GREATER
TOMPKINS COUNTY MUNICIPAL
HEALTH INSURANCE CONSORTIUM
Municipalities building a stable insurance future.

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MINUTES
Greater Tompkins County Municipal Health Insurance Consortium
Joint Committee on Plan Structure and Design
May 2, 2013 – Noon
Old Jail Conference Room

Approved
11/7/2013

Present:
Municipal Representatives: 9 members
Mary Mills, Village of Cayuga Heights; Mack Cook, City of Cortland; Judy Drake, Town of Ithaca; Schelley Michell Nunn, City of Ithaca; Jennifer Case, Town of Dryden; Irene Weiser, Don Barber, Town of Caroline; Jeff Brockway, Town of Groton; Ruth Hopkins, Town of Lansing; Anita Fitzpatrick, Tompkins County

Municipal Representative via Proxy: 2 member
Betty Conger, Village of Groton; Laura Shawley, Town of Danby

Union Representatives: 4 members
Chantalise DeMarco, County White Collar-CSEA; John Licitra, Town of Ithaca Teamsters; George Apgar, President; Ithaca Professional Fire Fighters Assoc. and Ithaca Area Fire Fighters #73 (2)

Union Representative via Proxy: 1
Patty VandeBogart, TC3 Staff Unit

Others in attendance:
Steve Locey, Locey & Cahill; Beth Miller, Nora Putnam, Ken Foresti, Excellus; Sharon Dovi, Tomkins Cortland Community College

Call to Order

Ms. DeMarco called the meeting to order at 12:04 p.m.

Consultant Updates

Flex Spending Accounts Requests and EAP (Employee Assistance Program) Request for Proposals (RFP)

Mr. Locey reported they are putting together a survey on both the Flex Spending and Employee Assistance Program Request for Proposals and will be sending to all employers to obtain updated information. They received updated pricing information from the Flex Spending Account administrators and are waiting to go back to EAP providers until the survey is done. He said last year when did the original RFP there were seven respondents and they have broken out information because of the many different ways programs are being administered. He said when there is a flex spending account that pays for unreimbursed medical expenses some administrators and employer plans will allow a member to use a debit card against their flex spending program so there is pricing with and without debit card availability. The other elements are that there may be participants that are in medical only, have dependent day care,

health reimbursement arrangements, have cash subsidy programs, or have other elements. Mr. Locey said there are many program variations and they are trying to confirm what they would charge for each or collectively for all. They will be sending out updated survey instruments in the next couple of weeks. Once they have responses they will bring them back to the Committee. In terms of current providers, he said everyone in the Consortium currently has EBS RMSCO or Sieba Limited.

Mr. Locey did not have an update on current pricing information for the EAP Request for Proposals; they will be sending out the survey. He noted one of the difficulties with EAP pricing is that some pay by contract and some pay hourly and those different arrangements need to be translated to get everyone on even ground to perform an analysis.

Medicare Supplement

Mr. Locey distributed background information on current plan designs, information on Medicare, and actual Consortium costs on Medicare-age population versus everyone else in the program. Mr. Locey said now that there are two years of data there is information available that may be useful as there are discussions of other types of plan designs.

Mr. Locey distributed a breakdown of the different medical plan options that are available. There are two types: indemnity with a deductible and co-insurance or a PPO style plan where a flat co-payment is paid for office visits. In looking at the differences in those two programs from a cost perspective on an average per life basis he said they have found there wasn't much difference in the cost in the plans from a medical perspective. The reason is because under both programs predominantly all the expenses are paid in full. This is true for the Medicare age population as well. The next document distributed showed a breakdown by age bands from January 1, 2011 to December 31, 2012. Overall in terms of covered lives the Consortium has approximately 4,100 covered lives with 1,500 covered lives in indemnity plans and 2,700 in PPO programs with demographics similar in both.

Mr. Locey distributed a breakout of both Medicare Part A and B components from a cost perspective. The Medicare Part A deductible for 2013 is almost $1,200; this is what they would have to pay for inpatient hospital stay; once they pay that deductible and if they are in the hospital beyond 60 days there is a daily co-insurance they have to pay. The level of that is $196; on the 91st day it jumps to $592. The Medicare Part B deductible for this year is $147; the monthly premium is $104.90.

