Minutes of the Advisory Health Benefit Committee Meeting of April 17, 2012 at the District Office, Minden, Nevada

Committee Members Present
Larry Lipmann, DCPEA
Christine Cooley, DCPEA
Andrew Fromdahl, DCPEA
Marie Parola, DCSSO
Holly Luna – District Office
Shannon Brown, DCAA

Absent
Dwight Langdon, DCBDA
Diana Schefcik, DCSSO

Also present at the meeting were Lloyd Barnes with LP Insurance Services, Windy Culver-Molezzo with Hometown Health, Judy Britt with Hometown Health, and Nikki Bertone of DCSD Human Resources. Meeting began at approximately 4:02pm.

Roll call of members and external representatives was taken. The committee members adopted the Agenda, motioned by Marie Parola, seconded by Shannon Brown. There was no public comment.

Consent Items: The minutes of the Regular Meeting of March 20, 2012, were brought forth for adoption. Adoption was motioned by Larry Lipmann, seconded by Shannon Brown, and adopted 6-0.

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

Exhibit 1
Net paid claims for the month of March ($357,115) were lower than the monthly average for the previous plan year ($488,969). On a composite basis the average monthly claims cost per employee for the current plan year to date is $528.03 compared to $632.29 for the previous plan year, or a decrease of 16.49%. For employee only claims, costs were down from $470.46 to $362.75, a decrease of 22.89%. For dependent only claims, costs were up from $697.85 to $716.11, an increase of 2.62%. Additionally, the cost per member (employee or dependent) was down from $433.88 to $369.65, a decrease of 16.72%.

Exhibit 3
Total net plan costs for March ($415,048) were lower than the monthly average for the previous plan year ($550,791). On a composite basis, the average total cost per employee per month for the current plan year to date was down from $712.23 to $604.55, or a decrease of 15.12%. Employee only costs were down from $534.71 to $423.99, a decrease of 20.71%. Dependent only costs were up from $765.52 to $782.49, an increase of 2.22%. Additionally, the cost per member (employee or dependent) was down from $500.00 to $422.87, a decrease of 15.12%.

Exhibit 5
Overall utilization of the various medical services coverage by the plan for the current plan year to date is relatively consistent with those of the previous plan year with the exception of Inpatient Hospital expenses which are 11% this plan year versus 15% for the previous plan year.

Exhibit 6

There have been no claims that have exceeded $87,500 though the month of March. The top portion of this exhibit illustrates claims once they have exceeded $87,500 and shows the changes in total paid amounts from month to month. The bottom portion illustrates the amounts by which each of these claims has exceeded the specific stop-loss level of $175,000 on a month to month basis. The large claim last reported in February at $50,000 has gone up to $57,000, still below the specific level above. HHP indicated they have a weekly meeting, and this claim is on the weekly radar to be managed by a case manager and account manager in order to monitor this claim.

Exhibit 7

Our calculations estimate the Incurred But Not Reported (IBNR) claims liability as of the end of March at $721,321, down from February.

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 1168 claims, 1,192 were paid by month's end, leaving 160 claims remaining open. 1,045 Claims were paid within 15 days. 100 Claims were paid within 16 – 30 days and claims that extended past 30 days totaled 47. The Customer Service Calls report was not available for this meeting, and will be presented at the next meeting.

Review 2012 Projected Rates:

LP provided a report showing actual costs from February of 2011 through March of 2012 - the report is based on the last, most current 12 months of rolling data. The report showed rate projections beginning July 1, 2012. The report indicates a change to 13%, versus the previous 28% - although not fully comparative based on the January 1 start date (28% original projections) versus the July 1 start date (revised projections to 13%). This shows that while we are still in a deficit from a rate projection standpoint of premiums versus claims, the plan is running better than previously shown. Lloyd indicated we will most likely utilize $780,000 of reserves if no adjustments are made, which is down from $1 million + at last projection.

Review Prescription Claims Data:

The executive summary shows a 5 year synopsis, showing an improvement in cost, paying attention to the net Per Member per Month cost (PMPM). First quarter was $58.53 per member per month. The PMPM shows it is to 54% average for five quarters. The Claims Summary shows a trend that the generic utilization rate is increasing from 68.1% in first quarter, to 73%. For every 1% increase in generic utilizations, there is a PMPM reduction in cost by 1-2%. Another driving factor is percentage utilizing prescription plan to 44.2% overall. Trends are driven by 1) number of prescriptions per month that a member uses, 2) Drug Cost (brand name vs. generic, and 3) inflation.

When looking at specialty prescriptions (Biologics) PMPM, net overall is 54.47% for rolling five quarters. Even though these medicines are not largely utilized, the costs are so expensive it drives the plan cost up. Seeing a decrease in the report provided shows that there is a loss of these types of medications being utilized within our plan. There is no limit or government regulation on pricing of these medications, resulting in the pharmaceutical company setting the price they choose. In order to mitigate threat of not being able to use these types of drugs due to cost, some pharmaceutical companies have indicated they will pay the members co-pay which results in a much cheaper cost out-of-pocket cost to the member, but the effect to the plan itself

is that costs are raised as the plan pays for the cost of the drug. The co-pay percentage of total cost is 28.6%, with average co-pay percentage at 31%, meaning our members are paying less than other members with Catalyst as a total percentage cost.

Possible opportunities to aid in Cost Management, while not currently in our plan, include programs such as the Formulary Advantage Program (FAP) which includes Generic Utilization and Step Therapy programs. These require that the member tries the generic drug first. Should that not work, then the plan would allow the brand name. Any past trial results in an automatic approval of the brand name, to lessen the negative effects on the employee. This option includes a 90 day period hard edit, (a claim the pharmacy will not process and will reject, utilizing communication from the pharmacist, recommending switching to the generic format). With that said, if it's justifiable for the member to maintain the brand name drug, the plan would require a letter from the provider indicating the reason, would perform a review, and make the determination to continue approving the brand name drugs. These opportunities guarantee minimal disruption to members, simple transition and use a lowest net cost approach.

In the FAP, phase one is a three month intervention phase, where Catalyst/HHP would sending targeted letters to those members utilizing brand name drugs, to let the member know if there are generics to be used, explains to the member discussion points for the patient and their provider. Also, with the FAP, 24/7 Pharmacy Techs are available to aid a patient. Drugs that can have negative effects such as psycho-tropic medications (anti-depressants, etc.), would be grandfathered in to avoid negative change to the aid the patient receives from the medications. This approach would generally apply more to medications easily managed similar to blood pressure and cholesterol medicines. This option includes a 90 day period hard edit, (a claim the pharmacy will not process and will reject, utilizing communication from the pharmacist, recommending switching to the generic format). With that said, if it's justifiable for the member to maintain the brand name drug, the plan would require a letter from the provider indicating the reason, would perform a review, and make the determination to continue approving the brand name drugs.

Another option is moving to the HHP formulary, which has been in place for years now, and was the basis for the FAP described above. The largest difference between the Catalyst FAP described above, and the HHP Formulary Program is HHP has a four tier formulary with a specialty co-pay of 20%. Either of the options could result in significant cost savings to the plan.

Correspondence:
No correspondence received.

Future Agenda Items: General claims review as usual at next meeting.

Next Meeting(s): The next Committee Meeting was set for **May 15, 2012 at 4:00pm at the District Office. Committee anticipates no meetings in June or July as the Committee can waive up to two meetings.**

The meeting adjourned via motion by Shannon Brown, seconded by Andrew Fromdahl at approximately 4:48 p.m.

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