Minutes of the Advisory Health Benefit Committee Meeting of August 28, 2012 at the District Office, Minden, Nevada

Committee Members Present	**Absent**
Christine Cooley, DCPEA	
Christine Bredow, DCPEA	
Allen Gosselin, DCPEA	
Marie Parola, DCSSO	
Diana Schefcik, DCSSO	
Holly Luna – District Office	
Shannon Brown, DCAA (departed 4:58pm)	
Dwight Langdon (arrived 4:20pm)	

Roger Olsen and Lloyd Barnes with L/P Insurance Services were in attendance, and introduced a new member of their team, Tom Marshall. Windy Culver-Molezzo with Hometown Health was also in attendance. Meeting began at approximately 4:03pm.

Holly indicated she had received an email from the DCPEA President Brian Rippet, indicating member changes as follow: Andrew Frahmdahl is no longer filling in for Christine Bredow, and Christine will be participating going forward, and Allen Gosselin has taken the place of Larry Lipmann, retired. Roll call of members and external representatives was taken noting that Dwight Langdon would be arriving late. The committee members adopted the Agenda, motioned by Marie, seconded by Christine Cooley. One public member is in present. There was no public comment.

Consent Items: The minutes of the Special meeting on May 7, 2012 and Regular Meeting on May 15, 2012 were brought forth for adoption. Marie questioned the 5/7/12 minutes with regards to the District contributing additional monies towards the premiums. Holly referenced that there was no consensus on that item as noted by the minutes. Marie also noted that the bulleted list from 5/7/12 had been revised. There was no motion to change the minutes from either meeting. Adoption was motioned by Shannon Brown, seconded by Allen Gosselin, and adopted 6-0 without changes.

Claims Review: Roger Olsen, L/P Insurance Services, was present to review the claims report data.

Exhibit 1

Net paid claims for the month of July ($310,231) 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 $560.00 compared to $632.29 for the previous plan year, or a decrease of 11.43%. For employee only claims, costs were down from $470.46 to $406.71, a decrease of 13.55%. For dependent only claims, costs were down from $697.85 to $666.98, a decrease of 4.42%. Additionally, the cost per member (employee or dependent) was down from $443.88 to $392.59, a decrease of 11.56%.

Exhibit 3

Total net plan costs for July ($367,861) 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 $636.08, or a decrease of 10.69%.

Employee only costs were down from $534.71 to $467.58, a decrease of 12.55%. Dependent only costs were down from $765.52 to $732.91, a decrease of 4.26%. Additionally, the cost per member (employee or dependent) was down from $500.00 to $445.12, a decrease of 10.98%.

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 (11% versus 15% for the previous plan year).

Exhibit 6
There have been no claims that have exceeded $87,500 though the month of July. 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.

Exhibit 7
Our calculations estimate the Incurred But Not Reported (IBNR) claims liability as of the end of July at $702,874.

Exhibit 8
Our calculations estimate the Incurred But Not Reported (IBNR) claims liability as of the end of the previous month at $716,764.

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 1,489 were paid during the month, leaving 208 claims remaining open. 1173 Claims were paid within 15 days. 183 Claims were paid within 16 – 30 days and claims that extended past 30 days totaled 133. Customer Service call volume accepted 6,166 calls, averaging 41 seconds to answer. There was a noted abandonment rate of calls received at 4%.

Summary of Benefits and Coverage Form: The prior proposed standard format has not changed. HHP is formatting a document for DCSD to keep DCSD in compliance for the September 23 required deadline. A revised document will represent the plans available as of Open Enrollment for the revised plan as of 1/1/13. A template will be provided for DCSD approval prior to the September meeting. Due to timing, Holly will approve the draft in order to meet the deadline, and then the final templates will be brought before the September meeting for discussion and action to accept the template with any noted revisions.

DCSD Plan Review: Previously, the Committee held discussions for the basis of mediation with bargaining units regarding plan change options. Over the summer break, Holly asked that Lloyd Barnes, L/P Insurance Services, prepare a revision of the options based on more current claims data for discussion. Lloyd focused on the Standard Renewal Process showing the plan has been performing well over the first 6 months of the calendar year, and no large claims reported yet. However, the budget projections are still showing a $971,491 funding deficit, (15.9% - a reduction from previous projections) based upon a January 1, 2013 renewal. Current enrollees are shown as 760 participants. That 15.9% is the difference between the revenues that the current rate of $575 generates, and what the estimated claims data projects as plan expenditures. In order for the benefits to remain unchanged, the plan would need to be funded at

$7.1 million dollars, which is $971,000 more than the current contributions. A projected 20% increase is estimated for Stop Loss coverage, and is a standard rate projection currently used for most public plans.

