

STATE EMPLOYEE GROUP BENEFITS ADVISORY COUNCIL MEETING MINUTES

Wilderness Room, 2401 Colonial Drive
Helena, Montana

December 7, 2010

SEGBAC Council Present

Chairman: Russ Hill, Administrator, Department of Administration, Health Care and Benefits Division
Member: Monte Brown, Operations Manager, Department of Transportation
Member: Kelly DaSilva, Human Resource Manager, Legislative Branch
Member: Richard Cooley, Portfolio Manager, Dept of Commerce, Board of Investments
Member: Erin Ricci, Admin. Asst. / ICCW Representative, Department of Natural Resources & Conservation
Member: Tom Schneider, Montana Public Employees' Association
Member: Tom Bilodeau, Representative, MEA-MFT
Member: John McEwen, Representative, State of Montana Retirees
Member: Mary Dalton, Medicaid & Health Services Branch Manager, DPHHS, Health Resources Division
Member: Steve Barry, Administrator, Staff Services Division, Department of Corrections

SEGBAC Council Absent

Member: Amy Sassano, Deputy Budget Director, Governors Office, OBPP
Member: Mike Cooney, Senator, Senate District 40

Staff

Karen Wood, Deputy Administrator
John Thomas, Senior Health Officer
Melanie Denning, Health Officer
Jackie Dunbar, Medical Management Supervisor
Jessie Eickert, Systems Analyst
Amber Godbout, Attorney
Charlotte Hafer, Customer Service Assistant
Cathy Reagor, Nurse Case Manager
Sherri Rickman, Nurse Case Manager

Kelly Grebinsky, FSA, Principal, Actuaries Northwest
Laura del Guerra, Take Control

Guests

Ginger Lindsey, BCBS
Kim Stubby, BCBS
Cindy Kwasney, BCBS

L'Joy Griebenow, New West
Bernard Khomenko, MAHCP

Call to Order & Old Business

Russ Hill called the meeting to order at 8:35 AM. There was a new member to the council present. Russ had everyone go around and do introductions. Brian Ehli is replacing Tom Bilodeau as the Representative for MEA-MFT.

John McEwen moved to approve the minutes. Tom Schneider seconded the motion. There was no discussion. All approved, motion passed.

Financial Report

Kelly Grebinsky, with Actuaries Northwest Inc, went over the third quarter financial report. He explained that the table on page 1 is the comparison of Medical, Rx, and Dental claims. This table shows the 12 month trend. Medical is at 5%. There have been some large claims paid in the third quarter. The Prescription trend is at -15.9% reduction over last year. This is attributed to URX. Dental is at a 5.6%

decline. The table on page 2 is the update on general reserves. We are at \$53.9 million in the fund balance. We are above the 300% of reserves. He then moved on to page 4. This table shows the income and expense by combined medical plans and dental plan. Medical claims for July 1-September 30 are \$21.4 million. The prescription claims are \$5.4 million. He then moved on to page 7. This shows the Indemnity Plan at a loss ratio of 96.5% year to date. The managed care plans on page 8 for third quarter shows Blue Choice at 79.7% loss ratio, Peak at 66.6% and New West at 85.1% for a total loss ratio of 81.1% for the third quarter. Year to date Blue Choice 74.2%, Peak 93.7%, New West 102.4% for a total of 82.8% loss ratio. The difference for New West is the amount of people who moved off the plan in January and had claims last year. Those claims were paid this year. On page 9, this table shows Actives vs. Retirees. The loss ratio for Actives and COBRA is 78.2% for year to date. Retirees under 65 stayed the same at 163.2%. For retirees over 65, the loss ratio is 87.6%. The total for all retirees the loss ratio is 119% for this year compared to 131% last year. Page 10 shows the projections through 2013. There is a projected gains for 2011 but the outlook for the years after isn't very good.

URx Update

Karen gave an update on URx that was implemented in January 2010. With URx, the average weekly claims are \$407,907. Last year the average weekly claims were \$503,359. We are saving close to 30%. We have been doing a lot of training our members on how the plan works. There has been a lot of positive feedback from both the members and the providers. Plan exceptions are forms that member have their providers fill out when they cannot take an alternative medication. To date we have received 1780 plan exception forms. There have only been 118 denied. The other benefit of URx is that members have access nationwide to pharmacies because Med-Impact has a nationwide network. Overall, members have a 5% decrease in medication cost. The PTAC committee reviews medications on a quarterly basis. In theory, as other groups join our URx plan, our cost to MAHCP will decrease.

