Minutes
Greater Tompkins County Municipal Health insurance Consortium
Finance Committee
March 27, 2013 – 1 p.m.

Approved 4-18-2013

Present: Don Barber, Liz Karns, Mack Cook, Jared Pittman
Excused: Glen Morey
Staff and guests: David Squires, Jerry Mickelson, Joe Mareane, Michelle Pottorff

Call to Order

Mr. Barber called the meeting to order at 1:04 p.m.

Approval of Minutes of February 22, 2013

It was MOVED by Ms. Karns, seconded by Mr. Cook, and unanimously adopted by voice vote by members present, to approve the minutes of February 22, 2013 as submitted with Mr. Pittman abstaining.

Draft JURAT

Mr. Barber reported Randy Shepherd of the Bonadio Group has provided a copy of the draft JURAT report and has asked that comments be submitted prior to April 1st. He will be meeting with the Department of Financial Services prior to the filing to make sure it is in proper order. Mr. Locey spoke to the way the form was developed and said this report has nothing to do with a municipal cooperative benefit plan; it is designed for an insurance company. He said the State treats the Consortium like it is an insurance company and many of the same factors do not apply.

Other Business

Mr. Squires announced the person in the Finance Office who handles the billing for the Consortium will be retiring at the end of April and he will be taking over those responsibilities until a permanent replacement is found. He also reported that the Board will be receiving information tomorrow that will show that the income for the Consortium that has been reported is substantially below budget. This is because there has been a problem with the billing process through the County. Because of delay in posting a payment the Consortium's cash position for February is about $3 million below where it should be. He said although there is still an issue with the TC3 payment, the County's payment issue has been resolved. Mr. Locey said a meeting will take place after this meeting to resolve the issue so that each entity can directly get a bill and be provided with its specific enrollment information.

Budget Preparation Overview

Mr. Barber said in the very near future the Committee should be looking at the budget and looking at what things are assumed, what is known, data estimates, and premium equivalent rates.

Mr. Locey distributed several documents. He said everything associated with the Consortium from a financial standpoint starts with the budget, including the development of the premium equivalent rates. First, there needs to be an understanding of what the Consortium's

liabilities and expenses are and how much revenue needs to be generated in a given year. Once this information is developed it dictates the premium. In terms of the premium from the Consortium's perspective the rates are a way for the Consortium to gather its revenue. The premium equivalent rates are created and billed to the entities so that they can charge their employees and retirees. Mr. Locey provided a line item comparison from 2011 to 2012 of the line item budget items. The document may be expanded to include new taxes associated with the Affordable Care Act and a break-out of revenue items.

There are a number of revenue sources, the premium revenue being the largest portion. On an annual average basis the premium accounts for approximately 95% of the total revenue. The ancillary benefit premiums are only a pass-through. Mr. Squires reiterated his previous recommendation that the Consortium no longer handle these. *Mr. Barber said he doesn't think this would be a big issue and suggested Mr. Squires offer the Board of Directors a recommendation.* Mr. Squires said he would suggest setting up a different bank account and handling these outside of the Consortium's finances. This would also eliminate the requirement to report this information to the New York State Department of Financial Services. Mr. Locey said the original capitalization investment and the associated interest is also recorded as interest income on reserve funds. Included in "other" are prescription drug rebates and Stop Loss insurance recoveries.

On the expense side, medical and prescription drug claims are "hard" numbers, however, there is an expected deviation due to different illness patterns, different people covered, and different mandates. The Admin. Fees, NYS Graduate Medical Expense, and Stop Loss Insurance are fairly predictable. The legal fees is a soft number built in just to have funds to cover a lawsuit, claim appeal, or something that comes up concerning a plan document where a legal opinion is needed. The remaining fees, such as consultant fees, audit fees, insurances, internal coordination, and surety bond fee/loan interest collectively total less than ¼ of a percent of the Consortium's expenses. The Advance Deposit to Excellus was a large one-time payment that is incrementally increased each year. The total balance is to equal two weeks worth of paid claims; therefore, the increase from year-to-year is the difference and is based on the value of claims. Mr. Locey said the money is sent out as if it were an expense but it sits at the Blues in an account; therefore, it should be considered as an asset of the Consortium. Mr. Barber said the Bonadio Group is working this out with the Department of Financial Services.

