MINUTES 2/13/17

SELF-INSURANCE PROGRAM BOARD MEETING

A meeting of the Self-Insurance Program Board of Trustees was called to order at 8:05 a.m., Monday, February 13, 2017, in Personnel Conference Room #2 at 20 E. Main Street, Suite 130, Mesa.

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Linee Ferguson	Fenton Moran	Tracy Hurt, Board Secretary
Kelly Vorseth		Jan Ashley, Emp. Benefits Administrator
Board Chair Mark Freeman		Nitra Hawkins, Safety Administrator
Michael Kennington, CFO		Candace Cannistraro, Ofc of Mgmt & Bdgt Dir
		Jim Smith, City Attorney
		Jason Reed, Asst. City Attorney III
		Lisa Angiano, MA I Safety Services
		Nicole Stec, Employee Health & Wellness Mgr
		Marcus Steele, Sr Budget Analyst, OMB
		Robert Baer, Budget Coordinator, OMB
		Alicia White, City Council Asst.
		Citizens Present
		None

The meeting was called to order by Board Chairperson, Councilmember Mark Freeman at 8:05am.

Since the last board meeting there have been two new members added to the Board. Board Chair Freeman opened the meeting with introductions of all attendees present. Board Chair Freeman asked if there were any citizens present. There were no citizens present.

The next order of business was to hear presentations and budget recommendations for the Public Property and Public Liability Trust Fund, the Worker's Compensation Trust Fund and the Employee Benefits Trust Fund.

Jim Smith, City Attorney, gave an overview of the Public Property and Liability (PPL) trust fund stating that the fund pays out the claims for liability brought against the City. Trip and fall cases, police excessive force cases, and other various types of cases, whether in state court or federal court, are paid through the PPL trust fund. The City may also resolve claims before they are filed as lawsuits. The fund balance is set at $10M and the claims portion historically has been set at approximately $3M, although last year we changed it to $4M due to potential increases in claims. $1M pays for the litigation group (there are six members of the litigation group). $1.3M covers insurance payments. This totals the expenses at $6.3M.

Referring to the PPL Board Report, Jim explained some of the pressures on the fund. There were three trials last year, all federal court. The City prevailed in all three cases. We are seeing increases in claims and foresee more cases going to trial. This is a national trend as nationally more cases are going to trial. This puts pressure on the fund through multiple factors: the number of claims, the size of the claims, the insurance pressures and the SIR (self-insured retention).

Jim explained the SIR for the new board members and how the insurance is structured. The first $3M is the self-insured retention and the trust fund pays for that. Over that amount, we then have layers of excess insurance: $10M, then $5M, then another $10M, then $25M which stacks up to a $50M insurance coverage. If we have a claim that goes over $50M the trust would then pay for that overage as well as the first $3M.

Last year we changed how we procured insurance due to industry pressure and to be competitive in the market. Historically, we went out for bid every year. This type of insurance is not a set rate and the insurance companies do in-depth research and review of the City. They interview us and look at police policies and review how much property we have. We provide a substantial amount of materials/information to them. There is a tremendous amount of work in order to get a specific rate for the insurance, whether it is the first layer or second layer, etc. We also have other secondary types of insurance for the airport, etc. and those are explained within the PPL report.

Last year we went to a multi-year concept to enable the possibility of renewing the insurance for up to two additional years for a three-year window. However, this is not a multi-year contract as the insurance companies will not provide multi-year contracts. They will consider you for an additional year after each year. They will not lock themselves into a multi-year contract due to the risk. Over the last five years two large insurers have gone out of the market nationally due to police excessive force claims.

In order to ensure that we are competitive and getting the best rate to renew the contract without going back to Council for approval, the insurance agency has to limit rate increase to less than 2.5%. Refer to Exhibit 3 of the PPL Report to see the1.3-1.33% increase over all of our insurance costs. The excess liability had a 1.8% increase.

Another item to note is that we had to change one of our excess carriers. Our second layer carrier for the $5M did not want to cover that layer and we procured a new carrier. The previous carrier did, however, choose to insure the following layer at the $15M level. They obviously have done some analysis and found that a lot of lawsuits are settling out at their previous coverage amount. We foresee this as a trend for the future - there will be premium increases nationally and we feel fortunate that we were able to keep the rate down to 1.8%.

Linee asked Jim to explain the "multi-year" concept if we can't sign a multi-year contract with the insurance agency. Jim explained that the multi-year concept is the ability to renew and sign another one-year contract with the agency without the need for rebid and presenting to Council for approval as long as the rate increase is below the 2.5%. As long as the rate increase in below 2.5% we have the ability to sign a new year contract – we don't have to, it is not required, but we have the ability to do that. This stipulation was included in the procurement RFP so that all agencies knew that this was a requirement for renewal of three one-year contracts. Jim also explained that we are on a calendar-year contract and not fiscal year, so we were pleased to get the 1.8% and sign before the calendar year expired.

