MEMORANDUM

To: Tom Foley, County Executive
Pam Moran, Superintendent

From: Health Care Executive Committee

RE: 2013-2014 Medical and Dental Insurance Programs

Date: February 2013

The Health Care Executive Committee (HCEC), the members of which represent several departments in the School Division and Local Government, as well as other affiliated organizations who participate in our health and dental plans, develops recommendations for our medical and dental plans based on the following objectives:

- offer affordable options that meet varying needs of employees and their families
- maintain reserves at approximately 25% of claims
- ensure plans are in compliance with Health Care Reform
- maintain our competitive position for benefits (slightly above market)

Plan Review Process

The HCEC works routinely with KSPH Employee Benefit Management, to review our health care plan. This includes:

- Detailed reviews of claims utilization with Coventry's medical director
- Analysis of market information on plan design and employee/employer premiums.
    - Plan design includes: inpatient/outpatient coinsurance, co-payments, annual deductibles, out-of-pocket maximums, emergency room co-payments, prescription drug co-payments
- Employee Feedback- input from employees via focus groups and surveys
- Review and projections of reserve balance.

Health Care Reserve Fund

As our medical plan is self-insured, the County is responsible for all claims. Reserve funds serve to cover any difference between claims paid, but not covered by the revenues (employee premiums collected & Board contributions). If claims exceed our revenue collections, the difference is paid from our reserves; if revenue exceeds claims, the difference is added to our reserves. Ideally, a reserve balance of at least 25% of total claims should be maintained. According to projections (based on the best historical and trend analysis information available at that time), the reserve will be at the target balance of 25% of annual medical claims by September 2014. To protect the plan against potentially devastating single large claim(s), the County continues to purchase reinsurance, referred to as *Specific Stop Loss reinsurance*. This type of coverage limits our liability for a single claim to $200,000 (*Specific Stop Loss*).

Total Compensation

The HCEC considers the Total Compensation for employees in developing recommendations. Attachment B provides a five year history of Compensation and Benefit Actions.

Background:

Medical Scoring Analysis

The adopted benefits strategy is to target benefits slightly above market (105th percentile). The benefits package is reviewed comprehensively and the medical plan is the cornerstone of that strategy. In order to evaluate the plan design and premium costs to employees and Board contributions, staff worked with Tom Mackay, our benefits consultant with KSPH Employee Benefit Management, to develop a model quantifying those elements. Based on this model, last year we were slightly above our target in several plan design areas.

FY 11-12 Plan Year (October through September)
In order to bring our high plan closer to that of our market, significant plan changes were made this plan year to all three plans. These included an emergency room co-pay increase, reinstatement of co-pays on outpatient mental health services (in line with PCP co-pays) and a $5 increase on non-preferred prescriptions co-pays.

RFP Process:

We issued an RFP for medical coverage in January of 2012 and received five proposals. All proposals were reviewed, evaluated, and analyzed against a common set of criteria including: Quality of Administration, Network Access, Cost, and the Offeror's Credentials. Based on the analysis, the contract was awarded (renewed) to Coventry) for all lines: medical claims administration, prescription drug claims administration, and stop loss insurance. Coventry reduced the annual administrative service fees per member from $29.20 to $27.70, which is guaranteed for three years and will result in approximately $231,700 annual savings.

FY12-13 Current Plan Year (October through September)
To meet individual needs and offer affordable health care choices, three plans with varying co-pays and premiums had been offered for several years. A review of national survey data of government employer-sponsored health plans indicated that we were above market in terms of our high option plan design. The high option health plan was also well above market in regard to employee cost-sharing. In order to maintain comparability with other health plans and for cost savings, the HCEC recognized that we could not continue to offer the high plan without significantly increasing the monthly premium rates to the point where they would not remain affordable for our employees. Accordingly, we moved to a two plan option structure and the following plan changes were made effective October 1, 2012:

