



Medical Benefits Committee

Minutes

Thursday, March 3, 2005

11:00 am

Room 510

Present: Pegi Ard, Debora Bone, Doug Deaver, Sue Greytok, Olivia Hand, Leah Hlavaty, Sue Holt, Brian King, Cathleen Reno, Jerry Sauter, Stephanie Stainback, Kathie Welch

Absent: Kate Hartzell, Cliff Nichols, Michele Rivard, Topsy Smalley

I. Call to Order

Pegi opened the meeting at 11:00 am.

II. Agenda Modifications

None.

III. Approval of Minutes

Stephanie asked for clarification on page 3, 5th paragraph from the bottom. The minutes should be amended to say "Pegi would need to cost that out."

Stephanie asked to delete on page 4, "In order to keep choice, deductible will have to rise."

Kathie requested the word "punished" on page 4 be replaced with "shouldn't have their rates go up."

Sue Holt requested to add that "Pegi said" we used to send out Cruz News on page 3, paragraph 5.

It was moved/seconded (Holt/Welch) to unanimously approve the minutes with the noted corrections.

IV. Response to request for information

These will be covered in the remaining agenda.

V. Health Savings Accounts

Jerry passed out an overview of Health Savings Accounts (HSAs). Where it fits in with Cabrillo is much like a Section 125 plan (Flexible spending accounts). It is a benefit plan purchased from the JPA as part of the larger consortium. Please refer to the attached handout.

Features of the Health Savings Accounts (HSAs)

- Employer contribution to HSAs is optional. There is a benefit, however, to employees as well as employers when pre-tax income is reduced.
- HSA funds roll over from one year to the next. The money can be used after the employee is 65, however contributions to HSAs are not allowed after 65.
- HSAs are much like a Section 125 Flexible Spending Account that reimburses consumers for health related expenses. However, they have seamless integration with medical plans and broader capabilities than Section 125 accounts. Dollars to be applied to a deductible could automatically come out of an HSA. Where the flexible spending plan requires all money to be spent at the end of the year, the HSA dollars roll over.
- HSAs are done by a carrier and banks. It would be much like managing your money at Wells Fargo or another financial institution.
- An employee manages an HSA much like a 401(k) or 403(b).

Example:

Employee A has a Blue Cross 80/60 plan with a \$2000 deductible and no employer contributions. The employee elects to put \$100 per month into a HSA and accumulates \$1200 in a year. After a \$500 emergency room visit is reimbursed, there is a \$700 balance left over. Now the employee has a \$10,000 appendectomy: \$700 comes from the HSA and the employee will need to contribute an additional \$800 before the plan coverage kicks in.

This falls in where it can be structured where employee and employers collaborate.

Jerry stated that HSAs can narrow the corridor of the expenses, but the combination of out of pocket and deductible has been a concern for employees when reviewing this type of program.

Brian commented that in the Health Savings Accounts, where you are on the income cycle affects the savings realized.

Sue Holt asked if we are considering this for PPO enrollees under 65. Is it possible to consider and HRA instead of HSA for those over 65? This would be an option for those who are not ready to try an HMO, but are ready to try the concept. Jerry replied that it depends on how many Districts in the JPA would offer this option.

VI. Cabrillo survey—Medical benefits

Sue distributed a handout summarizing the responses received to date from the email survey sent to Classified, Certificated, Managers and Confidentials regarding their thoughts about whether they will stay with or change their health plan choice in the coming fiscal year. Of 173 responses to date, fewer than 20% would change plans given what is known today. If the rates increase by 25% that may change, but it appears there is still a large PPO pool.

There was discussion regarding retirees and if there is enough information without having polled them. 98% of retirees are on the PPO. It appears people are attached to their plan.

The JPA survey distributed by Keenan has not been collated yet.

VII. Timeline for rate setting

Rate setting for the JPA is scheduled for April 28, 2005. From an administrative perspective (open enrollment, plan effective dates), it's difficult to push the date for rate setting out because enrollment would be in late-May and early-June. It would be very challenge for carriers and vendors to get everything up and running by July 1st.

VIII. Common Risk Pool:

Jerry explained that group insurance, by definition, is a form of subsidizing one group by another. The PPO plans are self-funded; every enrollee is lumped into one pool. The JPA, however, is comprised of 11 member Districts. By lumping 11 Districts together, subsidizing occurs at the JPA level. For example, if one District has a bad year in terms of high claims, the other Districts, in effect, subsidize them because all 11 are pooled together when rated for risk. Retirees are subsidized by active employees, certificated subsidize classified who tend to enroll more families. If the HMO and PPO plans are lumped together for a common risk pool, how would that be different?

A common risk pool for the two plan options raises people's awareness differently, but it's unclear why. It is a risk-sharing model; just because people choose PPO as opposed to a HMO doesn't really change the common risk pool, in effect. The dialogue is the same.