Another pressure on the fund in addition to the rates increasing and excess carriers changing is the SIR. Currently it is $3M and there is pressure to increase that amount. Insurance carriers want the SIR to increase so that it reduces their risk, while at the same time rates are increasing. We expect that pressure to continue, and long term as we look out 5-10 years that SIR amount may increase. We went with Travelers a year ago and they renewed and hopefully we will be able to keep it under 2.5% again. There is another year option to renew and we hope to have good news next year as well, and then we expect to see a price increase after that.

Chair Freeman asked if the premium would decrease when the SIR is increased. Jim explained that there are multiple stages in acquiring the insurance and some of the quotes were actually higher. The agency must feel comfortable because of the volume of risk. Referring to their premium of $629,000, one large claim could wipe that out. The risk for them is tremendous. Once we surpass the $3M SIR, they could lose all three years' worth of premiums in one claim and that is how the industry is viewing it. The carrier really must get to know their client and they do track all of our activity, both the positive and the negative.

Refer to Exhibit 2 – Claims/Lawsuits Expenditures. This is how much we pay out in more than claims as it includes our fees, expert fees, etc. You can see that we have had a few spikes and now three

years of very low numbers. The litigation team has done exceptional work and it's a combination of exceptional work and not settling one of the larger cases we have. We previously averaged at $3M but due to Jason and Marc's success, we have now been able to reduce that to $2.5M. We know that we have a number of large claims pending that we are seeking resolution on and so we expect to see a spike in the future. We want to do what's right and we don't just look at the bottom line. If there is liability, we look to do an appropriate settlement. In some cases, we are a co-defendant and must push them forward to resolution. We hope in the next year to settle a couple of these cases. It will result in a spike, but for us it will be a good thing because we can resolve some of the risk on some of these cases and handle them in an appropriate manner.

Kelly asked if Jim knew the approximate dollar amount for those cases. Jim advised that it would not be appropriate to share at this time since they are still pending.

Chair Freeman noted that the timing of cases resolving affects the expenditures for the fiscal year and Jim agreed, stating that spikes could occur due to multiple cases resolving or a large case resolving.

Michael asked if the $3M SIR is met, does the insurance carrier take over after that or is there any additional amount we must pay per case? Jim said normally they take over, although there are some exceptions. Willful, malicious, criminal acts are an exception. The $3M is an eroding $3M so all of our costs for outside experts, outside attorneys, etc. decreases that $3M. This is why it is sometimes beneficial to retain outside counsel for some of our larger cases.

Jim concluded with the recommendation to keep the claims portion of the fund at $4M as it was increased in the previous year.

Candace Cannistraro, Office of Management and Budget Director, recommended budgeting for next year to maintain the $10M fund balance with the $4M claims portion remaining the same. This would result in a $6.3M City contribution included in the FY 17/18 Property and Public Liability Fund Budget recommended to Council. She asked if there were any questions on the fund balance and referred to the graph contained in the Office of Management and Budget FY 17/18 Funding Recommendations for the PPL Fund report to note the target fund balance and the ending fund balance comparatively each fiscal year. She explained the drop in the fund balance below the target on some years was a result of the recession and the building up of the fund over the next couple years.

Chair Freeman asked if there were any questions, and when none, then introduced the Worker's Compensation fund presentation by Nitra Hawkins, Safety Administrator.

Nitra referred the board to the Worker's Compensation (WC) presentation to highlight the program at the City of Mesa. We are mandated by state law that requires all public and private employers to provide worker's compensation coverage for their employees. The City of Mesa is self-insured as of July 1, 1982, and the trust fund was established at that time. The City of Mesa's Worker's Compensation Program provides medical and lost time wage compensation benefits to City employees who have a work-related injury or illness. This benefit is also extended to our official volunteers.

The WC Trust Fund is 100% funded by the City. There are no premiums collected from our employees. The funding streams for the WC Trust Fund come from monthly department rate charges (out of the general fund), excess WC insurance reimbursements which covers us above our $1M self-insured retention (SIR). We receive different reimbursement amounts based on claims that have come in. In 2015, we received $154,176 and in 2016, we received $225,160 in reimbursement. Subrogation reimbursements are another funding source, utilizing first-lien rights against third parties at fault. We can recoup our payments for medical and lost wages from those other insurance companies. In 2016, approximately $59,867 was recovered back into the trust fund.