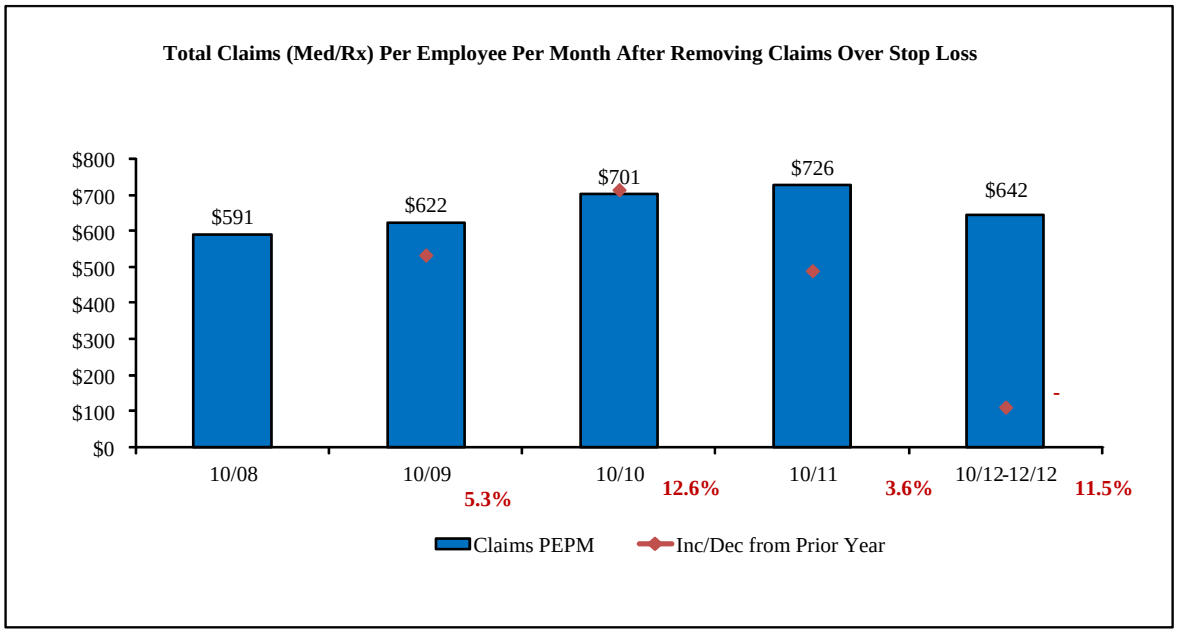
- Plan names were changed to Plus Plan (former Middle Plan) and Basic Plan
- Enhanced women's preventive and contraceptive coverage added (in accordance with Health Care Reform)
- The changes from the former High option plan to the new Plus plan were as follows:
    - Change in coinsurance from 95% to 90% (in-network) for inpatient admissions, specialty diagnostic services (CAT scans, MRIs, etc.), and outpatient surgeries
    - Change in out of pocket maximums from $1500/$3000 to $2000/$4000 (individual/family)
    - Employees on the High plan at employee only and employee + child continued to pay the High plan premium with the move to the Plus plan; those at employee + spouse/children or family levels saw reduced premium rates with the move to the Plus plan. This was done to keep our premiums at each level in line with our market.
- No changes to the low plan design/premiums.

As we had communicated earlier in the year that premium rates would not change for the upcoming plan year, we **temporarily** allowed those currently on the Middle plan at employee only and employee + child tiers to continue paying the same premiums. The balance of the premium cost was supplemented for one year by funds from the health care reserve. As of October 1, 2013, all will use the same premium structures.

Claims

The following chart illustrates our claims history. As expected based on the plan design changes, the total claims have decreased.

