Minutes of the Advisory Health Benefit Committee Meeting of January 17, 2017 at the District Office, Minden, Nevada

Committee Members Present
Christine Cooley, DCPEA
Mike Ashton, DCPEA
Lisa Voss, DCSSO
Marty Swisher, DCAA
Keith Lewis, District Office

Absent
Brian Rippet, DCPEA
Dave Dickey, Chapter 6 – Bus Drivers
Debbie Haskins, DCSSO

Marilyn Stevens, Hometown Health; Lloyd Barnes, LP Insurance; Tom Marshall, LP Insurance were present, along with Holly Luna, Business Services and Cori Isherwood, HR Benefits Coordinator.

The meeting was called to order at 4:30 p.m.

1. Call to Order

Committee member and attendee roll call was taken. Ms. Voss moved to adopt the agenda, seconded by Mr. Swisher. Mr. Lewis called for public comment. There was none.

Motion carried 5/0.

2. Public Comment #1

There was no public comment offered.

3. Committee Members' Comment

Mr. Lewis called for comments from any committee members. No comments were offered.

4. Approval of Minutes of the October 18, 2016 Meeting (For Possible Action)

Mr. Lewis stated Mrs. Moore is writing the Minutes for the Committee. Minutes were noted to contain the main points in conversation and are not a verbatim transcription. The October 18, 2016 Minutes had been provided for the Committee to review and proof. Mr. Lewis called for a motion.

> Based on Mr. Lewis' statement, Ms. Voss moved to approve the Minutes of October 18, 2016, seconded by Mr. Ashton.

Mr. Lewis called for public comment. There was none.

Motion carried, 5/0.

5. Approval of Minutes of the November 1, 2016 Meeting (For Possible Action)

Mr. Lewis stated due to feedback, revisions were made to the November 1, 2016 Minutes based on committee input. Mr. Lewis had added Ms. Voss' request to have wellness program information provided. Another revision, was to add that any change in employees paying a premium, such as a $10 premium, becomes a negotiation issue due to opening the door for premium opt out.

> Mr. Swisher moved to approve the Minutes of November 1, 2016, seconded by Ms. Voss.

Mr. Lewis called for public comment. There was none.

Motion carried, 4/0/1. Mrs. Cooley abstained.

6. Approval of Minutes of the November 29, 2016 meeting (For Possible Action)

Committee members stated they had not yet reviewed this set of Minutes; therefore, this Item would come back for approval at the next meeting.

7. Review of Claims (Information and Discussion)

Mr. Barnes began by reporting on the full plan year January – December 2016, Exhibit 1 and 2. The total claims for the year are $6.5 Million with an average per month of $538,000. A 5% increase in paid claims had occurred over 2015. The composite cost per employee was $676 compared to $631 in 2015, a 7.13% increase in total cost.

Exhibit 3 and 4, Total Plan Costs included fixed fees for paid claims in the net plan cost. Fees brought the total paid claims cost to $7.2 Million. The monthly average for 2016 was $598,000 vs. $575,000 in 2015, a 4% increase. The net cost per employee equaled $751.00 per employee, per month. The cost in 2015 was $708.00, equaling a 6% increase in total cost.

During 2016, hospital admissions averaged 6.6 per month vs. 6 in 2015 as shown in the Claim Utilization Report, Exhibit 5. Hospital stays increased to 17 days this year from 15 in 2015. The cost per stay increased from $14,300 to $15,800 year over year. The cost per day equaled $6,000. Prescription expense equaled 15% of plan costs; up from 12% in the previous year.

Exhibit 6, Claims in Excess of $87,500, had been provided as monthly data. Stop Loss insurance received for the year equaled $424,000. The largest portion of the Stop Loss funds had been received by the district; although, some Stop Loss would be forthcoming. A total of 7 large claims over 50% of the self-insured retention rate of $87,500, had occurred. There were no new claims in December.

Through use of a formula, Exhibit 7 reflected an estimated IBNR rate of $806,464 as of December 31, 2016. Exhibit 8 showed data based on claims from December 1, 2015 – November 30, 2016 with an estimated IBNR of $816,000.

8. Customer Service Review (Information and Discussion)

Ms. Stevens reported claims turnaround time and call volume data. Claims had decreased in December. The total number of paid claims for December equaled 1071; 31 claims were open at the end of the month; 97% (1037 claims) of claims were paid in 15 days; $99.5% were paid within 16-30 days (29 claims); and 5 claims were paid in over 30 days.

The call volume was high in December. The average seconds to answer calls increased some over November. The call abandonment rate was reported to be high at 6 seconds. This data included all call volume, not just DCSD. Work was underway by Hometown Health to break out the individual customer call volume. More customer service representatives would now be onboard to provide answers unique to specific areas such as Senior Care Plus, Commercial insurance and Third Party Administrator (TPA) calls. There are dedicated representatives handling L/P Insurance calls also. More information would be reported in the spring time with regard to company changes. It was noted hold time is calculated into the data provided.

