



April 6, 2011

Mr. Kenneth Janis  
Vice President of Health Care Finance  
Kelsey-Seybold Clinic  
8900 Lakes at 610 Drive  
Houston, TX 77054

Dear Kenneth,

Kelsey-Seybold retained Aon Hewitt to evaluate the financial efficiency and plan performance of the KelseyCare managed care product. This letter documents the findings of our analysis.

## Background

Kelsey-Seybold Clinic has established a health plan offering in the Houston market that includes the Kelsey-Seybold Clinic panel of physicians and the hospitals where this panel admits patients. This product is called KelseyCare. Physician services in the KelseyCare product are provided on a capitated basis (KelseyCare bears the financial risk of care costing more than expected). Other services are provided on a self-insured basis (the employer bears the financial risk of care costing more than expected). Kelsey-Seybold is partnered with CIGNA to deliver a fully-insured solution.

Kelsey-Seybold engaged Aon Hewitt to prepare an analysis of the financial efficiency and plan performance of KelseyCare by comparing book-of-business results to the Hewitt Health Value Initiative™ (HHVI) database. For purposes of this study, the book-of-business includes the following:

- AutoNation
- Colt International
- H-E-B
- Hendee Enterprises
- Kelsey-Seybold Clinic
- Port of Houston
- Spring ISD
- St. Luke's Episcopal Health System
- United Space Alliance

## The Hewitt Health Value Initiative™

The Hewitt Health Value Initiative™ (HHVI) is an ambitious effort to collect and summarize information to improve the understanding of health plan cost and value among major employers. The

HHVI started in 1996, and has expanded to over 300 employers. Results are reported for over 1,800 health plans in 140 market areas across the United States.

Within each health care market, we develop both a financial efficiency score, Financial Index (FI), and a Plan Performance Score (quality) for each plan an employer offers, an average for the health plan across all employers, and an overall community average (a description of the methodology can be found in the next section). Not only do employers learn how their plan experience compares to other employers offering the same plans, but they also learn where their plans stand against other plans in the community and against the community average.

### ***Methodology—Financial Index***

There are a number of factors that contribute to the cost of a health plan. The FI measure adjusts these costs for the impact of quantifiable factors such as demographics of the covered population, plan design specifications, and geographic cost differences, so that plans can be compared to one another on a more equitable basis. The resulting financial comparisons can help identify the combined impact of remaining factors such as cost efficiency of the delivery system, industry differences, overall health risk, and lifestyles of the covered population—factors that are either subjective in nature or difficult to measure individually.

The results of this analysis should be considered a barometer of the relative costs of different plans; data should not be interpreted as absolute costs. Instead, the information is intended to be used as a basis for more focused discussion between employers and their health plans to better understand premium calculations and cost increases.

### ***Data Collection***

As part of the study, we collected the following medical program information from Kelsey-Seybold for each employer participating in the KelseyCare product:

- Employee Census Data;
- Plan Design Summaries;
- Self-funded Premium Equivalent Rates;
- Capitation Rates;
- Stop Loss Fees;
- Basic Claims and Administrative Expenses; and
- Prescription Drug Claims Detail.

Per capita costs were calculated for each plan and adjusted for the factors listed above (employee demographics, plan design, and geographic location). Similar per capita costs trended from the prior year's study are also included for each market for employers who have not updated their data.

In each market, an average adjusted cost is calculated. An FI score is then assigned to each plan offered by each employer in that market, reflecting the relationship between the plan's adjusted cost and the market average. An FI score greater than 100% indicates better-than-average value; a score less than 100% indicates worse-than-average value.

The Baseline Index of 100% represents the average for all health plans studied. However, when focusing on a specific health plan, it is generally better to compare its value to the average index of its plan type. For example, you may want to compare KelseyCare to the HMO average and not the baseline 100% value. Index values may vary annually due to differences in plan enrollment and other external factors beyond the plan's control.

