Maine-Endwell CSD Health Insurance Task Force Report

On January 18, 2018, Superintendent VanFossen requested I chair a task force to look into strategies and find potential ways the District can make structural changes and create savings within our current health insurance offerings. The task force committee was comprised of the following members representing a cross section of our District:

Jeff L'Amoreaux, Assistant Superintendent, Chairperson for Task Force
Patrick Cowburn, Broome-Tioga-Delaware Health Insurance Consortium Consultant
Jay Bongiornio, Regional Sales Manager for Excellus Blue Cross and Blue Shield
Edward Vaughan, Partner at ENV Insurance
Bob Miller and Sue Rhea, Transportation Unit
Sheri Hohn and Laura Bryant, Support Staff Unit
Tim Weyant and Ken Corson, Maintenance and Custodial Unit
Lynne Musa, Teacher's Unit
Greg Asfoury, Administrator's Unit
Dan Hennessey, Community Member
Bill Austin, Community Member
Doug Peters, Community Member
Gregg Armezzani, Board Member
Bill Powell, Board Member
Joe Beasley, New York State United Teachers Labor Relations Specialist
Kate Andreatta, New York State United Teachers Labor Relations Specialist

BACKGROUND

The Maine-Endwell CSD has belonged to the Broome-Tioga-Delaware Health Insurance Consortium since 1988. The Consortium is a self-funded health insurance cooperative that currently consists of 23 school districts, and our local BOCES. Each component school is represented in the Consortium by a school board member and each school receives one vote on Consortium matter. On an annual basis, the Consortium hires consultants to help manage the day-to-day operations. The consultants include an attorney, an administrator, and a health insurance consultant. The Consortium also has five people from the various member schools that serve on a rates committee. This committee works with the consultants to help determine the funding levels necessary to keep the Consortium financially whole. Based on the recommended funding levels, the rates each school pays for the next year are determined.

Each member of the consortium has their own plan and benefit structure that they have negotiated with their respective bargaining units at their district. Each component school has their own required funding level based on their plan and benefit structure, as well as the component schools performance over the previous three years of claims. The consortium utilizes a 3-year modification rate that is specific to each school's performance. As the renewal date approaches, the Consortium sets an average rate increase for the entire Consortium. From that rate, each school's modification rate is factored into the equation, resulting in rates that are above, or below, the Consortium average. For example, the average increase for the Consortium in 2018-19 was 4.25%. Maine-Endwell's 3-year modification rate was 1.035, or 3.5% over the Consortium average. By adding the 4.25% and the 3.5%, the District's increase for 2018-19 was 7.75%.

In 2011, the District moved all Medicare eligible retirees out of the Maine-Endwell Excellus plan over to the Hartford, under a Medicare Supplemental Plan. This move saved the District approximately $1.0

million in the 2012-13 school budget. However, moving Medicare eligible members out of the Consortium to their own plan also moved our best performing group from our claims data. Currently, when a retiree reaches age 65, Medicare is the primary payer for insurance claims, approximately 65%. The 35% balance of the claim is then paid by our Supplemental Hartford plan.

The District has also experienced several large claims over the past five years. In the Consortium, each district is responsible for their own claims. They are able to spread out the large claims over three years as part of the rate modification calculation. However, when you have multiple large claims in back-to-back years, the costs add up quickly. For example, the District had a large single claim in the 2014-15 year of $916,567. At that time, the average total claims for that 3-year period was approximately $7.2 million. That means that one claim, 12.7% of our average total claims, was able to be spread out over the next three years of our increases starting in 2015-16 through 2017-18. So to pay for that claim, in each of the three years, the District contributed an extra 4.23% into the Consortium to pay the single large claim.

Large claim amount		$916,567
Total average claims		$7,200,000
Percent of claims= $916,567/$7,200,000	=	12.7%
3 year pay back= 12.7% / 3 years	=	4.23%

Due to these factors, the District has seen a 3-year spike in claims and correspondingly, rates as of 2016/17 through 2018/19 (see Figure 1.1 below).