Mr. Locey distributed claims data broken out by age band through December 31, 2012. When the Consortium began in 2011 there were only about 500 covered lives that were age 65 or older. That number has steadily increased to almost 600 which is a 20% increase. He noted the population 45 to 64 has decreased since the Consortium began. He reviewed medical claims data broken out with the same demographic groups and said for 2011 and 2012 calendar years for the age 0-25 in 2011 the average was $2,100 in medical expense paid out per covered life. In 2012 that jumped to $2,800. A jump like this typically is the result of a large loss. There is a large jump in cost for the age 45-64 at $5,600 for 2011 and $5,775 in 2012. When Medicare becomes primary for the majority of the over age 65 population there is huge decrease as Medicare is picking up most of the cost. He noted the information presented included both active and retired persons over 65 so it is skewed somewhat with employees over age 65 who are working; they are working on separating out the information. In 2011 the Consortium spent $2,200 and in 2012 spent $3,381 per covered life for this population. In terms of average costs as a whole in 2011 it was $3,576 and $4,033 in 2012. In terms of average medical paid claims costs the 0-24 population represented 30.03% of the population and had

19.24% of costs; the age 25-44 category represented 21.33% of the population with 17.33% of costs; the age 45 population represented 36.29% of the population with 54.34% of the costs; and the over age 65 population represented 12.35% of the population with 9.09% of the costs. He also noted this information reflects medical data only.

Mr. Locey reviewed the 2012 Rx paid claims on a percentage basis and stated the following: the 0-24 population represented 29.61% of the population and had 9.30% of costs; the age 25-44 category represented 22.17% of the population with 14.24% of costs; the age 45-64 population represented 35.27% of the population with 48.69% of the costs; and the over age 65 population represented 12.96% of the population with 27.76% of the cost. The average annual cost for paid Rx claims is $1,563. The annual cost of Rx claims for the 0-24 population was $491; the 25-44 population was $1,004; the 45-64 population was $2,158; and the over age 65 population was $3,349. The Consortium averages 1.2 prescriptions per covered life per month. The 0-24 population average was .44; the 24-44 population was .75; the 45-64 population was 1.62; and the over age 65 population average was 2.81. He said in looking solely at the drug data the data is not skewed because the cost to the program remains the same. The Consortium only sees relief on the medical side with the Medicare-age population. Mr. Locey said a very large piece of the benefit for the over age 65 population comes from the drug benefit as the average drug plan cost is $3,205 for this population and the average cost for the Consortium as a whole is $1,476.

Mr. Locey distributed a Medicare supplement model plan and reviewed the contents. He noted he is still gathering information on Medicare Part D premiums and will provide that when it becomes available. In the model plant he estimated Medicare supplement premium for medical coverage only would be approximately $200 per month. He said with drug being the major expense for this population it will have a huge influence on what the monthly premium would end up being.

Ms. DeMarco said there are a wide range of Medicare Part D plans; Mr. Locey agreed and said they are gathering information from Excellus on different types of supplement plans that are available. The plan presented in the document represents the bare minimum of what a Medicare Part D program would look like.

It was noted that any new plan would need the approval of both the Board of Directors and the New York State Department of Financial Services; however, Mr. Locey noted it is not a requirement that a new plan begin on January 1st.

Update from Board of Directors

Mr. Barber said the Finance Committee is also looking at the issue of creating a Medicare Supplement plan; however, the Federal government is subsidizing the Medicare plan and this skews the information. If there is a plan proposal brought forward this Committee would consider that plan.

Mr. Barber provided an update on the Board of Directors March 28 meeting and said the State auditor has moved back to New York City and is continuing work. One issue the State has raised as a concern relates to this Committee and the lack of quorum at meetings. He said the Consortium's financial report has been filed with the State and reported the Consortium ended 2012 with a strong financial position and one of the reasons for this is because claims were under the projected amounts. A proposal was also brought forward to the Board concerning the impact on labor representation on the Consortium if the addition of municipalities to the

Consortium goes beyond 17. A committee has is working on this and will be making a recommendation to the Board.

The Board also created an Orientation Committee that will be working on reaching out to not only municipal partners but also the employees and bargaining units as they join the Consortium. A Committee was also created to help employees be more engaged in their own health and making lifestyle choices that reduce the costs of health insurance and keep them healthier.

Discussion of Quorum

Ms. DeMarco said the Committee has discussed the issue of quorum several times and asked for comments. Ms. Nunn suggested looking at a percentage figure being be used. Ms. DeMarco said part of what the Orientation Committee will be working on is making representatives aware of their role on the Committee and addressing changes in both elected and union leadership. It was agreed that Ms. DeMarco will work with Ms. Conger on developing a proposal for discussion and consideration at the next meeting.

Presentation of Health Management Report

Ms. Putnam reviewed the report which is available on the Consortium's website: www.tompkins-co.org/healthconsortium/Resources/2012%20UR%20presented%20%20May%202013.pdf

During the review the following points were noted in changes from 2011:

- The average number of contracts was 2,005 in 2012 (0% change)
- The average number of members was 4,448 (+1%)
- The plan cost was up 7%
- The member cost was up 18%
- The total cost was up 9%
- The cost per contract per year was up 7%
- The plan cost per member per month was up by 6%
- The total cost per member per year was up 8%

The Consortium vs. a comparison population showed a plan cost per contract per year being 30% higher with a member percentage cost share being 57% lower; cancer was the top diagnostic category; the top services with significantly higher PMPMs were: radiology, emergency room, lab, and therapeutic injections which are typically tied to cancer treatments (e.g. chemotherapy).