Mr. Barber said two critical numbers on the document are the paid medical and paid prescription drug claims and asked for an explanation of how these numbers are determined. Mr. Squires said medical claims are electronically paid bi-weekly to Excellus. He said the claims fluctuate depending on whether there are four or five weeks in a month. The prescription drug billing is bi-weekly and one of those cycles includes an administrative charge; this can also fluctuate as there are three cycles in some months as opposed to two.

Mr. Locey said expenses are benefit-driven as claims are approximately 95% of the budget. He provided information showing the relationship of medical claims versus prescription drug claims and noted a couple of items relative to the trend of both. Historically prescription drug claims have been trending faster than medical claims; however it has slowed over the past year, mostly due to there being a lot of highly utilized drugs that are now available in a generic

form and also because drug claims are much more predictable from month to month as they are mostly maintenance-type drugs being used.

Mr. Locey provided information on how Locey and Cahill analyzes and trend paid claims data in terms of the budget. He reviewed how claims are analyzed and said the medical claims tend to fluctuate much more and has to do with timing of payment and severity of claims. The medical claims make up approximately 72.4% of the total and the prescription drug claims make up about 27.6 percent of the total aggregate expense. In addition, Locey and Cahill is looking at the data to analyze trend information, noting the Consortium is still fairly immature and there have been some big changes in terms of census since it first started. He said the trend of growth (without the City of Cortland and Town of Lansing) from April, 2011 to December 31, 2012 was showing at 3.19%. This is slightly lower than what they are seeing with other municipal groups they work with which is about 6%. The information for those groups is also based on around six years of experience, whereas the Consortium's information is based on a much shorter time. He said this has to be estimated realistically, yet conservatively. In terms of contract count, approximately 200 family and 100 individual contracts were added by the addition of the City of Cortland and the Town of Lansing.

Mr. Locey said once a budget is finalized they begin to develop premium equivalent rates and provided information on indemnity plans versus PPO plans showing the monthly paid claims by covered life for plan type. He explained the difference between the two plans, stating an indemnity plan is an older style health insurance plan that includes paid-in-full medical, hospital, surgical and everything that falls into the major medical category are subject to a deductible co-insurance. With most indemnity plans the major medical claims account for less than 15% of the total claims. A PPO plan is different in that instead of a deductible and co-insurance, a co-pay is paid when a person goes to a physician's office; all of the other elements are fairly similar in terms of the underlying benefit. The variance between an indemnity plan and a PPO in the public sector is nominal.

Once the budget is done the premium equivalent rates are developed. They include two segments: medical broken out between PPO and Indemnity, and drug. By separating these it provides an understanding of the financial impact when negotiating. Looking at the population that is covered they come up with a base which is an average cost per covered life for all the expenses of the Consortium. From there they begin applying variables, such as going from individual to family, variances in benefit and different copay levels. Once the variances are set they go back and look at them periodically but they do not look at them regularly. In a community rated environment they cannot charge one group more than another based on risk, charges have to be based on benefits covered under a plan. Mr. Locey said the factor for the Consortium in determining covered lives for family rates is 2.4 times.

Mr. Barber summarized the process, stating that Mr. Locey builds the budget and then looks at the number of covered lives and this sets the base rate. Benefits factors and variables are then applied. *Mr. Barber said it would be helpful if after Mr. Locey went through the process of determining premium equivalent rates if he could explain what went into the process.*

Medicare Supplement

Mr. Locey distributed additional information and stated they looked at data relative to the Medicare-age population. He noted that although they are working on this, the information provided is not broken out between Medicare-age retirees and Medicare-age actives. He said the breakout of the drug data is not relevant because Medicare does not cover drug expenses. On the medical side, however, there is a big difference. The information broken out demographically in different age bands and Mr. Locey noted that the age 45 to 64 age group is predominantly the most expensive age group. The other group that is very expensive is the age 0 to 1 because of premature births, at-risk births, etc.