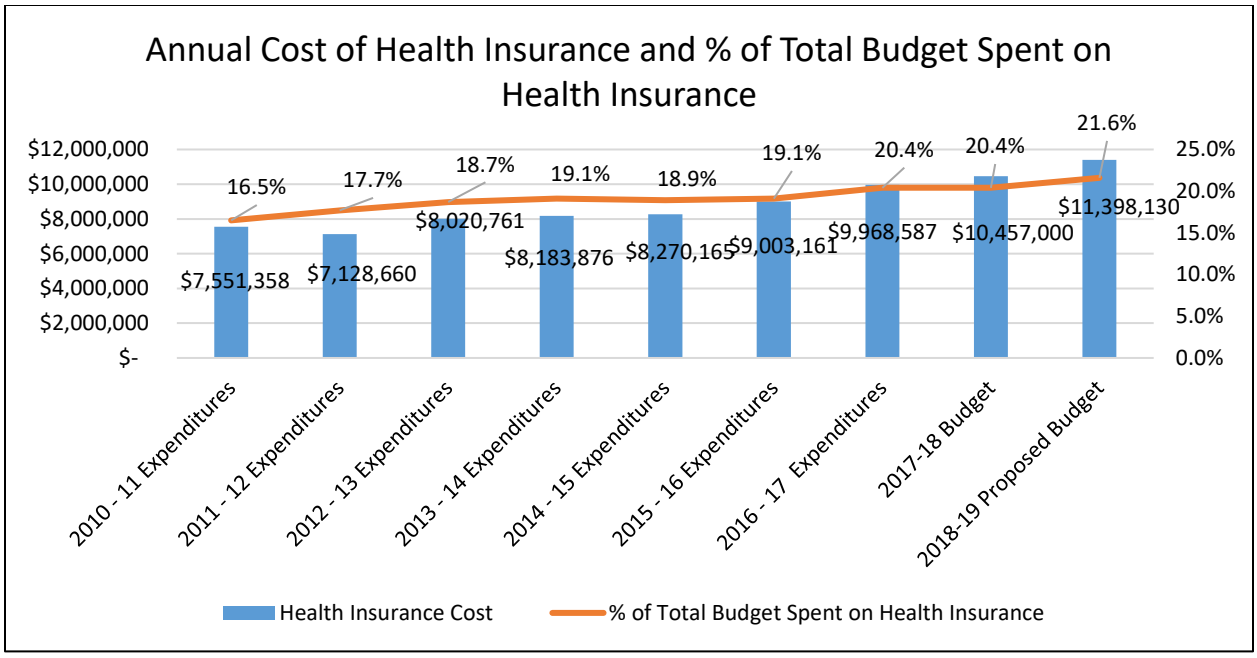
As can be seen by the chart below (Figure 1.1), the average increase over the past 18 years has been 9.8%. That means our health insurance costs are doubling every 7.3 years. In Figure 1.2, you can see that the percentage of our budget that goes to pay for health insurance benefits has gone from 16.5% of the total budget in 2010-11 to 21.6% in 2018-19. From a school budget perspective, our increases are financially unsustainable.

FIGURE 1.1

Fiscal Year	% Increase	Fiscal Year	% Increase
2001/02	11.4%	2010/11	5.7%
2002/03	24.9%	2011/12	3.9%
2003/04	23.5%	2012/13	4.5%
2004/05	14.3%	2013/14	10.2%
2005/06	11.7%	2014/15	1.9%
2006/07	9.9%	2015/16	9.6%
2007/08	3.1%	2016/17	13.5%
2008/09	0.5%	2017/18	14.4%
2009/10	5.7%	2018/19	7.9%

Average % increase 2001/02 thru 2018/19: 9.8%

FIGURE 1.2



OBJECTIVES

The main goal of the taskforce was to look into, and provide, recommendations for long-term structural savings for health insurance. The task force invited members from all six bargaining units at the District. It was important to have bargaining unit representation to allow the units to hear what options are out there, and to have them weigh in on the information presented. Ultimately, any changes to the level of benefits provided by the District, or change in contribution levels by any of the bargaining units, would have to be negotiated as part of future contract settlements.

At the onset of the task force, four areas of study were recommended for review:

1) Does it make sense to stay in our current health insurance consortium, or is it feasible to look to have Maine-Endwell go out on its own? Could this could be accomplished either in a self-funded or self-insured health insurance plan?
2) Are there different insurance plan option within, and outside of the current health consortium that are viable?
3) Are there areas for savings within our prescription drug plan at Maine-Endwell?
4) Are there areas for savings within co-pays, deductibles and employee contributions?

As we progressed through meetings, other areas of savings where identified, and will be discussed in a later section. The biggest area identified was the potential of moving retirees from the Hartford supplemental Medicare plan to a Medicare Advantage plan.

