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 5, 2016 – 1:30 p.m.
Department of Emergency Response Conference Room, Health Department

Approved

Present:
Municipal Representatives: 11 members
Judy Drake, Town of Ithaca and Board of Directors Chair (arrived at 1:36 p.m.); Michael Murphy, Village of Dryden; Carissa Parlato, Town of Ulysses (excused at 2:36 p.m.); Schelley Michell Nunn, City of Ithaca (arrived at 1:40 p.m.); Eric Snow and Dale Taylor, Town of Virgil; Charmagne Rumgay, Town of Lansing; Betty Conger, Village of Groton; Brooke Jobin (arrived at 1:36 p.m.), Tompkins County

Municipal Representative via Proxy: 3
Jennifer Case, Town of Dryden (Proxy – Judy Drake); Tom Brown, Town of Truxton (Proxy – Judy Drake); Alvin Doty, Town of Willet (Proxy – Judy Drake)

Union Representatives: 11 members
Phil VanWormer, City of Ithaca Admin. Unit; James Bower, Bolton Point-UAW Local 2300; Olivia Hersey, TC3 Professional Admin. Assoc. Unit; Jon Munson, Town of Ithaca Teamsters; Jeanne Grace, City of Ithaca Exec. Assoc. (arrived at 2:05 p.m.); Teresa Viza, TC Library Staff Unit (excused at 2:40 p.m.); Tim Arnold, Town of Dryden DPW; Kate DeVoe, TC Library Professional Staff Unit (excused at 2:40 p.m.); Jason Thayer, TC3 Staff Unit; Doug Perine, Tompkins County CSEA White Collar President; Tim Farrell, City of Ithaca DPW

Union Representatives via Proxy: 0

Others in attendance:
Don Barber, Executive Director; Steve Locey, Locey & Cahill; Meghan Feeley, ProAct; Matt Losty, Beth Miller, Excellus; Sharon Dovi, TC3 Human Resources

Call to Order

Mr. VanWormer, Chair, called the meeting to order at 1:30 p.m.

Approval of Minutes of April 7, 2016

It was MOVED by Ms. Conger, seconded by Mr. Perine, and unanimously adopted by voice vote by members present, to approve the minutes of the April 7, 2016 meeting as submitted. MINUTES APPROVED.

Chair's Report

Mr. VanWormer reported the Consortium newsletter contains a section entitled "Labor Lens" and members are encouraged to submit suggestions for topics for this section.

Executive Director Report

Mr. Barber reminded members the next educational retreat will be held on May 10th and will focus on how premium rates are determined for the Consortium's health plans. He reported on submissions for the Consortium's logo contest and said approximately 15 designs were submitted. Mr. Barber reported on financial data for the first quarter of 2016 and said the Consortium is in good financial shape; claims are running under budget and revenues are coming in as predicted. He distributed copies of the Consortium's 2015 Annual Report and stated the document is available on the Consortium's website.

Ms. Drake and Ms. Jobin arrived at this time.

At this time there was a discussion of the following resolution that was Tabled at the March 24, 2016 Board of Directors meeting to allow for discussion and input from this Committee.

RESOLUTION NO. 2016 – APPROVAL OF GUIDELINES FOR MEMBERS CHANGING PLANS

Mr. Barber said there can be financial implications as people change plans quickly. The Board of Directors at its March meeting had discussion of these implications and a question was raised as to how and why the three-year period contained in the resolution was selected. He noted that the resolution recommends members establish guidelines and that any policy must be set by the employer.

Ms. Hersey asked Mr. Barber to address why the time period of three years was chosen. Mr. Barber said the reason for having some amount of time before members could change plans is to recoup a loss that can occur from a person moving between plans. Mr. Locey said he is seeing more plans establish these kinds of safeguards and some have even adopted rules that restrict members from moving back to a greater plan once a decision has been made to move down to a plan with a lower benefit level. These types of decisions are made to protect plans from having an adverse risk selection which can impact all of the other members in the plan. This is a long-term strategy and an attempt to manage risk and avoid people having move in and out of different plans based on their particular need at the time. Ms. Drake said the Audit and Finance Committee discussed different periods of time and one reason the three-year period was chosen was that this is the time period that is in the Municipal Cooperative Agreement designates as the period of time a municipality has to wait before coming back to the Consortium once it leaves.

