



# GTCMHIC RETREAT

Education Retreat of the:  
Greater Tompkins County Municipal  
Health Insurance Consortium  
September 15, 2014

# Welcome

On behalf of the Greater Tompkins County Municipal Health Insurance Consortium we welcome you to the 2014 Educational Retreat. We thank you for taking the time out of your busy schedules to join us for an evening 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.



# Goal of Retreat

The goal of this retreat program is to present information to the GTCMHIC Board of Directors, Union Leaders, and Local Government Leaders to develop a deeper appreciation for their responsibilities, explain in basic terms how insurance and specifically risk pools work, provide information on the basics of the health care system and its interaction with insurance, develop an appreciation for the changes in health care, health insurance, and regulation which occurs regularly without any action by the Consortium, and frame the challenges facing the Consortium as we move forward. To accomplish this, we are going to try and provide information to help you answer the following questions:

# Goal of Retreat

- ❖ **What is Health Care?**
- ❖ **What is Health Insurance and is it necessary?**
- ❖ **Why do Health Insurance costs rise so fast?**
- ❖ **Why was the GTCMHIC created?**
- ❖ **How does the GTCMHIC work?**
- ❖ **What is a benefit plan?**
- ❖ **How does the insurance system work?**
- ❖ **Has the GTCMHIC been successful to date?**
- ❖ **What challenges lie ahead?**

# Retreat Agenda

- ❖ Welcome & Introductions (5:00)
- ❖ Health Care, Insurance, and Cost Changes (5:15)
- ❖ What is GTCMHIC and how does it work? (5:30)
- ❖ Snack Break (6:00)
- ❖ Benefit Plans and how the system works (6:10)
- ❖ How does the Consortium measure up?(6:40)
- ❖ Challenges (7:10)
- ❖ Summarize & Questions (7:15)
- ❖ Prizes

# 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 I

## Health Care Basics:

Beth Miller, Excellus BlueCross BlueShield

Ashley Masucci, ProAct, Inc.

# What is Health Care?

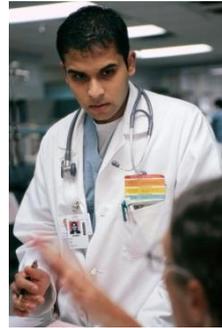
- ❖ Health care (or healthcare) is the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in human beings.
- ❖ Health care is delivered by practitioners in allied health, dentistry, midwifery (obstetrics), medicine, nursing, optometry, pharmacy, psychology and other various health professions.
- ❖ It refers to the work done in providing primary care, secondary care, and tertiary care, as well as in public health.

# Health Care is a Business

- ❖ Patients purchase health care products and/or services from private sector medical care providers and/or facilities.
- ❖ Medical care spending is tracked as part of the Consumer Price Index (CPI) a measure of the change over time in the prices paid by consumers for goods and services.
- ❖ In 2013, health care spending in the United States of America accounted for approximately 17% of the estimated \$16.8 Trillion Gross Domestic Product (GDP).
- ❖ Medical care spending is a major component of our GDP which is growing faster than other CPI tracked goods and services.

# Patient Care Choices

- ❖ Where can I access care?  
(Place of Treatment)
- ❖ What Services do I Need?  
(Type of Service)
- ❖ How much will it cost me for my care?  
(Out-of-Pocket Cost)



# 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)



# 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

# Prescription Drug Basics

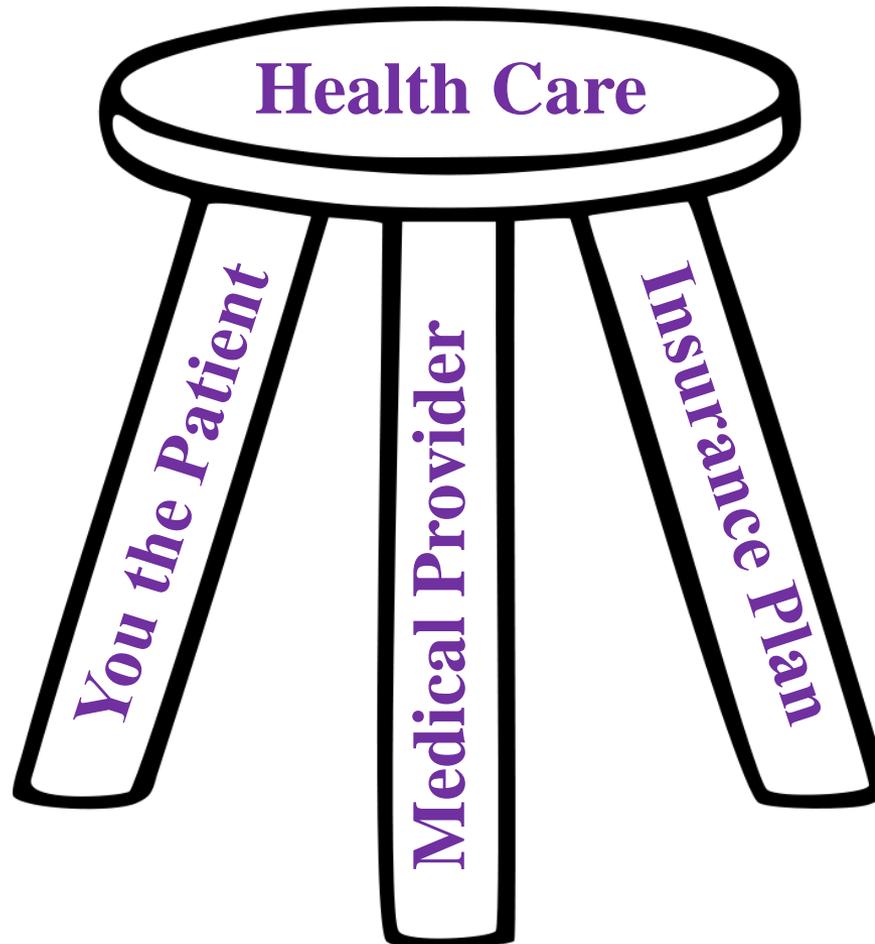
- ❖ Generic Medications (Tier 1)
  - ❖ 78% of Prescriptions Filled
  - ❖ Average Cost Per Prescription = \$17.92
- ❖ Brand Name Medications
  - ❖ Includes Preferred (Tier 2) and Non-Preferred (Tier3)
  - ❖ Specialty Medications are Commonly Tier 3 Drugs
  - ❖ 22% of Prescriptions Filled
  - ❖ Average Cost Per Prescription = \$245.70
- ❖ Specialty Medications
  - ❖ 1.05% of Prescriptions Filled
  - ❖ 25.27% of Overall Prescription Drug Spend
  - ❖ Average Cost Per Prescription = \$2,205.33

# Your Cost of Care

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



# Working Collaboratively





PART II

# Health Insurance 101:

Steve Locey, Locey & Cahill, LLC

# Why Do I Need Health Insurance?

- ❖ Illness, Disease, and Injury are Unpredictable Events.
- ❖ The Cost of Services can be Exorbitant.
- ❖ Approximately 20% of the Population Spends 80% of the Premium Dollars Collected.
- ❖ Pooling Risk Protects You from Financial Catastrophe.
- ❖ The Patient Protection and Affordable Care Act Requires You to Have Health Insurance.
- ❖ One never knows when they or a loved one will be part of the 20% population.

# What is Health Insurance

- ❖ Health Insurance is an agreement in which a person or a person's employer makes regular payments (premiums) to a company and the company promises to pay money and/or cover certain medical (health care) services, procedures, materials, or costs if the person is sick or injured (benefits).
- ❖ The amount of the premiums and the level of benefits will vary based on the agreement the person or the person's employer has with the insurance company.
- ❖ Even though our use of medical services increases with age, our premium is pooled over a broad demographic population which evens out the premium cost over a person's lifetime.

