2017 Health Insurance Rates: Unraveling the Mystery

When CalPERS recently announced that its open enrollment period for 2017 health insurance plans was to begin on September 12 and end on October 7, it also announced its 2017 rates.

That’s when CSUEU members at some campuses, particularly those without a Kaiser HMO available in the region, discovered they would be hit by significant health insurance hikes starting in 2017.

We’ll try here to unravel the mystery of your health insurance rates, including:

1. **Who sets them**
2. **How they’re set and the reasons why in some cases the percentage increase for 2017 is so high for employees**
3. **How this all works out in practice**
4. **Why chapters in such locations as Chico and Humboldt are particularly impacted by price hikes**
5. **Open enrollment information and definitions**

1. **Who sets your health insurance rates?**

CSUEU doesn’t negotiate health insurance rates, and it never has. CalPERS and the insurance companies set rates.

CalPERS, which by design has board members representing our interests either through active state and local agencies or as all-member representatives, serves as our agent in decisions made with insurance companies to set each year’s rates. The role of CalPERS is outlined in Article 21.4 of the CSUEU/CSU contract.

Early each year, CalPERS works with each carrier to analyze previous, confidential claims data, ultimately mutually agreeing on separate plan rates for the upcoming plan year that are deemed reasonable based on that data. This analysis involves CalPERS and actuaries sifting through mountains of proprietary information.

2. **How your health insurance rates are set**

The 100/90 formula requires CSU to pay 100 percent of the weighted *average* healthcare premium for all employees and 90 percent of the weighted *average* additional premium for employees’ family members.
That weighted average is derived by calculating the average 2017 fees for the four most popular HMO or PPO plans of the previous year. In 2016, those four plans were:

- Blue Shield Access+ (HMO)
- United Healthcare (HMO)*
- Kaiser (HMO)
- PERS Choice (PPO)

Once that average is derived, it means that CSU pays a maximum of that weighted average.

For 2017, that average is $707 for one employee, $1349 for the employee plus one other person, and $1727 for one employee plus two others. If the provider’s plan costs more, the employee pays the difference; if the provider’s plan costs less, which is usually the case with Kaiser in particular, the employee pays nothing.

These are statewide rates applying universally to all state departments on the 100/90 formula, including the CSU. They apply only when the state of California is the employer, not when public agencies—such as cities and counties or public agencies—are the employer, in which case rates can vary regionally.

The 100/90 formula is generous by every standard. On average, other state employees have their medical premiums subsidized at 80 percent of this average and must pay out of pocket for all premium costs that exceed that 80 percent threshold.

* United Healthcare is a runner-up to and replacement for Blue Shield NetValue, which couldn’t be used for this calculation because, as explained in item #5 below, Blue Shield is not offering Blue Shield NetValue next year.

3. So how does this all work out in practice?

Here’s an example. The 2017 total monthly premium for one person for Kaiser Permanente California is $662.92. Because that’s less than the $707 maximum that CSU pays for one person in 2017, the employee’s share is zero.

Here’s another example. The 2017 total monthly premium for Blue Shield Access+ California is $830.44 for one person. Since CSU pays no more than $707 for one person in 2017, the employee pays the difference, which amounts to $123.44.

For the employee, that’s a nearly 100 percent increase over the 2016 monthly premium of $62.45.

Why such a big hike for the employee? It’s because:
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- the 2017 rates for Blue Shield Access+ rose significantly over 2016, but
- the 100/90 formula, based on the 2017 rates of the four most popular providers of 2016, creates a weighted average premium for the employer that doesn’t cover all of the Blue Shield Access+ increases, so the employee must make up the difference.

4. Why are chapters in such locations as Chico and Humboldt so impacted by price hikes?

For a variety of reasons, certain parts of the state have a shortage of available health insurance providers. Those areas include Chico, Humboldt, Monterey, and San Luis Obispo, where Kaiser, for instance, is unavailable. Unfortunately, there are regulatory requirements that preclude many HMOs from going into those areas, even when they want to expand there.

That’s bad enough for members when the region has a couple providers available, but real hardship occurs when a single HMO is available, as in Chico, where the only HMO option is Blue Shield Access+. If members in Chico want to continue with an HMO rather than switching to a less expensive PPO, they must contend with the 2017 fee hikes outlined in the example above.

Explains Doug McKeever, the deputy executive officer for CalPERS Benefit Programs Policy and Planning, “This is the challenge for CalPERS: how do we provide affordable healthcare to those areas where there is no competition? We haven’t been able to find a solution to that yet, because not all of our carriers on the HMO side either can or want to meet the necessary regulatory guidelines.”

He points out that CalPERS’ average 2017 health insurance increase for the entire population of employees across the state is just four percent—but that’s small consolation to regions such as Chico and Humboldt, where, for all the reasons mentioned above, the percentage hike is far higher.

5. Open Enrollment Ends October 7, 2016

Members are able to use their my|CalPERS accounts to access, download and print any of the CalPERS Open Enrollment publications designed to help them make informed health plan choices.

Note that Blue Shield NetValue will no longer be available to CalPERS members effective January 1, 2017. During open enrollment, current Blue Shield NetValue enrollees will need to switch to another health plan altogether. If they don’t take any action, they and their eligible dependents will be automatically enrolled in the Blue Shield Access+ health plan effective January 1, 2017.

If you have any questions concerning your health plan options for 2017, please call CalPERS at (888) 225-7377. Informational materials are also available at www.calpers.ca.gov/.

Definitions

- HMO stands for health maintenance organization
- PPO stands for preferred provider organization
- EPO stands for exclusive provider organization
All these plans use a network of physicians, hospitals and other healthcare professionals to give you the highest quality care. The difference between them is the way you interact with those networks.

**HMO plans**

With an HMO plan, you pick one primary care physician. All your healthcare services go through that doctor. That means that you need a referral before you can see any other healthcare professional, except in an emergency. Visits to healthcare professionals outside of your network typically aren’t covered by your insurance.

For example, if you get a skin rash, you won’t go directly to a dermatologist. You’ll first see your primary care physician, who will examine you. If your primary care physician can’t help you, he or she will give you a referral to a trusted dermatologist in your network.

One exception: women don’t need a referral to see an obstetrician/gynecologist in their network for routine services.

Coordinating all your healthcare through your primary care physician means less paperwork and lower healthcare costs for everyone.

**PPO plans**

PPO plans give you flexibility. You don’t need a primary care physician. You can visit any healthcare professional you want without a referral, inside or outside your network.

Staying inside your network means smaller co-pays and full coverage. If you choose to go outside your network, you’ll have higher out-of-pocket costs, and not all services may be covered.

**EPO plans**

EPO plans combine the flexibility of PPO plans with the cost savings of HMO plans. You won’t need to choose a primary care physician, and you don’t need referrals to see a specialist.

But you’ll have a limited network of doctors and hospitals from which to choose. EPO plans don’t cover care outside your network unless it’s an emergency. It’s important to know who participates in your EPO plan’s network, because you'll pay all costs if you go to a doctor or hospital that doesn’t accept your plan.

**Which one is right for me?**

If you prefer to have your care coordinated through a single doctor, an HMO plan might be right for you. If you want greater flexibility or if you see a lot of specialists, a PPO plan might be what you’re looking for. And if you're interested in saving money by using a smaller network of doctors and hospitals, an EPO plan might be a good fit.