From: Jonathan Welch

Sent: Wednesday, July 23, 2014 9:21 AM

To: Rick Smith, Ed Adams, Christie Jordan

Cc: Mike Evatt, Rhonda Thurman, Greg Martin, Jeffrey Wilson, George Ricks, Donna Horn, David Testerman, Joe Galloway

Subject: Insurance

I'll apologize now but I'm going to have a lot of questions this month.

Christie, since the last MOA how much have we increased premiums on each of the categories of insurance? And how much have we increased salary? The reason I ask is with another $100/month increase I'm pretty sure take home wages will actually go down in aggregate over that time period.

I know this is one way to get to the 4,000,000 number but that increase is half of the 4,000,000. I don't see that as a cost containment strategy so much as kicking the can down the road until next year Bc the underlying structure of the plan does not fundamentally change. We just change who is bearing the brunt of the cost from us to our employees.

To actually change the plan and to contain cost we have to move people off the lowest deductible plans. We don't want to with our current employees but limiting new hires to a higher deductible plan will contain costs better long term. We know that's why blue cross has done that with their employees (no one has less than a 4000$ deductible) and Erlanger and others have done the same.

If we don't do these things now we will be faced with this next year, or if we have an unexpected increase in revenue, we will potentially ignore the increases for a couple of years until we reach a budget crunch again. I would prefer to see us implement true long term cost containment as opposed to balancing it once again on the backs of current employees with a short term band aid.

Just for clarification and Ed this is probably a question for you, with typical turnover, approx 300 per year, what would the one year cost savings be if they were limited to a higher deductible plan? And can that plan be the same level of coverage just after the deductible is hit?

Also do we have a number on how much we would save by requiring spouses to take a plan that their employer provides as opposed to declining it and coming onto ours? I know we have an idea of the number of people in that situation but what would be the actual savings?

Also, the 100$ spouse increase will that apply to our current high deductible plan as well?

Depending on the answers as many people as this would effect and as much as this affects our long term budget I think we need a work session at the least where the board can hear each other's concerns and questions before we vote.
The ideas and framework presented were a good start but there are other longer term containment strategies we need to discuss.

Thank you

Jonathan Welch,DDS
District 2
290-3988

Response:

From Ed Adams

Sent: Tuesday July 29, 2014 4:12 PM

To: Jonathan Welch, Rick Smith, Christie Jordan

Cc: Mike Evatt, Rhonda Thurman, Greg Martin, Jeffrey Wilson, George Ricks, Donna Horn, David Testerman, Joe Galloway, Leon Rash

Subject: Insurance

Dr. Welch,

I have prepared the following responses to your specific insurance recommendation questions in collaboration with Christie Jordan, Leon Rash and Superintendent Rick Smith. Christie Jordan has and/or will respond to several historical financial questions you have brought up in your recent emails.

1. "Requiring spouses to take a plan that their employer provides as opposed to declining it and coming onto ours." We considered that option with our initial recommendations. As background, the current spouse enrollment is 1709 in all medical plans for the year 2013. Those spouses incurred $9,208,515 in medical expenses for the year 2013. The current spouse enrollment in all plans consists of 70% male and 30% female. We can assume that a majority of those male spouses are likely employed and likely have medical plans available where they work. It is impossible to know the exact number. But, if we assume that 50% of the 70% male spouses have other coverage available, that would be 598 spouses (35%). 35% of the total expenditures would be $3,222,980 per year. The problem with these assumptions is that we do not know which spouses incurred those expenses; those with other coverage available where they work or those without where they work. At best, these figures are estimates based on possibly false assumptions. The only way to know what savings would be generated is after the fact. The actual numbers could vary tremendously.

Administratively, there would be considerable difficulty in auditing and enforcing this type of restriction as well as many issues that would need to be addressed, such as how to handle self-employed individuals, spouses who become unemployed, become eligible for Medicare, secure employment, change jobs, become unemployed, lose coverage where they work, become divorced, married, etc. Verification would involve securing affidavits from spouse's employers and verifying the required information on an ongoing basis.

The recommended increase for spouse coverage need not affect all employees, if those with working spouses enroll in medical plans available where their spouses are employed. The recommended increase would not affect employees with individual (single) coverage.

2. "Also, the $100 spouse coverage increase will that apply to our current high deductible plan as well." Our recommendation is to not pass on this increase for spouses on our current high deductible plan at this time as an incentive for more employees to consider the high deductible option.