AREA 1 Findings:

In 2010-11, the District worked with an insurance consultant to determine options that it could look at to save money in the health insurance area. One of the areas analyzed was having the District self-fund its own health insurance plan. The review looked at 3 years of claims data, analyzed stop loss premiums for large claims, how it could administer its prescription drug plan and other areas. After the review, it was determined that there were potentially some savings in the self-insured model, but the negatives to the move outweighed the positives. The largest detriment to moving in this direction was the District needing to front approximately $1 million for a reserve for claims and run outs. At that point, the District did move the Medicare eligible members to the Hartford Plan, saving approximately $1 million. This was a recommendation of the consultant at that time.

In 2016, facing a proposed 13.5% increase in health insurance, the District once again analyzed moving to its own self-insured plan. The same conclusion was reached, and the consultant report recommended the District remain in the BTD Consortium. The biggest reason for the recommendation revolved around several large claims that the District had incurred. These claims ranged from $300,000 to $1,000,000. Because the Consortium allows these claims to be spread out over a 3-year period, the consultant made the recommendation for the District to stay in the Consortium as this was most beneficial at the time.

As part of the Task Force, the District is still reviewing information with another consultant (Relph Benefits Advisors) to see if self-insuring makes sense. The amount of information required by the consultant is very large, and meetings are currently being held with Relph Benefits. When the information and analysis is complete, this report will be amended to include the findings.

UPDATE: The district met on November 10, 2018 with Relph Benefits and have a punch list of data needed to get an actual review done to see the feasibility of self-insuring. The consultants are aiming for an early Spring date to have the analysis completed.

AREA 2 Findings:

In March, the District met with representatives from IOA Insurance and Integrity Health of New Jersey. The dialogue centered around the concept of a Partnership Health Clinic (PHC). Under this model, the District would be required to build out its own health clinic in one of its buildings. Integrity then would provide medical services to staff and retirees with no out of pocket cost to the employees or retirees. The cost savings in this model come from the efficient management of the care provided, and a reduction in cost due to the reduced overhead of hiring their own staff in the PHC directly. The scope of services was limited to Rx dispensing, X ray, well visits, walk in visits and other lower end medical services. This service would potentially capture roughly 30% of the total claims that the district would normally incur in a year, or $3 million. Through the management of the care and the tight control of the overhead costs by Integrity, the estimated savings could be in the $300,000-$500,000 range annually. However, the District would be required to pay for the construction of the clinic (several million dollars)

out of its own pocket. Integrity Health has two school districts in New Jersey that have both been under the PHC model for over 5 years. They have not expanded in New Jersey since then and they currently have no such models in operation in New York State.

In reviewing the model with the Task Force, there were many questions and potential pitfalls the District would need to navigate. The concept has been tabled and no further discussion or analysis was completed.

During the negotiations process with our support staff (MESSA), the parties agreed to put a new plan in place for newly hired employees after July 1, 2018. The plan highlights are listed below:

	Individual	Family
In Network Deductible	$750	$2250
Out-of-Network Deductible	$1500	$4500
Max Out-of-Pocket In-Network	$2500	$7500
Max Out-of-Pocket Out-Network	$2500	$7500
Emergency Room Co-Pay	$100	
Prescription Co-Pay	$10/$35/$70	

The cost of the new plan provides savings of 11.4% versus the cost of the current individual and family plans. This change to the new plan will result in an estimated savings of $30,000 per year as new members are hired by the District to replace current members who leave our District.

The parties were also able to agree that current members of the health plan would also pay the Emergency Room $100 Co-Pay that is in the new plan. This resulted in an estimated annual savings of $4,000 moving the entire MESSA group to the new co-pay.

AREA 3 Findings:

Prescription drug costs account for 27.6% of the total cost for Maine-Endwell. For the 2017-18 year, the total cost of prescription drugs was $2,346,702 for our District. The consultant the District is working with on the self-insured data is also researching the potential of carving out our prescription drugs from the Consortium and self-insuring/self-funding that through at third party administrator (TPA). That data is still being reviewing and the report amended to include any findings.

The District worked with Excellus Sales Manager Jay Bongiorno to look into prescription edits for the current plan. There are four prescription edits that the Task Force reviewed. Below is a summary of each edit:

PRIOR AUTHORIZATION

Our clinical pharmacists and physicians review medication requests to make sure the choice of drug or dose is appropriately prescribed based on FDA and manufacturer guidelines, medical literature, safety, use, and benefit design. Prior Authorization measures the effectiveness of policies by monitoring and reporting approval and denial rates.

