GTCMHIC RETREAT

Education Retreat of the:

Greater Tompkins County Municipal Health Insurance Consortium

Building Medical and Rx Benefit Plans

June 12, 2015

PART 1

Welcome and Introduction

Don Barber, Executive Director GTCMHIC

Welcome

On behalf of the Greater Tompkins County Municipal Health Insurance Consortium we welcome you to the 2015 Educational Retreat. We thank you for taking the time out of your busy schedules to join us for a day of learning and collaborating with the objective of increasing everyone's knowledge base to make the Consortium even more successful for many years to come.

GTCMHIC Retreat Agenda

- Welcome & Introductions
- Background & Update
- Health Insurance Risk Models
- What are benefit plans?
- Federal and State Mandates
- Creating, Changing Benefit Plans
- Using the benefit plan
- Provider Networks and Costs
- Wellness Programs
- Summation and Questions & Answer Session

Introductions

- Today's Presenters
  - Don Barber, Executive Director GTCMHIC
  - Steve Locey, Locey & Cahill, LLC
  - Beth Miller, Excellus BCBS
  - Ashley Masucci, ProAct
- Participants in Attendance
- Acknowledgements

PART II

GTCMHIC Background & Update

Don Barber, Executive Director GTCMHIC

Article 47 of the NYS Ins. Law

- Allows Municipalities who Employ <50 Employees to Pool with Municipalities who Employ 50 or more Employees.
- Regulatory Requirements Include, But are not Limited to:
  - Adoption of a Municipal Cooperative Agreement
  - Establishment of Financial Reserves to Cover Liabilities
  - Creating a Role for Labor in the Governance Structure
    - Joint Committee on Plan Structure and Design
    - Voting Seats on the GTCMHIC Board of Directors
  - NYS DFS Reporting and Oversight

GTCMHIC Certificate of Authority was Issued on 10/01/2010

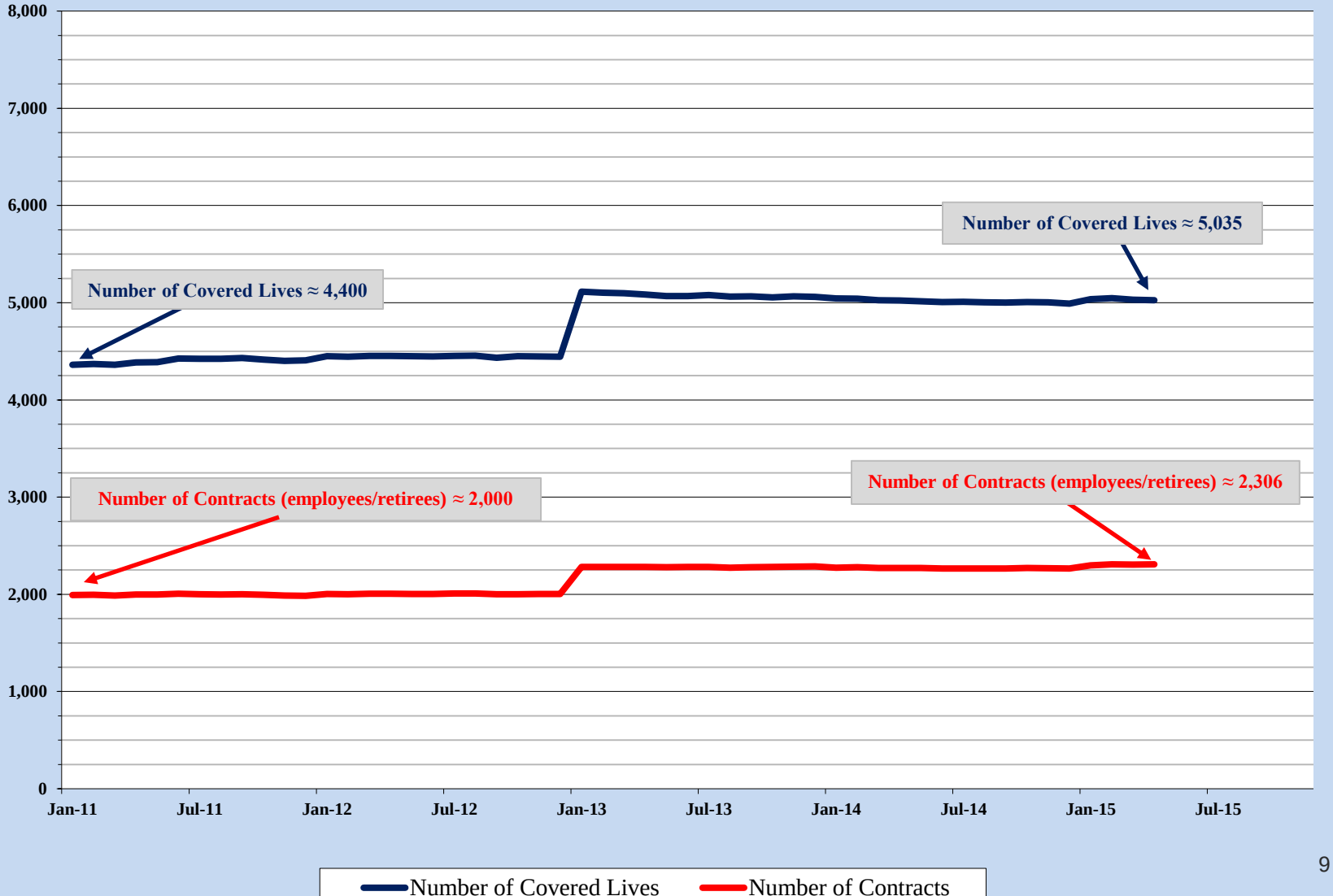
GTCMHIC Operations Began on 01/01/2011

GTCMHIC Update

Our List of Municipal Partners

- City of Cortland
- City of Ithaca
- County of Tompkins
- Town of Caroline
- Town of Danby
- Town of Dryden
- Town of Enfield
- Town of Groton
- Town of Ithaca
- Town of Lansing
- Town of Ulysses
- Town of Willett
- Village of Cayuga Heights
- Village of Dryden
- Village of Groton
- Village of Homer
- Village of Trumansburg

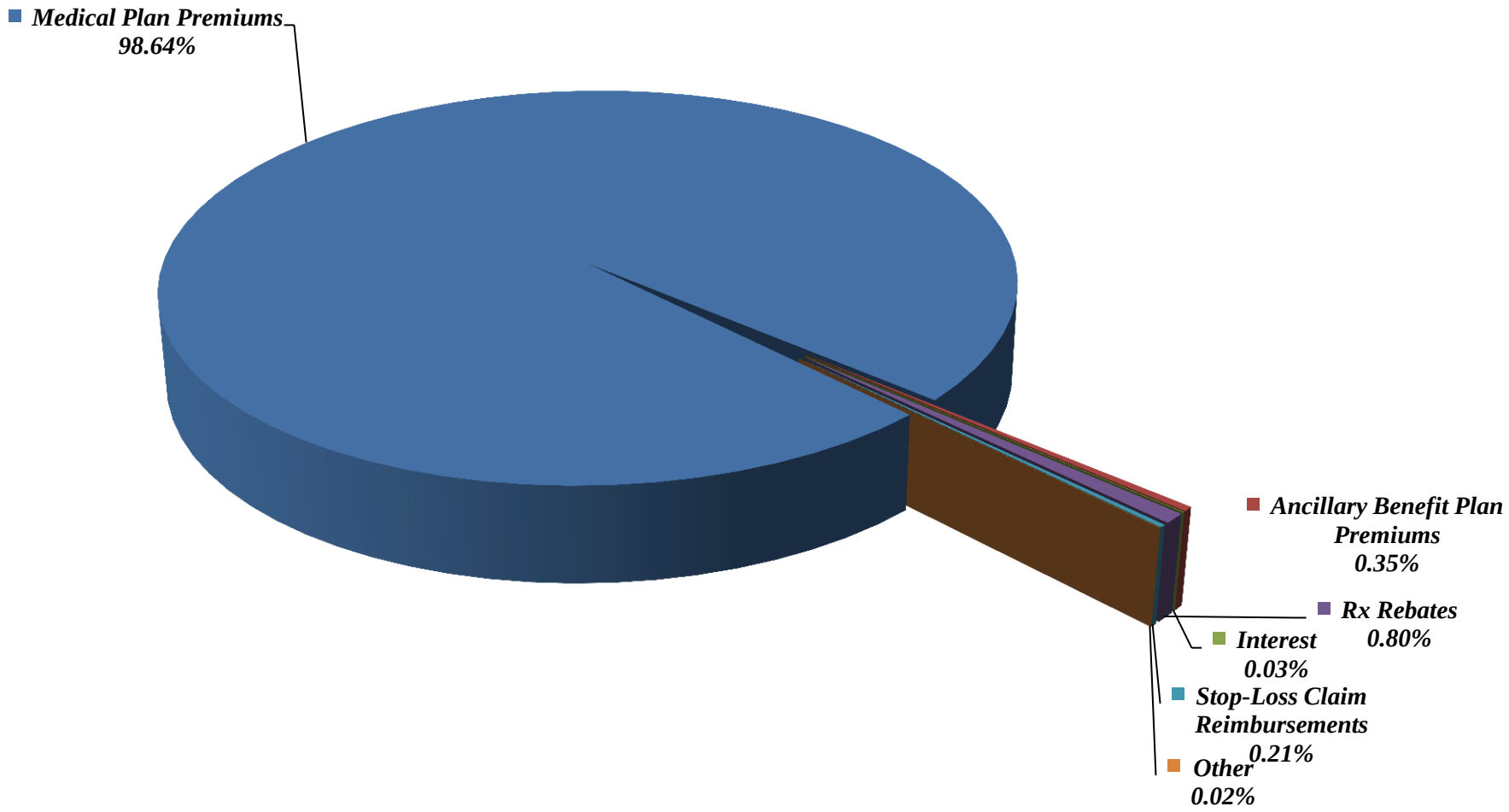
Greater Tompkins County Municipal Health Ins Consortium
2011-2015 Monthly Covered Lives and Contracts
January 1, 2011 to April 30, 2015