3. "What would the one year cost savings be if they (new hire employees) were limited to a higher deductible plan? And can that plan be the same level of coverage after the deductible is hit?" Again, the answer can only be based on assumptions that may or may not be true. It is impossible to predict what expenses a new hire may incur and/or if they will enroll in a high deductible plan at HCDE vs the Market Exchange vs enrolling as a dependent on their spouse's coverage. The unknowns could greatly affect the potential savings from no savings at all to significantly high numbers. Based upon our statistics of plan utilization by age band, it is unlikely that 300 new hires would incur expenses above the $5,000 deductible. Most new hires are younger and incur far less claims than the average employee at HCDE. The major unknown would be what the claims of this group might be, regardless of the plan selected, AFTER the deductible is met. Since A.C.A. now requires no limits on lifetime coverage, any claim could result in millions of dollars of expense, regardless of which plan they are enrolled.

Further caution on this subject is advised. There has been considerable discussion and debates concerning the non-discrimination issues, or Section 105-h of the Affordable Care Act, which essentially prohibits employers from carving out high option plans to their rank and file and even more concerning-having an equal employer contribution level across the board. Thus far, this has been postponed by the IRS until further notice. However, plan sponsors still face a myriad of mandates and requirements which loom on the horizon. Restricting plans available to new hires may be interpreted as a violation of these non-discrimination provisions and we recommend not to impose this restriction at this time, only to find out later that we must rescind the restriction. I have enclosed a copy of the latest release from the DOL on this issue for your review.

Our current High Deductible Health Plan is not exactly the same as the other two medical plan options we now offer, after the $5,000 deductible is met. The benefits are similsr to traditional HDHP's. We currently have 11 people enrolled in this plan.

In addition, there is considerable concern about the ability to recruit new teachers with such a high deductible plan as the only option for new hires.

4. You may recall from our meeting that we discussed that these recommendations are not a total solution, but a low key plan for the first year of what will certainly be a multi-year strategy to get medical plan costs under control. We have investigated high deductible health plans with health savings accounts, non-smoker discounts, plan design options, plan deductibles, co-pays, managed care, wellness, health coaches, on site clinics/pharmacy and other employee benefits options; but chose not to make recommendations on all of these options in the first year, for many strategic reasons.

There are many reasons why medical insurance is an issue every year. First, it is our second largest expense after wages. Health Care Reform has made a huge impact on our ability to control cost by extending coverage, removing limits, increased taxes and compliance. Medical inflation at HCDE has averaged 6% per year for the past 5 years and what little cost shifting and control that has taken place has been restricted greatly by the negotiation process. We expect the issue of rising medical costs will continue to be at least an annual discussion as we keep pace with compliance and an aging population.

5. While replacing a traditional model with a High Deductible Health Plan (HDHP) is the overwhelming trend, its basic premise is cost shifting. An over-all objective to eventually migrate all employees to a high deductible model makes sense, but requires several key components in order to be successful, as other major employers in our area have found out. Successful strategies for HDHP include employee education, a health savings account, tangible incentives and an average of 3 years to phase in the program. In the meantime, our current strategy is to move in that direction in phases, while maintaining a competitive medical plan and sharing more realistic cost with employees. Our surveys verify that our employees have a better plan and pay a lower amount for their medical insurance. The number of dependents we insure adds credibility to those surveys.

In today's environment, containing costs depends on three major factors: insuring fewer people, appropriate cost sharing with employees so they have a vested interest in making wise health decisions and take personal responsibility for their health and finally, providing employees with the tools to make informed decisions. Our recommendations for 2015 are just a start of what will be an ongoing effort in managing our health care budget.

If you have any further questions, please let us know.

Best regards,

Ed Adams, SPHR
Benefits Consultant to HCDE

Response:

From Jonathan Welch

Sent: Wednesday, July 30, 2014 10:14 PM

To: Ed Adams, Rick Smith, Christie Jordan

Cc: Mike Evatt, Rhonda Thurman, Greg Martin, Jeffrey Wilson, George Ricks, Donna Horn, David Testerman, Joe Galloway, Leon Rash

Subject: Insurance

Ed,

As I said last night I appreciate the response but as often happens the answers left me with more questions. Some of these may be better answered by Christie or Rick.

I'll outline these with your numbers for easy reference

1.) Thank you for the breakdown of spouses and potential savings. While it is dangerous to draw concrete numbers from well educated assumptions it seems reasonably safe to assume we could save between $1,500,000.00 on the low end and as much as $5,000,000 on the high end when we add in female spouses who may have coverage. Either way that is a significant savings.