9. Self-Insurance Fund Projected Financials (Information and Discussion)

Ms. Luna provided static claims data from the December Budget Amendment. The rate change for dependents had been increased by 3% as decided upon by the Board. A cash flow statement through December was shared, along with a rolling estimate that was affected by changing premium payments. The $10.00 employee contribution rate had been dropped. The December Amendment contained premium payments and insurance proceeds received from Stop Loss reimbursements. An adjustment to the claims expense had also been incorporated. For the first time in approximately five years, there had been 5 months of claims expense in a row under $500,000. This helped the average claims cost. The Health Fund Ending Fund Balance (EFB) was $3.4 Million at the end of 2016.

Ms. Luna added that a difference in the EFB from one side of her spreadsheet to the other, from $2.7M to $3.4M was due to a change in claims expenditures. The claims expenditures have been reported as a static figure 3 times each year, the last time is December and lagged by two months - November and December. As a result, two months ago the EFB was $2.7M and at this time $3.4M.

10. Healthy Tracks Presentation (Information and Discussion)

Ms. Stevens offered to have a Hometown Health representative provide a formal presentation on Healthy Tracks in February. A brochure was provided and explained. To use the Healthy Tracks program, employees are given access to a portal with wellness challenges and training. Employees would log in to take a health assessment and then track their exercise and nutrition. Quarterly wellness workshops are included along with health coaching and activities. A fee is charged to the district at the rate of approximately $3.00 per employee. A report would result in order that data could be tracked as to success of the program.

Ms. Voss inquired about educating employees regarding different aspects of wellness, such as flu prevention on a timely basis. Ms. Stevens replied the health coaches that provide presentations would target certain times and events. Reviewing data from all employees could also assist in providing information regarding a high amount of a particular health condition in the district population. Hometown Health staff could provide additional educational workshops for an extra fee.

Mr. Lewis commented that the Committee could oversee educational offerings. Another avenue to explore is the Nevada Business Group on Health wherein employees seek information that could help them with their health issues prior to scheduling doctor appointments.

Mr. Barnes added that the first step is to define the wellness program desired by DCSD. A structure would be needed to oversee and support the program to attain success. Wellness was noted to be a broad topic. Questions suggested to drive discussion included, “Do we tie the program to premiums?” “Incentivize?” “Offer a newsletter?”

While industry studies have shown wellness programs reduce costs for insurance, a reduction in insurance costs is not what typically plays out. Results of engaging wellness education may include improved employee attendance, less disability claims and increased productivity and morale; although, this is tough to determine. A large district was reported to have had a professional analysis performed on results received. They found absenteeism improved, but there was no reduction in health insurance costs following wellness program implementation. Email and newsletters sent out to employees helped to better invest in culture, moreover than insurance expense.

Two types of wellness programs existed that had different compliance rules.

Activity Based: Encouragement is provided to participate and rewards may or may not be offered for participation. In this model, rewards could be based on participation only, rather than on health status. If a reward is offered to everyone based on participation only, this falls under non-discrimination law. There are no Accountable Care Act rules for participatory programs; although the ADA does place a cap on incentives for participation and there is a requirement for reasonable accommodation.

Outcome Based: Individuals are tested, measured and screened to truly improve their health status. Managing weight, lowering blood pressure and cholesterol could result but is more invasive to employees and more work for the employer to have in place. This category requires oversight and compliance to regulatory rules. Reasonable alternatives and accommodations are required. Financial incentive rewards are offered by some plans. Reimbursements could be provided for fitness center fees and tests. Reasonable alternatives have to be provided for employees not achieving the appropriate level of health. A reasonable alternative could be met by someone providing evidence of their care under a doctor. Disclosure of reasonable alternatives would need to be provided to employees.

Another wellness incentive to consider is using a Health Risk Assessment (HRA), questionnaire based on medical information. Lifestyles would be measured. Aggregate data would be provided for the group to the employer, not personal, individual data. The HRA is a tool to gather data voluntarily provided by employees. The tool can be a gatekeeper to lower premiums, through participation. The HRA would need to be designed to exclude genetic history due to the Genetic Nondiscrimination Act (GINA).

When participation is completely voluntary, the number participating is typically small. Those who do participate, have the healthiest habits. Incentives work to pull in persons who don't have the healthiest habits. To have a fair program, not challenged by employees, a notice for alternative standards would be made available. Participants would also need to be informed as to how data would be used.

In conclusion, the program could be designed a number of ways. The goal is to help employees be healthy. It is important to have champions lead the program and to allow for fun and competitions to keep people engaged. It was recommended the program plan be built over time with a move to incentive based wellness possibly occurring in the future.

Mr. Barnes suggested Committee members login to the Healthy Tracks website and become familiar. When hearing the formal presentation yet to come, it was recommended that it would be best to keep a global concept in mind.

11. Self-Insurance 3-Tier Stop-Light System (Information and Discussion)

Mr. Lewis led a discussion regarding the meter system created by the Committee to monitor the Health Insurance Fund ending fund balance. It was to be determined if further descriptive information could clear up any misunderstandings within the process. In November, the self-insured health fund was deemed to be in the green light zone, indicating changes to the plan were unnecessary. The current status reflected overall success within the plan. Ms. Luna was asked to provide background on the stoplight meter system.