In reviewing cost distributions Ms. Putnam said 12% of members did not have any incurred costs throughout 2012, the 15% of members accounted for 75% of plan costs; this is very similar to what they see elsewhere.

Ms. DeMarco spoke to the percentage of people with zero costs and asked if there is any historical data on these individuals including when they would come into the system and whether they come in having untreated medical conditions or a catastrophic illness. Ms. Putnam said she can look into this but typically what they find is this is generally a very young population who are not receiving services.

The number of claimants with Plan costs greater than $25,000 was 93 (6% increase);

Percent of members with a plan cost of greater than $25,000 was 2.09% (5% increase);
Plan cost for claimants greater than $25,000 was $6,733,249 (19% increase);
Percent of Plan cost for claimants greater than $25,000 was 39% (15% increase);
Average Plan cost per claimant greater than $25,000 was $72,401 (13% increase);
Plan cost PMPY adjusted for $25,000 threshold was $2,934 (4% decrease)

Mr. Locey commented that in 2011 the Consortium received less than $150,000 back from Stop Loss for the entire year. This year the Consortium will be close to $1 million in recovery from Stop Loss insurance.

Ms. Putnam reviewed the top ten diagnosis and plan costs; four of those are active and forecasted to exceed claims this year of $50,000. Five out of the ten have a cancer-related diagnosis.

Inpatient admissions were 326 (13% decrease);
Average length of stay was 5.7 days (25% increase);
Physician office visits were 19,487 (2% increase);
Emergency room visits was 1,061 (4% increase)

The average total cost for emergency room visits was $1,438; the average total cost for a physician office visit was $120. Mr. Locey asked Ms. Putnam to include the cost or urgent care centers. The number of potentially avoidable emergency room visits was 200 with a total potential savings of $289,958.

Ms. Putnam reviewed highlights and recommendations contained in the report:

- Plan Costs for the 2012 calendar year rose by 7% while membership remained consistent with the 2011 timeframe. Plan Cost Per Contract Per Year was 30% higher than the municipality comparison while Member Cost Per Contract Per Year was 34% lower than the comparison population.
- Ninety-three members have 39% of plan costs. The plan costs for the high claimant population rose by 19% compared to the prior year. Four members had claims greater than $200,000. These four members are forecasted to have claims over $50K during the next twelve months.
- Five of the top ten high claimants had a most costly diagnosis that was related to the Neoplasms (cancer) diagnostic category.
- A slight increase in Emergency Room (ER) visits was seen however trends are continuing to be higher than the comparison population. During 2012, there were 239 ER visits per 1,000 members while urgent care visits per 1,000 members in 2012 was 204.
- The average cost per ER visit was $1,438. By encouraging members to utilize the physician office setting for the potentially avoidable ER visits, the plan could save nearly $290K.
- Consider Blue 4 You, a health awareness and preventive care program for your employees that can be billed through claims. Participants complete a health profile and receive a worksite health evaluation (a convenient, comprehensive and confidential state
- of the art blood screening). Employees then receive a personalized Health Report and have access to a private health management website as well as Health Focus Courses for Life. Employers receive an aggregate report to aid in analyzing health and wellness focus areas.
- Initiate a campaign to reduce unnecessary Emergency Department visits. Also promote ways to help members find a primary care physician and utilize urgent care centers.

- Provide wellness promotional information to help reduce incidence of back pain, cholesterol disorders, hypertension, diabetes, depression, and heart disease. Promote custom web portal and other wellness services such as, Step Up, Blue 365, and Advanced Care Planning.

Ms. DeMarco asked that Ms. Miller look into whether the 5-star Urgent Care Center on Meadow Street is a participating provider. Ms. Drake asked if the same kind of information can be provided for the Rx side. Mr. Locey will be contacting ProAct to see if reporting can be integrated.

New Business - Status of Prescription Drug Program Issues

Mr. Apgar asked what the status is of the prescription drug issues. Ms. Nunn said she believes the 30-60 day issue has been resolved at the City. She believes Mr. Thayer and Mr. Locey are continue to work together on other issues but it is her understanding they will need to go back to the City's former plan. Mr. Apgar said members are still having issues with prior authorization and the formulary.

Ms. DeMarco questioned the status of issue at the County level. Mr. Locey said he believes the 30-60-90 day supply have been resolved; any problems should be referred to him.

Reschedule July 4 Meeting

It was the consensus of those present to cancel the July 4, 2013 meeting rather than to reschedule due to the holiday.

Approval of Minutes

Approval of the minutes from June, July, August, October, December, 2012, and January, and March 7, 2013 meetings were deferred due to lack of quorum.

Old Business

There was no old business.

Adjournment

The meeting adjourned at 1:30 p.m.

Respectfully submitted by Michelle Pottorff, Administrative Clerk