Early Retiree Reinsurance Program (ERRP)

Jessie Eickert explained what this program is and how it works. The Early Retiree Reinsurance Program was created as part of the Affordable Care Act and allows participating employers to request reimbursement for a portion of the health care costs for early retirees and their dependents. In order to become a participating employer we submitted an application to the U.S. Department of Health and Human Services and received approval.

Requesting reimbursement is a two step process. Prior to submitting each reimbursement request, we are required to submit an Early Retiree List. The Early Retiree List is comprised of individuals who meet two primary considerations.

The first consideration is whether the individual is an early retiree. This determination is based on age, plan participation, and employment status. The individual must be:

- a. 55 or older
- b. enrolled in our medical benefit
- c. not eligible for coverage under Medicare
- d. not an active employee

If the member meets this criterion, they and their dependents may be eligible for the ERRP program reimbursement if they have accumulated \$15,000 or more in paid claims that are eligible for credit towards the ERRP cost threshold. Eligible claims are for a medical item or service that is covered by Medicare Part A, B, or D. If the retiree and/or dependent meet this dollar threshold, they are eligible for the ERRP reimbursement and can be included on the Early Retiree List. The ERRP program will reimburse 80% of all claims between the \$15,000 cost threshold and the \$90,000 cost limit for each retiree or dependent. The maximum eligible amount reimbursed for an individual is \$60,000 per calendar year. (**\$90,000 cost limits minus the \$15,000 cost threshold equal \$75,000 times 80% which equals the maximum of \$60,000 per early retiree.**)

We are working closely with our eligibility and data warehousing staff to create the Early Retiree List. Once the Early Retiree List is created, we will submit the list to Health and Human Services, who will

process the list and return a response file communicating the periods of time each individual is eligible for ERRP reimbursement. Using these timeframes, we will work with our data warehousing staff to aggregate cost data for all eligible members to report costs to HHS and request reimbursement.

Our initial eligibility Early Retiree List will be submitted to HHS by December 29th and we will request our first reimbursement by mid January. HHS has provided guidance on the frequency of reimbursement requests and will accept requests once per calendar year quarter for a plan year. Moving forward we will follow this guidance and submit files and request reimbursement on a quarterly basis until the ERRP funds are exhausted. \$5 billion have been allocated for the program and once the funds are gone, the program will end.

The funds we receive under the ERRP program will be used according to the guidelines established by HHS. Accord to HHS, we may use the money to reduce our health benefit costs or reduce the health benefit costs of participants, which would be premiums, copayments, deductibles, or coinsurance. We are going to use the ERRP proceeds to help us reduce our health benefit costs which will in turn be reflected in our members premiums.

Sick Leave Fund Workgroup

Erin Ricci, Kelly DaSilva, & Steve Barry will join the sick leave fund workgroup. Steve mentioned that he will be willing to participate but does not want to chair the group. Kelly mentioned that someone from HCBP should chair and she suggested Karen. Karen agreed to chair this workgroup. Mary would like the draft policy sent to all committee members so that their comments can be forwarded to the group.

Autism Benefit Recommendation

John Thomas updated the committee on the Autism benefit. He mentioned that an Autism Benefit committee was formed to develop a QCC for Autism. After extensive work, the group looked at what Blue Cross was developing. The Autism committee determined that what they were trying to accomplish was very similar to Blue Cross. The group decided to stop working and follow the medical policy of both Blue Cross and New West. Mary Dalton moved to adopt the medical TPA for Autism. Tom Schneider seconded the motion. There was no discussion. The motion was approved to follow the medical policies from Blue Cross and New West with regard to Autism.

EAP Transition Update

Jackie Dunbar gave an update on the transition from Reliant Behavioral Health to HCBP. The RBH contract was cancelled effective December 31, 2010. Our office has created the Healthy for Life- Weight Management Program to replace the Why Weight program. This will be available to plan members who are interested in managing their weight and meet certain enrollment guidelines. Participants will learn to incorporate lifestyle changes as they achieve weight and health goals.