Ms. Luna offered that in April 2016 a chart was created as a response from the Committee to the School Board, to have a guideline for monitoring the health insurance EFB. Minutes are available online from the spring Committee Meetings for review. It was determined a reserve of 3 times Incurred But Not Reported (IBNR) would be a formula for success allowing for a reserve to be in place for large claims. The health committee step by step process and timing had been discussed last spring. The question was, "At what time would there be concern for not

maintaining enough funds to cover claims?" The Committee's 3 times IBNR formula was a result of discussions to explain what drives the ending fund balance. Last spring, working with L/P Insurance, L/P cautioned that the stoplight system should not be the only measure in determining the status of the fund. The meter system would be offered as a visual warning mechanism. The presentation to the Board of the stoplight review system occurred November 2016.

Mr. Barnes supported using the stoplight system and defined IBNR is an estimate of liability for the plan. The liability being funds not yet paid out in claims that were still working through the system. Should the plan end immediately, 1 IBNR would be necessary to pay the remaining liability. Nevada does not have a statutory requirement for self-funded public entities that requires maintenance of any particular amount in reserve. In the current model, the vision is if the IBNR level drops below 3, into the 2-3 range, a serious look at the overall plan needs to occur. A drop to the 1-2 range might require action; and a drop to 1 represented an underfunded expense ratio. The district monitors the revenues vs. expenses and what funds are drawn from for the insurance fund. If expenses are higher than normal, the ending fund balance will decrease.

Mr. Barnes stated four choices make the determination for health plan funding.

1) Spend from the Health Insurance Fund
2) Spend from the General Fund
3) Increase premiums paid by employees
4) Reduce plan benefits

Ms. Luna cautioned that the IBNR system is volatile and should not be used alone to project the fund's health, in that the previous year's trend may be different than what is to come in the new year.

Mr. Barnes mentioned as the IBNR cost increases, so does the IBNR increase. There is an issue in the IBNR not providing for an accurate reflection of the fund balance; although, IBNR overall is a good look at the fund, based on history.

Mr. Lewis thanked Ms. Luna on behalf of the Committee for all of her work over time. This would be Ms. Luna's last meeting.

Discussion continued regarding the number of claims for Stop Loss Insurance typically running at 5-8 per year. The stoplight system provided for 10% of increasing expenses. A premium holiday could be a possibility in the event claims drop and the health fund is larger - above the 3 times IBNR level.

Ms. Cooley stated problematic issues from the past. Following the onset of a premium holiday, several months later the committee was asked to decrease benefits or increase costs to employees. In the June or July timeframe, the Board was asked to allow for a premium holiday, for which a discussion had not taken place at the Committee level; although, by September the Committee was asked to entertain benefit cuts. This bouncing within the plan and ending fund balance effect was undesirable. Committee members did not wish to build the fund to benefit other areas of expense within the district, only the health plan. The intention of the stoplight system was not to lock in a particular number that determined a time or fund amount resulting in definite action. During a presentation to the Board, the hard line numbers were presented, that did not reflect Committee's intent for use of the scale. The intent was to view the fund within a range to see if a plan revision might be necessary. In review, ultimately, the Committee determined the disconnect that followed the Board presentation, was viewing the stoplight

system as a hard line scale when the best method is to watch the fund when between 2-3 on the IBNR scale.

12. Correspondence (Information and Discussion)

Mr. Ashton reported an employee mentioned to him that a prescription cost jumped from December to January.

Mrs. Isherwood responded she would be glad to assist with any problematic issues. With regard to generic prescriptions, it was not picked up in the coding during the transition from Hometown Health to Welldyne that the DCSD generic prescriptions are not subject to a deductible. Upon discovery, this issue was cleared up the second week of January. In the case of an employee overpaying for their prescription, it was suggested the individual call Mrs. Isherwood and/or return to their pharmacy and clear up the mistake. The DCSD website lists deductibles and all correct information under the benefits section. Mr. Lewis offered to email employees, if necessary, to clear up this initial error.

Ms. Stevens added Hometown Health had a provision for individuals unable to take generic prescriptions that could assist with costs through an override process. It was uncertain if Welldyne has the same option. The authorization list had been sent to Welldyne from MedImpact.

13. Future Agenda Items (For Possible Action)

Mr. Swisher stated the Wellness follow up presentation should be on the future discussion list. It was determined about 30 minutes should be allowed for the follow-up presentation.

Mike Ashton left.

14. Public Comment #2:

There was no public comment offered.

15. Adjourn

At 6:09 p.m., Ms. Voss moved to adjourn, seconded by Ms Cooley.

Motion carried, 4/0.

Next Meeting:

The next regular meeting is set for Tuesday, February 28, 2017, at the District Office, 4:15 p.m.

Respectfully Submitted,

Keith Lewis, Director Human Resources
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