Minutes of the Advisory Health Benefit Committee Meeting of March 20, 2012 at the District Office, Minden, Nevada

Committee Members Present	**Absent**
Dwight Langdon, DCBDA	Marie Parola, DCSSO
Larry Lipmann, DCPEA	
Christine Cooley, DCPEA	
Andrew Frohmdahl, DCPEA	
Shannon Brown, DCAA	
Diana Schefcik, DCSSO (Replacement for Tami Beckett)	
Holly Luna – District Office	

Also present at the meeting were Roger Olsen and Lloyd Barnes with LP Insurance Services, and Windy Culver-Molezzo with Hometown Health. One member of the public was in attendance. Meeting began at approximately 4:10pm.

Roll call of members and external representatives was taken. The committee members adopted the Agenda. There was no public comment.

Consent Items: The minutes of the Regular Meeting of February 21, 2012, were brought forth for adoption. Andrew requested clarification regarding attendance indicating that Christine Cooley was not noted. With that stated as a correction, adoption of the minutes was motioned by Andrew Fromdahl, seconded by Shannon Brown, and adopted 7-0.

Claims Review: Roger Olsen, LP Insurance Services, reviewed the month of January's self-funded plan cost analysis data for the month of February.

Exhibit 1: Net paid claims for the month of February were $462,070. On a composite basis the average monthly claims cost per employee for February was $604.80, compared to previous monthly average of $558.70, as opposed to last year's monthly average 632.29, resulting in claims being down by 11.64%. Composite cost per member, including dependents is $423.53 for February, year to date cost per member is $390.98, compared to the previous year cost of $443.88, down 11.92%.

Exhibit 3: Total plan costs for the month of February were $520,074. Composite plan cost per employee for February was $680.73; for the plan year to date: $635.61, compared to last year costs of $712.53, resulting in a decrease of 10.76%. Per member composite costs are down 11.1% from $500.00 to $444.50.

Exhibit 5: Total Hospital Admits current monthly average is 6 month, vs. last year at 6.17, the number of hospital days were down to 10.5 vs. 18.33 last year. Average length of stay is down from 2.97 to 1.75. Cost per stay down from $12,233 to $8,545; however, the cost per day rose from $4,115 to $4,183. Allocation of various categories: Treatment is in line with last year, but will see variations as we are only in the second month of the year. An example is in-patient hospital this year is only 12%, last year was 15%. All other is 10% as last year was 5%. LP expects that amounts should level off as the plan year continues. Larry Lipmann clarified that hospital was in-patient or out-patient, and Lloyd explained they are separated on the report.

Exhibit 6: This report tracks any claims over $87,500. However, there is one claim that is being processed for $50,513, which Roger felt was mentionable.

The last two Exhibits provided shows incurred but non-reported (IBNR) claims liability at $756,898 as of February 29th, 2012. For comparison purposes, corresponding figure for last month was $760,370, showing little movement.

Dwight asked if the lower claims cost is due to employees not yet meeting their deductibles. Lloyd explained it could affect the figures by roughly one to two months. Roger explained the graphs show we are slightly lower than last year, but really considered similar.

Discussion then ensued as to the number of stays or admits, jumping from one in January, to 11 in February. Roger and Lloyd explained that there is time involved in processing the claims, and that date is the date the get logged under, meaning that January's number may have come from December events, etc.

Hometown Health Statistics Review: Copies of the "Claims Turnaround Time Report" and "Hometown Health Customer Service Department Stats" were provided by Windy Culver-Molezzo, Hometown Health. The Turn Around Time report shows that of 1165 claims, 1,065 were paid by month's end, leaving 199 claims remaining open. 994 Claims were paid within 15 days. 66 Claims were paid within 16 – 30 days and claims that extended past 30 days totaled 5.