Ms. Michell-Nunn arrived at this time.

Ms. Hersey said she understands this is a recommendation for municipalities to adopt guidelines and a municipality could negotiate with its bargaining units what the rules surrounding when members could change plans and if and how long they would have to wait to move to a new plan would be. However, she believes members will need to morally weigh the business-end of the Consortium with the impact on the person. She said the purpose of the Consortium is to provide people with insurance coverage so that they are not put into harm's way and end up making bad choices on how they get their healthcare. She said people need to think not only about what they can afford for healthcare but what their personal risk is. She questioned how many people who are able to change plans would do so and expressed concern for members who may not receive the care they need or be stuck in financial ruin because they are stuck in a decision they made in which they chose a plan that left them faced with paying extremely high out-of-pockets costs.

Mr. Locey explained scenarios that could result in the situations where the amount of revenue could be much lower than the amount of claims as a result of someone changing plans based on their personal situation. This is a balancing act but an attempt to allow flexibility while protecting the Consortium from having a budgetary issue in the future.

Mr. Murphy felt the guidelines were reasonable, make sense, and noted they do provide some flexibility based on someone's personal situation.

It was MOVED by Mr. Murphy, seconded by Mr. Arnold to recommend the resolution be approved by the Board of Directors as written. A voice vote resulted as follows: Ayes – 18, Noes – 3 (Farrell, Hersey, and Thayer). MOTION CARRIED.

WHEREAS, the Consortium has over 100 plan combination options that any of our partners can by resolution add to their list of plans available to their employees, and

WHEREAS, the recently adopted "metal level" plans (platinum, Gold, silver, and bronze) as well as Medicare Supplement have different actuarial conditions for setting premiums than the other Consortium plan offerings, and

WHEREAS, employees frequently changing between these five plans or between any of these five plans and another Consortium plan can have adverse consequences with not enough premium being raised to cover claims, and

WHEREAS, employees staying with their selection of one of these five plans for a period of at least three years will allow for adequate capture of premium for claims, and

WHEREAS, the Consortium does not want to interfere with municipal partners offerings and employees ability to choose, and

WHEREAS, the qualifying events that allow changes in benefit plans at the time of the event are: marriage, divorce, legal separation, annulment, birth, change in legal custody status, dependent ages off, adoption, death, start of or loss of employment, start of or loss of eligibility for Medicare or Medicaid coverage, change in residency, and

WHEREAS, the Consortium Benefit Plans are administered on a calendar year basis, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the Board of Directors recommends to our municipal partners that they each adopt a policy that will restrict individuals from changing from the platinum, gold, silver, bronze, and medicare supplement plans to another plan for three years after coverage begins,

RESOLVED, further, That the Audit and Finance Committee recommends that the Board of Directors adopts the policy that all non-qualifying event benefit changes are submitted to the medical plan administrator by December 1 for implementation on January 1.

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Presentation of Excellus Health Plan Management (Utilization) Report

Ms. Miller and Mr. Losty presented the Committee with the Excellus Health Plan Management Report for claims incurred from January 1, 2015 thru December 31, 2015 and paid through March 31, 2016.

The following items were highlighted during the report which is posted under the Resources tab on the Consortium's website:

There were approximately 50 members added in 2016;
There was a 4% decrease in the Plan cost and a 2% decrease in the member cost;
Total claims per employee increased at only 6.6% since 2011 and the total cost per member increased 14% since 2011.

Ms. Grace arrived at this time.

The Plan cost per contract was 11% higher than the comparison population. This was 30% in 2012 and shows the gap is narrowing. The Consortium had a higher average age and lower member costs which are two differences between the Consortium and the comparison population;
There were 63 fewer hospital admissions in 2015. There was a 14% decrease in inpatient claims and a 3% decrease in outpatient claims;
Participating providers were 96.2% and non-participating providers was 3.8%; network savings was 44%. 30% of out-of-network claims were for psychiatric services and tend to have been out-of-network.