# Sample Excellus BCBS Client

Incurred between January 1, 2012 and December 31, 2012, paid through March 31, 2013

## High Cost Claimant Costs by Member (>= \$25,000)

	High Cost Claimants by Most Costly Diagnosis	Prior Plan Cost	Current Plan Cost	UM	CM	DM	Rx Sp CM		
1	196 Secondary and Unspecified Malignant Neoplasm of Lymph N	\$335,633	\$1,063,623	YES	YES	NA	NA		
2	238 Neoplasm of Uncertain Behavior of Other and Unspecified	\$13,124	\$441,920	NA	NA	NA	NA		
3	227 Benign Neoplasm of Other Endocrine Glands and Related S	\$103,889	\$393,046	YES	YES	YES	NA		
4	572 Liver Abscess and Sequelae of Chronic Liver Disease	\$47,576	\$260,259	YES	NA	YES	NA		
5	162 Malignant Neoplasm of Trachea, Bronchus, and Lung	\$52,141	\$191,355	NO	NO	NO	NA		
6	724 Other and Unspecified Disorders of Back	\$9,684	\$174,144	YES	NA	NA	NA		
7	733 Other Disorders of Bone and Cartilage	\$73,675	\$133,579	YES	YES	NA	NA		
8	99681 Complications of Transplanted Kidney	\$6,074	\$121,509	YES	YES	NA	NA		
9	562 Diverticula of Intestine	\$1,855	\$119,026	NA	NA	NA	NA		
10	V5811 Encounter for antineoplastic chemotherapy	\$295,897	\$114,362	YES	NA	NA	NA		
11	189 Malignant Neoplasm of Kidney and Other and Unspecified	\$16,753	\$104,522	YES	YES	NA	NA		
12	715 Osteoarthritis and Allied Disorders	\$23,273	\$104,433	YES	NA	YES	NA		
13	753 Congenital Anomalies of Urinary System	\$14,937	\$102,991	YES	NA	NA	NA		
14	153 Malignant Neoplasm of Colon	\$2,451	\$100,764	NA	NA	NA	NA		
15	536 Disorders of Function of Stomach	\$8,254	\$99,967	YES	NA	NA	NA		
16	491 Chronic Bronchitis	\$19,091	\$97,636	YES	NA	YES	NA		
17	428 Heart Failure	\$129,961	\$92,629	YES	NA	NA	NA		
18	99666 Infection and Inflammatory Reaction Due to Internal Joi	\$26,714	\$89,488	YES	NA	YES	NA		
19	237 Neoplasm of Uncertain Behavior of Endocrine Glands and	\$0	\$88,683	NA	NA	YES	NA		

14 People Exceeded \$100,000 in Medical Paid Claims in 2012 for a Total Spend of \$3,425,533



UM - Utilization Management, CM - Case Management, DM - Disease Management, Rx Sp CM - Pharmacy Benefit Specialty Drug CM

# How are Premium Rates Set?

- ❖ Predict Overall Expense Budget
  - ❖ Paid Claims Statistical Trend Models (94% of expenses)
  - ❖ Administrative and “Overhead” Expenses
  - ❖ Insurance Costs – Even Insurance Companies Buy Insurance
  - ❖ Taxes and Fees
- ❖ Determine Reserves / Liability Adjustments
- ❖ Expenses + Reserve/Liability Adjustments = Income
- ❖ Premiums = 98% of Income
- ❖ Adjust Premiums Based on Benefit Design Using Excellus, ProAct, and Locey & Cahill, LLC Data Bases

# Why Purchase Stop-Loss Insurance?

- ❖ Article 47 Require the Purchase of Stop-Loss Insurance
- ❖ Aggregate Stop-Loss Insurance
  - ❖ Protects the GTCMHIC from financial harm caused by all claims exceeding projections which could be caused by a pandemic.
  - ❖ Annual Consortium Deductible = 125% of Expected Claims Cost
  - ❖ Consortium Coverage Maximum = \$1,000,000
  - ❖ Annual Cost  $\approx$  \$75,000
- ❖ Specific Stop-Loss Insurance
  - ❖ Protects the GTCMHIC from financial harm caused by a single catastrophic large loss case.
  - ❖ Annual Per Person Deductible = \$300,000
  - ❖ Coverage Maximum Per Person = \$1,700,000
  - ❖ Annual Cost  $\approx$  \$650,000



# PART III

## Hyper-Inflation of Health Insurance:

Beth Miller, Excellus BlueCross BlueShield

Ashley Masucci, ProAct

# 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)

# Medical Technology Advancements

- ❖ MRI, CAT Scans, Digital X-Rays
- ❖ Transplants (Heart, Kidney, Liver, etc.)
- ❖ Cancer Treatments and Therapies
- ❖ Joint Replacements (Knees and Hips)
- ❖ Premature Newborn Treatment and Care
- ❖ Flu Shots and Shingles Vaccine
- ❖ Specialty Pharmaceuticals

# Specialty Medication Pipeline

- ❖  $\approx$  1,300 New Drugs in Development
- ❖  $\approx$  600 Specialty Drugs in Late-Stage Development
  - ❖ 40% of these Medications are Oncology Drugs
- ❖ Pipeline Outlook
  - ❖ Oncology
  - ❖ Rheumatoid Arthritis
  - ❖ CNS Disorders
  - ❖ Infectious Diseases
  - ❖ Respiratory Disorders

# 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
- ❖ 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



PART IV

# GTCMHIC Overview:

Don Barber, GTCMHIC Executive Director

## Consortium Goal

**Municipalities pool their resources to provide health insurance plans and benefits which are less costly and more stable while maintaining the level of benefits guaranteed by each Municipality's Collective Bargaining Agreements, Personnel Policies, and/or Local Laws.**

# Why was the GTCMHIC Started?

- ❖ Due to limited revenue from property taxes, local governments formed the TCCOG to find ways of sharing services.
- ❖ At TCCOG meetings, health insurance became a focus as premiums were outpacing the growth in revenue.
- ❖ TCCOG was awarded a Shared Municipal Services Incentive (SMSI) grant of nearly \$250,000 to assist in the development, approval, and implementation of the GTCMHIC.
- ❖ Article 47 of the New York State Insurance Law allowed all municipalities to belong to the GTCMHIC.
- ❖ Not one Article 47 Municipal Cooperative Health Benefits Plan had been created since the legislation passed in 1992.

# Creating the GTCMHIC

- ❖ Creating a governance structure was no small task and establishing balance between large municipalities like the County with over 1,200 employees with small towns and villages with less than 10 employees required a significant amount of negotiation and creativity.
- ❖ In 2009 the framework of the GTCMHIC was formed with the drafting of the Municipal Cooperative Agreement (MCA) which had to be signed by all participating municipalities. Late in 2009 and into 2010 the GTCMHIC submitted its application to the NYS Ins. Dept. and soon discovered that the hardest work was still to come.
- ❖ One task was to create a meaningful role for labor within the Consortium's decision making process. Joint Committees on benefit plan design had been used in other municipal insurance risk pools and seemed to make sense for the GTCMHIC. However, NYSID's reading of Article 47 required Labor to have voting seats on the Board.

# Starting the GTCMHIC

- ❖ The Participating Municipalities collectively had to invest \$1,220,000 into a Rate Stabilization Reserve to satisfy the capital surplus requirements of Article 47. To meet this requirement, capitalization was not done equally
- ❖ We negotiated with the NYSID for an IBNR reserve equal to 12% of the expected incurred claims for the year. This was one half of the statutory requirement of 25% and 5% less than the reserves required by other municipal cooperative health benefit plans by the NYSID.
- ❖ GTCMHIC was awarded a Certificate of Authority on October 1, 2010
- ❖ The GTCMHIC began operations on January 1, 2011 and started providing health insurance coverage to approximately 4,400 people. In 2011, the GTCMHIC collected approximately \$26,000,000 in premium and paid out approximately \$22,000,000 in benefits.

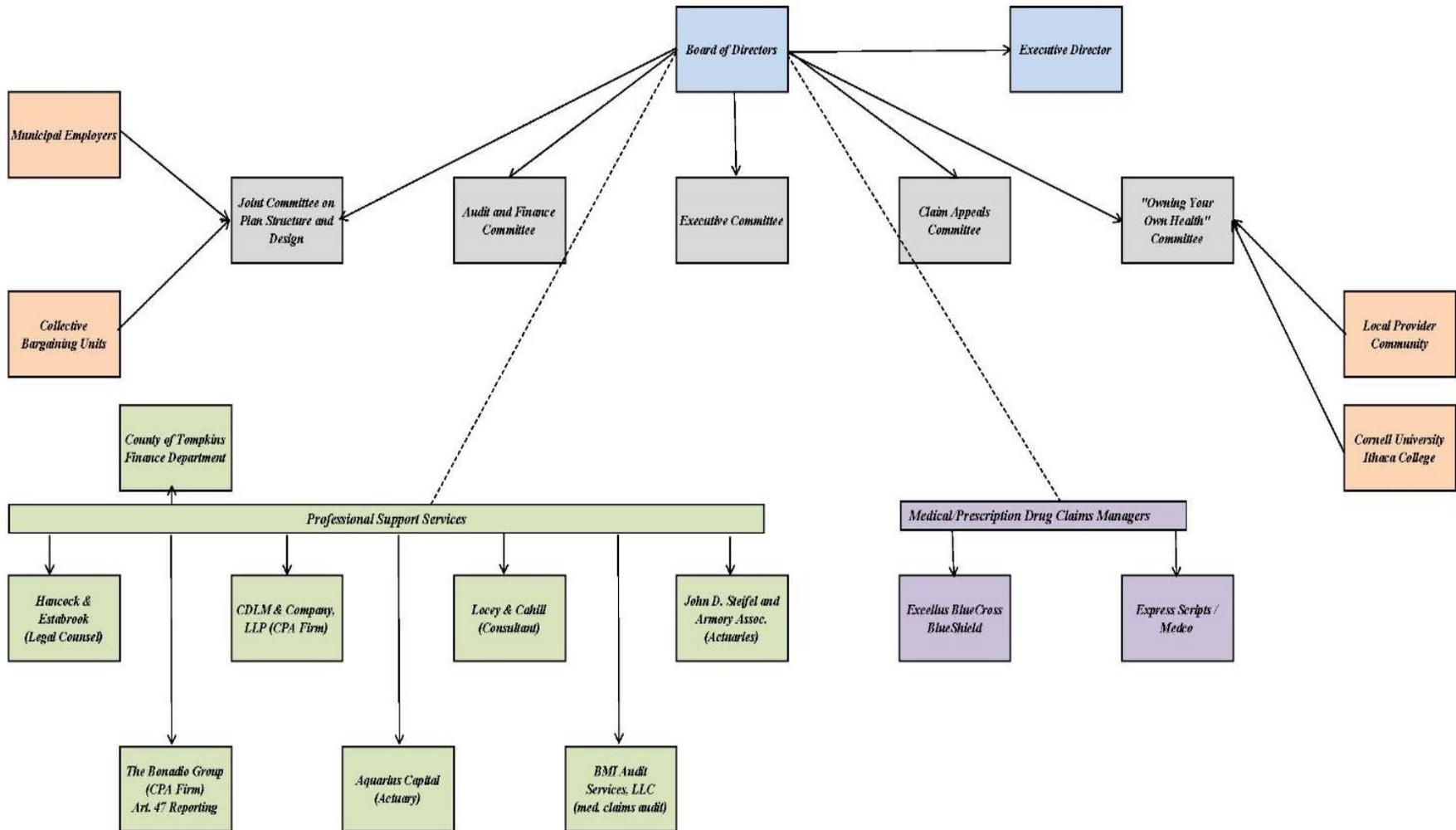
# The Municipal Cooperative Agreement (MCA)