STEP THERAPY

Within specific therapy classes, multiple drugs are available to treat the same condition. Members are required to try clinically effective, lower-cost medications before we will cover another higher-cost drug for that condition.

GENERIC ADVANTAGE PROGRAM (MAC)

Promotes the use of generic medications. If a member chooses to stay on a brand name drug that has a generic equivalent, the member will be subject to the MAC Penalty. The penalty is the difference in cost between the AWP discounted brand amount and the discounted generic amount plus the generic copay.

MANDATORY MAIL ORDER:

Mandatory Mail Order requires members to fill certain maintenance medications through ESI Mail Order only and increases member savings for up to a 90-day supply. This channel is not only the most cost-effective, with the deepest discounts, but also increases adherence by ensuring patients have the right medication at the right time.

The District was able to negotiate all four prescription edits into the Support Staff contract effective 9/1/18. This resulted in estimated annual savings of $60,000 for MESSA. Below is a summary of estimated savings if all five remaining bargaining units agreed to the four Rx edits:

Prior Authorization Savings:	$59,128
Step Therapy Savings:	$99,580
Generic Advantage Program:	$84,905
Mandatory Mail Order:	$89,984
Total Estimated Savings:	$333,597
Less Estimated Savings from MESSA:	($60,000)
Remaining Estimated Savings at M-E:	$273,597

AREA 4 Findings:

The first two items, co-pays and deductibles, offer opportunities to save money. The task force spent one meeting reviewing what the changes from the current plan would look like if the District plan was changed to a PPO model. It was noted by the Excellus representative at the meeting, Jay Bongiorno, that many districts across the state have moved to a PPO model and away from the model we have at Maine-Endwell. There was a lengthy period of questions and answers around the topics.

As noted in AREA 2 Findings, the Support Staff bargaining unit did make significant changes to the plan benefits for newly hired members.

The District, through negotiations, currently has all six bargaining units, and those not covered by a collective bargaining agreement, paying a percentage of the cost of health insurance. As of July 1, 2018, each unit pays the following percentage towards the cost of health insurance:

Administrators:	20%
Teachers:	11%
Support Staff:	9%
Transportation:	9%
Food Service:	9%
Custodial:	9%
Confidential:	12.5%
Superintendent:	25%
Asst. Superintendent	20%

Other Areas Explored:

As noted in an earlier section, one area that recently came up was looking at our Medicare Supplemental Plan to see what savings there might be in moving that group of retirees into a Medicare Advantage Plan. The current supplemental plan offered by the District is administered by the Hartford Group. Under this plan, the retiree participates in Medicare Part A & B as the primary insurance. Claims not covered by Medicare are then processed through the Hartford Supplemental Plan.

A Medicare Advantage Plan is administered by a private insurance company, such as Aetna or Humana for example. This plan replaces the actual Medicare coverage by the Federal Government, and also provides supplemental insurance as well. Because the private insurance company runs the plan, there are federal government subsidies that go back to the private insurance company for doing this. The subsidies allow the private companies to keep the monthly cost down significantly. The district recently received quotes from both the supplemental side as well as the advantage side. Below is a summary of the quotes:

The Hartford (supplemental insurance):	$513.69 single cost plan per month
Humana (advantage insurance):	$219.50 single cost plan per month

There are currently 343 Medicare aged retirees in the District's supplemental insurance plan, so the savings of $294.19 per month multiplied by the 343 members equals $100,907.17 per month. There is an opportunity to save $1,210,886 annually by making the switch from a supplemental plan to an advantage plan. With that said, there are also potential differences between the two plans in terms of benefits, networks available, coverages, etc. The District is currently receiving proposals and having meetings with the Hartford, Aetna, and Humana to determine what it would need to do to keep Medicare benefits whole for participating retirees. These meetings are set up for mid to late August with the respective companies. If the Medicare Advantage plans seem to be a feasible alternative, the District would seek to meet with representatives of the various bargaining units and their respective NYSUT representatives.

