remove the unwarranted 1.5% "risk" charge from the 2008 rates.

Please give us your response and preferred meeting date no later than August 16 so we can make sure all schedules and meeting location details can be attended to.

Sincerely,

Jeffrey G. Whitman

Copy:
Mr. Frank Frazier, County of Los Angeles CEO, Vice Chair of EBAC
Mr. Blaine Meek, CAPE and Chair of EBAC
Ms. Marian Hall, County of Los Angeles DHR
Ms. Marci Burns, Mercer
Ms. Anne Clifford, Fickewirth & Associates

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ATTACHMENT E

Recent Developments in Kaiser's Implementation of the County CMGO Program

In 2006, Kaiser focused on getting employees to use its resources appropriately through targeted newsletters, information on chronic conditions, promoting on-call use and hired a dedicated clinical services manager specifically to work with County employees in areas of chronic disease control and clinical care interventions.

Thus far in 2007, Kaiser has made strides in increasing engagement with Local 721 and County management on development of its reporting package. The development of group specific disease management outcome measures for the most prevalent chronic conditions (diabetes, asthma, coronary artery disease, heart failure, and depression) was accomplished and then reported in a custom Partnership in Health (PIH) report. In addition, with assistance from Local 721 and County management, Kaiser expanded its reporting capabilities to include the Periodic Utilization Report (PUR), which shows high level utilization trends for inpatient, outpatient, pharmacy and other services among County employees, and the "Dashboard", an executive summary which recaps the PIH and PUR reports. As the PUR and PIH reports continue to be reviewed by labor and management, Kaiser has committed to revising their reports to satisfy County needs. Kaiser is in the process of developing a "personal care note" tool that will be customized for the employee and based on the member's own clinical information.

Increased engagement of Local 721 members was targeted and an improved wellness program was launched in July 2007 at the Civic Center Wellness Fair. The focus of the wellness program is to improve the health of County employees and mitigate increasing health costs. An integral part of the wellness program is the individual Total Health Assessment (THA), which is used to determine the individual's health risk factors. Based on results of the THA, the program offers disease specific management programs, on-line programs (Healthy Lifestyles Programs), and an incentives/rewards program for those participating and completing the various programs. This is a long-term initiative to improve overall employee health and productivity and whose impact will be measured over time.

Kaiser has met with EBAC, the joint CCU-management committee, to begin engagement on the CMGO program and is in the process of scheduling further meetings. Topics for discussion will be a comprehensive disease management program and reporting package specifically for CCU employees.

The CEO, DHR, and Kaiser are planning to develop PUR and PIH reports for non-represented employees. Kaiser advises us that the reports will be forthcoming soon. We are looking at launch of the non-represented wellness program in early 2008.

ATTACHMENT F

(This document is incorporated into both the SEIU Local 721 and Coalition of County Unions Fringe Benefit MOUs)

APPENDIX A

SEIU Local 660 – County of Los Angeles
Joint Labor Management
Health Insurance Cost Mitigation, Goals, and Objectives
Wellness and Health Insurance
Cost Containment Strategic Action Plan

I. Guiding Principles

A. *Provide competitive and highly values employed benefits designed to help attract and retain healthy employees.*

B. *Provide quality, comprehensive and flexible benefits that meet the diverse work-life needs of employees and their dependents.*

C. *Create a County-wide wellness and consumer-wise culture by promoting adoption of healthy lifestyles and the cost sensitive use of health care benefits as tools to help control costs, reduce employee absenteeism and improve morale and productivity.*

D. *Obtain outstanding market value (cost, benefits, access and quality) for all benefits offered to employees.*

E. *Improve the effectiveness of County-wide wellness and disease management programs by focusing and coordinating existing County wellness programs to be consistent with this cost mitigation strategy.*

II. Strategic Goals

A. Measurably control costs and level off annual rate increases below average/normal cost trends

1. The County and Local 660 will work collectively to limit annual HMO rate increases to less than normal/average cost trend rate, or 5% whichever is less.

2. *Assure carrier administrative fees (profit, retention, etc.) are appropriate given actual claims expense and loss ratios.*

B. *Measurably reduce unnecessary health care utilization to levels below current Options levels and to levels that reflect a healthier population*

1. *Reduce key utilization measures from current Options levels, including hospital, physician and prescription drug utilization.*

   Promotion of wellness and preventative office visits should be encouraged to avoid unnecessary urgent/emergent care/hospital visits.

