Minutes of the Advisory Health Benefit Committee Meeting of September 25, 2012 at the District Office, Minden, Nevada

Committee Members Present	**Absent**
Allen Gosselin, DCPEA	
Christine Bredow, DCPEA	
Christine Cooley (4:03pm)	
Dwight Langdon, DCBDA	
Marie Parola, DCSSO(4:17pm)	
Diana Schefcik, DCSSO	
Holly Luna – District Office	
Shannon Brown, DCAA	

Roger Olsen of LP Insurance Services was in attendance. Windy Culver-Molezzo with Hometown Health was also in attendance. Meeting began at approximately 4:00pm.

Public Comment: None

Consent Items: The minutes of the regular meeting on August 28, 2012 were brought forth for adoption. Adoption was motioned by Allen Gosselin, seconded by Christine Bredow, and adopted 6-0.

Claims Review: Roger Olsen, LP Insurance Services, Inc. was present to review the claims report data.

Exhibit 1

Net paid claims for the month of August ($458,694) 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 $566.15 compared to $632.29 for the previous plan year, or a decrease of 10.46%. For employee only claims, costs were down from $470.46 to $410.04, a decrease of 12.84%. For dependent only claims, costs were down from $697.85 to $678.18, a decrease of 2.82%. Additionally, the cost per member (employee or dependent) was down from $443.88 to $396.93, a decrease of 10.58%.

Exhibit 3

Total net plan costs for August ($515,839) 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 $642.22, or a decrease of 9.83%. Employee only costs were down from $534.71 to $470.88, a decrease of 11.94%. Dependent only costs were down from $765.52 to $744.19, a decrease of 2.79%. Additionally, the cost per member (employee or dependent) was down from $500.00 to $449.13, a decrease of 10.17%.

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 (10% versus 15% for the previous plan year).

Exhibit 6
There has been one claim that has exceeded $87,500 though the month of August. 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 of which there are zero claims to-date.

Exhibit 7
Our calculations estimate the Incurred But Not Reported (IBNR) claims liability as of the end of August at $694,910.

Exhibit 8
Our calculations estimate the Incurred But Not Reported (IBNR) claims liability as of the end of the previous month at $702,874.

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 1342 claims received during the month (358 open from prior month), 1,440 were paid by month's end, leaving 107 claims remaining open. 1,271 Claims were paid within 15 days. 116 Claims were paid within 16 – 30 days and claims that extended past 30 days totaled 53. Customer Service call volume accepted 6,938 calls, averaging 45 seconds to answer. There was a noted abandonment rate of calls received at the standard rate.

Summary of Benefits and Coverage Form: Windy Culver-Melezzo produced a draft document based on our current plan. It was noted that based on the plan start date of January 1, HHP determined that a final document should include any plan changes, and MUST be ready for Open Enrollment to avoid severe penalties. The penalties would derive from the Health Care Reform Act and the penalty would accrue on a daily basis. However, the plan changes must be finalized before the form can be finalized. Windy reminded the group that the turnaround time for HHP to build a new plan is 30 days, at a minimum, once the new plan structure was determined. The intention of the committee will be to make decisions regarding the plan document and summary form at the Health Advisory October meeting for action with the intention of finalizing and bringing the presentation of the plan document and summary form before the Board at the November Board meeting. As such, the Summaries of Benefits and Coverage Forms will be reviewed again at the committee level prior to finalization.

Self-Insurance Fund – Ending Fund Balance Report: Holly distributed a preliminary report providing 2011-12 fiscal year claims and ending fund balance data. Total claims were equal to $5.3 million, less than budgeted in the December Amendment. The December Amendment ending fund balance shows as $2,087,332. Taking into consideration reduced claims and underestimated premiums, the unaudited Ending Fund balance as of June 30, 2012 would be closer to $3.3 million.

DCSD Plan Review: Roger provided a handout prepared to show previously considered options as well as some additional factors as requested by committee members. He shows the current plan, status quo, resulting in a deficit of approximately $900,000. The first page showed the effects of the following: increasing the employee only rate from $575 to $585 as well as to increase the dependent rates by $25 (resulting in a shortfall of $755,602), or increasing the employee only rate from $575 to $585 as well as to increase the dependent rates by $50

(resulting in a shortfall of $697,942). All projections were based on current participant enrollment. These options do not include any plan design changes.

The handout went on to show the effects of incorporating the proposed changes into the plan design (deductibles, co-pay rate changes), resulting in a shortfall of approximately $547,000 + without any change in premiums. Additionally, by increasing the employee premium to $585 and bumping dependent rates by $25, the shortfall would decline to $404,514. If the committee proposes to increase dependent rates by $50 (not $25) and incorporate the plan changes, the shortfall would decline to $346,854. A deficit of over $300,000 would still remain, and committee members would like to entertain pulling this amount from the Ending Fund Balance.

Shannon Brown was interested in the impact and limits of the HSA and any changes to the HSA deductible or the co-pay. Roger confirmed that the scenarios do not show any change to the HSA deductible or co-pay. Holly asked Roger to confirm that our current plan is in alignment with required IRS changes as of 01/01/2013. Holly indicated that the only change noted would be to increase the monthly differential to the employee HSA account by the $10 increase in the employer paid premium, thus increasing the net benefit to the employee.

A motion was brought forward by Shannon Brown that the committee adopt and bring before the October 9th, 2012 Board meeting the following recommendations: 1) the employer paid employee premium would increase to $585/month from $575, 2) the dependent to $50 above revised employee rate, 3) proposed plan changes, and 4) offsetting the remaining shortfall of $346,000+ with the Self-Insured Health Insurance ending fund balance. All changes to be effective January 1, 2013. Motion was seconded by Dwight Langdon. Motion unanimously adopted 7-0.

GAP Insurance: Holly had a discussion with Tom Marshall prior to the meeting, and relayed to the Committee that the GAP insurance as quoted required more aggressive changes to the plan than has been recommended. Also, it was noted that the quote required that each plan participant must be covered, and if dependents/spouses are not included GAP insurance costs would increase. An example of GAP coverage assuming that the plan required a $1,000 hospital admit fee: if an employee should have a hospital admission, and the hospital admission fee is $1,000, the employee would then turn and submit a claim to the GAP Insurance company for that $1,000 with the cost to the plan remaining $0 (with exception of costs to cover the GAP insurance premiums). Again, because the proposed plan changes do not include adding the $1,000 hospital admit fee, the need for the GAP insurance is a moot point. This option be filed away for future discussion should a GAP situation arise. The committee chose to take no action at this time.

Correspondence: None at this time.

Future Agenda Items: For November: discussion/action of format review of Insurance Summaries, and discussion/action of Stop Loss Insurance Quote.

Next Meeting(s): The next Committee Meeting was set for **October 16, 2012 at 4:30pm at the District Office. The November meeting is currently showing as November 20, 2012, to begin at 4:00pm.**

The meeting adjourned via motion by Christine Bredow, seconded by Marie Parola at 5:40 pm.

Respectfully Submitted,
Holly Luna, CFO, Business Services
Douglas County School District
(775) 782-5131