The WC Trust Fund pays for industrial injury and illness claims, medical (chiropractor visits, physical therapy, dr. visits, hospital) and lost income/wages. When an employee is out after surgery we pay

them the statutory requirement of 66 2/3% of their wages. The WC Trust Fund also pays legal costs; network access fees for medical providers such as AZ Blue Cross / Blue Shield; self-insurance surety bonds; special and administrative taxes (Industrial Commission of Arizona); excess worker's compensation insurance premiums (SIR); and personnel costs for the program administration. We have two worker's compensation claims representatives and a portion of my salary that comes out of the trust fund.

Linee asked if there were a total of three or more employees paid from the trust fund. Nitra clarified that there are a total of 9.5 employees under the worker's compensation and safety services umbrella. In addition to the two worker's comp reps, there are four in safety services, two senior program assistants for bill pay, and a part-time program assistant for new claims.

The WC program is self-administered and staff processes the claims. In 2015, we had 407 new claims (this is in addition to claims that are already ongoing), and in 2016 we had 394 new claims.

We have a very robust first-contact program. Our part-time program assistant is dedicated to contacting the employee as soon as the claim comes in so that the employee knows the status of their claim and to check on the employee to be sure they are ok. She will answer any questions they may have and give them the name of their claims adjuster. She will communicate with them via phone or email, whatever they prefer. We have received a lot of positive feedback and this has been a successful program. In 2016, she made 394 phone calls to employees with new claims.

Chair Freeman asked the timeframe that an employee has to submit a claim. Nitra stated that according to state law, an employee has one year from the date of injury or when they should have known the medical issue is a result of the injury. Chair Freeman asked what the reportable period is. Nitra stated that there should be an incident report at the City within 24 hours. They then have a year from that date of injury to make a claim.

Chair Freeman asked if there have been any denials due to the reporting period? Nitra answered that since we are not open seven days a week there may be a delay from the time the supervisor gets the report to submitting it to our office and it is not our goal to deny.

Our two worker's compensation representatives manage an average of 170 claims each at one time. Some claims may open and close quickly while others may last for years. Some are simple (like a tetanus shot) and some are complex. Our oldest active claim goes back to September, 1985. Worker's Compensation is a lifetime right. So, if the injury happened here, we actually own that claim for the lifetime of that employee. We lost our oldest claimant three years ago. She died of natural causes, but her claim was from 1984.

Michael asked if we have a program to check on these claimants after a certain period of time to see if they are still injured and Nitra explained that we do have a quarterly check-in. The older claims are given supportive care benefits (four doctor visits per year) and then after the year we must have some type of medical renewal to continue. They must also report annual income each year.

Michael asked if there is a threshold of annual income at which worker's compensation stops the payments. Nitra stated that is depends on the average monthly wage was that was established in that year by the Industrial Commission. The current average monthly wage maximum is approximately $4,500, but the lowest was $1,000 long ago. There are variables based on the date of the injury.

Kelly asked if there has been a trend upward in claims and stated that it would be helpful to see a graph for total claims. Kelly asked if we are currently dealing with approximately 350-400 claims and has that been the norm. Nitra stated that prior to 2014 we had approximately 437. It varies, but one thing to keep in mind is that although we may have less claims in number, the severity of individual claims can be high. Nitra said that she will provide a graph with a longer history for the next meeting to show the fluctuation.

Candace indicated that in the OMB FY 17/18 Funding Recommendation report for Worker's Compensation you can see the total expenses and cost of claims year over year. The report shows cost of claims back to FY 13/14 and claims have been consistently around $3M. Nitra indicated that she will provide a five-year history of claims for next meeting.

Nitra continued with the Worker's Compensation Bill Payment Program that is staffed by two Sr. Program Assistants that process and pay the medical bills submitted. They are knowledgeable regarding procedure codes, and they track and monitor the accuracy of the submissions. In 2016, they processed 4,465 medical bills totaling $1,428,167.

Linee noted that these are calendar year figures and Nitra confirmed that they track by calendar year because they are required to submit calendar year totals to the Industrial Commission.

The next part of the WC program at the City of Mesa is Cost Containment. Our goal is cost containment without sacrificing the quality of care that our claimants receive. We have a directed care policy that requires claimants to use a designated facility (Banner Occupational Health) for their initial visit. The goal is to get the employee in timely so that referrals can be made and the paperwork that the Industrial Commission requires is done there. Once that visit occurs, they can go to any medical provider of their choosing. Our goal is to get them in quickly and get them the resources that they need to reduce the severity of the claim.

Another cost containment is using AZBCBS as our worker's compensation provider network. The benefit of being a self-insured entity is the ability to negotiate our contract and Jan Ashley, our Benefits Administrator does a great job of negotiating our worker's compensation access fees portion as well. We have providers that agree to take worker's compensation claimants and agree to a discounted pricing under BCBS. In 2016, our provider bills came in at $3.2M and yet we paid just over $1.2M with a savings of approximately $2.1M.