- ❖ The MCA is an agreement between municipal owners of an Insurance Company that writes benefit plans which must be approved by the NYS Dept. of Financial Services.
- ❖ The MCA provides the operational framework of the GTCMHIC by:
  - ❖ Affirming the shared fiscal responsibility for covering all eligible incurred claims. Each municipalities financial stake is based on total premiums contributed;
  - ❖ Establishes the Board of Directors which consists of one representative for each municipal member and a number of labor representatives who each have equal voting power. However, weighted voting can be invoked in certain instances, but has not been to date;
  - ❖ Stipulating that the Board is responsible to direct & protect the Consortium;
  - ❖ Creating the Joint Committee on Plan Structure and Design
  - ❖ Describing how municipalities may join the Consortium, leave the Consortium, or how the Consortium could be dissolved.

# What is the Financial 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

Greater Tompkins County Municipal Health Insurance Consortium



# Financial Impact of Consortium

- ❖ The Consortium reduced overall health insurance spending by:
  - ❖ Pooling Resources and Increasing Efficiencies
  - ❖ Increasing Buying Power (“Economies of Scale)
  - ❖ Reducing Administrative Expenses
  - ❖ Spreading Risk Over a Larger Population
  - ❖ More Stable Annual Premium and Budget Process

# Employee/Retiree Protections

- ❖ Benefits and Rights Protected by Collective Bargaining Agreements / Personnel Policies
- ❖ New York State Department of Financial Services Guidance and Oversight
- ❖ Representation in the Process
- ❖ Sharing of Information and Results

# Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC)

- ❖ The Consortium Today “At a Glance”
  - ❖ 15 Municipal Employers
    - ❖ 1 County, 2 Cities, 8 Towns, and 4 Villages
  - ❖ 4 Large Employers (greater than 50 employees)
  - ❖ 11 Small Employers (less than 50 employees)
  - ❖ Approximately 2,280 Total Employees/Retirees
  - ❖ Approximately 5,050 Covered Lives
  - ❖ 2014 Health Insurance Budget = \$37.8 Million
  - ❖ Only New Article 47 Consortium Since 01-1993

Take a  
**BREAK**

GET OUT OF YOUR CHAIR,  
IT'S **KILLING** YOU





PART V

# 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.

# 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)

# Biggest Misconception

## *My Health Insurance hasn't changed in twenty years.*

- ❖ For Most Municipal Employees, other than Rx Co-Pays, this statement is *false* as Health Insurance is ever-evolving and improving in favor of the member:
  - ❖ New Medical Procedures
  - ❖ New Pharmaceuticals
  - ❖ Mandated Benefits (Federal and State)
  - ❖ Affordable Care Act
- ❖ The fact is Health Insurance has changed dramatically in the past twenty years. Even if a Member's deductible, co-payment, or out-of-pocket maximum has not.

# 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 are necessary to gain new members to the consortium and to offer labor and management the required tools to keep costs in check while still providing excellent benefits.

# How are Changes Made?

- ❖ 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



# PART VI

## Using a Benefit Plan:

Beth Miller, Excellus BlueCross BlueShield

Ashley Masucci, ProAct



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

Pay Co-Pay

to Doctor



Billed to Insurer



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

DATE OF SERVICE	CODE	DESCRIPTION OF SERVICE	CHARGES	PAYMENTS	BALANCE
09/01/10	XXXXA	OFFICE VISIT 20 MINUTES	\$200.00	\$100.00	\$100.00
09/01/10	XXXXB	BLOOD DRAW	\$100.00	\$100.00	\$1.00
CURRENT	00-00 DAYS	00-00 DAYS	00-120 DAYS	120+ DAYS	AMOUNT DUE:
\$0.00					\$07.00

## 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

by Insurer/Admin.

Claim received



Discounted rate paid

to Medical Provider





PART VII

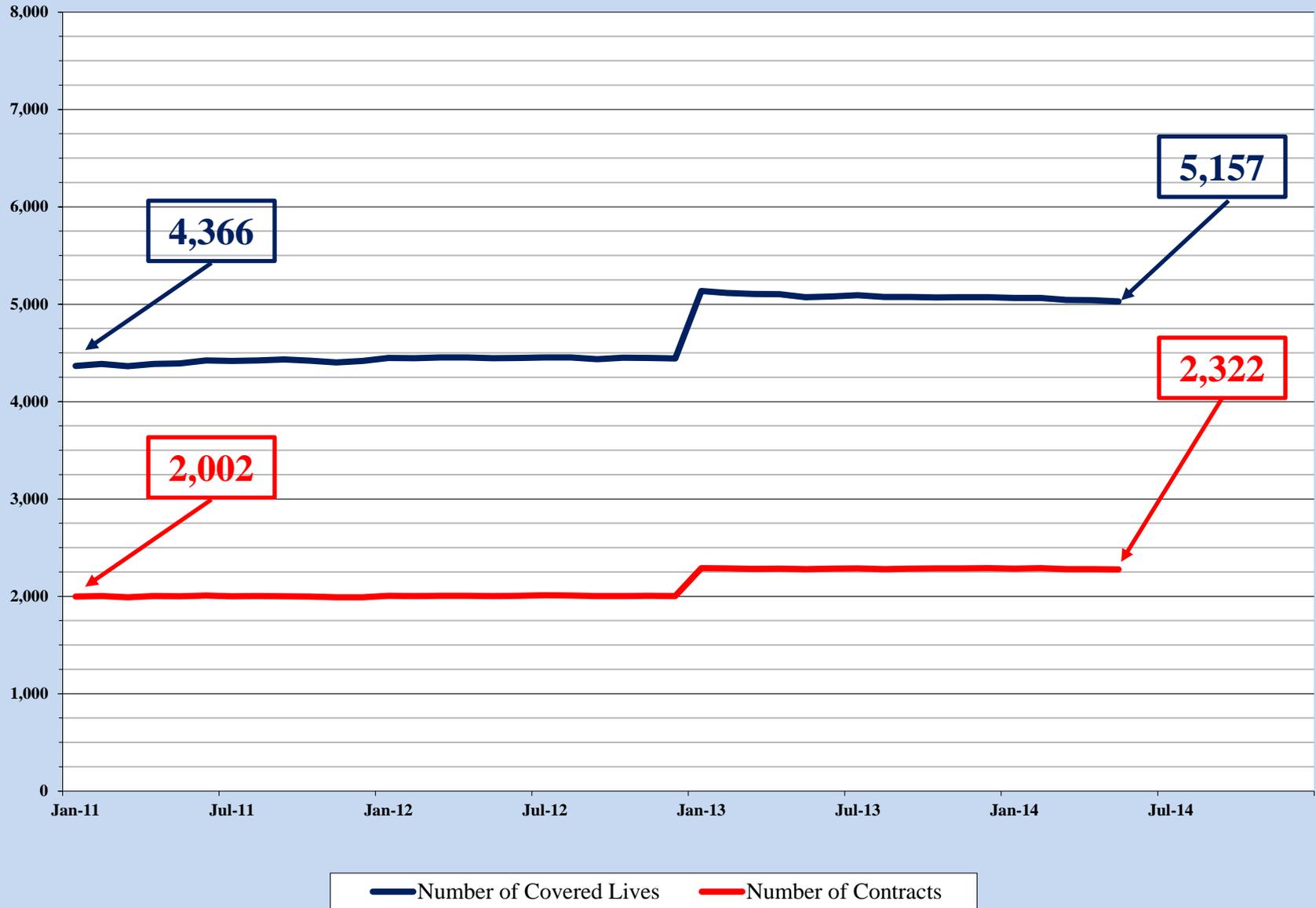
GTCMHIC Growing Larger & Stronger:

Steve Locey, Locey & Cahill, LLC

# Greater Tompkins County Municipal Health Ins Consortium

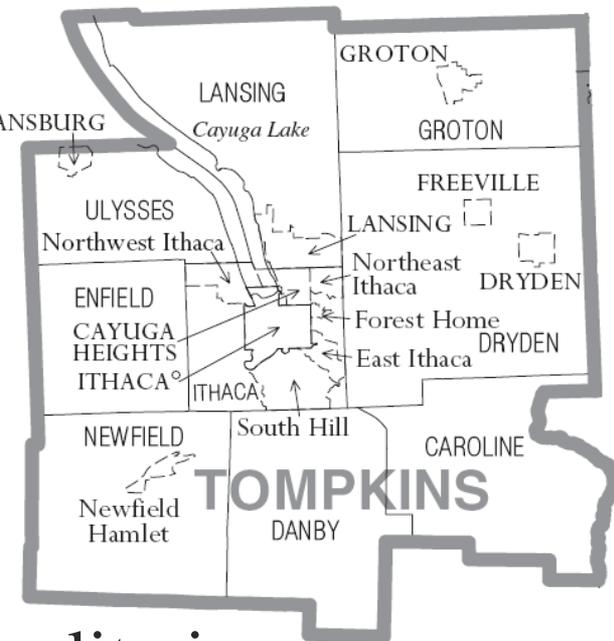
## 2011-2014 Monthly Covered Lives and Contracts

January 1, 2011 to June 30, 2014



# Who is in the Consortium?

Consortium membership was initially offered to each municipality within the geographical boundaries of Tompkins County which included the County, City of Ithaca, and thirteen Towns and Villages.



This has now expanded to any municipality in Tompkins County and the Counties contiguous to Tompkins County which includes any municipality in Cayuga, Chemung, Cortland, Schuyler, Seneca, and Tioga Counties.

# Current Consortium Members

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

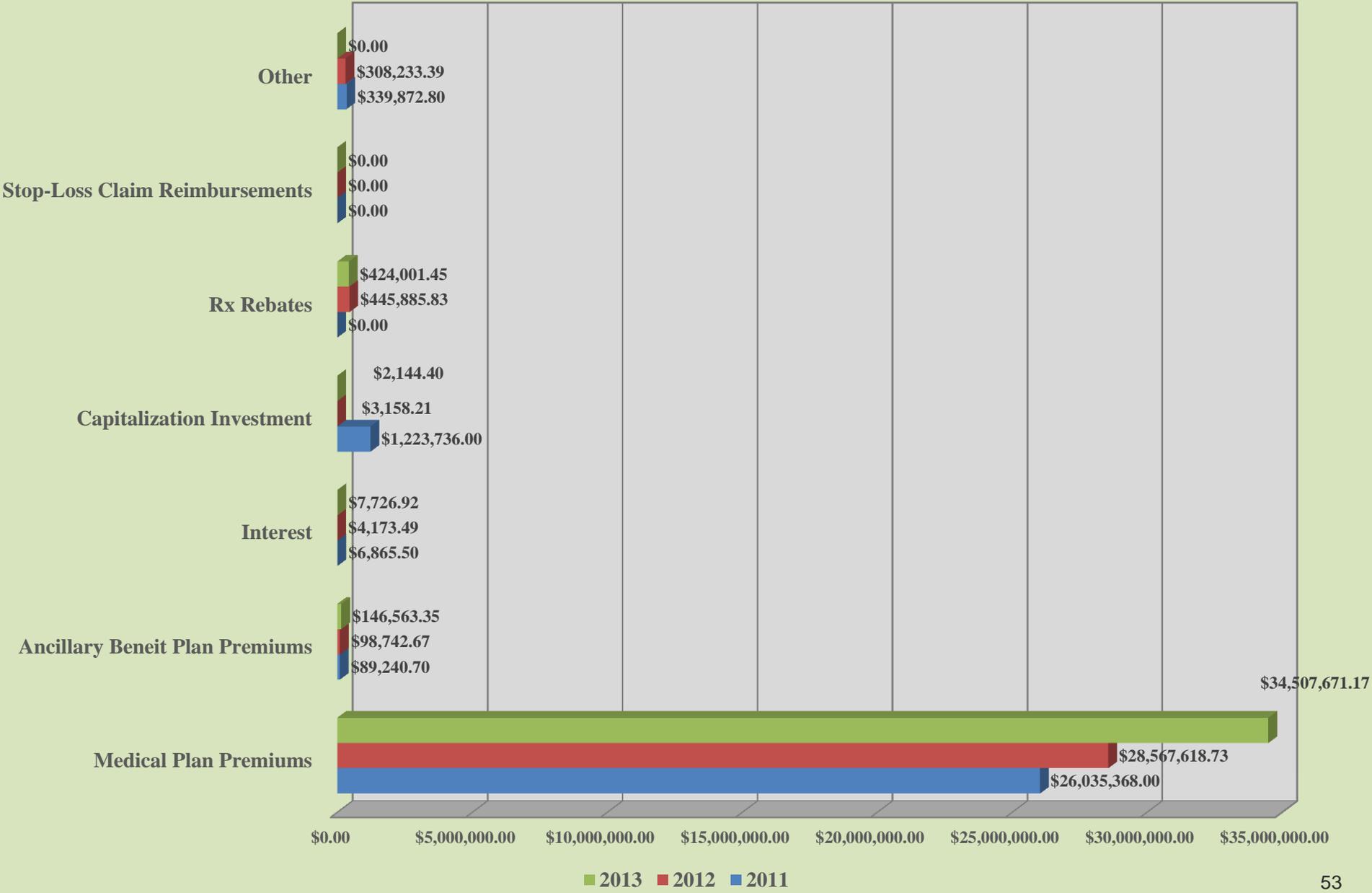
Village of Cayuga Heights

Village of Dryden

Village of Groton

Village of Trumansburg

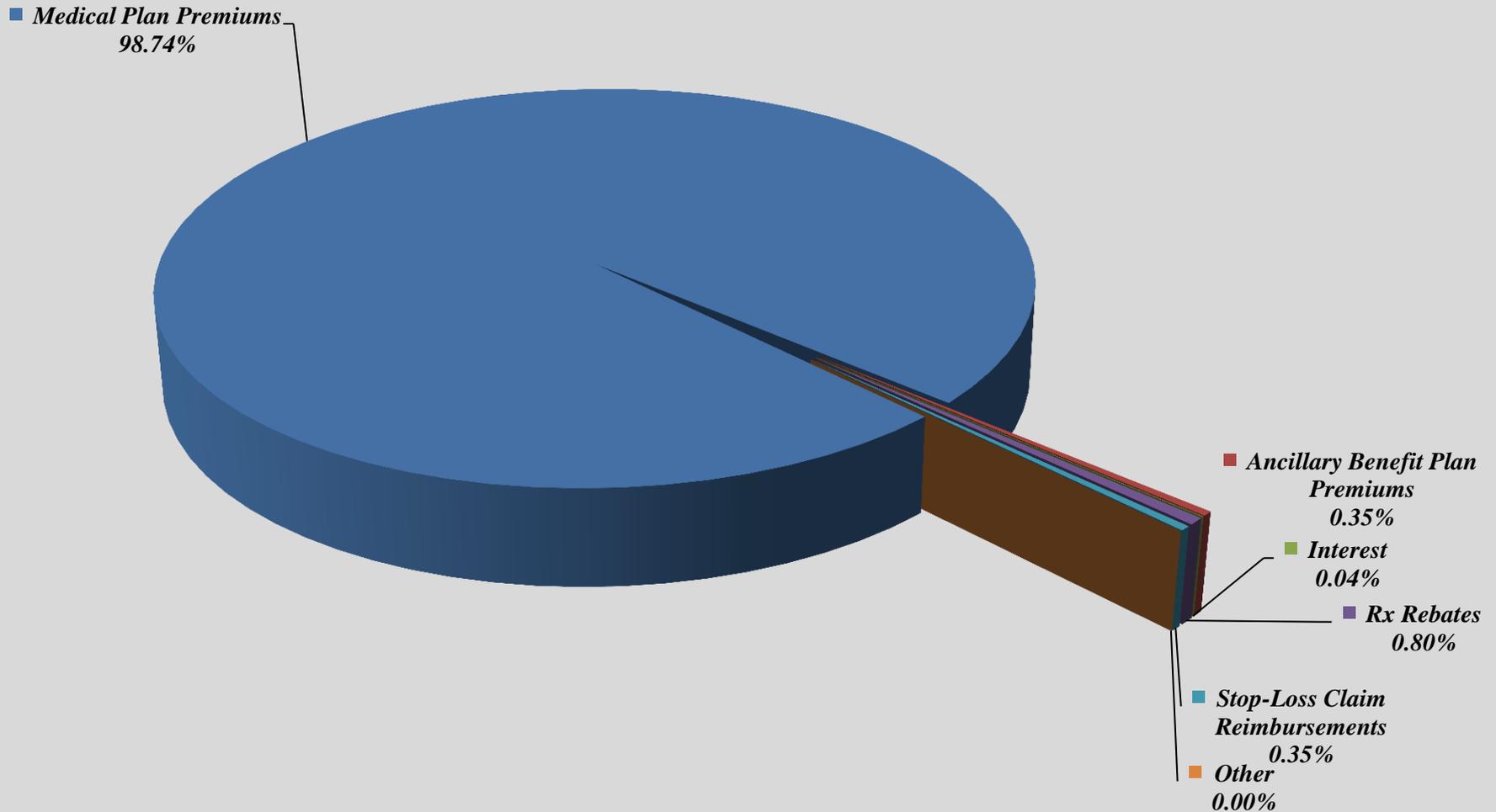
# Greater Tompkins County Municipal Health Insurance Consortium Income Distribution (2011 - 2013)