Historical and Current Medical Paid Claims (after removing claims over stop loss)



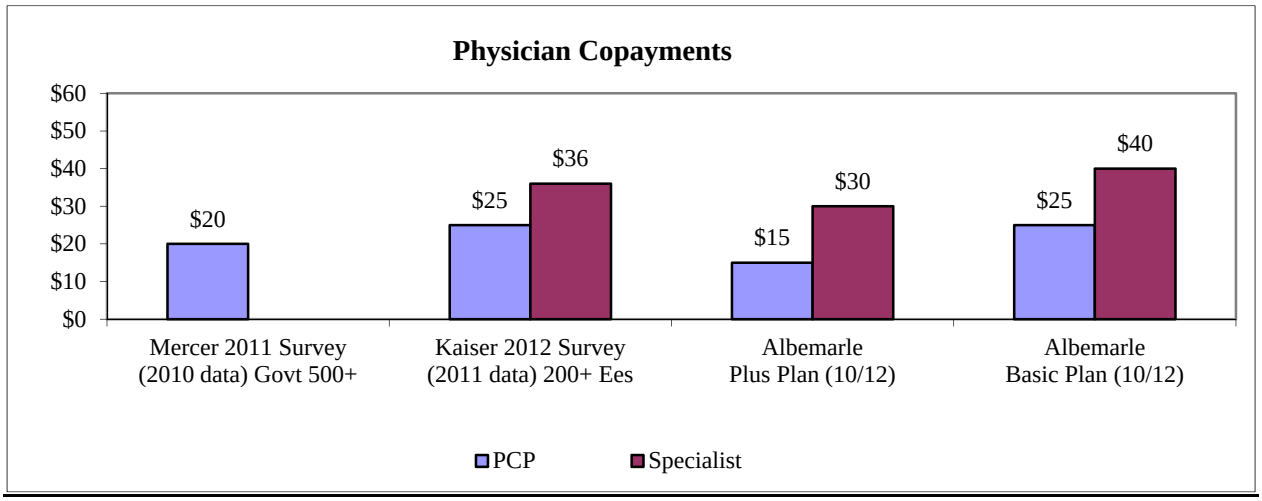
Average increase in claims after stop loss	
Last three years	7.2%
Last two years	8.1%
Last year (2011)	3.6%

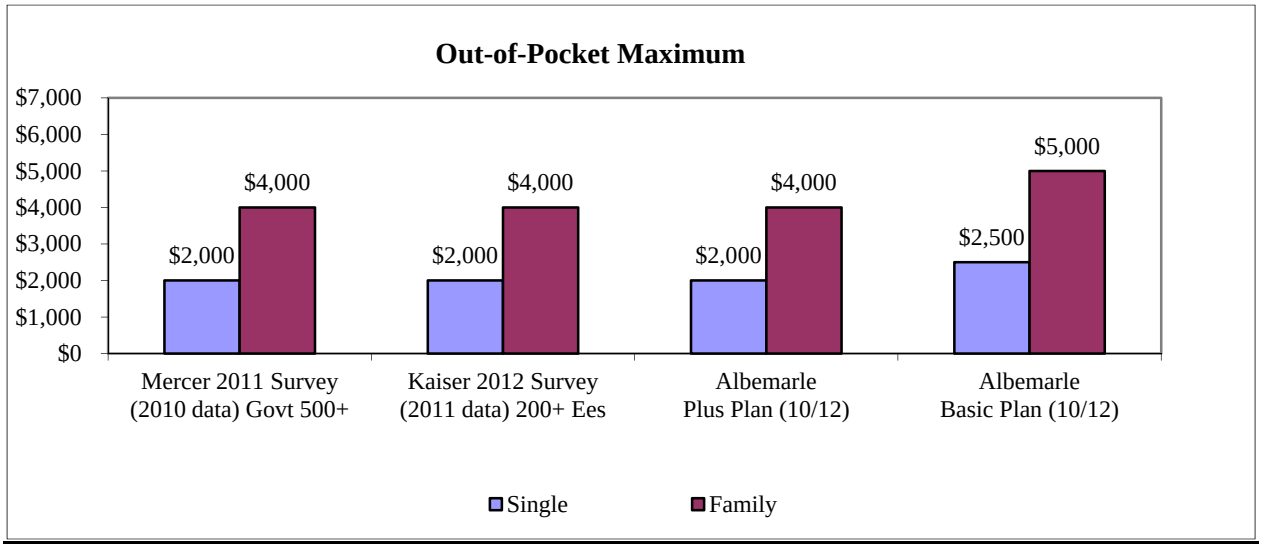
Plan changes	
10/10 plan year	Added coinsurance to High plan
10/11 plan year	Minimal changes
10/12 plan year	Eliminated high plan
10/13 plan year	Considering adding annual deductible to plans