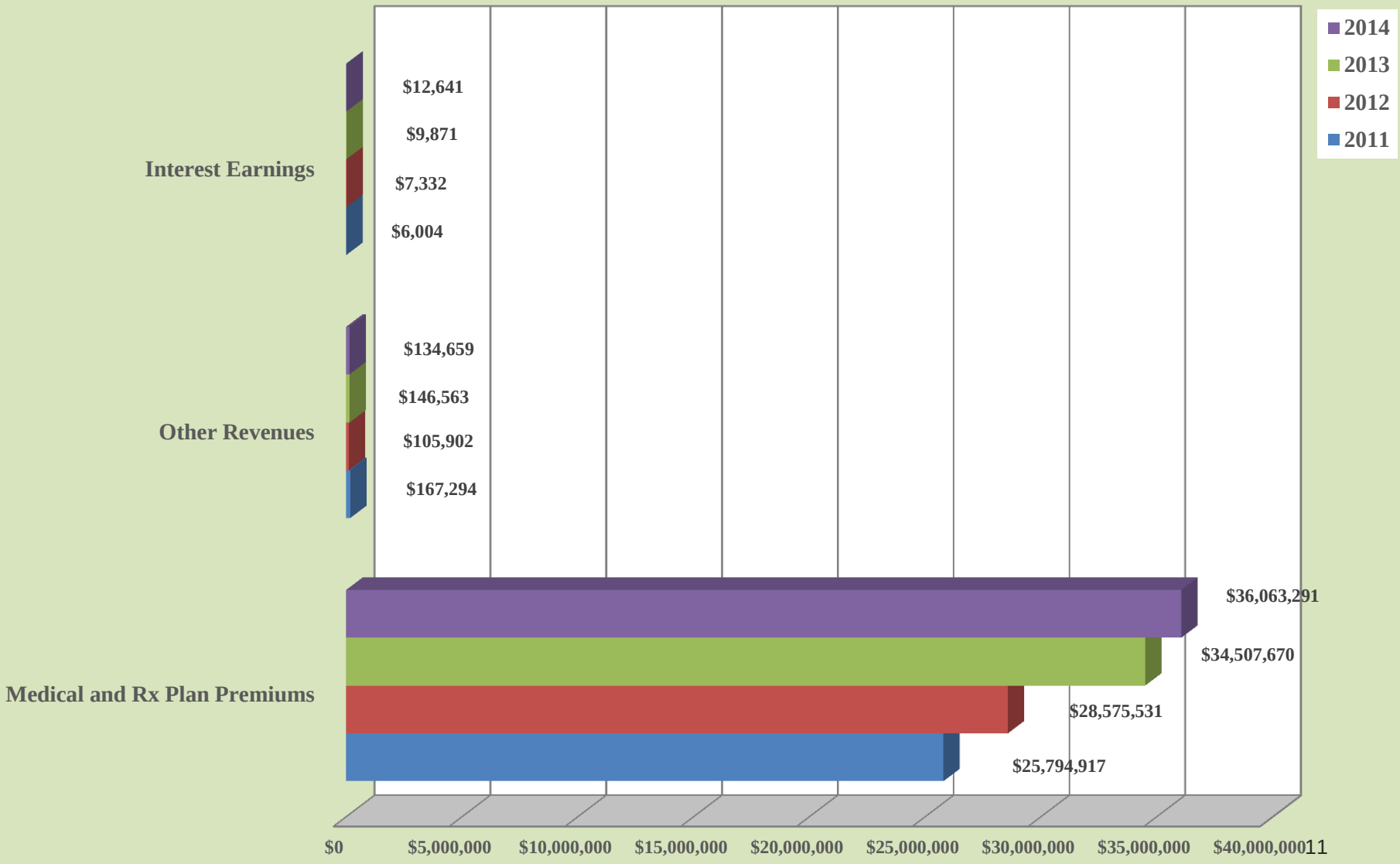
Greater Tompkins County Municipal Health Ins. Consortium

2014 Income Distribution

January 1, 2014 to December 31, 2014



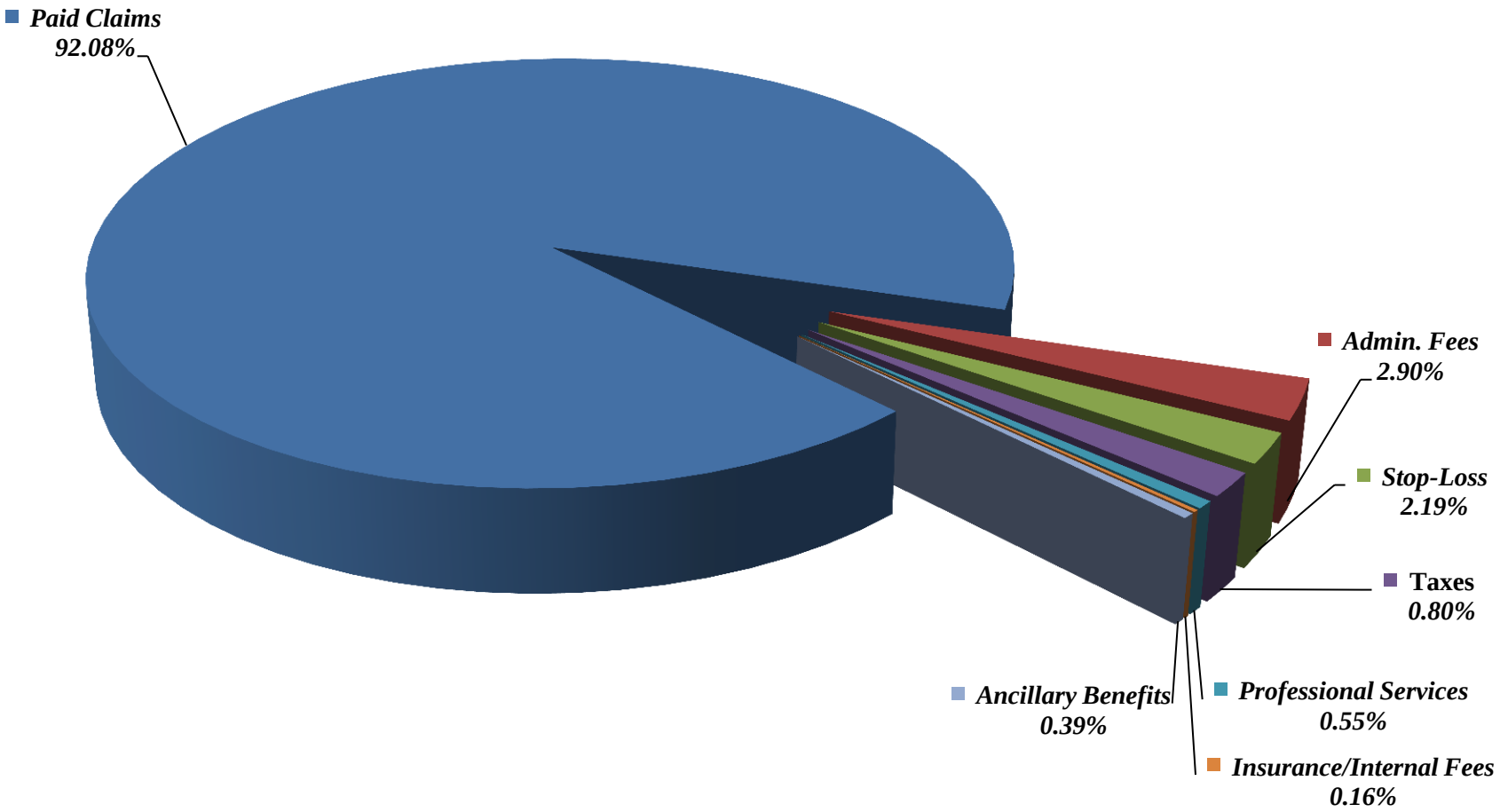
Greater Tompkins County Municipal Health Insurance Consortium
Income Distribution (2011 - 2014)