This comprehensive "Healthy for Life" program combines incentives for members who are already engaged in maintaining good health as well as for those who are struggling to get there.

The Weight Management program benefit includes:

- 16 week module, followed by six month module via group webinars focusing on: nutrition education and skills (grocery shopping, preparing food at home, choosing healthfully while eating out, food budgets, etc...) and physical activity promotion sessions.
- One on one access to a Registered Dietician(RD) and Registered Nurse (RN)(via e-mail or telephone)
- Weight tracker and calorie counter
- Reimbursement of some medical expenses (i.e., doctor visits, physical therapy, some medications)
- Weight loss expenses upon approval by RD case manager – gym membership, physical therapist, exercise physiologist or personal trainer, Weight Watchers dues. This will be based on an individual needs and the expenses will not be reimbursed until the member has successfully completed the entire program.

Prerequisites for Enrolled Program:

- Participant must be ready and able to devote the time required by the program.
- Participant must have participated in the Health Screenings within the last year.
- Participant must be enrolled in the SOM Health Plan.
- Participant must fill out a health contract and meet certain weight and health criteria.
- Participant must be able to participate in physical activity.
- The first cycle will be limited to 25, and contracts are due by January 7, 2011.

Anyone has free access to our in-house RD and RN.

We have also developed a Healthy for Life-Prenatal Program to replace the MommyTrax program. This free and confidential prenatal program is available to all State of Montana employees that participate in the State's health care plan. As an additional benefit, if enrolled within the first trimester, **the deductible and co-payments and/or coinsurance for doctor's fees and first ultrasound may be waived.** This means that these fees are paid by the State of Montana health insurance plan rather than by the patient (as applicable).

Plus everyone who enrolls gets

- Free prenatal vitamins;
- Pregnancy risk screenings;
- Healthy pregnancy booklet;
- Access to a Registered Nurse and Registered Dietician;
- Post-partum and follow-up screenings.
- Caring for your newborn booklet

Once a health risk assessment has been completed, members will be required to keep in contact with their Case Manager based on the outcome of the assessment. Members rated at a higher risk will be required to be in contact every month whereas lower risk members will only need to check in every trimester.

Our in-house dietician will also be working with members to help decrease risks through nutritional counseling and remaining active during pregnancy. Breast feeding education will also be included in the information provided.

Member's can choose between conversing via telephone or e-mail with the case managers and registered dietician.

Jackie also went over the newsletter that will be going out to all members later this week. There is going to be a big push in February for the tobacco cessation program.

Take Control Diabetes Program

Laura del Guerra from the Take Control program gave an explanation of the Take Control Program. This program has been assisting diabetics for more than four year by applying their comprehensive risk reduction model with a unique telephonic delivery method. We believe that everyone can live well with diabetes. Long term health can improve and health care costs decreased if patients know about their disease, receive education, and become active participants in managing their diabetes.

A diabetes disease management program offers many benefits to employers including:

- Decreased health care costs on average 70% of the time.
- Patients who undergo DSMT have, at a minimum, a 10% higher adherence and compliance rate with clinically appropriate, evidence-based medical treatments to improve health outcomes.
- Decreased Emergency room visits

- Decreased Hospital Length of stay
- Increased Productivity
- Decreased absenteeism.

Take Control offers two distinct programs. First is the Risk Reduction Program. This is designed for diabetics at increased risk for complications with an A1C>7%. There are currently 141 participants enrolled in this program; 62% women, 38% men. Studies show a 1 point decrease in A1C translates into a 35% decrease in the risk of diabetes-related complications, such as eye, kidney and nerve problems. The second program is the Education and Support Program. This is designed for diabetics with an A1C<7%. By providing ongoing diabetes education and monitoring of A1C's this group should remain at lower risk for complications and not become a burden to the insurance plan. There are currently 77 participants enrolled; 61% women, 39% men. The age group of 51-60 comprises 48% of Education and support population. Over the course of the last 12 months, 12 ESP participants (16%) with an A1C>7% who were moved to the Risk reduction program for immediate education aimed at reducing their A1C.