Doug asked if it is possible to have a common risk pool with one self-insured plan and two fully-insured plans. Jerry replied that there is a model in Southern California, called "REEP", which pools its HMO and PPO plans. The JPA pays the monthly capitation, and the other "fee for service" expenses are lumped together in on self-funded pool.

Pegi asked whether it is possible to get rates for more than one year. Jerry replied that no carriers will do multi-year rates in this market.

If the JPA offered California Care and a PPO, would that eliminate adverse selection? Jerry replied that no, it would not.

If there is a common risk pool on all the plans, would the HMO cost be higher? Jerry replied that we don't know, but we assume that it would. There would be an increase in rate of increase for the HMO, and a decrease in rate of increase for the PPO. When the pool takes a 10% increase, all plans would get a 10% increase.

Doug asked for data of what the JPA is costing the carriers. Jerry replied that Keenan gets the claims information. It boils down to capitation vs. fee for service. How many times are HMO people going to a doctor in a capped environment? On the PPO side, it's an underwriting challenge in the fee for service environment.

Having a common risk pool is the main option in order to meet all of the objectives of the JPA Executive Board and Advisory Committee: 1) save the PPO, 2) save the HMO, 3) contain costs and 4) reduce or eliminate adverse selection. These are the goals.

This common risk pool could be all HealthNet with a PPO offering on the side for retirees.

Pegi said that there is a lot of frustration about the plan changes that became effective January 1. It appears there will be little, if any, credible data before setting rates on April 28. The focus of this committee is to make recommendations to the Advisory Committee to the JPA. Can we buy more time before setting rates? Can we get more credible info from surveys? Jerry replied that rates can be set later, but then enrollment becomes the issue. People expect the plans to be up and running by July 1st—there needs to be some time to complete the administrative tasks associated with enrollment.

Stephanie asked if the current contract can be extended $\frac{1}{4}$ of a fiscal year. Jerry replied that it is possible but has never happened. Rates will change on the fully-insured program July 1. The rates for the self-funded plan can be set later. There is a hesitation to go past July 1 because it affects open enrollment as well as flex spending accounts.

Jerry said that it is possible to make plan changes and to have a later enrollment and effective date. Renewal could be July 1, open enrollment in October and an effective date of January 1. Extending the renewal date is a financial concern from the JPA perspective. It is also a concern from the employee perspective because employees are "trapped" at the new, higher rates for an additional period of time.

Jerry asked what is the purpose of pushing out the renewal date and trying to get more data. If it is to have more options, that would be reasonable. After a plan change, it's not clear whether something is a true trend or if behavior modification kicked in. Stephanie replied that we want real claims experience on which to base our decisions, that we are short on time to implement changes in July. We may not have to make many changes in the short-term if utilization is decreased as much as we suspect it may be by dint of the mid-year plan changes that were made.

From a public relations perspective, people are expecting to be able to change plans on July 1. Is it possible to suggest an "as is" renewal on July 1? Debora Bone stated that trust was broken when there was no open enrollment in January; to institute another unknown would not be prudent. There needs to be an opportunity for reenrollment and an effort to stabilize things this July. If we renew "as is" for one more year, that allows time to do more research for next year. If we keep the self-funded PPO plans, the only sensible thing the JPA Board can do is to set a rate high enough to cover the cost of the plans. If they don't go high enough, then they will have to do another mid-year adjustment. It would be better to overestimate and build up some reserve.

Jerry replied that there is some danger to building a reserve: by inflating the PPO rates and getting a good renewal of the HMO, then that creates adverse selection. What should be done when we talk about putting in an adverse selection "load" is that it really should be put on the HMO plans. That way, if there is migration to the insured program(s), the JPA as a whole does not "lose" funding.

Pegi asked if it was fair to ask Jerry what he would do. He replied that it is very difficult to give good consulting right now without data. All of these options look great, but without seeing numbers and hard data, it is very difficult to say what is the sound path. It

really depends. The Board has to decide about risk: do we want to be in the self-insurance business?

Olivia asked whether there is a pattern of going to HMOs in the areas Keenan serves. Jerry replied that it depends on cost and area. Santa Clara offers a PPO, San Mateo has an HMO only. JPAs in Southern California tend to be HMO only. Individual districts have eliminated PPOs in the Sacramento Region. Olivia replied that based on her research community colleges are maintaining their PPOs—it is a necessity.

Doug asked Jerry to summarize: Jerry replied that it would be possible to do a common risk pool for an HMO and PPO offering, it's just not clear how that would be structured given our current plan designs.

Pegi asked if we could ask others on the JPA to do a survey—we could email the advisory committee our survey as a model.

Olivia expressed concern that retirees weren't surveyed. Nearly all retirees are in the Prudent Buyer plan and are not interested in changing. It's important to have their numbers included.

Next meeting dates: 3/10 at 1 pm room 510--cancel
 3/17 from 12:00-2:00 in room 510
 3/22 from 1:00-3:00 in room 830
 4/7 from 12:00-2:00 in room 510

The meeting adjourned at 12:40 pm.