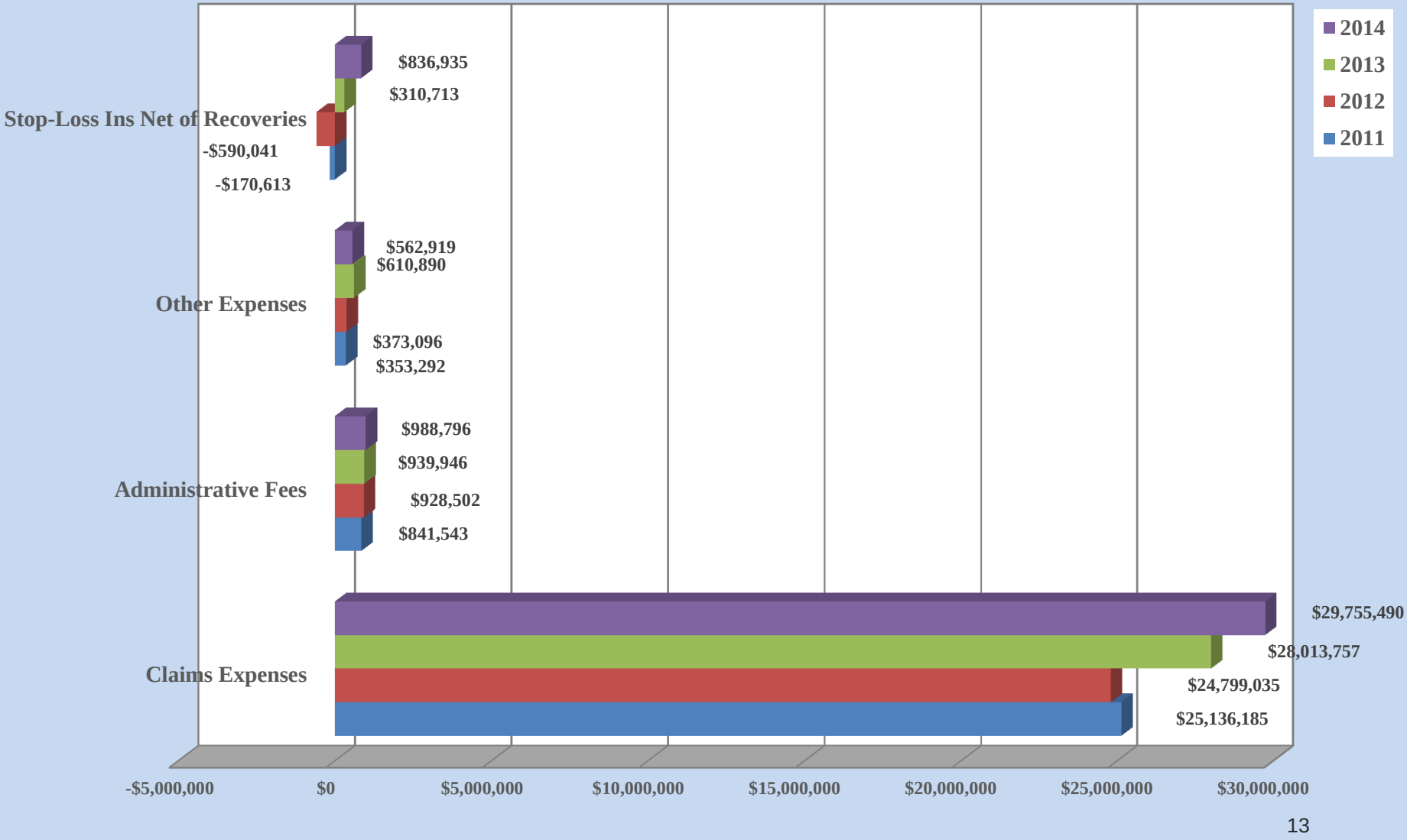
Greater Tompkins County Municipal Health Ins. Consortium

2014 Expense Distribution

January 1, 2014 to December 31, 2014



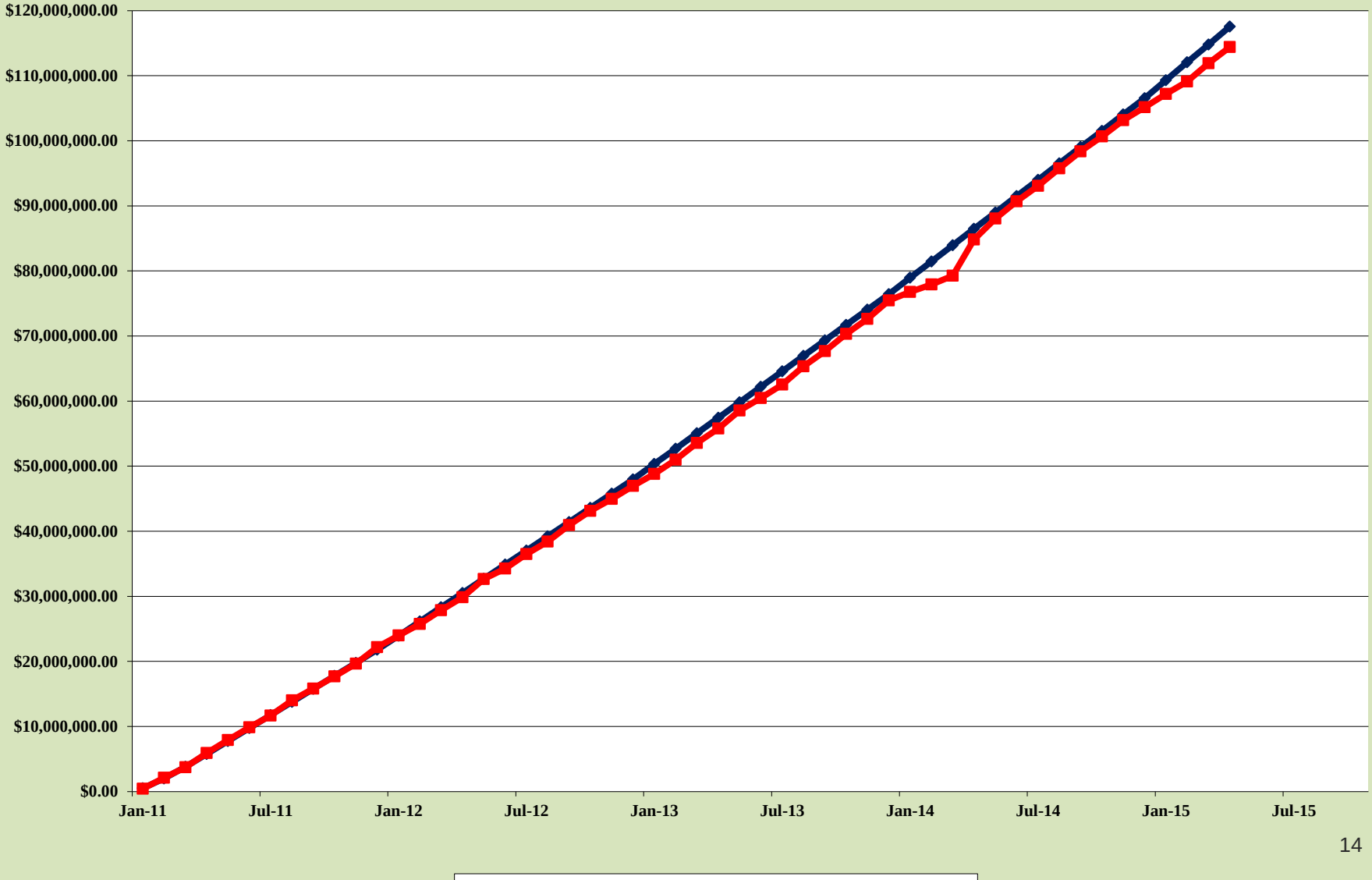
Greater Tompkins County Municipal Health Insurance Consortium
Expense Distribution (2011 - 2014)



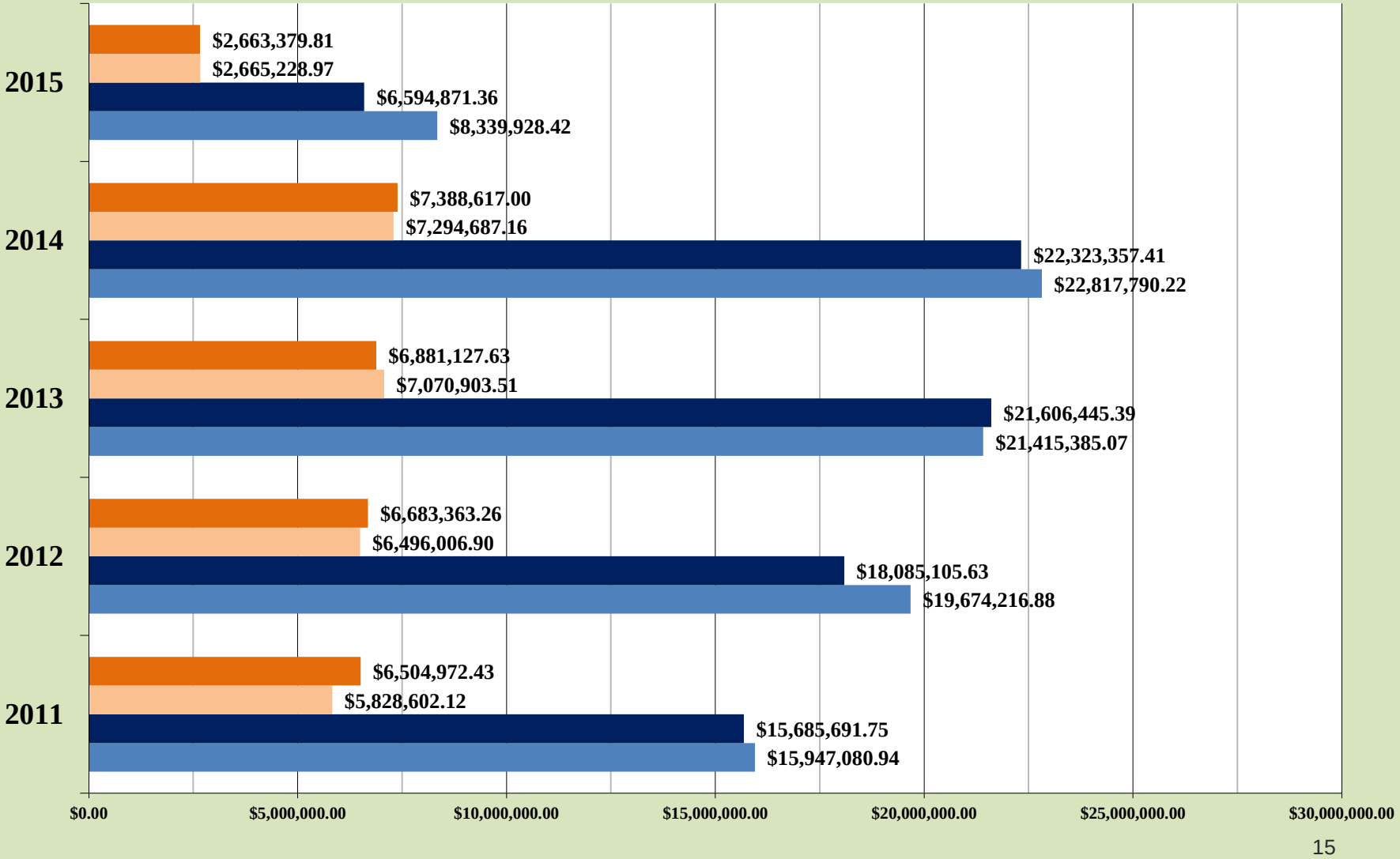
Greater Tompkins County Municipal Health Ins Consortium