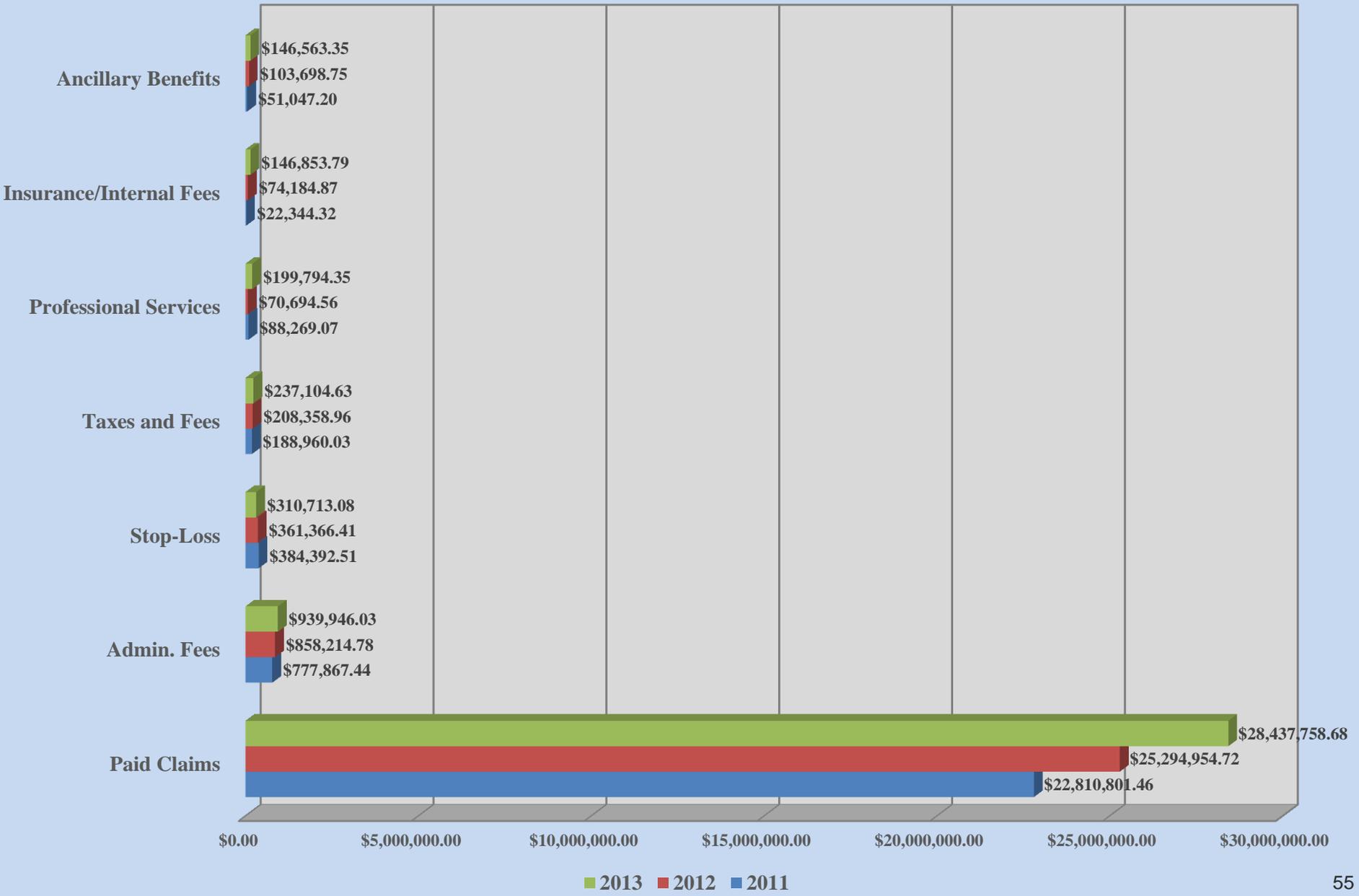
# Greater Tompkins County Municipal Health Ins. Consortium

## 2014 Income Distribution

January 1, 2014 to July 31, 2014



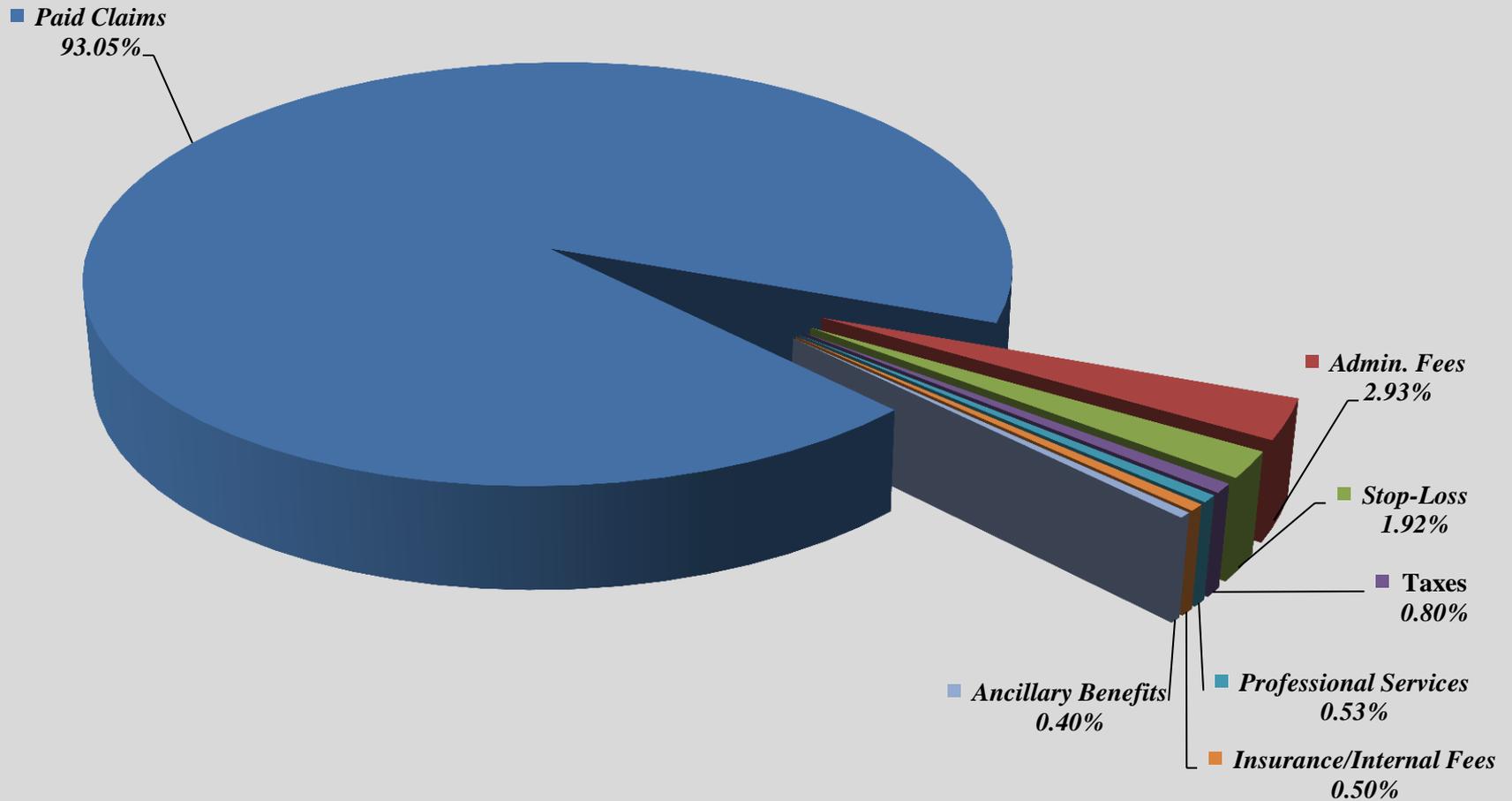
# Greater Tompkins County Municipal Health Insurance Consortium Expense Distribution (2011 - 2013)