Mr. Murphy asked if Excellus is negotiating more with psychiatric providers to become participating providers. Ms. Miller explained that because of psychiatric providers have a "niche" market they resist becoming a participating provider and if someone needs a specific service they are likely going to pay for the service regardless if the provider is a participating provider.

Mr. Bower asked if there is any legislation that addresses provider reimbursement costs. Mr. Locey said there is no legislation and nothing in the Affordable Care Act that has addressed the cost of care which he believes is the single largest issue.

Ms. Jobin asked if hospitals that have inpatient psychiatric care more likely to be in-network. Mr. Locey said anyone who works for a hospital is in-network. However, if a provider is located at the hospital but not employed by the hospital they may not be a participating provider. It was felt this is something that would be important for members to be aware of.

(Highlights continued)
18% of the members account for 80% of claims;
There was a 6% increase in the number of claimants with a plan cost greater than $100,000; however, the cost of those claims were 8% lower;
The average length of stay increase due to more mental health and substance abuse services;
The number of admissions decreased by 17% and the average length of stay increased by 6.1%;
The number of emergency room visits decreased by 5% which is 6% lower than the comparison population, and the number of potentially avoidable visits decreased by 14% which is 32% lower than the comparison population;

The large increase in visits to urgent care facilities was noted. In response to a question of what examples would be potentially avoidable visits to the emergency room, Mr. Losty said he would provide additional information to the Committee. It was suggested that information about this could be included in the Labor Lens section of the newsletter.

Ms. Viza said some providers are now charging an additional charge if a visit is after hours. Ms. Miller found this surprising and advised her to contact Excellus customer service. Mr. Arnold said Cayuga Medical Center recently instituted a $25 facility fee to patients and this is not billable to insurance. Others were not aware of this and it was suggested that this is something members should be made aware of.

Mr. Losty reported Telemedicine is a service that is now available. Telemedicine is the remote delivery of health care services and clinical information using telecommunications technology. Board certified physicians are now seeing approximately 1,000 across the country for minor conditions. There are many advantages to using this service that it is available at any time and allows patients to choose which doctor they wish to see and also provides immediate

service to people who don't have easy access to care. Ms. Miller said this is now a service that Excellus is mandated to provided. There is a cost to adding this innovative program at a cost per contract. Mr. Bower asked if there has been any evaluation of this program. Ms. Miller said they have looked at many issues including security and offering local providers an opportunity to join this. At this time they are watching it closely but do not have enough experience to produce data to evaluate. There is a $40 cost of service and the member copay is a decision the group would make.

Ms. Parlato was excused at this time.

Continued Information on Actuarial Calculator

Mr. Locey distributed a document containing a number of options particularly related to the Platinum Plan as that plan will be more involved than the other metal level plans. He said in adjusting the actuarial value the up-front deductible has the most impact when altered.

Ms. Viza and Ms. DeVoe were excused at this time.

Mr. Locey referred to the options and said Excellus put together the options based on the current plan being at 93%, although he noted that number is continuing to be examined. He walked members through the range of options presented and explained the impact on the actuarial value by making changes that range from increasing things such as copays for primary physicians, specialists, diagnostic labs, prescription drug tiers, diagnostic labs, and out-of-pocket maximums. He noted that those things that have the highest utilization typically have the greatest impact.

Mr. Locey distributed and reviewed a document showing how the Consortium's Platinum Plan compares to the Excellus Platinum Plan. He recommended the Consortium adopt a more consistent strategy related to the out-of-pocket maximum to make it more consistent. He said that the actuarial value for the Consortium's Platinum Plan will need to be adjusted by 1.25-2.25% to bring it into the middle of the required 88%-92% range.

Next Meeting Agenda

The following items were suggested for inclusion on the next agenda:

Continued discussion of actuarial values that will result in information being ready for labor representatives to take back to their groups and this Committee prepared to make a recommendation at its July meeting

Adjournment

The meeting adjourned at 2:57 p.m.

Respectfully submitted by Michelle Pottorff, Administrative Clerk