2011-2015 Monthly Paid Claims v Budgeted Claims

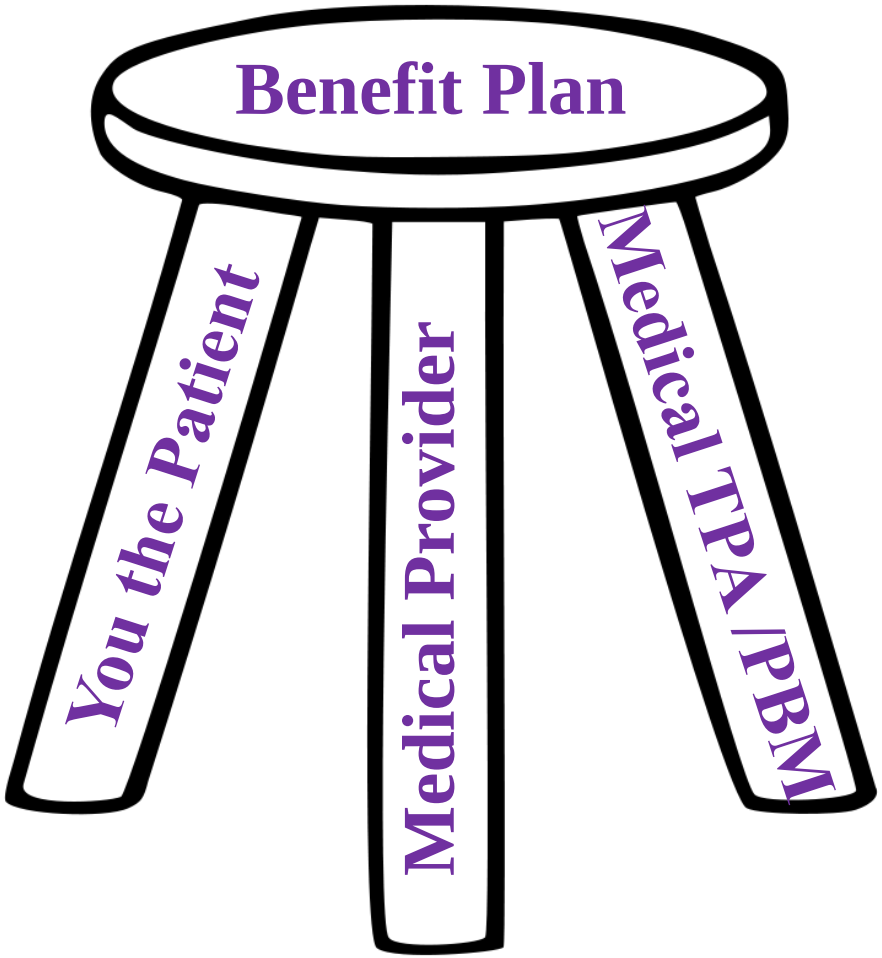
January 1, 2011 to April 30, 2015



Greater Tompkins County Municipal Health Ins Consortium
2011-2015 Annual Paid Claims v Budgeted Claims



Working Collaboratively



PART III

Health Insurance Risk Models

Stephen Locey, Locey & Cahill, LLC

NYS Health Insurance Risk Models

- NYS Fully-Insured Health Insurance Plans:
  - NYS Insurance Law Article 32 Commercial Insurance Companies
    Examples: Aetna, CIGNA, Guardian, MVP, United Healthcare
  - NYS Insurance Law Article 43 Not-for-Profit Insurance Companies
    Examples: Excellus, Emblem Health (GHI), HealthNow
  - NYS Public Health Law Article 44 Health Maintenance Organizations
    Examples: CDPHP, Excellus, Oxford, United Healthcare

NYS Health Insurance Risk Models

- NYS Self-Insured Plans
  - Single Employer Self-Insured Plan
  - ***Article 47 Municipal Cooperative Health Benefits Plan***
    Greater Tompkins County Municipal Health Insurance Consortium
  - Article 44 Employee Welfare Funds

Risk Models Prior to the Formation of the Consortium

All Participating Municipalities were Fully-Insured through an Article 43 insurance company, Excellus BCBS using the following financial models:

Experience Rated:

City of Cortland
City of Ithaca
County of Tompkins
Town of Ithaca

Community Rated:

Town of Caroline
Town of Danby
Town of Dryden
Town of Enfield
Town of Groton
Town of Lansing
Town of Ulysses
Town of Willett
Village of Cayuga Heights
Village of Dryden
Village of Groton
Village of Homer
Village of Trumansburg

Who Assumes the Risk?

Insurance Company **Annual Financial Risk Level**

Employer **Annual Financial Risk Level**

What is Our Risk Model?

- Self-Insurance
- Article 47 of the N.Y. State Insurance Law
- Premiums and Risks are Pooled
- Premiums are Established to Cover Statistically Predicted Claims and Fixed Costs (admin. Fees, insurances, etc.)
- Paying for Actual Claims Incurred
- Maintaining Reserve Accounts
- Excess Funds are Invested and Used for Future Budgets

Article 47 of the NYS Ins. Law

MUNICIPAL COOPERATIVE HEALTH BENEFIT PLANS

Section 4701. Legislative findings.
4702. Definitions.
4703. Application for certificate of authority.
4704. Conditions for issuance of certificate of authority.
4705. Municipal cooperation agreements.
4706. Reserve and surplus requirements.
4707. Stop-loss requirements.
4708. Contingent liability.
4709. Plan benefits and disclosure.
4710. Additional filing requirements and annual report.
4711. Examinations.
4712. Suspension or revocation of certificate of authority.
4713. Plan dissolution.
4714. Transition.

Article 47 Plan Benefits

§ 4709. Plan benefits and disclosure.

(a) The governing board of the municipal cooperative health benefit plan shall deliver or cause to be delivered the plan document to all participating municipal corporations and to unions which are the exclusive collective bargaining representatives of employees covered by the plan and the summary plan description to every employee or retiree of participating municipal corporations covered by the plan.

(b) The summary plan description shall be subject to regulation as if it were a health insurance subscriber certificate, provided that the superintendent may modify or suspend any provision of this chapter or regulation promulgated thereunder pertaining to scope or type of coverage, if the superintendent determines:

(1) such provision of this chapter or regulation to be inappropriate for municipal cooperative health benefit plans;

(2) such modification or suspension not to be prejudicial to the interests of covered employees, retirees or dependents; and

(3) such modification or suspension not to be destructive of competition.

(c) Conspicuously printed on the first page of the plan document and summary plan description, in at least ten point bold-face type, shall be the following statement: "This municipal cooperative health benefit plan is not a licensed insurer. It operates under a more limited certificate of authority granted by the superintendent of financial services. Municipal corporations participating in the municipal cooperative health benefit plan are subject to contingent assessment liability."

PART IV

What are Benefit Plans?:

Steve Locey, Locey & Cahill, LLC

What are Benefit Plans?

Benefit Plans are a contract between a person and/or their employer and a licensed health insurance company that contains a listing of covered medical care services provided to eligible.

As part of a benefit plan health insurance companies typically contract with health care service providers who offer medical care and/or services to you at a reduced agreed upon amount.

Benefit Plans must meet minimum Federal and State requirements and include all mandated benefits.

What plans are available?

- GTCMHIC has a menu of plan options for consideration by labor and management. New plans may be added upon request and approval by the Board of Directors.
- Indemnity, PPO, Comprehensive, and Medicare Supplemental plans are available, along with the recently added plan that meets the definition of a “Platinum” metal level plan as offered on the “health insurance exchange.”
- A variety of plan offerings offer labor and management options for negotiation when premiums increase consumes most of compensation increase.

Alphabet Soup of Health Insurance

- Indemnity or Traditional Plans
- Preferred Provider Organization (PPO) Plans
- Point of Service (POS) Plans
- Health Maintenance Organization (HMO) Plans
- High Deductible Health Plans (HDHP)
- Health Savings Accounts (HSA)
- Flexible Spending Accounts (FSA)

Member's Share of the Costs

- Premium Contributions
- Annual Deductibles
- Coinsurance Amounts (e.g., 20%)
- Copayment Amounts (e.g., $15.00)
- Out-of-Network Provider Balance Bills
- Non-Covered Products or Services

PPO Plans vs Indemnity Plans

Plan Benefit and Cost Sharing Highlights		Sample PPO Plan		Sample Indemnity Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	**Individual**	Not Applicable	$1,000 Out-of-Network (Medical Only)	$100 Combined In and Out-of-Network (Medical Only)	
	Family	Not Applicable	$3,000 Out-of-Network (Medical Only)	$200 Combined In and Out-of-Network (Medical Only)	
Out-of-Pocket Maximum **(Medical Plan Coinsurance and Medical Plan Copayments, Deductible is not included in this amount)**	**Individual**	$1,000 In-Network (Medical Only)	$1,000 Out-of-Network (Medical Only)	$400 Combined In and Out-of Network (Medical Only)	
	Family	$3,000 In-Network (Medical Only)	$3,000 Out-of-Network (Medical Only)	$800 Combined In and Out-of Network (Medical Only)	
Out-of-Pocket Maximum **(Rx Plan Copayments)**	**Individual**	$1,000 Rx Copays Only	Not Applicable	$1,000 Rx Copays Only	Not Applicable
	Family	$3,000 Rx Copays Only	Not Applicable	$3,000 Rx Copays Only	Not Applicable
Primary Care Physician		$10.00	20% After Deductible	20% After Deductible	20% After Deductible
Specialist Physician		$10.00	20% After Deductible	20% After Deductible	20% After Deductible
Inpatient Hospital		Covered In Full	20% After Deductible	Covered In Full	0% of Allowed Amount
Annual Maximum		Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximum		Unlimited	Unlimited	Unlimited	Unlimited

Rx Plans 2-Tier vs 3-Tier vs 4-Tier

- 2-Tier Rx Plans have different copayments for generic medications and brand name medications.
- 3-Tier Rx Plans utilize a formulary to segregate medications into three tiers. Tier 1 is typically generic medications, Tier 2 is for preferred brand name medications and Tier 3 is for non-preferred brand name medications.
- 4-Tier Rx Plans are very similar to 3-Tier Rx Plans with the exception that these Plans create an additional Tier 4 for Specialty Medications with an even greater copay.