### ***Actuarial Factors***

The factors used in FI calculations were developed by Hewitt for its health care consulting practice, and are based on the following sources:

- Plan design factors are developed using Hewitt's health care pricing system. The primary source of data for the system is our proprietary database developed from claims analysis of major clients. It represents over eight million life years of data.
- Geographic area factors are a compilation of major insurance company data, data from The Society of Actuaries, and Hewitt's claims databases. There are separate geographic factors for each three digit ZIP Code by plan type (i.e., Indemnity, PPO, POS, and HMO).
- Demographic factors for age, sex, and family status are developed from our own claims database, and checked for consistency with insurance company rate manuals.
- The actual FI calculations used to combine these factors and adjust per capita costs were performed using generally accepted actuarial practices and principles.

### ***Methodology—Plan Performance Index***

The Plan Performance Score is calculated using Hewitt's HHVI database. The database contains information on more than 500 HMO plans, 500 POS plans, and 800 PPO plans. The HHVI Request for Information (RFI) is used to collect plan performance information from health plans. Hewitt consultants refer to the Plan Performance Scores, detailed Plan Performance Profilers, and Key Indicator Reports for purposes of selecting and evaluating managed care networks.

In addition to providing weighted raw Plan Performance Scores, we also provide a Plan Performance Index (PPI). This index works much the same as the FI, where 100% is the average.

### ***Data Collection***

Hewitt distributes its HHVI RFI to all health plans annually. After performing a reasonability check of the data, the RFI scores are loaded into the HHVI database. Health plans are given an opportunity to review and verify the information as it appears in the database. Health plans can update their information throughout the year.

The RFI includes fact-based questions about each health plan's characteristics. Questions are designed to cover the data listed below.

Clinical Quality	Administrative Effectiveness	Organizational Stability
Clinical Prevention	Member Services	Provider Compensation
Utilization	Access	Membership
Provider Management	ID Card Issuance	Financial Stability
Disease Management	Health Education	NCQA Accreditation

Each of these subcategories contains key indicators; those measures, which many employers use to assess, plan performance in more detail. For example, employers commonly are interested in childhood immunization rates and percent of board certified primary care physicians. A more complete description of the subcategories and key indicators, along with plan-specific responses, can be reviewed through the Plan Performance Profiler.

Approximately half of the RFI questions reflect Health Plan Employer Data and Information Set (HEDIS) data reporting elements developed by the National Committee for Quality Assurance (NCQA). Health plans are instructed to answer the questions in accordance with HEDIS methodologies.

**Basic Calculation Methodology**

To acknowledge the relative importance of the RFI questions and corresponding focus areas (Clinical Quality, Administrative Effectiveness, and Organizational Stability), a weighting system was universally applied as follows:

Focus Area	Weight
Clinical Quality	45%
Administrative Quality	35%
Organizational Stability	20%

These weights were determined based on Hewitt's experience with employer areas of focus. Weights for subcategories were determined by distributing the focus area weights across questions within subcategories.

Most questions are scored against a benchmark standard. These standards are based on data from several sources, including NCQA, Healthy People 2010, American Association of Health Plans

(AAHP), American College of Obstetrics and Gynecology (ACOG), The American Cancer Society, market averages, and Hewitt's HHVI database. A team of Hewitt clinicians and managed care specialists developed standards for areas in which industry standards do not exist. Some information requested in the survey, while considered critical, is provided for informational purposes only as benchmark standards are not yet established nor considered appropriate.

Health plan responses are scored against standard ranges using a five-point scale in which "1" fails the standard, "3" equals the standard expected range, and "5" exceeds the standard. Scored responses are then multiplied by the question weight factor. Plan Performance Scores are then computed by focus area and totaled for an overall score. The Index is determined by dividing the total raw score by the market average Plan Performance Score—the higher the score, the better the plan's performance.

Because no contractual relationship exists between Indemnity plans and the providers their enrollees utilize, we are unable to provide PPI scores for Indemnity plans. Also, we have not pursued qualitative data from network vendors who cover fewer than 500 members across all HHVI participants.

### ***Completion Index***

The Completion Index (CI) is the weighted percent of scored RFI questions the health plan has answered. Most HMOs are expected to answer a majority of the questions, while POS and PPO plans typically have lower completion rates reflecting their inability to collect centralized data. For example, no PPO can collect HEDIS data.