# *Greater Tompkins County Municipal Health Ins. Consortium*

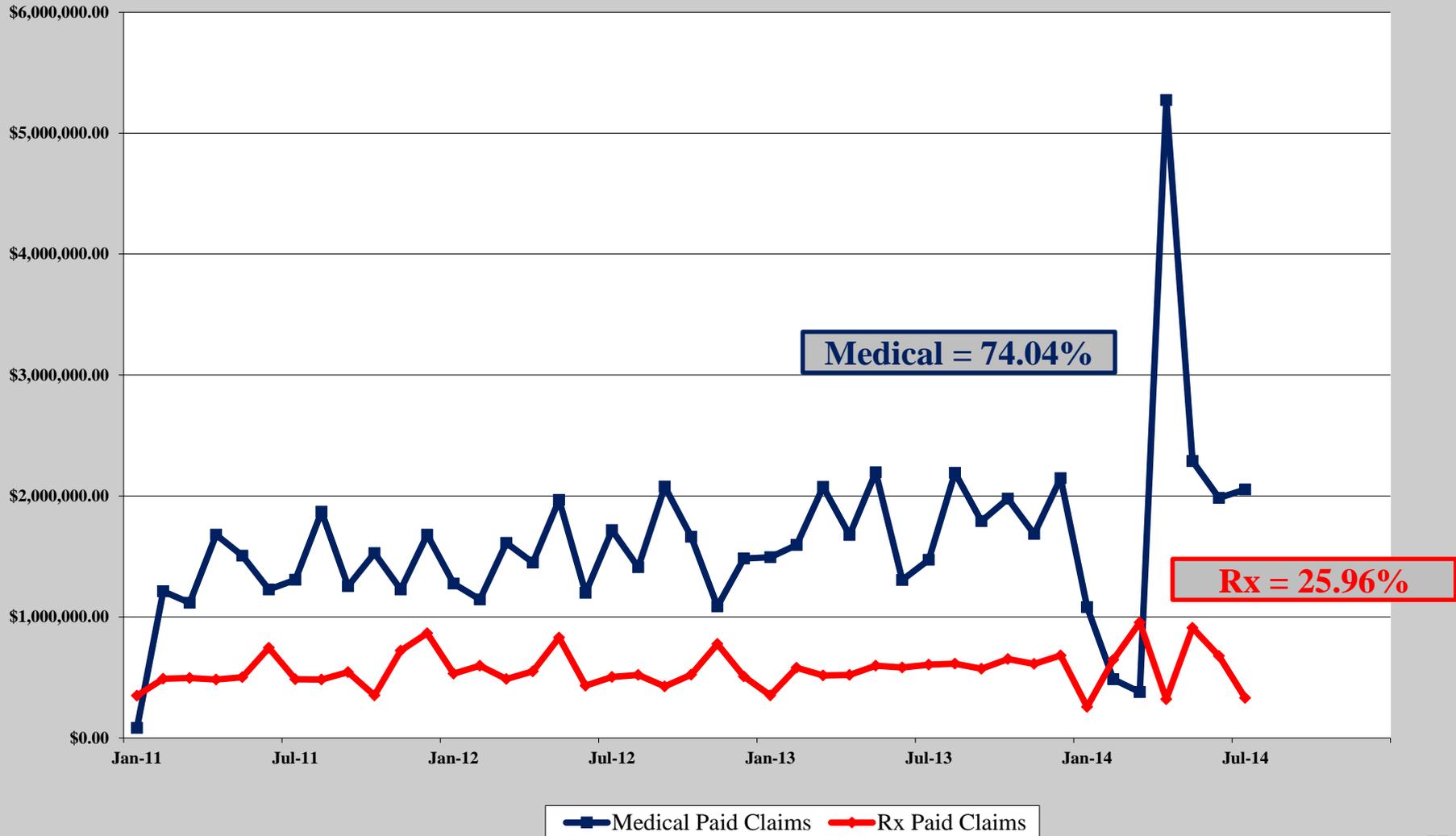
## 2014 Expense Distribution

January 1, 2014 to July 31, 2014



# Greater Tompkins County Municipal Health Insurance Consortium

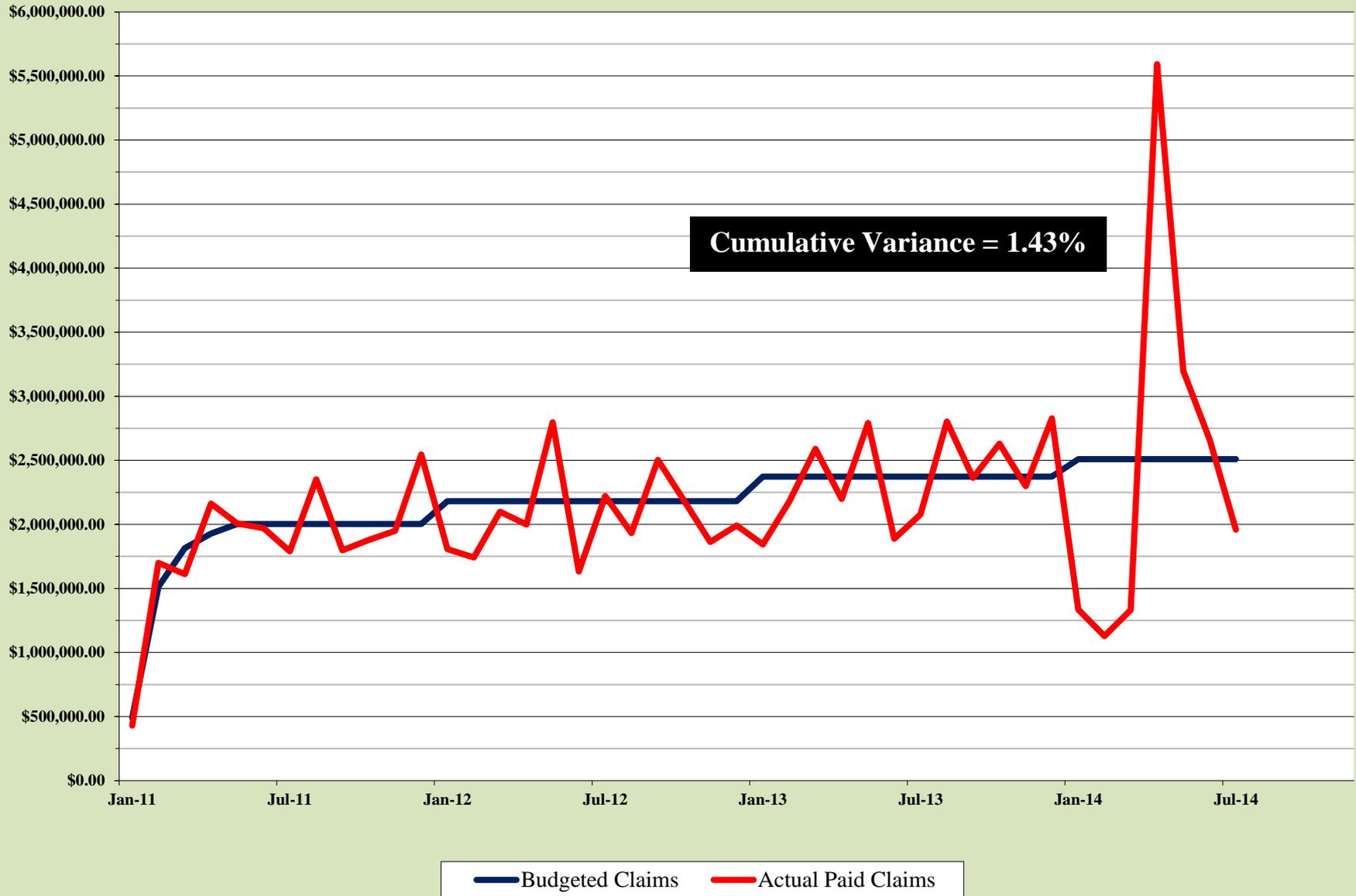
Monthly Paid Claims  
January 1, 2011 to July 31, 2014