Sample 2-Tier / 3-Tier Rx Plans

Prescription Drug Plan Rates (Two-Tier Co-Payment Structure				
Plan Code	*Retail Pharmacy*		*Mail-Order Pharmacy*	
	Generic	*Brand Name*	*Generic*	*Brand Name*
2T1	$1.00	$1.00	$0.00	$0.00
2T2	$2.00	$5.00	$0.00	$0.00
2T3	$2.00	$10.00	$0.00	$0.00

Prescription Drug Plan Rates (Three-Tier Co-Payment Structure						
Plan Code	Retail Pharmacy			Mail-Order Pharmacy		
	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
	Generic	Preferred Brand	Non-Preferred Brand	Generic	Preferred Brand	Non-Preferred Brand
3T3	$5.00	$10.00	$25.00	$10.00	$20.00	$50.00
3T6	$5.00	$15.00	$30.00	$10.00	$30.00	$60.00
3T7	$5.00	$20.00	$35.00	$10.00	$40.00	$70.00
3T9	$10.00	$25.00	$40.00	$20.00	$50.00	$80.00
3T10	$15.00	$30.00	$45.00	$30.00	$60.00	$90.00
3T11	20%	20%	40%	15%	15%	40%
3T13	20%	30%	50%	20%	30%	50%

It should be noted that 3-Tier models typically include managed care elements such as Step-Therapy, Prior Authorization, Generic Fill Requirements, etc.

Actuarial Value (AV)

The term "Actuarial Value" references the share of hospital, medical, surgical, and pharmacy care expenses the plan covers for a typical or average group of enrollees within a standard deviation of + or - 2%.

A Plan can determine its AV by using:

1. The AV Calculator developed by the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) which was implemented in accordance with the Patient Protection and Affordable Care Act of 2010; or

2. The services of an Independent Actuary who will evaluate the Plan's benefits to determine the likely amount of out-of-pocket costs for the average person covered by the Plan.

Actuarial Value Calculator

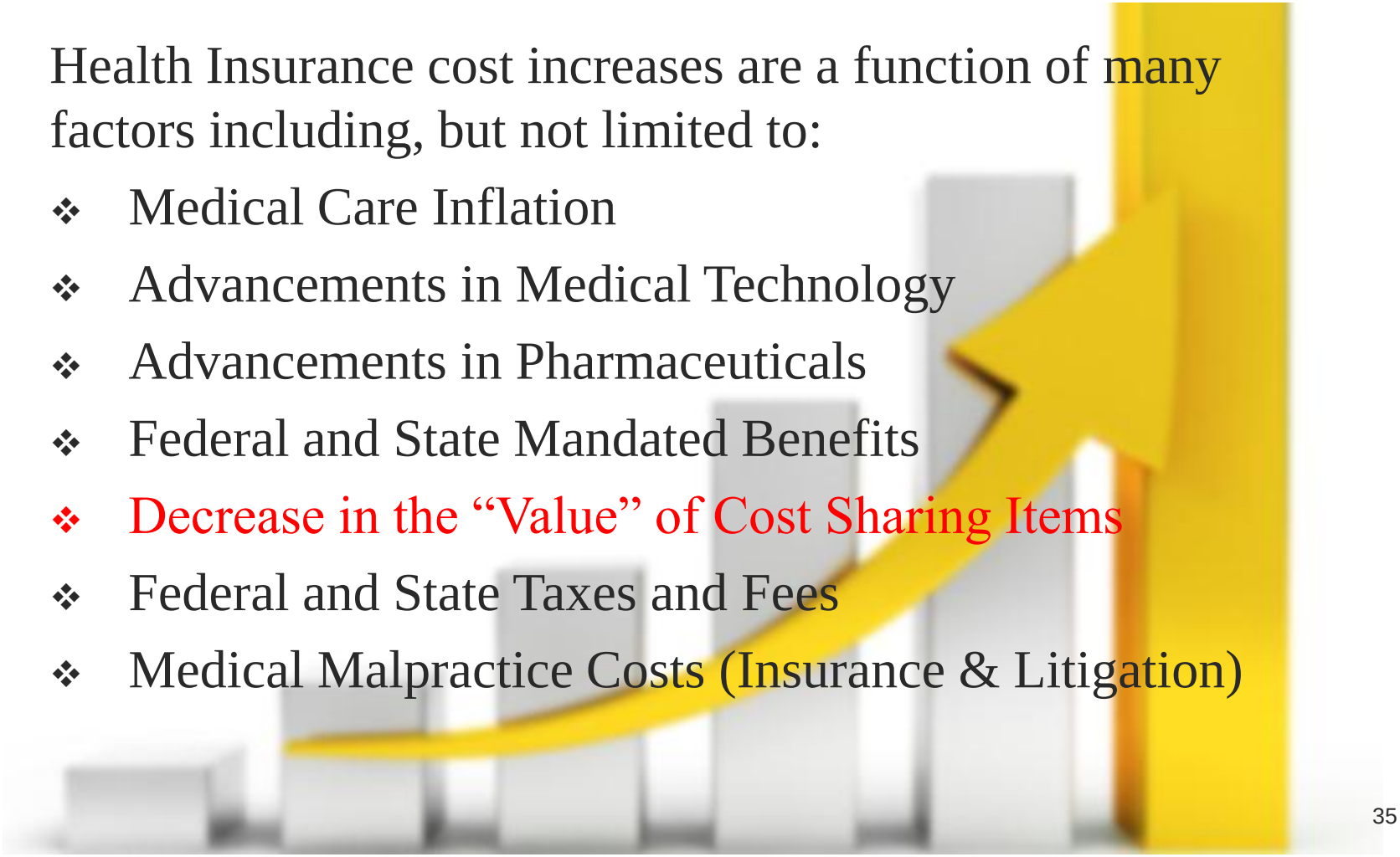
The term “Actuarial Value” references the share of health care expenses the plan covers for a typical or average group of enrollees within a standard deviation of + or - 2%.

As an example, if enrolled in a Platinum Plan the ***average person*** would expect the plan to cover approximately 90% of their health care costs in a given year.

Why Have Health Insurance Costs Increased Faster than CPI

Health Insurance cost increases are a function of many factors including, but not limited to:

- Medical Care Inflation
- Advancements in Medical Technology
- Advancements in Pharmaceuticals
- Federal and State Mandated Benefits
- Decrease in the "Value" of Cost Sharing Items
- Federal and State Taxes and Fees
- Medical Malpractice Costs (Insurance & Litigation)