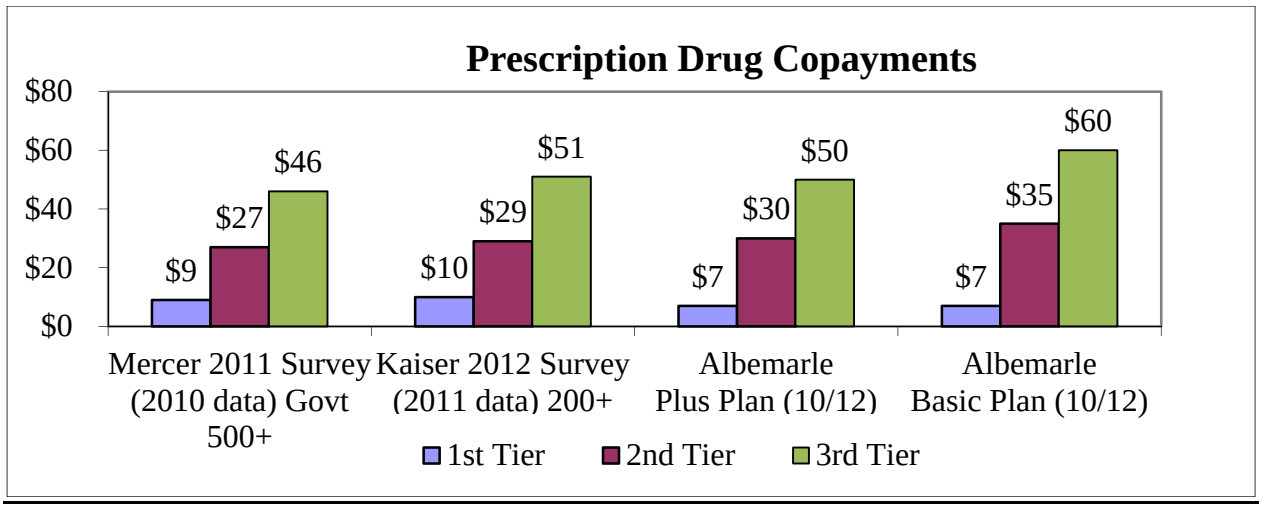
Market Competitiveness

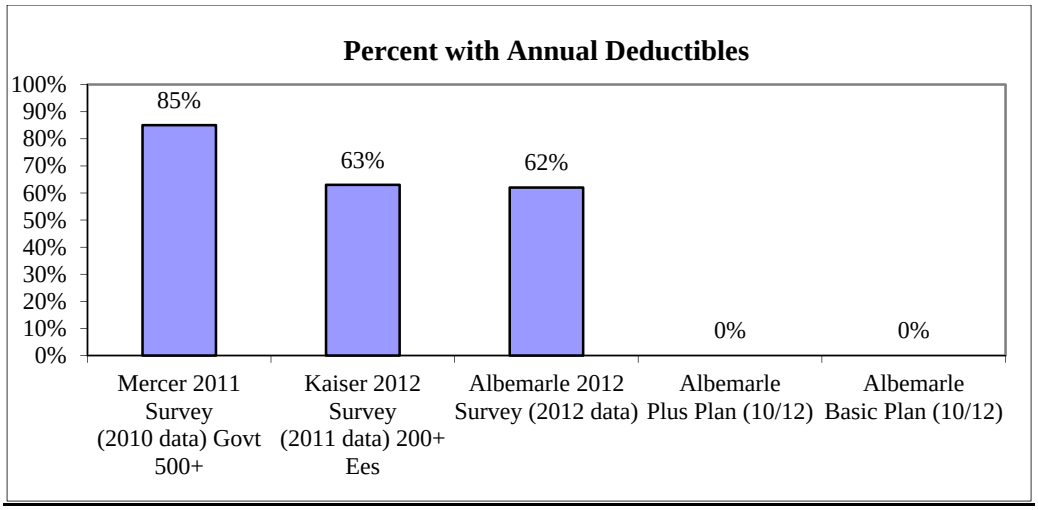
Offering a competitive medical plan that balances the benefit design against the cost to fund the program is a major consideration each year. The benchmark data, while not an exclusive comparison with our adopted market, indicate that our health plan design and premium amounts are currently achieving our targeted benefits strategy to be slightly above market.

Plan Design


Physician Copayments
$60
$50
$40
$30
$20
$10
$0
$20
$25
$36
$15
$30
$25
$40
Mercer 2011 Survey (2010 data) Govt 500+
Kaiser 2012 Survey (2011 data) 200+ Ees
Albemarle Plus Plan (10/12)
Albemarle Basic Plan (10/12)
PCP
Specialist


Out-of-Pocket Maximum
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
$2,000
$4,000
$2,000
$4,000
$2,000
$4,000
$2,500
$5,000
Mercer 2011 Survey (2010 data) Govt 500+
Kaiser 2012 Survey (2011 data) 200+ Ees
Albemarle Plus Plan (10/12)
Albemarle Basic Plan (10/12)
Single
Family


Prescription Drug Copayments
$80
$60
$40
$20
$0
$9
$27
$46
$10
$29
$51
$7
$30
$50
$7
$35
$60
Mercer 2011 Survey (2010 data) Govt 500+
Kaiser 2012 Survey (2011 data) 200+
Albemarle Plus Plan (10/12)
Albemarle Basic Plan (10/12)
1st Tier
2nd Tier
3rd Tier



Total Cost- Employee Premiums and Board Contribution Amounts

The benchmark data indicated that the premiums (Plus plan) compare as follows:

Annual Costs	Albemarle	2012 Market
Total Cost		
Individual	$7,225	$ 6,496
Family	$9,973	$ 16,706
Employee Premiums		
Individual	$480	$ 750
Family	$3,228	$ 6,539
Board Contributions		
Individual	$6,745	$ 5,745
Family	$6,745	$ 10,167

The total cost of our plan (Employee Premiums and Board Contributions) is slightly above our market for individual; yet significantly lower (40%) than our market for family coverage. This is significant, as while we offer rich plan in terms of coverage and copays, the overall cost is low.

Considerations:

Although we have made plan design changes resulting in cost shifting to employees, we have not had an employee premium increase since 2008. The HCEC is sensitive to the impact that out-of-pocket costs have on our covered members. Due to good performance within our self-insured pool, we have actually reduced the plan cost to the Board. We are particularly fortunate in both these circumstances, given the recent increases many employers have been faced with implementing.

This year, facing a 7% premium increase, the HCEC considered implementing a $200 deductible to the plan as this would have reduced the premium increase from 7% to 4.2%. Employee feedback collected through focus and advisory groups indicated that majority employees prefer a higher premium increase over implementation of a deductible. Our adopted market has started to implement deductibles, as sixty-two percent of localities have done so this year. Based on the significant plan design changes implemented the past two years, and in light of the premium increase, it is recommended that we continue to evaluate implementing deductibles for the next plan year.