Participant Benefits include:

- At program entry applications are reviewed and all current risk factors are identified. Letters are sent to participants addressing all risk factors and areas of concern.
- "Ask an Educator" program
- Free testing supplies
- Access to monthly newsletter and all group education.

Voluntary Employee Benefits Association (VEBA) Plan

Melanie Denning gave an update on the VEBA plan. The Health Care & Benefits Division had contracted for administrative services for its VEBA plan beginning in 2003. The original contract was divided into four administrative pieces and contracts were signed with;

- VEBA Services Group-Mark Wilkerson, Consulting
- Washington Trust-Trust & Asset Manager
- AIG Valic-Training & Education
- Rehn & Associates-TPA

The contract with AIG Valic was termed in 2008 due to cost and education came in house and the remaining contracts expired June 20, 2010 and August 31, 2010. We have extended these agreements to December 31, 2010, while we pursue a new vendor through the procurement process.

On March 26, 2010, HCBP issued its first proposal and received 2 responses. The committee disqualified each proposal as non-responsive for failure to comply with major portions of the RFP requirements. On June 23, 2010, HCBP issued a revised and updated proposal and there was only one vendor response. This too was disqualified for failure to comply with major portions of the RFP requirements.

Given all of these changes, HCBP still didn't receive a satisfactory response to the proposal approval from Procurement was sought for direct negotiation. HCBP communicated with Rehn & Associates about pursuing this contract through Health Insurance Services Northwest (HISN). They had planned on submitting a proposal but elected not to due to a perceived conflict of interest with one of their intended subcontractors. Any potential for conflict of interest is eliminated due to the fact that the original contract ends in December 2010. A phone conversation was had with representatives from HISN to confirm their interest in providing the services sought in the RFP. They did state that it was their intention to submit an offer to this RFP and elected not to do so at the last minute due to the perceived conflict of interest. We feel this group has the knowledge and ability to service our VEBA contract needs based on their qualifications and their past history in working with the State of Montana Health Care and Benefits Division. HISN has indicated they are willing to provide documentation showing their ability to provide the services. Approval was sought and received from the Procurement division. We are in the final stages of contracting with HISN for a contract start date of January 1, 2011.

Currently, there are 128 state groups, 2 University campuses with 6 groups, 7 K-12 schools for 10 groups, 5 cities with 12 groups, and 8 counties participating in VEBA. Participation is a rolling number of accounts as when accounts hit a zero balance, they are complete as well as new enrollments every month. There are currently 470 active accounts as of November 30, 2010 with a total account balance of \$3,293,267. We are also working on the loan forgiveness as part of house bill 3.

Administrator Update

Russ mentioned that he has formed 5 workgroups within HCBD. The first is Health Care Reform. This group's goal is to identify changes that are required by the current Healthcare Reform Act; to stay current and focused with our State Plan as it relates to this Act, to keep up-to-date with timelines, to inform stakeholders, and to facilitate required changes. The second group is Health Care Cost Control. This group needs to think of costs being at or below national trends. The third group is Workers Comp. This group's goals are to increase return to work placements and improve the process for medical providers to determine return to work options. The fourth group is Legislative. This group's goal is to monitor, respond and participate in the 2011 legislative session. Russ will be the "front" person for HCBD for the legislative session this year. The final group is the Staff education and engagement group. This group's goal is to create and maintain a professional, diverse, and responsive workforce.

Russ gave an update on Health Care Reform. Montana is the first state in the nation to allow state employees to put their children on CHIP. We have made all decision that needed to be made. We are a grandfathered plan for 2011, no pre-existing conditions for member under 19 years old, adult child coverage until age 26, no rescissions of coverage except under limit circumstances, elimination of lifetime limits, elimination of annual limits, Early Retiree Reinsurance Program (ERRP), and limitation of flex spending reimbursement for OTC medications. Every year we will make the decision on whether or not to keep the grandfather status. The state plan is in compliance with PPACA and the state plan will continue to monitor PPACA.

Russ handed out little goodie bags to our retiring board members, Monte Brown and Tom Bilodeau. He thanked them for their years of service.

The next meeting will tentatively be March 1.

There was no public comment.

Tom Schneider moved to adjourn the meeting. Mary seconded the motion. There was no discussion. The meeting adjourned at 12:22 PM.