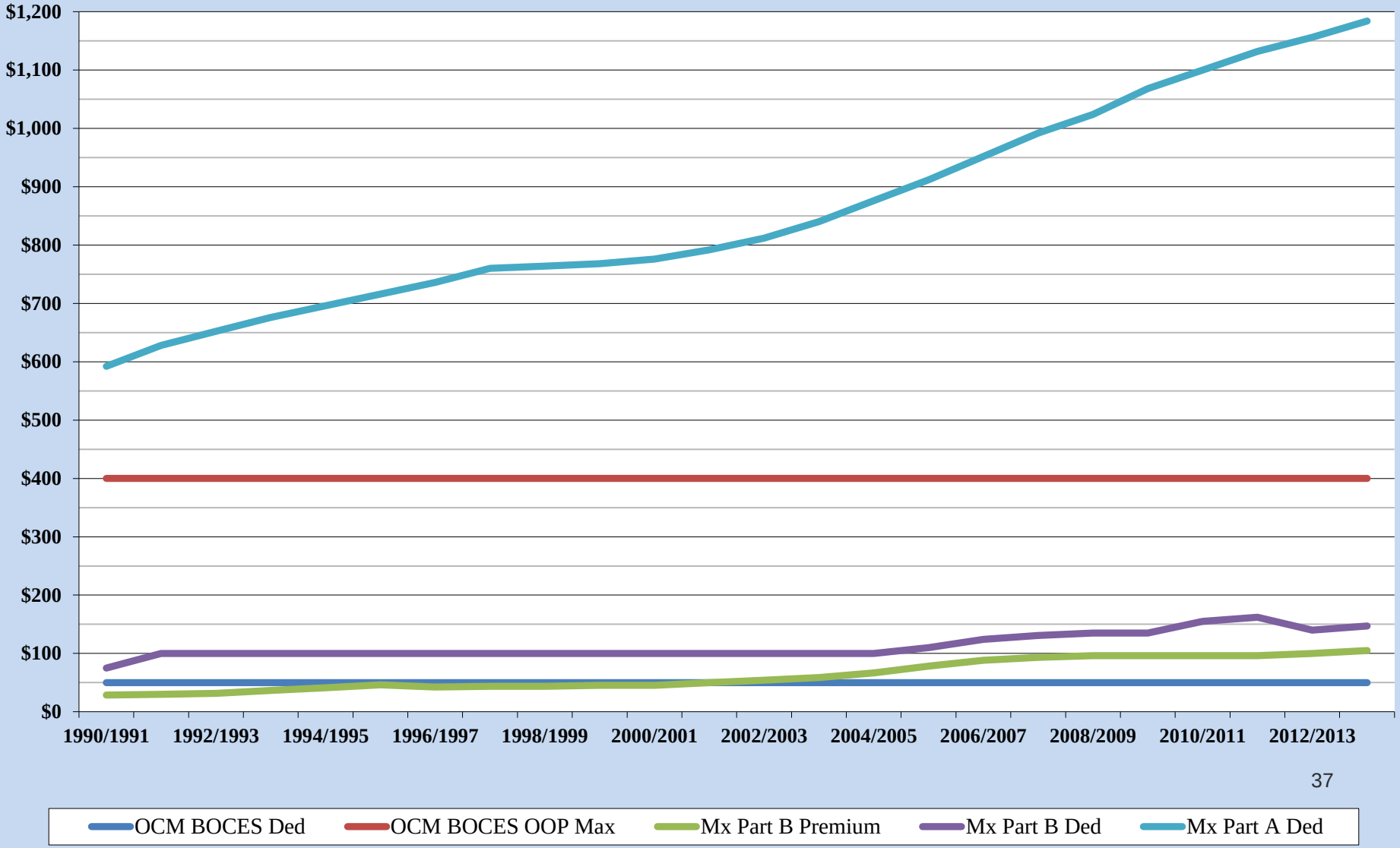
Benefit Plans Haven't Kept Pace

- Health Insurance Evolves Over Time
- 3 to 5 Years Between Contracts
- Health Insurance Trends Outpace Cost-Sharing Changes
- Lack of Focus on True Cost Distribution
- Plans are Negotiated Line Item by Line Item
- Modest Premium Changes = "Major" Benefit Changes

Cooperative Health Insurance Fund of CNY

BOCES Benefits vs. Medicare Benefits

1990/1991 to 2013/2014



"ACA Metal Level Plans"

Levels of Coverage:

The Affordable Care Act contains language which defines the Actuarial Value (AV) of a health insurance plan's coverage based on the percent of health care expenses covered by the plan for a typical population. Health insurance plans will be placed into four categories based on their Actuarial Value (AV):

- Platinum Plan Models — Actuarial Value (AV) = 90%
- Gold Plan Models — Actuarial Value (AV) = 80%
- Silver Plan Models — Actuarial Value (AV) = 70%
- Bronze Plan Models — Actuarial Value (AV) = 60%

It should be noted that the most common plan models found in the Health Insurance Exchanges are PPO Style Plans and High Deductible Health Plans.

ACA 2015 Mandated Limits

- Maximum Annual Deductible = $6,600 Ind. / $13,200 Fam.
- Maximum Annual Out-of-Pocket = $6,600 Ind. / $13,200 Fam.
- No Annual Limit on Essential Health Benefits
- No Lifetime Limit on Essential Health Benefits

The above maximums and limits must include all out-of-pocket expenses such as deductibles, coinsurance amounts, and copayments for the hospital, medical, surgical, and pharmacy benefits. This maximums and limits do not include any costs related to out-of-network provider billings and/or the cost for any non-covered services or products.

Calculate

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$500.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$3,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined
		$500.00
		60.00%
		$3,000.00

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$25.00	☑	☑		
Specialist Visit	☑	☑		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑		$40.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☑		$40.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑		$40.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		$40.00	☑	☑		
Skilled Nursing Facility	☑	☑		$250.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☑		$5.00	☑	☑		
Preferred Brand Drugs	☑	☑		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value:	82.4%
Metal Tier:	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$100.00			$100.00
Coinsurance (%, Insurer's Cost Share)			80.00%			80.00%
OOP Maximum ($)			$400.00			$400.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$0.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		$0.00	☑	☑		
Skilled Nursing Facility	☑	☑		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☑		$5.00	☑	☑		
Preferred Brand Drugs	☑	☑		$20.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑		$35.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑		$35.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.

Actuarial Value: 95.2%

Metal Tier:

Maintaining a Plan's AV

- The GTCMHIC established the following process to ensure the Standard Metal Level Plans maintain an Actuarial Value (AV) as defined by the Patient Protection and Affordable Care Act (ACA) equal to an overall plan benefit for the average participant of 90% for the Platinum Plan, 80% for the Gold Plan, 70% for the Silver Plan, and 60% for the Bronze Plan:

1. Changes to the benefits provided by the Metal Level Plans will occur no more frequently than once a year with said benefit changes being effective on January 1st of the year following the adoption of the said benefit change.

2. Changes to the benefits provided by the Metal Level Plans will be approved by the GTCMHIC's Board of Directors on or before November 1st of each year provided the benefit changes maintain the Actuarial Value of the plan in question as defined in Resolution No. 001-2014.

Maintaining a Plan's AV (continued)

3. Changes to the benefits provided by the Metal Level Plans will be communicated to the affected members no later than December 1st of each year.

4. The GTCMHIC will adhere to the following definition of the Actuarial Value of each plan.

   The Greater Tompkins County Municipal Health Insurance Consortium Standard ACA Metal Level Plans will have an Actuarial Value (AV) as defined by the Patient Protection and Affordable Care Act (ACA) equal to an overall plan benefit for the average participant of 90% for the Platinum Plan, 80% for the Gold Plan, 70% for the Silver Plan, and 60% for the Bronze Plan.

Maintaining a Plan's AV (continued)

Said AV will be calculated annually using the AV Calculator developed by the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) which was implemented in accordance with the Patient Protection and Affordable Care Act. If such calculator is no longer available or in use, the GTCMHIC will have an independent Actuary develop the AV of the health insurance plan on an annual basis. In either case, it is the intent that the result will represent an empirical estimate of the AV calculated in a manner that provides a close approximation to the actual average spending by a wide range of consumers in a standard population and that said AV will be equal to 90% for the Platinum Plan, 80% for the Gold Plan, 70% for the Silver Plan, and 60% for the Bronze Plan within an acceptable deviation of + or – 2%

PART V

Federal and State Mandates:

Stephen Locey, Locey & Cahill, LLC

NYS Minimum Benefits

In New York State, the New York State Department of Financial Services regulates health insurance plans to ensure the benefits provided are consistent with the Codes, Rules and Regulation of the State of New York (CCR-NY) for insurance products. In the following, we have provided the actual language as it currently appears in the CCR-NY which forms the basic requirements for all health insurance plans in New York State. Many of these provisions have been augmented through mandated benefit changes either on a Federal or State Level. However, this language should provide an understanding of how health insurance has improved over the years, many times without the need for collectively bargaining the changes.

1. Basic Hospital Insurance (11 CRR-NY 52.5)
2. Basic Medical Insurance (11 CRR-NY 52.6)
3. Major Medical Insurance (11 CRR-NY 52.7)

ACA Minimum Essential Benefits

ACA required the Secretary of the United States Department of Health & Human Services to specify the "essential health benefits" (EHB) to be included in the "essential health benefits package." Starting in 2014, the EHB are required to be included in all Qualified Health Plans (QHPs). EHB is defined in Section 1302(b) of the Patient Protection and Affordable Care Act and includes at least the following general categories of benefit:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness and chronic disease management
- Pediatric services, including oral and vision care.

State and Federal Mandates

- 1993 to 2003
  - 30 New Benefit Mandates
- 2003 to 2013
  - 51 New Benefit Mandates
  - 2010 PPACA Added

Legislative changes to health insurance are mandated changes which occur without Consortium approval. In addition, these changes are made outside of the collective bargaining environment without labor or management consideration or approval.

Government Mandate Highlights

- Well Child Visits
- Routine Cervical Cancer Screenings
- Mental Health Parity Act
- Diabetic Treatment
- Chiropractic Care Coverage
- Adopted Newborn Coverage from Birth
- Breast Reconstruction
- Oral Contraceptives
- Prostrate Cancer Screenings
- Exclusions
- Annual Routine Physical and Adult Immunizations
- Bone Density Treatment
- Chemical Dependency for inpatient and outpatient
- Contraceptives Drugs & Devices
- NYS Dependent to age 29
- HCR Dependents to 26
- NYS Same Sex Marriage
- Timothy's Law (Mental Health Parity)
- Removal of Annual Maximums

What Can Be Excluded?

- Aviation
- Convalescent and Custodial Care
- Cosmetic Services
- Coverage Outside of the US, Canada, or Mexico
- Dental Services
- Experimental or Investigational Treatment
- Felony Participation
- Foot Care
- Government Facility
- Not Medically Necessary
- Military Service
- No-Fault Automobile Insurance
- Services Not Listed
- Services Provided by a Family Member
- Services Separately Billed by a Hospital Employees
- Services with No Charge
- Vision Services
- War
- Worker's Compensation


Pause
Break

PART VI

Creating and Changing Benefit Plans:

Steve Locey, Locey & Cahill, LLC

Consortium Specific Benefit Plans

- Idea for New Plans or Potential Modifications to “Old” Plans comes from Within the Consortium or from Outside Potential New Partners
- Plan Consultant Researches and Presents Draft Plan
- After Consideration by Consortium Committee Structure, the Board of Directors Considers Plan for Adoption
- Adopted Plans must be Approved by NYS DFS Before Issuance in Accordance with §4709(b)

NYS Insurance Law §4709(b)

§ 4709. Plan benefits and disclosure.

(a) The governing board of the municipal cooperative health benefit plan shall deliver or cause to be delivered the plan document to all participating municipal corporations and to unions which are the exclusive collective bargaining representatives of employees covered by the plan and the summary plan description to every employee or retiree of participating municipal corporations covered by the plan.