With the over age 65 population the bulk of the expenses are for prescription drugs. In 2012, however, there must have been an over age 65 active who had significant claims as the medical expenses appear very high. When this has been done in the past and the Medicare age population has been separated into retired versus active they typically have found their drug expenses to be approximately $4,000 per covered life and their medical expenses less than $1,000. In aggregate they are in the $4,500 to $5,000 range which is comparable to the overall average.

Mr. Locey stated the complexity in trying to come up with different rates, such as a Medicare supplement or a two-person rate is that if premiums change for one group and expenses stay the same the revenue has to be made up somewhere else. He said another complexity is that there are many different plans and many different contribution rates and trying to come up with one global solution is very complicated.

Mr. Barber said his interpretation from the information presented is that the costs for the over age 65 population is close to what the cost is for the average population; therefore, the retirees are not subsidizing the plan. Mr. Locey said that is correct and what they are finding in most of the analysis they are doing. He stated there is a huge drop off in the medical costs for this population when Medicare becomes primary but they are only dropping down to the costs of the average age population because the drug costs are significantly higher. Mr. Barber asked how the private sector is providing a Medicare supplement and if they are providing prescription drug coverage. Mr. Locey said many private sector employers do not provide coverage to retirees, they do not provide prescription drug coverage, or they receive the Retiree Drug Subsidy to offset some of the retiree costs. The Medicare Advantage program receives money from the federal government to subsidize the plan they are providing because it is in lieu of Medicare. Mr. Locey said it has been rumored that part of balancing the State Budget is going to include a sharp decrease in the amount of funding for Medicare which is going to impact Medicare Advantage plans and will ultimately raise premiums and lower benefits.

Stop Loss and Reserving

Mr. Locey distributed information on the Annual Aggregate Stop Loss Insurance. The first document displayed information on what Locey and Cahill evaluated in 2013 for Stop Loss insurance. There are two types of Stop Loss insurance, one is Specific and covers individuals and Aggregate covers the entire population. Under Specific, if an individual exceeds the

deductible level the claims are paid and submitted to the Stop Loss carrier for reimbursement to the Plan. On the Aggregate side the insurance company sets the expected claim cost for the entire population and there is an attachment point. For the Consortium it is 125% of expenses above claims costs; if the Consortium reached that number it would reimburse the Consortium for everything above that. Most of the Consortiums they work with do not purchase Aggregate; the Consortium purchases it only because it is mandated to. He said this costs the Consortium approximately $40,000 and will likely never be used as it would mean the budget would have been off by 25% in a given year. Also, the coverage is minimal as it only provides $1 million once the operation goes beyond the attachment point.

Mr. Locey also distributed a history of what Stop Loss insurance has been purchased for 2011-2013 that showed three members had claims that exceeded $200,000 in 2011 and 5 in 2012. Total eligible reimbursements in 2011 were $146,000 and $976,000 in 2012.

Mr. Locey said in terms of integrating the drug reporting with the medical reporting, Excellus is taking in the data from the drug company for anyone who exceeds $10,000 in drug expenses for the year.

Next Meeting

Mr. Baber said the Bonadio Group will be meeting with the Audit Committee on April 18th and recommended that this Committee join them as it will be a good time to go through the 2012 financials. He suggested the Committee also discuss the 2014 budget and a process to pay back the Capitalization Reserve. Mr. Barber also noted that the Department of Financial Services views the Consortium's reserves as being at the very minimum level and there should be discussion of what the Consortium's goal is for those levels.

Adjournment

The meeting adjourned at 2:31 p.m.