Roger then dispersed a document updated by taking some of the original proposed plan changes previously discussed, and updated with the current utilization trends – providing the caveat that there is a level of volatility to the numbers due to the length of projection. Roger then provided a summary of the contents of the document and their effects: deductible changes, co-insurance changes, etc. The proposed medical and prescription components were in excess of $400,000 in savings when combined, and dental component savings in excess of $23,000 when combined. Marie indicated that the diagnostic lab and x-ray component had not been addressed in the previous consensus items which showed adding a $25 co-pay. Holly concurred that it was not a line item sought as a solution in the previous May 7th meeting. However, Lloyd indicated this would result in an additional reduction estimated in excess $100,000.

Holly asked that each item listed be discussed point by point at this time. There were no comments/questions on deductible changes, co-insurance changes, lifetime maximum, standardization of the plan, calendar year prescription deductible, and formulary step-therapy plan.

Diagnostic lab and x-ray co-pay were questioned from the perspective of participants not wanting to have a preventative diagnostic performed due to a new co-pay. Lloyd clarified that there are times when the deductible will be favorable, and times when it won't be due to change in the deductible. However, if the diagnostic lab is part of the well care program (preventative care services covered at 100%), there would be no co-pay.

Additionally, the proposed dental coverages were shown as a potential change from a $25/year annual deductible to $50 deductible ($2,217 in savings to the plan). Again, this line item was noted as not having been addressed as a solution in the May 7th meeting.

With regards to next steps, Holly asked that Lloyd go back to the budget rate calculation, and show the effect of a premium rate change as of January 1, 2013 from $575 to $585, and changing the employee spouse and dependent rate (at increments of $25 and $50/month), to see the effect of the various proposed scenarios, and their effect on the bottom line rate change. Lloyd also noted that the committee will have one more month's data included in the rates (August).

There was discussion of the timeline necessary for the implementation of any plan changes by HHP by January 1, 2013 including open enrollment (mid-November to beginning of December), approval of any proposed changes by the Board (November 13), and consensus / action by the Committee between now and then. If necessary, additional meetings may be required to procure results prior to beginning of November.

GAP Insurance: Holly review the last discussion of GAP Insurance, and requested guidance from the Committee regarding next steps. Tom Marshall provided background from his Washoe experience indicating that the only known provider was American Fidelity, and outlined Washoe's GAP Insurance. It was motioned that Holly would seek quotations that covered the following: district paying for employee only, and dependent / spouse coverage costs picked up by the employee, and that the quote should be based on some of the preliminary proposed plan changes rather than the current plan. Additionally, the Committee determined to re-agendize this

for the September meeting for future discussion/action. Motioned by Marie Parola, seconded by Christine Cooley, and with motion passing 7-0.

Correspondence:
Holly received an Employee Benefit Alert from L/P Insurance Services: a "Comparative Effectiveness Fee" to be paid once annually, to be payable on July 31, 2013, based on average number of plan participants under the medical plan ($1.00 per head), for the policy or plan years ending as of October 1, 2012, required by the Healthcare Reform Act.

Lloyd also forewarned of a coming transactional Reinsurance Fee, estimated to be $5-10 per employee, which would not be effective until 2014.

Also, HSA limits have now been announced by the IRS, and as such, Holly asked the brokers to bring anticipated changes that will affect the District's HSA plans beginning January 1, 2013.

Future Agenda Items: Holly will bring an estimated Ending Fund Balance (FY11/12) of the Insurance Fund to the September meeting as a starting point for the plan change discussion. It was again noted that it was the Committee's intention to bring a recommendation for plan changes to the November Board Meeting.

Additional items to be discussed will be: Claims Report and Customer Service, Review of the Summary of Benefits Template, Quote for GAP Insurance (if received in time).

There was a request to change the meetings starting time from 4:00pm to 4:30pm. The discussion noted the change for consideration when the meetings would be simplistic and short (reviewing monthly claims data) versus when there is involved discussions (plan and/or rate changes). The group determined this item will be reviewed each month when setting the next meeting date/time based on the future agenda items of the subsequent meeting.

Next Meeting(s): The next Committee Meeting was set for **September 18, 2012 at 4:00pm at the District Office. The October meeting was noted as currently showing as October 16th, to begin at 4:00pm.**

The meeting adjourned via motion by DwightLangdon, seconded by Marie Parola at 5:13pm.

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