# Greater Tompkins County Municipal Health Ins Consortium

## 2011-2014 Monthly Paid Claims v Budgeted Claims

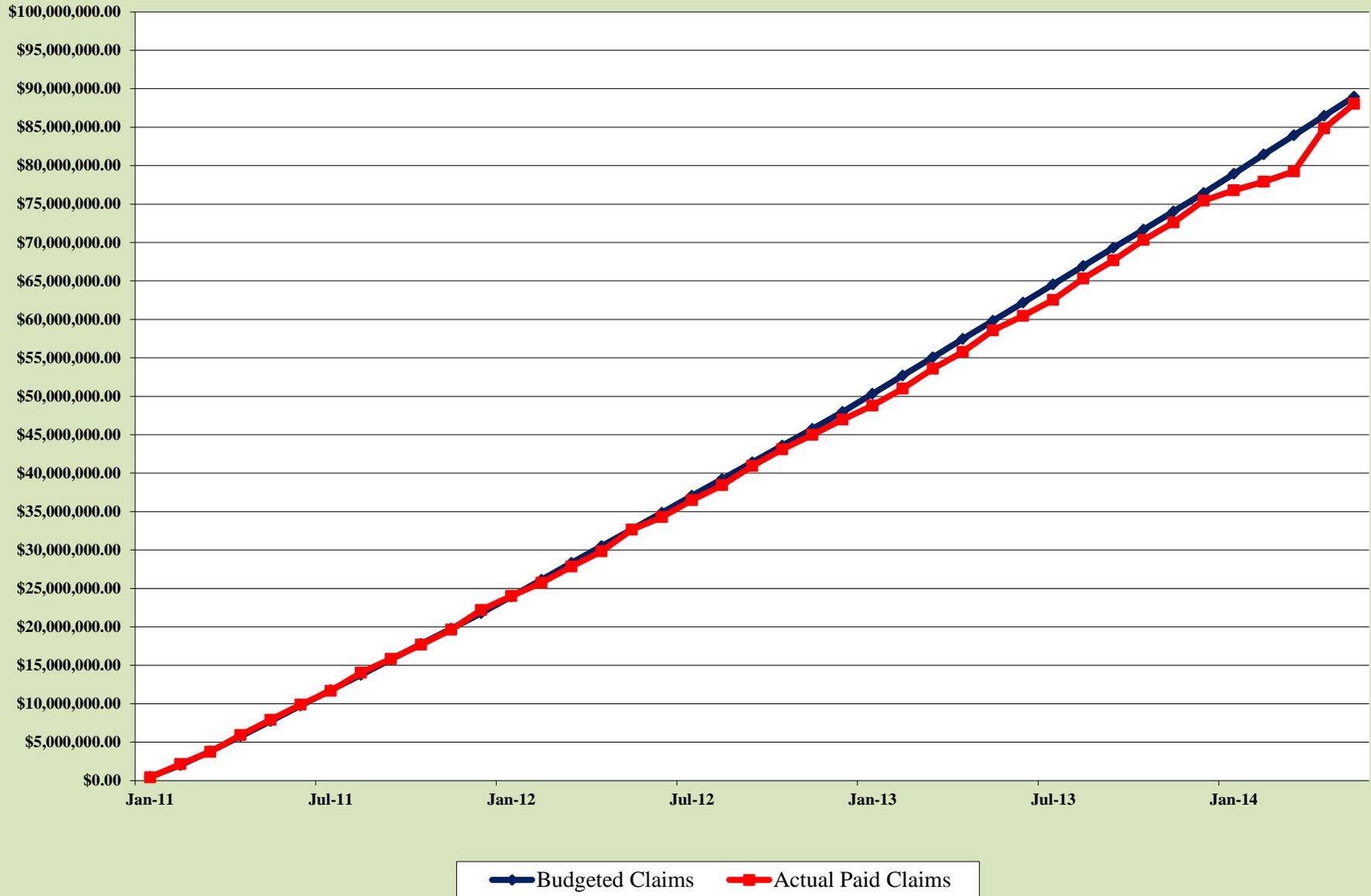
January 1, 2011 to July 31, 2014



# Greater Tompkins County Municipal Health Ins Consortium

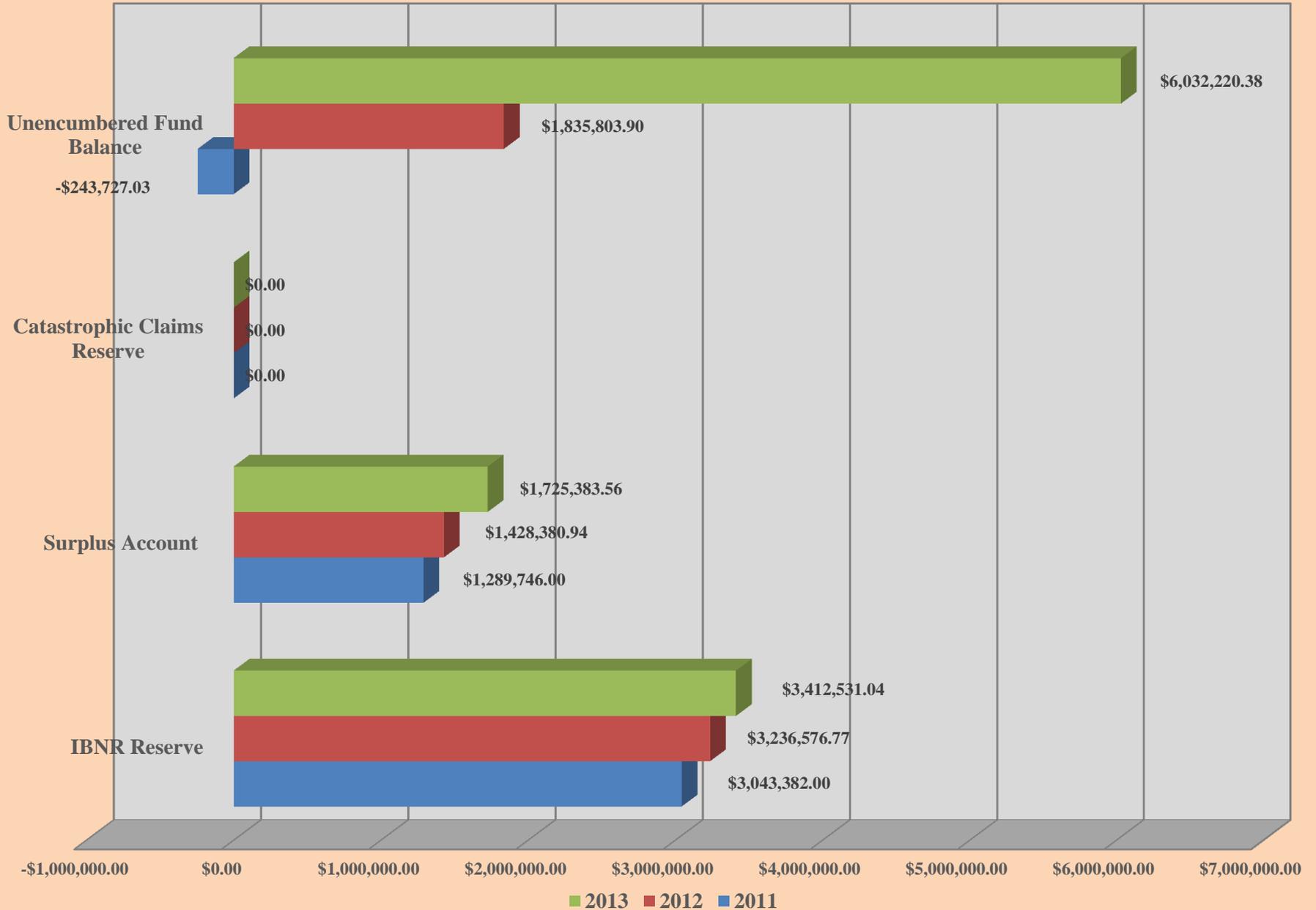
## 2011-2014 Monthly Paid Claims v Budgeted Claims

January 1, 2011 to July 31, 2014



# Greater Tompkins County Municipal Health Insurance Consortium

## Net Income (Fund Balance) Distribution (2011 - 2013)



# Greater Tompkins County Municipal Health Insurance Consortium

GTCMHIC Budget Income % Increase and Excellus Small Group PPO % Rate Increase

<i>Fiscal Year</i>	<i>Budget Income % Increase</i>	<i>Excellus BCBS Small Group HMO % Increase *</i>	<i>Excellus BCBS Administrative Fee</i>	<i>Excellus BCBS Administrative Fee % Increase</i>
<i>2011</i>	9.50%	10.00%	\$28.00	n/a
<i>2012</i>	9.50%	11.50%	\$29.12	4.00%
<i>2013</i>	9.00%	11.90%	\$30.43	4.50%
<i>2014</i>	8.00%	<b>ACA</b>	\$31.80	4.50%
<i>2015</i>	5.00% (estimated)	12.20%		
<i>Average Increase</i>	<b>8.20%</b>	<b>11.40%</b>		<b>4.33%</b>

\* Data Provided by New York State Department of Financial Services Reports for Excellus BCBS Small Group PPO Plans in the Syracuse New York Region.



# PART VIII

## Challenges – Today and Future:

Steve Locey, Locey & Cahill, LLC

Beth Miller, Excellus BlueCross BlueShield

Ashley Masucci, ProAct, Inc.

# Specialty Medications

## What are Specialty Medications?

*High cost oral or injectable medications used to treat complex or chronic conditions. These drugs are predicted to become more prevalent as treatment is moving more and more to an in-home setting for conditions requiring Specialty Medications.*

## 2013 Avg. Plan Cost Per Script:

***\$2,205.33***

## 2013 # of Specialty Prescriptions:

***804 Scripts for 110 Members***

## 2013 Avg. Member Cost Per Script:

***\$13.10***



# Specialty Medications

**Where can members have specialty medications filled?**

At any in-network Specialty Pharmacy. ProAct is partnered with Noble Health Services, a Specialty Pharmacy located in New York State.