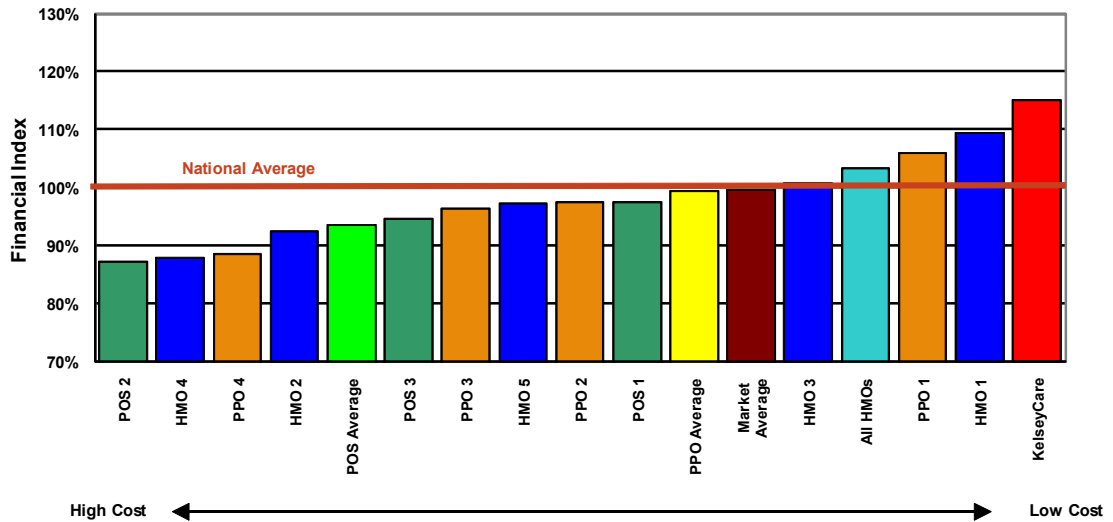
The CI helps employers discern whether a low PPI is attributable to a health plan's actual poor performance (high CI) or an inability to report data (low CI). Some employers tolerate a health plan's missing data, while others may find an inability to report data inexcusable.

## Summary of Findings

The KelseyCare program is very competitive financially with the top plans in the market. The program's Plan Performance Index is the highest in the market.

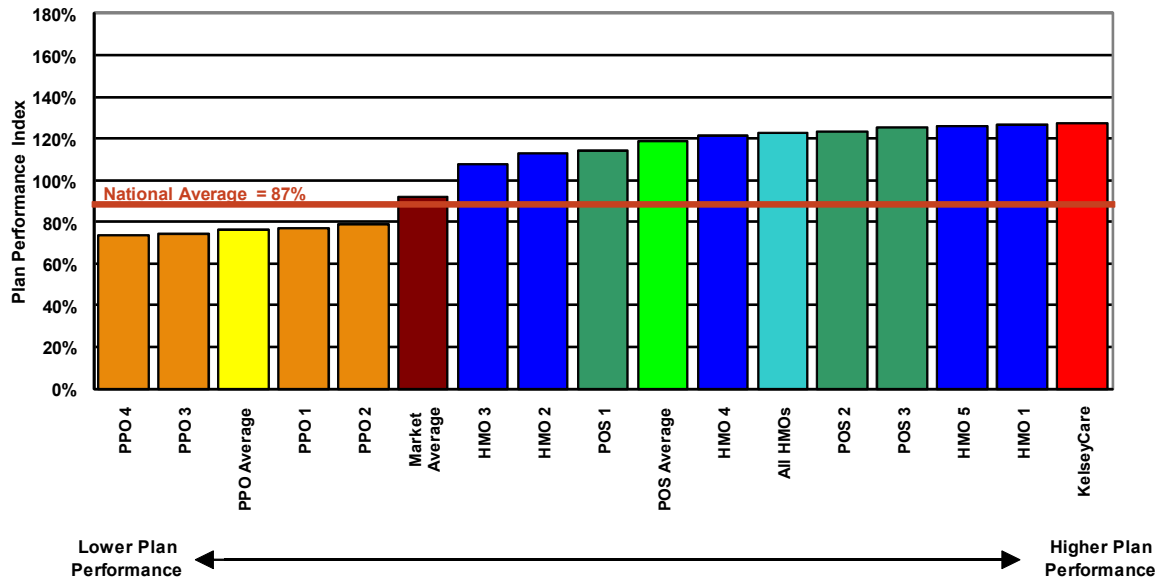
### **Financial Index**

KelseyCare's Financial Index of 115% is 11% higher than the HMO market average of 103%. As shown in the chart below, no other HMO in the market has a higher average Financial Efficiency Index.