(b) The summary plan description shall be subject to regulation as if it were a health insurance subscriber certificate, provided that the superintendent may modify or suspend any provision of this chapter or regulation promulgated thereunder pertaining to scope or type of coverage, if the superintendent determines:

(1) such provision of this chapter or regulation to be inappropriate for municipal cooperative health benefit plans;

(2) such modification or suspension not to be prejudicial to the interests of covered employees, retirees or dependents; and

(3) such modification or suspension not to be destructive of competition.

(c) Conspicuously printed on the first page of the plan document and summary plan description, in at least ten point bold-face type, shall be the following statement: "This municipal cooperative health benefit plan is not a licensed insurer. It operates under a more limited certificate of authority granted by the superintendent of financial services. Municipal corporations participating in the municipal cooperative health benefit plan are subject to contingent assessment liability."

Building a Health Insurance Plan

Basic and Required "Building Blocks" of a Benefit Plan

- Determine the "Style" of the Plan or Type of Plan (indemnity, PPO, POS, HMO, HDHP, etc.)
- Membership (Who is Covered?)
- NYS Minimum and Mandated Benefits
- PPACA Essential Health Benefits
- List of Exclusions

Who is Required to be Covered?

- Contract Holder
  - Active Employees
  - Qualified Retirees
- Dependent Children
  - Covered to Age 26
  - Handicapped Dependents
  - Young Adult Option
- Qualified Medical Child Support Orders
- COBRA Continuation of Benefits

Who May Also be Covered?

- Legal Spouses
  - Same Sex Marriages Where Legally Recognized
  - Includes Separated, but Not Divorced Spouses
- Domestic Partners
- Dependent Children to Age 30
  - New York State “Make Available Option”

Building a Health Insurance Plan

Key Decision Elements in Overall Plan Design

- Member Cost Sharing Items and Levels
  Deductibles, Coinsurance Amounts, Copayments, Limits
- Out-of-Network Reimbursement Methodology
- Day Limitations on Certain Benefits
  (e.g., Physical Therapy, Speech Therapy, Physical Rehab)
- Inclusion of Optional Benefits
  (e.g., Acupuncture, Vision, Hearing, Dental, and Wellness)

How are Changes Made to "Old Style" Health Insurance Plans?

- Plans may only change upon successful collective bargaining or legislative action as permitted.
- The GTCMHIC cannot unilaterally change benefit plans.
- Each municipality has their own group number and selected plan offerings per their agreements and policies.
- To add a new plan you must contact Beth Miller at Excellus BCBS who will coordinate with Ashley Masucci at ProAct, Inc.
- Please allow 60- 90 days to implement a new group

How are Changes Made to "GTCMHIC Metal Level" Plans?

- AV is Calculated on an Ongoing and Periodic Basis
- If AV is not within Standard Deviation Range, Suggested Changes will be Reviewed with the Joint Committee
- The Joint Committee will Recommend Changes to the Board
- The Board of Directors will Approve the Plan Changes
- Notifications are Made to Covered Members
- Changes are Coordinated with Excellus and ProAct
- Plan Changes Effective January 1st Following Approval

PART VII

Using a Benefit Plan:

Beth Miller, Excellus BlueCross BlueShield

Ashley Masucci, ProAct

Common Types of Services

- Primary Care Services and Immunizations
- Diagnostic Laboratory and Radiology
- Convenient Care / After Hours Care
- Urgent Care / Emergency Care
- Specialist Care (orthopedics, oncology, cardiology, etc.
- Surgical Services (Surgeon and Assistant Surgeon)
- Anesthesiology Services
- Therapy Services (Physical, Speech, Occupational, etc.)
- Rehabilitation Services (Physical, Mental Health, etc.)
- Pharmaceutical Services and Medications

Person Needs Medical Care

Medical Care is Sought

Common Questions to ask the Doctor:

1. What are my treatment options?
2. What services will be performed?
3. What services do I really need?
4. How much will the services cost?
5. Will a generic drug work for me?

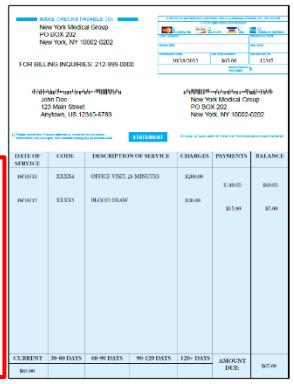
Cost of Care Billed to Insurer

Pay Co-Pay to Doctor

Insurer Determines if service is covered

Discounted rate paid to Doctor

Bill to Patient



Common Patient Costs:

1. Deductible
2. Coinsurance Amounts (e.g., 20%)
3. Non-Covered Items/Services
4. Non-Par Provider Balances

Claim received by Insurer/Admin.

Claims Adjudication Process:

1. Is the Patient covered by the Plan?
2. What type of plan design is in place?
3. Is the service a covered item?
4. Is the service medically necessary?
5. Is the Provider participating?
6. Does the Patient have cost sharing?
    a. Deductible
    b. Coinsurance
    c. Copayment

Discounted rate paid to Medical Provider

PART VIII

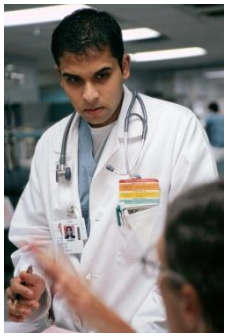
Provider Networks and Costs:

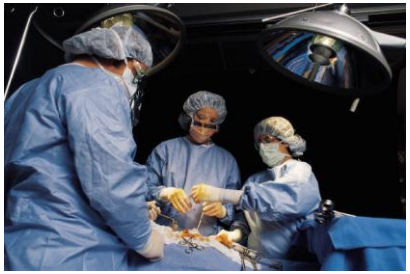
Beth Miller, Excellus BlueCross BlueShield

Ashley Masucci, ProAct, Inc.

Arenas of Care

- Hospital
  - Inpatient
  - Outpatient
- Medical/Surgical Care
- "Major Medical"
- Prescription Drugs





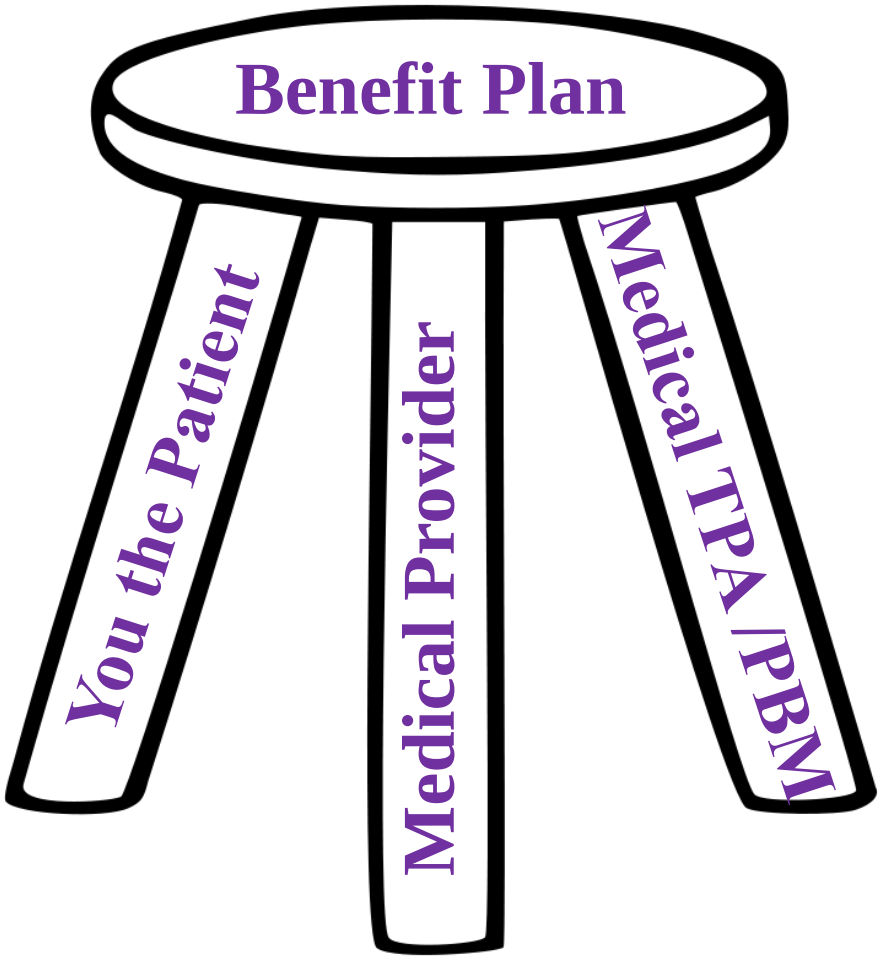
Common Places of Treatment

- Hospital
  - Inpatient Services
  - Outpatient Services
  - Emergency Care Services
- Skilled Nursing Facilities
- Ambulatory Surgical Care Centers
- Urgent Care Facilities
- Residential Psychiatric / Substance Abuse Facilities
- Physician Offices / Clinics
- Patient's Residence (Home Care or Visits)
- Pharmacies (Retail, Mail-Order, and Specialty)

Provider Networks

- Healthcare Services Covered by a Benefit Plan Need Pre-Determined, Discounted Pricing from Medical Providers, Facilities, and Pharmacies to Reasonably Predict Claims Costs and Resulting Premiums.
- Health Insurance Administrators and Prescription Benefit Managers Need a Provider Network in Order to Keep Prices Down and Provide Covered Members with Access to the Care They Need.
- The GTCMHIC Contracts with Excellus BCBS for Hospital, Medical, and Surgical Claims Administration and with ProAct for Prescription Drug Claims Administration.

Working Collaboratively



In-Network vs Out-of-Network

- In-Network Care
  - Is care provided to a patient by a medical care provider, facility, or pharmacy who has a contract in place with an insurance company, third party administrator, or pharmacy benefit manager to deliver medical services, care, and/or materials at a pre-determined cost or pre-determined rate of reimbursement. The patient is only responsible for their deductible, coinsurance amounts, and/or copayments not to exceed their out-of-pocket maximum for the year.

