Minutes of the Advisory Health Benefit Committee Meeting of March 19, 2013 at the District Office, Minden, Nevada

Committee Members Present	**Absent**
Shannon Brown, DCAA	Christine Bredow, DCPEA
Allen Gosselin, DCPEA	Christine Cooley, DCPEA
Marie Parola, DCSSO (*arrived @ 4:40pm*)	Dwight Langdon, DCBDA
Paula Henricks, DCSSO	
Holly Luna – District Office	

Dianne Schefik will no longer attend as a representative for DCSSO. Paula Henricks will now represent for DCSSO.

Lloyd Barnes and Mark Garrett of L/P Insurance Services and Windy Culver-Molezzo with Hometown Health were in attendance. Meeting began at approximately 4:30p.m.

Public Comment: None

Consent Items: Adoption of the agenda was motioned by Shannon Brown, and seconded by Allen Gosselin, adopted 4-0. The minutes of the regular meeting on February 26, 2013 were adopted; motioned by Allen Gosselin, seconded by Shannon Brown, and adopted 4-0.

Claims Review: Mark Garrett of L/P Insurance presented the monthly claims reports.

Exhibit 1

Mark mentioned that while we are running more than 15% higher than last year, February definitely improved over January. Net paid claims for the month of February ($375,562) were lower than the monthly average for the previous plan year ($458,787). On a composite basis the average monthly claims cost per employee for the current plan year to date is $704.52 compared to $602.35 for the previous plan year, or an increase of 16.96%. For employee only claims, costs were up from $453.28 to $534.68, an increase of 17.96%. For dependent only claims, costs were up from $642.66 to $738.60, an increase of 14.93%. Additionally, the cost per member (employee or dependent) was up from $421.94 to $518.68, an increase of 22.93%.

Exhibit 3

Total net plan costs for February ($424,033) were lower than the monthly average for the previous plan year ($518,128) mostly associated with the reduction in stop loss insurance expense, a decrease of 23.88%. On a composite basis, the average total cost per employee per month for the current plan year to date was up from $680.26 to $769.46, an increase of 13.11%. Employee only costs were up from $515.84 to $598.80, an increase of 16.08%. Dependent only costs were up from $708.84 to $784.58, an increase of 10.69%. Additionally, the cost per member (employee or dependent) was up from $476.51 to $536.06, an increase of 12.50%. A Stop-Loss Reimbursement of $15,090 for a Large Claim in the prior policy year was noted.

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 (down to 9% from 14% in prior year), Outpatient Hospital (up to 10% from 7 % in prior year), and Outpatient Surgery (which appeared to spike last month up to 23% from 19% in prior year). These three types of utilization bear monitoring.

Exhibit 6

There have been no claims that have exceeded $87,500 though the month of February. 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 February at $730,494.

Exhibit 8

Our calculations estimate the Incurred But Not Reported (IBNR) claims liability as of the end of the previous month at $744,234.

After a review of the report from LP Insurance, Holly questioned if the drastic change from January to February could have to do with an increased number of pay cycles. Windy indicated it was a 5 week month, but she and Lloyd indicated that they needed to take a second look at the outpatient surgeries (such as colonoscopies and various others). Lloyd indicated that colonoscopies should not be considered surgery, but more of an outpatient category which had spiked last month. Many clients are seeing an elevated number of outpatient surgeries over the last few months, and LP Insurance and Hometown Health are trying to understand why. Windy indicated that she would like to have the claims reviewed from the provider perspective to see if it could be one provider recommending more outpatient surgery options. This will be reviewed and brought forth at the April meeting.

Hometown Health Statistics Review: Windy Culver-Molezzo presented the HHP Statistics Review, and issued copies of the "Claims Turnaround Time Report" and "Hometown Health Customer Service Department Stats" – both of which reflect HHP's entire book of business, not solely DCSD stats. The Turn Around Time report shows that of 1,353 claims received, 1,747 were paid by month's end (including most of the prior month's open claims), leaving 150 claims remaining open. The reason there were more claims paid than received is that sometimes when a new plan is formed, claims must be held until reports can be tested and ran and verified before processing while incorporating the new plan changes. 1,246 Claims were paid within 15 days

(71.32%). 477 Claims were paid within 16 – 30 days (98.63%), and claims that extended past 30 days totaled 24. Customer Service call volume was reported at 7,216 with 6,359 calls answered, a reduction from February, which is a normal trend. The month of February showed that 7,918 averaging 45 seconds to answer, below the preferred 60 second timeframe, and that the callers waited patiently for answers to their questions, showing the abandonment rate remained approximately 4%.

Lloyd questioned the call data figures, and indicated a difference in the accepted vs. answered calls, and the abandonment rate. He indicated he's coming up with a 13% abandonment rate. Windy indicated she would check into that discrepancy and report back the following month.

Plan Document Update (Admin Report):

Windy Culver-Molezzo presented an update regarding the Benefit Plan Document. Once the final benefit levels were approved by the Board, an intensive period follows to get the plan document restructured to incorporate those changes, along with Health Care Reform changes and to shift from a grandfathered plan to a non-grandfathered plan. Regarding a required deadline or timeline, self-funded public entities do not have requirements; however, the district is utilizing the ERISA standard of 120 days for revisions and implementation.

The process included a team within Hometown Health of experts who reviewed all approved plan changes for regulatory compliance regarding key areas of the plan. They look to see if any issues exist in their particular area (Customer Service, Reimbursement Services, IR, Legal, and specifically with the Medical Director's oversight) so that when the plan document is finalized, any existing issues will be addressed prior to rolling out the plan document. Applicable changes were noted, and then forwarded to an external group, PHIA, that reviews plan language regarding reimbursement, appeals, etc., for compliance and healthcare reform regulations.

PHIA also ensures there is full compliance with the numerous federal guidelines, (e.g., including Women's Health and Cancer, Newborns' and Mothers' Health Protection Act). A final report is presented to HHP noting any possible need for corrections. Then it's reviewed at an editorial level to ensure that the document flows, terminology is accurate and easily understood, and for general formatting. Holly is currently reviewing the final document, and will return final comments to HHP. Any deviations from the last review by PHIA will be resubmitted for PHIA's final overview. Any final modifications will be made, and the plan document will be ready for public distribution. This thorough review process is intended to ensure regulatory compliance, as well as improve Customer Service, and faster adjudication of claims.

Holly commended HHP for the thorough review as the previous plan document was very confusing, included a number of amendments, and was awkward and cumbersome for both users and the TPA. The revised plan document will be more user-friendly and understandable by the general member group. Once the final document is approved, Holly will have it posted to the district website – hopefully by the next committee meeting. Due to the ongoing Health Care Reform Act, the plan document will require major revisions yet again next year.

Health Care Reform Update (Admin Report):

There was nothing at this time, but will remain a standing segment on future agendas.

Correspondence (Report):
There was none.

Future Agenda Items:
Business as usual, and will include an overview of final Plan Document when ready.

Next Meeting(s): The next Committee Meeting was set for **April 16, 2013 at 4:30p.m. at the District Office.**

The meeting adjourned via motion by Marie Parola, seconded by Shannon Brown at 4:57pm.

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