**Example conditions that may require Specialty Medications:**  
Hepatitis B and C, Rheumatoid Arthritis, Anemia, HIV, Cancer, Multiple Sclerosis

**Why Fill your Specialty Medication at Noble?**

24 hour clinical support, Free educational materials, Free ancillary Supplies, Home Delivery

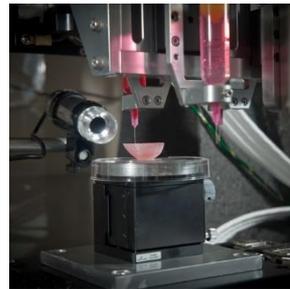


# Medicine of the Future

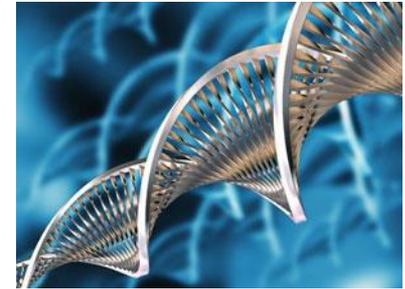
Universal Electronic  
Medical Records



3D Printing of Prosthesis  
and Exoskeletons



Genetic Engineering  
Genome Sequencing



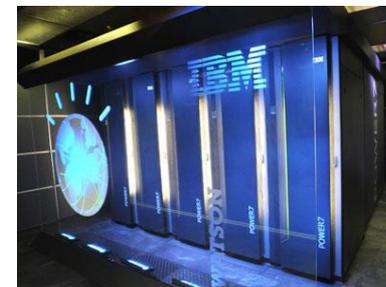
Greater Use of Robotics  
(e.g., Prosthetics)



Electronic  
Diagnostics and  
Remote Treatment



Diagnostic Artificial  
Intelligence



# ACA Key Mandated Benefits

## 2014 Changes

- ❖ Individual Mandate to Purchase Insurance
- ❖ Health Insurance Exchanges
- ❖ Premium and Cost Sharing Subsidies
- ❖ Employer Requirement to Offer Coverage
  - ❖ *Delayed Until January 1, 2015*
- ❖ Wellness Rewards (30% to 50% of Premium)
- ❖ Fees on Health Insurance Sector

# ACA “Metal Levels”

## Affordable Care Act Metal 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 or “metal levels” based on their Actuarial Value (AV):

- ❖ Platinum Plan Models      Actuarial Value (AV) > or = to 90%
- ❖ Gold Plan Models          Actuarial Value (AV) > or = to 80%
- ❖ Silver Plan Models        Actuarial Value (AV) > or = to 70%
- ❖ Bronze Plan Models        Actuarial Value (AV) > or = to 60%

# ACA Taxes and Fees

- ❖ **Patient Centered Outcomes Research Institute (PCORI) Trust Fund Fees:**
- ❖ **Transitional Reinsurance Program Fees**
- ❖ **Cadillac Tax – Excise Tax on High Cost Plans**

# ACA Taxes and Fees

## *Patient Centered Outcomes Research Trust Fund Fees:*

This provision of the Affordable Care Act requires all health insurance plans, including self-insured plans, to pay a fee to the Federal Government to fund the development of a not-for-profit organization which will do research to evaluate and compare the health outcomes and the clinical effectiveness, risks and benefits of certain medical treatments, services, procedures, drugs and other techniques that will help treat, manage, diagnose, or prevent illness or injury. These research fees start with the plan or policy years ending on or after September 30, 2012, and ends with plan years or policy years ending before October 1, 2019.

The fee for the 2013 Fiscal Year of the GTCMHIC was \$2.00 per covered which totaled \$10,178.00 for the year. Said fee was paid prior to July 31, 2014 as a one time payment utilizing the IRS Form 720. This fee increases by an inflationary escalator yet to be determined for the 2014 Fiscal Year which is due on July 31, 2015 and each year thereafter through the 2018 Fiscal Year.

# ACA Taxes and Fees

## *Transitional Reinsurance Program Fees:*

The Affordable Care Act creates a temporary (2014 to 2016) reinsurance program which will require the Federal Government to collect payments from health insurers to provide payments to plans, both inside and outside the Health Insurance Exchanges that incur high claim costs from enrollees. This program was established by the Affordable Care Act to help the Health Insurance Exchanges and insurance carriers keep premiums affordable. The assumption is that covered members of these plans will present a greater risk of claims cost as it is believed that many have not been receiving regular medical care. The result is a patient pool with a greater likelihood to have chronic and catastrophic medical conditions. Based on current estimates, these fees will equal approximately \$5.25 per covered life per month (\$63.00 per year). For the GTCMHIC this fee will cost the Consortium approximately \$320,000 for the 2014 Fiscal Year. Self-insured plans like the GTCMHIC are only required to pay this fee in the first year while fully-insured plans have to pay this fee for three years.

# ACA “Cadillac Tax”

Effective January 1, 2018

- ❖ Tax on High-Cost Medical Insurance Plans
  - ❖ ACA 2018 Limits:
    - ❖ Individual Coverage = \$10,200
    - ❖ Family Coverage = \$27,500
  - ❖ Excise Tax = 40% of Each Dollar Over Limit
  - ❖ Applies to aggregate expenses of employer-sponsored health insurance plans which based on our current understanding will include the actuarial value of a Health Reimbursement Arrangement (HRA), if offered by the employer.

# County of Tompkins

## Affordable Care Act "Cadillac Tax" Impact Analysis

<i>County of Tompkins CSEA PPO Plan</i>								
<i>Fiscal Year</i>	<i>Monthly Premium</i>		<i>Annual Premium</i>		<i>"Cadillac Tax Threshold"</i>		<i>Excise Tax Per Contract Per Year</i>	
	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>
<b>2014</b>	\$734.04	\$1,608.75	\$8,808.48	\$19,305.00	n/a	n/a	n/a	n/a
<b>2015</b>	\$792.76	\$1,737.45	\$9,513.16	\$20,849.40	n/a	n/a	n/a	n/a
<b>2016</b>	\$856.18	\$1,876.45	\$10,274.21	\$22,517.35	n/a	n/a	n/a	n/a
<b>2017</b>	\$924.68	\$2,026.56	\$11,096.15	\$24,318.74	n/a	n/a	n/a	n/a
<b>2018</b>	\$998.65	\$2,188.69	\$11,983.84	\$26,264.24	\$10,200.00	\$27,500.00	\$713.54	\$0.00
<b>2019</b>	\$1,078.55	\$2,363.78	\$12,942.55	\$28,365.38	\$10,200.00	\$27,500.00	\$1,097.02	\$346.15

<i>County of Tompkins CSEA Indemnity Plan</i>								
<i>Fiscal Year</i>	<i>Monthly Premium</i>		<i>Annual Premium</i>		<i>"Cadillac Tax Threshold"</i>		<i>Excise Tax Per Contract Per Year</i>	
	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>
<b>2014</b>	\$744.09	\$1,612.67	\$8,929.08	\$19,352.04	n/a	n/a	n/a	n/a
<b>2015</b>	\$803.62	\$1,741.68	\$9,643.41	\$20,900.20	n/a	n/a	n/a	n/a
<b>2016</b>	\$867.91	\$1,881.02	\$10,414.88	\$22,572.22	n/a	n/a	n/a	n/a
<b>2017</b>	\$937.34	\$2,031.50	\$11,248.07	\$24,378.00	n/a	n/a	n/a	n/a
<b>2018</b>	\$1,012.33	\$2,194.02	\$12,147.91	\$26,328.24	\$10,200.00	\$27,500.00	\$779.17	\$0.00
<b>2019</b>	\$1,093.31	\$2,369.54	\$13,119.75	\$28,434.50	\$10,200.00	\$27,500.00	\$1,167.90	\$373.80

### Assumptions:

1. 2014 Actual Premiums
2. 8% Annual Premium Increase (2014/2015 to 2018/2019)
3. Threshold = \$10,200 Individuals and \$27,500 Families

# Future Expectations

The past can be a great predictor of the future. As a result, we expect these items to impact health insurance coverages and costs as we move forward

- ❖ Medical Care Inflation
- ❖ Advancements in Medical Technology
- ❖ Advancements in Pharmaceuticals
- ❖ Federal and State Mandated Benefits
- ❖ Taxes and Fees



# PART IX

Summation and Q&A Period:  
Don Barber, GTCMHIC Executive Director

# Closing Thoughts

- ❖ We, the GTCMHIC, are unique in the health insurance marketplace.
- ❖ Article 47 provides Labor with opportunities not found in other insurance models.
- ❖ As an insurance company and patients, we have unique opportunities to manage our future.

# Closing Thoughts

- ❖ We have a responsibility to provide security for one another by keeping the GTCMHIC financially strong and viable.
- ❖ We have an obligation to one another to use our health insurance wisely by making choices based the best care available at the most reasonable price.
- ❖ Our insurance is our safety net, let's work together to keep it strong.







# GTCMHIC RETREAT

Education Retreat of the:  
Greater Tompkins County Municipal  
Health Insurance Consortium  
September 15, 2014