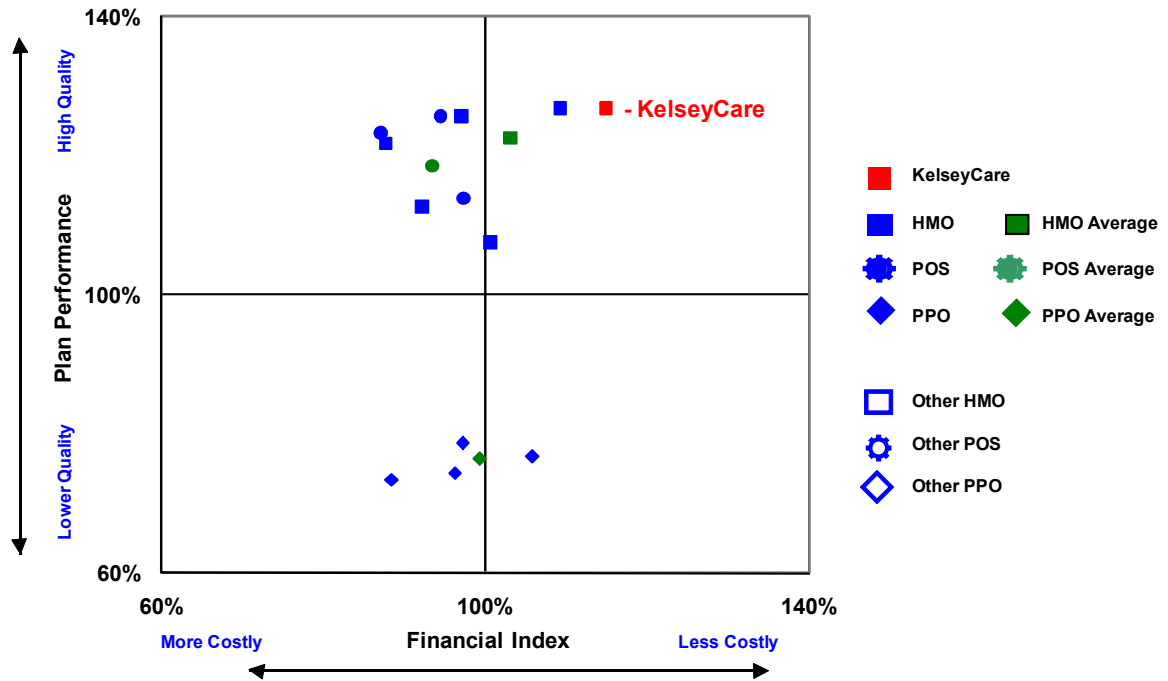
### Plan Performance Index

KelseyCare has a Plan Performance Index of 127%, which is above the HMO market average of 123% and is comparable to other HMO as the highest in the market. KelseyCare's Clinical Quality Score is the highest in the market.



### Market Profile

KelseyCare is positioned closest to the north-east corner in the grid below; it indicates that KelseyCare has the best combination of financial efficiency and plan performance score in the market.



The other HMOs included in the above charts are Aetna, Blue Cross, CIGNA, Humana, and United HealthCare.

## Distribution of Study

Kelsey-Seybold may share the finding of this analysis with prospective KelseyCare clients and their representatives provided that copies of this letter and the accompanying attachments are provided in their entirety. This analysis was prepared solely for the benefit of Kelsey-Seybold and is not intended to benefit any third parties.

Sincerely,  
Aon Hewitt



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Principal



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Actuarial Consultant

cc: Ms. Marnie Matheny, Kelsey-Seybold Clinic