Customer Service accepted 6,415 calls in the month of February, answering 6,103. Average seconds to answer a call were 45 seconds, increasing due to a higher volume of calls with the start of a new year. Those answered within 120 seconds were at 84%, where HHP aims for 100%. The Abandonment rate was 4% in January and 5% for February. Industry standard is 7%, but HHP strives to keep it less than that. It was asked if staffing is appropriate considering the expectations during these peak times, and Windy answered that the training of the representatives is a lengthy process, with high standards, before a representative can even take their first real call. Andrew asked if the total calls were from members, or did they include physician calls. Windy answered that these are all member calls. Christine Cooley asked how many claims continue from month to month. Windy explained she receives a report weekly that shows open claims, and the reasons they are being held (i.e.: subrogation, additional information requested from provider, etc.), and that it's a protection mechanism of our plan to review claims that seem odd at a deeper level. Weekly audits are performed by various departments to ensure claims are being resolved.

Summary of Benefits and Coverage Form: Holly Luna received a notification from LP with regards to the Health Care Reform Act and the requirement to implement the "Summary of Benefits and Coverage" (SBC). Holly asked LP to provide an overview of the legislated impact of this to DCSD's self-funded health insurance plan. LP indicated that they had employed Windy as a resource to prepare the overview. New regulatory requirements require plans to have a standardized format of communicating standardized summary of benefit that must be implemented by next year communicating a summary of the benefits options to the participants.

As a consumer, this regulation is a great resource as a participant in comparing plans, making plan changes, and more. Currently, implementation was to begin as of March 23, 2012. However, this has now been extended to September, and the timeline is still tentative. The document is a lengthy and intensive to prepare, but HHP has already begun working on the template, and utilizing the commercial side adoption first which will ease the adoption of self-

insured plans' summaries at a later date. If possible, it may be implemented earlier to assess feedback and note where improvements or greater clarification can be made to the template. Formatting requirements are very detailed, such as page count and font size. The TPA is working to comply with these regulations.

Windy provided a sample document to use as a visual aide to the following discussion. This document has to cover items summarizing key features of benefits, including benefits coverage, limitations and exceptions to the coverage, cost sharing provisions, renewability and continuation provisions, premium costs, deductibles, exclusions, contact information, and glossary of terms. What is included, what's not included is more easily communicated to the normal person who is unfamiliar with insurance. The document also requires three coverage examples: having a baby, treating breast cancer, or managing diabetes. These requirements are a minimum, and there are three different formats available to use. It's also wise to consider information that impacts Human Resources when trying to answer employee questions regarding the benefit structure. In fact, timelines are going to expressly outline that Human Resources must respond to requests within a certain timeframe (not more than 7 days) or face fines, up to $1,000, plus possible excise taxes and other penalties. It also the participant's rights, including appeal rights. Revised SBC will be required at least 60 days before any change to the plan.

As it's not required until post September 23rd (though still tentative), it gives the District and TPA time to define this document in compliance with the regulations. HHP is working on the template and preparing to roll out on behalf of DCSD. At this time, Windy is under the impression that simply dropping in the information would be part of the renewal process, but this has not yet been finalized. Fees may be associated.

Holly indicated that there was no action at this time needed, and questioned if this should be on the calendar in August as an action item requesting an update. This was agreed for an August Agenda.

Correspondence: Holly indicated she receives extensive correspondence regarding all matters insurance related. She mentioned that next January, employees will see a new box on their W-2, which clearly defines provided health benefits. At this time, it is not taxable for the 2012 calendar, but it is the first step towards categorization of benefits as taxable income as it relates to the Health Care Reform Act.

Future Agenda Items: In January, LP Insurance was asked to create a revision of the costs for the current 2012 plan year, but with newest actual information. Holly will ask that that be on the next agenda. Also, she asked that HHP revisit prescription coverage benefit and cost as a quarterly review.

Next Meeting(s): The next Committee Meeting was set for **April 17, 2012 at 4:00pm at the District Office.**

The meeting adjourned via motion by Andrew Fromdahl, seconded by Shannon Brown.

Respectfully Submitted,
Holly Luna, CFO, Business Services
Douglas County School District
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