UPDATE: The District has worked with Humana to roll out a Medicare Advantage Plan to all Medicare eligible retirees as an option, effective January 1, 2019. To start the process, the District has met with the NYSUT representatives of the various bargaining units. From there a

meeting with all the Presidents of each bargaining unit (or a designee) was held to review/analyze the side-by-side comparisons of each plan. There will be two informational meetings held on December 4th at the Staff Development Room at 10am and 2pm for retirees to come and get information about the plan. At the meeting will be Humana representatives as well as District representatives.
From the perspective of the District we feel the Humana Plan will offer the same or better benefits. The goal of the District is to use the concept of the option to try Humana to analyze if the Humana plan is indeed as good or better. In order to try and maximize the number of people that are willing to try the Humana plan, the District will also offer a $500 Health Reimbursement Account (HRA) card. The HRA will be managed through a company called ProFlex. The ENV Insurance Group will continue to provide their Medicare Call Center as they currently do for Maine-Endwell retirees that use the Hartford Plan and for any enrollees in the Humana Plan.

RECOMMENDATIONS:

As we begin the recommendations section, it is important to discuss a few important items related to the process of making potential changes to our health insurance plan.

First, almost every item discussed at the task force meetings would require the District to negotiate in good faith with the respective bargaining units of the District. All contracts at Maine-Endwell include language to the below that states:

"The District agrees to pay on behalf of each eligible employee participating in the Central New York Region-wide Blue Cross/Blue Shield Plan or any other Health Insurance Plan mutually agreed upon by the District and Association".

Second, any changes to retiree's health benefits must adhere to the above language. The District cannot unilaterally change benefits to retirees with a corresponding change to the active members.

Bottom line, unlike a private company, the District must negotiate any changes to the health benefits in good faith.

RECOMMENDATION 1:

The District should actively negotiate the four prescription edits to be included in the plans for the five remaining bargaining units that do not have it. These edits were described in Section 3 above, and the resulting savings to the District would be an estimated $273,597 to move the remaining five bargaining units over.

UPDATE: As of April 2020, two bargaining units have the four prescription edits in their plans, Support Staff and Food Service. The District will continue to attempt to negotiate these changes in the future.

RECOMMENDATION 2:

The District should actively negotiate to change the plans offered to new employees hired after the new contract dates start for the respective bargaining units. The savings for the Support Staff group was an estimated $30,000 per year to move the plan highlighted in AREA 2. Extrapolating that across the other five bargaining units could result in estimated $125,000-$150,000 annual savings for the District. The new plan incorporates changes to deductibles, medical co-pays and prescription co-pays.

UPDATE: The District has attempted to negotiate these changes into contracts, and is actively negotiating two contracts as of April 2020.

RECOMMENDATION 3:

Based on preliminary data, the annual savings potential is $1.2 million to move Medicare eligible retirees to a Medicare Advantage plan from our current Medicare Supplemental plan. An analysis needs to be completed that includes how the benefits in our current Hartford Plan line up with benefits offered in an Advantage Plan. If the analysis still shows the potential for savings, then meetings should be set up with the respective six bargaining units. The analysis is being completed now and findings will be presented to the District mid to late August. The District will be receiving 3 proposals. The first is the renewal quote from the Hartford Supplemental plan. The other two will be full quotes from Humana and Aetna for Medicare Advantage plans. There are 3 options available within this recommendation:

1- Stay with the Hartford Plan
2- Move all Medicare eligible retirees over to a Medicare Advantage Plan
3- Keep the Hartford Plan and offer a Medicare Advantage Plan as an option

UPDATE: As of January 2020, all retirees that are Medicare eligible are on a District sponsored Medicare Advantage plan with Humana. The District realized approximately $1 million in savings over the 2019-20 and 2020-21 budget cycles with this move.

RECOMMENDATION 4:

The District should actively negotiate for the $100 emergency room copay. The average emergency room visit is over $2,000 per Excellus. This copay would be less than 5% of the cost of the emergency room visit. The total savings available moving the remaining five bargaining units is approximately $16,000.

UPDATE: The District has negotiated this change to two current contracts and will look to negotiate the change in other contracts.

RECOMMENDATION 5:

The District should continue to examine the opportunities for saving by self-insuring or self-funding health benefits outside the Consortium. The District is currently working with another local school district and consultants from Relph Benefits Advisors to review this. The timeline to complete this analysis is the Fall of 2018.

UPDATE: The District has reviewed this with two different consulting firms. While there is potential for savings, those savings are negated as the District would owe approximately $1.5 million to the Broome-Tioga-Delaware Health Insurance Consortium for unpaid claims. This amount would be owed to the Consortium upon the District notifying the Consortium that they were leaving. The District has been exploring a high deductible plan concept within the Consortium since January 2020. The potential savings in year 1 would be in the $1.2-$2.0 million dollar range. The District is currently working with the six bargaining units about implementing this plan. As with any changes, it must be worked through the collective bargaining process.