- Out-of-Network Care
  - Is care provided to a patient by a medical care provider, facility, or pharmacy who does not have a contract in place with an insurance company, third party administrator, or pharmacy benefit. The patient is not only responsible for their deductible, coinsurance amounts, and/or copayments not to exceed their out-of-pocket maximum for the year, but is also responsible for any balances above the amount allowed by the insurance company, third party administrator, or pharmacy benefit.

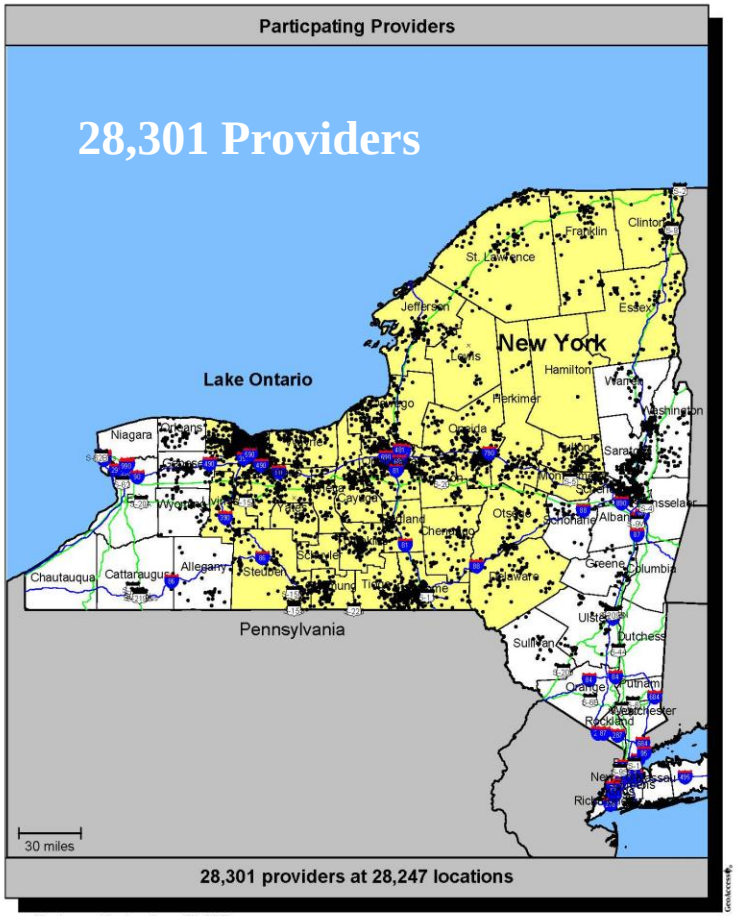
Medical Plan Administrator

- The Medical Plan Administrator, sometime referred to as a Third Party Administrator, for the GTCMHIC is **Excellus BlueCross BlueShield**. The services they provide to the covered members include, but are not limited to, the following:
  - Membership and Billing
  - ID Card Issuance
  - Customer Service
  - Claims Adjudication
  - Negotiated Discounts
  - Medical Provider Network Development and Management
  - Medical Case Management
  - Fraud and Abuse Detection

Excellus BCBS Service Area

Excellus BCBS Provider Network 1

Provider locations



- Single provider locations (28,232)
- Multiple provider locations (15)
- Excellus Service Area

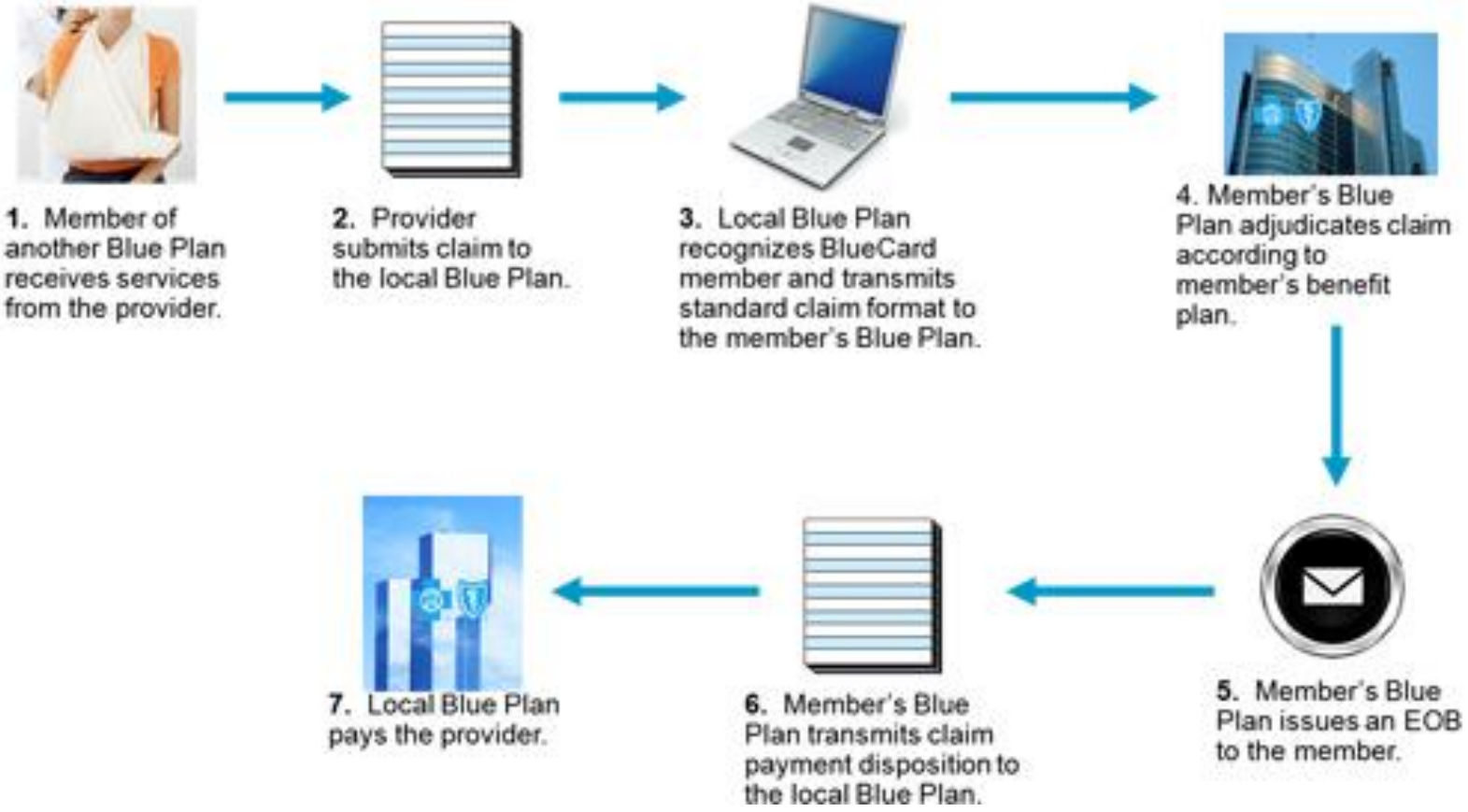
Excellus BCBS Provider Network 2

Provider locations

- Provider locations (80)
- Excellus Service Area

Out-of-Area Medical Care

- Excellus BCBS – Blue Card Program



Provider Network Savings

At a Glance

Greater Tompkins Consortium

Incurred between January 1, 2014 and December 31, 2014, paid through March 31, 2015

	Prior	Current	% Change
Provider Networks			
Percent Plan Cost to Participating Providers	97%	98%	1%
Estimated Provider Savings	$19,092,763	$18,543,872	-3%
Estimated Savings as Percent of Billed Amount	43%	42%	-2%

Prescription Benefit Manager

- The Prescription Benefit Manager (PBM) for the GTCMHIC is **ProAct, Inc.**, a subsidiary of Kinney Drugs, Inc. The services they provide to the covered members include, but are not limited to, the following:
  - Membership and Billing
  - ID Card Issuance
  - Customer Service
  - Claims Adjudication
  - Negotiated Pharmacy Discounts
  - Pharmacy Network Development and Management
  - Medical Case Management
  - Mail-Order Pharmacy Services
  - Specialty Pharmacy Services

ProAct National Pharmacy Network

ProAct's National Network includes over **67,000 chain and independent pharmacy locations** across the United States, Puerto Rico, the United States Virgin Islands, and Guam, with no major retail or key independent pharmacies excluded. Based on the National Council for Prescription Drug Programs files, over 90% of the pharmacies in the United States have enrolled in this network. Our retail pharmacy network provides member convenience no matter where they need to fill their prescription.

Balancing Cost and Access of Care

Excellus and ProAct are charged with keeping costs down while still providing access to the medical providers, facilities, and pharmacies patients need for their care. This is a delicate balance to achieve while also requiring participating providers to adhere to certain quality and accountability standards.

PART IX

Wellness Programs:

Don Barber, GTCMHIC Executive Director

Wellness Vision

A community that values and practices preventative health care to promote health and prevent disease.

Wellness Programs Work for Individuals and the Collective

- Healthy patients are happy, able to do more recreational activities for longer periods, and recover from injury and illness faster
- Many diseases are preventable with early diagnosis like glucose, blood pressure, cholesterol, and body mass index.
- Becoming aware of your numbers and making life style choices to lower your risk will keep out of the hospital and with your family , lower your costs of care and lower the Consortium's share of your cost of care.

Wellness & GTCMHIC Metal Plans

Wellness is a benefit component of all the GTCMHIC Standard Metal Level Plans (Platinum, Gold, Silver, and Bronze).

The GTCMHIC OYOH Committee Welcomes Your Ideas and Thoughts.

PART IX

Summation and Q&A Period:

Don Barber, GTCMHIC Executive Director