2. *Measure the affect of these reductions on Options costs and annual rate increases.*

C. *Measurably improve employee health status to levels better than average for similar employee populations*

1. *Increase employee participation in Wellness, Risk Reduction and Disease Management Programs.*

2. *Track employee participation levels, lifestyles/behavior changes and clinical outcomes year over year.*

3. *Measure the affect of these programs on employee health status, Options utilization, costs and annual premium rates.*

D. *Measurably improve quality of care*

1. *Hold carriers accountable for ongoing quality improvement related to clinical processes and outcome measures and employee satisfaction.*

2. *Study and compare HMO/PPO "unit costs" and clinical quality outcomes to help obtain the most cost effective and efficient delivery of services.*

3. *Develop performance guarantees with the carriers tied to the above goals.*

III. Short Term Objectives and Action Plan

A. Data collection and reporting

1. *Identify and compare the most prevalent, fastest growing, and costly disease/conditions and related risk factors for Options participants based on various measures of cost and utilization of services for each of the last two years.*

2. *Measure and compare Options specific utilization levels and costs over the last two years and identify cost trends and utilization patterns that are considered above average.*

3. *Benchmark past years and compare future clinical care outcomes, cost, utilization patterns, and employee participation levels yearly to develop cost, utilization, and participation measures to determine the effectiveness of disease management and wellness programs.*

4. *Measure carrier clinical quality and employee satisfaction improvement over the last three years through the use of CCHRI data and Options specific surveys. Also, measure provider specific performance against appropriate industry benchmarks.*

5. *Obtain and compare HMO unit costs and quality outcomes data to assess the cost and quality differences between HMO plans.*

6. *Incorporate County specific clinical disease management outcomes measures into HMO performance standards and financial penalties.*

B. Wellness, Disease Management and Employee Education

1. *Identify the availability of HMO/PPO Wellness, Risk Reduction and Disease Management Programs.*

2. *Implement "targeted" programs based on Options specific disease prevalence, related major risk factors and high cost areas of hospital, physician and prescription drug utilization.*

3. *Identify a) County b) Local 660 and c) HMO/PPO communication and incentive/reward resources that can be used to promote employee participation in and completion of Wellness and Disease Management Programs on a year-round basis.*

4. *Develop a year-round coordinated Carrier, County and Local 660 employee education and wellness campaign that targets major cost drivers and that promotes employee participation in wellness and disease management programs.*

   Education should also promote consumer-wise and cost sensitive use of health care services including targeted communication at the key time for patient decisions and engagement.

5. *Obtain written commitments from the carriers regarding their data reporting capabilities, financial and program resources in support of this strategy.*

6. *Prioritize, implement, coordinate and evaluate programs on an ongoing basis.*

7. *Investigate the new predictive modeling programs and other industry advancements that identify and avoid serious illness in advance.*

C. Plan Design and Funding

1. *Identify potential plan design and funding alternatives that will help reduce unnecessary utilization and costs and that incent members to use benefits in a more "consumer-wise" and cost effective manner.*

2. *Consider implementation of alternatives that have minimal impact on the employee's out-of-pocket expenses and that avoids cost shifting to employees.*

3. *Plan design changes need to assure appropriate access to desired services County-wide.*

4. *Identify and pursue development of potential strategic alliances with purchasing coalitions that would value to Options benefits as deemed useful.*

D. High Performing Providers

Have Options carriers identify high performing providers in efficiency and quality.

1. *Work with the carriers to develop an education campaign to motivate patients to use these providers.*

2. *Depending upon the results of the education program, consider reinforcing the education with financial incentives.*

3. *Develop a joint approach with the carriers to manage the least effective providers.*

E. Provider Contracting Management

1. *Require that the County's carriers present and initiate a business plan for trend management through provider contracting.*

Historical Footnote
Appendix A, negotiated during the 2003-2006 contract negotiations as a strategy to mitigate the upward spiraling cost of health insurance for employees, evolved in to the "Cost Mitigation, Goals and Objectives" (CMGO's) and have resulted in reduced costs during the annual rate renewal process.