RECOMMENDATION 6:

The District should continue to negotiate higher employee contributions to help offset the cost of health insurance. The attached Figure 1.3 shows data from the October 30, 2017 Fact Finding Report showing a comparison of schools in the Broome-Tioga BOCES region. As you can see, the District currently pays 91.1% of the cost of a family health insurance plan. The average in our BOCES is 87%. If the District paid the average amount that other schools paid, the reduction in cost would be approximately 4.1% of the annual premiums paid. The 2018-19 total premium cost for the District is $10,261,837. The potential savings for the District by moving to the average contribution amount would be $420,735. Every 1% increase in contribution level is $102,618 of annual savings.

UPDATE: For the 2020-21 school year, the District has the following negotiated % contributions in place:

Administrators:	15% Family	20% Individual
Food Service:	9.5% Family	9.5% Individual
Maint & Custodial*:	9.0% Family	9.0% Individual
Support Staff:	9.5% Family	9.5% Individual
Teachers:	12% Family	12% Individual
Transportation*:	9.0% Family	9.0% Individual
Management Confidential:	15% Family	15% Individual
Assistant Superintendent:	20% Family	20% Individual
Superintendent:	25% Family	25% Individual

*-contract under negotiations, this represents 2019-20 contract rates.

While the District has negotiated higher contributions, the underlying issue it faces is the benefit structure of the plan. With an average increase of 10%, the cost of the plans will double every 7.2 years, which is unsustainable.

RECOMMNEDATION 7:

If the District stays in the BTD Consortium, quotes for stop-loss insurance for large claim protection should be obtained and analyzed. This can be done working with the Consortium's consultant, KBM Management. Part of the benefit of being in the Consortium is spreading out large claims over three years so that the District is not hit hard in one year with a premium increase, rather it is spread out.

This can be done for a 3-year look back period to see what the cost for the insurance would have been versus that potential savings if a stop-loss would have been triggered.

The District has reached out to the Consortium consultant to initiate the process to receive quotes.

UPDATE: The District has done 3 separate analysis of utilizing stop loss, in the current Consortium model, the cost to purchase stop loss would be higher than the actual realized savings.

FIGURE 1.3

Teacher Health Insurance Survey

Broome-Tioga BOCES Component School Districts

for the 2016-2017 School Year

Compiled by the Cayuga-Onondaga BOCES Office of Personnel Relations

	PAID BY DISTRICT		PAID BY TEACHER	
	Individual	**Family**	**Individual**	**Family**
Chenango Forks	86%	86%	14%	14%
	$6,893.76	$17,116.08	$1,009.07	$2,880.23
Chenango Valley	90%	85%	10%	15%
	$7,729.68	$18,132.60	$858.84	$3,199.92
Deposit	76%	75.6%	24%	24.4%
	$7,175.00	$17,816.00	$2,265.00	$5,755.00
Harpursville	87.00%	89.50%	13.00%	10.50%
	$8,513.40	$20,780.64	$998.76	$2,831.76

Johnson City	100.00%	100.00%	0.00%	0.00%
	$7,764.96	$19,775.36	$0.00	$0.00
Maine-Endwell	**90.4%**	**91.1%**	**9.6%**	**8.9%**
	$8,563.48	**$21,429.48**	**$914.00**	**$2,100.00**
Susquehanna Valley	86%	86%	14%	14%
	$6,706.00	$16,664.00	$1,092.00	$2,713.00
Union-Endicott	89%	86.5%	11%	13.5%
	$7,514.77	$18,119.22	$928.79	$2,827.86
Vestal	88%	88%	12%	12%
	$9,137.67	$22,790.28	$1,246.05	$3,107.76
Whitney Point	90.00%	90.00%	10.00%	10.00%
	$8,508.60	$21,118.32	$521.00	$1,212.00
B-T BOCES	95%	85%	5%	15%
	$10,568.00	$23,467.00	$556.36	$4,141.04
Newark Valley	87.50%	87.50%	12.50%	12.50%
	$7,682.16	$19,088.28	$960.24	$2,386.08
Owego Apalachin	85%	85%	15%	15%
	$6,975.00	$18,200.00	$1,271.00	$3,158.00

Tioga	80%	80%	20%	20%
	$7,463.62	$18,639.84	$1,865.90	$4,659.96
AVERAGE	**88%**	**87%**	**12%**	**13%**
	$7,942.58	**$19,509.79**	**$1,034.79**	**$2,926.62**