Health Risk Assessments

The HCEC is currently reviewing best practices of incenting employees to complete Health Risk Assessments (HRAs). HRA's are seen as a best practice for organizations to assess the overall health of their employees. HRAs consist of a self-guided questionnaire regarding an individual's personal habits that may contribute to one's positive or negative health status. HRAs also include a biometric screening that allows employees to be aware of their cholesterol and sugar levels. The aggregate information is what is of extraordinary value due to the "real-time" data that is provided. This information allows staff to implement wellness programs and training that will curb future claims, as well as, reduce the highest risk health issues that employees face. HRAs in conjunction with the annual wellness survey and aggregate health insurance claims information are necessary to confidently derive and implement programs that will positively affect employee health, absentee rates, employee morale, productivity, and health insurance costs. Multiple studies have shown (peer localities have also confirmed) that for participation to rise to levels that would be considered meaningful and valid. An incentive (usually financial) is thought to have the greatest impact. There are multiple ways of incenting employees, however, the most successful means is to either provide a lump sum payment, or to reduce health insurance premiums; the latter has shown to produce much better results and would likely have less of an administrative burden than the former.

Dental Insurance

FY12-13 Current Plan Year (October through September)

There were **no** changes to our current dental plan premiums from that of the previous year. The coverage of both the High and Basic plan options was enhanced by: increases to the amount the plans pay annually, an increase to the amount covered for orthodontia (which is covered under the High plan only), and an increased amount covered for major services, like crowns (which are covered on the High plan only).

Our dental reserve balance is currently funded over the target. To bring the reserve balance into line, options include:

- Make plan design benefit enhancements (this would likely take years to show a sizeable impact and potentially result in an overly rich benefit in comparison with our market)
- Maintain current employee/Board contributions for the next few years, using fund reserves to absorb actual cost increases (this, too, would take a while to show the desired impact; additionally, we could be faced with a sizeable rate increase when we reached our optimal reserve balance, in order to maintain market levels)
- Implement a rate holiday for employee and Board contributions (this was deemed as the most practical and expedient alternative) for a period of time.

Regarding the timing of the rate holiday, options included beginning immediately, or at the start of the new plan year (October 2013). Implementing this rate holiday option immediately is recommended based on following reasons:

- Immediate "credit" would be given to current employees who, in theory, have created the reserve
- Spring/early summer is relatively light in terms of bringing in new hires (who would either get to participate in this premium holiday or have to pay premiums when the majority of enrolled employees are not, creating an additional administrative burdens).
- If we wait for the new plan year to implement the rate holiday, we likely will see increased enrollment from those who want to take advantage of the "free" year; this could result in unanticipated impact to the reserves. Additionally, a large number of newly hired employees (for the 13-14 school year) would also benefit from the rate holiday (assuming we did not design a separate premium structure for new hires).

Recommendations:

The HCEC considered a number of options in continuing to offer medical and dental plans that balance the needs of employees with the fiscal realities of funding the plans, particularly given the continuing escalation in costs for medical care. The recommendations:

Medical Plan:

1. Continue to offer the Basic and Plus plans through Coventry
    a. Both plans are Point-Of-Service Plans with the same benefit coverage
    b. There are differences in cost sharing (co-pays, co-insurance, out-of-pocket maximums, deductibles) and employee premium requirements
    c. The benefit summary is shown at Attachment C
2. Increase the Board contribution by 7% for the new plan-year starting October 1st
3. Set full-time employee premiums at the rates shown in Attachment D
4. Retain a self-insured medical plan with Specific-Claim-Stop-Loss insurance to limit our liability against any single large claim

Dental Plan:

1. Continue the contract with United Concordia
2. Continue to offer the Basic and High Options with no change in benefit design
3. Retain the current rates for the new plan year starting October 1st
4. Approve the employee premiums as shown Attachment D
5. Implement a dental rate holiday from March 2013 until September 2013 for all dental enrollees for this period, regardless of hire date.