My question is why is this potential savings not worth the difficulty in administration? The idea that the savings isn't worth the difficultly is lacking to me. We already track and verify a large amount of information regarding thousands of students and staff. Why is it too much trouble when millions of dollars are in question? It is simply an additional form to be verified during open enrollment. While we could concern ourselves with verification I would think that the consequences an employee would face for falsifying an affidavit would be too great for most to risk. And we wouldn't be the first company to do this. Many businesses require that information and Blue Cross in some cases aids in monitoring this. And do we really have employees who are staying on our insurance that are medicare eligible? That should absolutely be addressed, administratively difficult or not.

2.) Thank you, I just wanted to make sure

3.) You didn't answer my question. What would be the potential savings if we limited new hires to a higher deductible plan? Yes I know that with no lifetime limits one catastrophic event could cost untold millions. But that is exactly what insurance is for and is the risk we assume when we self insure. However if new hires are not put onto the higher deductible plan there is no chance for savings. I don't see how one side of that coin affects the other. Just because we could have higher claims we aren't going to address a way to potentially save? That seems to be what you imply. I'll let you clarify because if that is what you wrote it makes absolutely no sense.

In regards to caution is advised.... This is not nearly as complex as you want to believe. The statute is vague at best which is why it has been delayed until further notice. If it was a significant problem then why have any number of companies taken this step? And that is why I asked have we considered moving our higher earners to a high deductible plan. If you move your highest earners, our administration, to a higher deductible and therefore lower compensation basis plan, we won't run afoul of this statute even if it is implemented.

In regards to recruiting new teachers I have said this and continue to say that if insurance is our main recruitment tool we need to find a better one. Most young teachers, which are the majority of new hires are more concerned with their take home wages. Regardless we need to find a way to make the job more appealing than insurance benefits that most will not see the full benefit in cost from.

4.) Yes I do recall you saying it is a multiyear strategy. What I haven't heard is what exactly that strategy is, and what are the strategic reasons for not implementing now? The main strategic reason for implementing changes now is it is the one time when we don't have to negotiate changes. If we don't lay out the full strategy to the board now then next year we will be somewhat limited by new negotiations that may involve multiple groups. That is what has been told to me since last year when we made no real effort to negotiate. If we weren't going to negotiate last year then why are we waiting until next year to implement some of these changes? During my discussions with teachers most understand and would even be in favor of many of the items you laid out, wellness, non-smoker discounts, etc. If there are strategic reasons not to implement now the board needs to be made aware and then decide because it is the board that has to live with the decision. I'm not comfortable to only be able to say it was advised for strategic reasons we not do anything else. Especially when I don't know what the strategic reasons are or the multiyear plan. You allude to this in saying we have been greatly restricted by the negotiating process. That seems to point toward the need strategically to implement changes now.

5.) With only 11 people signing up for the current high deductible plan what can we do to make it more appealing and are we properly educating our employees? The biggest constant in any of the 3 year plans that have been implemented by other companies has been education of the employees, both in plan options and in wellness. This takes investment but if it will ultimately save money the board may find it worth the investment. What are we doing to educate, and how much will it cost to improve upon the employee education component and what will that entail? Once again in this answer you mention current strategy and to move in phases but as of yet the board hasn't been presented that strategy, timeline or phases.

So to sum up my questions,
1.) How much would we save by limiting new hires to a higher deductible plan?
2.) If this is the first step what is this multi-phase plan and what is the strategy going forward?
3.) What would the cost to truly implement a wellness component be and why not do that now?

4.) Are you really saying we aren't addressing spouses because it might be hard?

You mention surveys verify our employees have a better plan and pay a lower amount for their medical insurance. I'm sure they do. No one has ever disputed this as this plan is in your words last year at an open work session by far the best plan in the state. We can debate whether they pay a lower amount. It depends on what numbers are being used. But with the cost continuing to rise this lies squarely in what will the board's strategy be going forward. There can be different options but it should be the board's decision as to what that long term strategy is after being properly informed of options and the risk benefits associated with each. As of now I don't see how we have been properly informed of all the options and it seems to be assumed that we will accept this multiphase plan blindly without knowing what the next step is. I don't particularly like to blindly recommend any multiphase strategy that I don't know the timeline or the consequences of a decision. It's poor policy and poor stewardship to everyone, our students, our employees and the public we represent.