At our 2016 Trust Funds Board meeting we mentioned that we were exploring a Pharmacy Benefits Manager Program. We were able to pilot the program for one full year and we have had positive results. We will go out for RFP for a Pharmacy Benefits Manager to procure the best savings for worker's compensation prescription coverage. In 2016, we had over $82,000 in cost savings for our prescription benefits.

Linee asked how often we would send out for RFP for designated medical provider and pharmacy benefit manager. Nitra indicated that we typically go out for a three-year contract with options. We have one more year for our Banner contract, so we would need to go out next year again for bids. If we are dissatisfied, we can go out at any time, but three years is the objective. Cypress Care is currently doing our pharmacy benefits, and in 2015 we achieved $37,000 in savings. Last year, 2016, was the first year we were able to achieve full benefits. Provider to provider conversations make an impact on the quality of care and also reduce the cost.

Occasionally we have medical providers that are not in the BCBS network. We cannot mandate that claimants go to a BCBS providers, so we do have third-party providers that do not allow us any savings. We have been piloting a third-party review company to try to achieve some cost savings. As you can see in 2015, we were able to save $203,469 on third-party medical costs, so we will be going out for RFP for third-party review companies as well.

Michael asked how the third-party review saves us dollars. Nitra indicated that they review the "usual and customary" charges and if there is a charge that falls outside of that, they will provide statistics based on the procedure code and resubmit to medical provider for an adjustment of the charge. The third-party reviewer provides the data and negotiates with the medical provider on our behalf.

Kelly indicated that because it is out of network and non-contracted charges are higher and Nitra agreed that without the third-party reviewer we would have normally paid those higher charges. Kelly asked if we can require patient to go to a specific in-network provider, and Nitra stated that we cannot.

We can provide them a list of in-network providers, but they may go to the medical provider of their choice. We try to ensure they have all of the information to make their decision and we encourage them to use any of those providers, but we do not reach out to them if they choose an out-of-network provider.

Kelly and Linee noted that the percentage of out-of-network appears to be low, approximately 5% and Nitra said that it does vary and last year there may have been 37 out-of-network billings. We did have some ambulance companies that were charging an exorbitant amount and the third-party review company was readjusting those fees and some of those ambulance companies then came on board with BCBS. Kelly said that if the out of network numbers were higher it would be interesting to know what types of visits they were and to be sure that BCBS was able to provide those types of medical services.

Total cost avoidance for the WC Trust Fund was $2,367,935 in 2016. Some potential impacts to the trust in FY17/18 is the national increase in medical costs of 8%. We also have specialty providers that are leaving the BCBS network such as hand specialists, chiropractors, upper extremities specialists, etc. and we may be paying more for these types of providers out-of-network. This has been a continuing trend over the past 2-3 years.

Linee asked if there are surrounding city governments using this type of model for cost containment and Nitra stated that all have cost containment programs; however, we are one of two cities (Scottsdale being the other) that are self-insured and self-administered. Maricopa County just became self-insured in the last 2-3 years. Linee stated that she was wondering if there would be a benefit to multiple cities going in together for leverage in negotiating.

Chair Freeman asked why the specialist mentioned were leaving the network. Nitra indicated that she did not know the specific reasons. We are finding it a challenge to get people into the orthopedic specialists.

Candace presented the OMB Worker's Compensation Fund FY 17/18 Funding Recommendations report to review the financial side of the trust fund. The WC fund balance target is set to be equivalent to annual operating expenses. In the past couple years, we have had increased receipts into the fund over what we anticipated for expenses, so the fund has actually grown. For FY 17/18 we are going to try to bring the fund balance back down to the target. The difference between this fund and the PPL fund is that the PPL fund is a City contribution that we make through a transfer into the fund. For WC trust fund, we actually process through payroll. We can change the rates at any given payroll since we are self-administered; however, if we change it, it affects the departments budgets. If we increase it they would have more expenses than they actually budgeted for, and if we decrease it they would have savings in their budget, but the fund would not have savings. So, we try to do it on an annual basis to set the rates for the salaries we think we will have next year and then forecast the revenues into the fund itself. Looking at FY 17/18 we are reducing the rates for the departments which would give us some budget relief for all the various funds. This would be a one-year reprieve from those rates as we bring the fund balance back down, then we would return to the normal rates for the years after that.

Candace asked if there were any questions on how the fund is managed. There were no questions. She explained that claims the last three years have been consistent around the $3M mark and the variability is more on the contribution side as we have to estimate position vacancies and so forth. We budget as though every position is filled and we budget those contributions, although we do put in a vacancy rate so that we don't over collect. In 2016, we did not put as high a vacancy rate as we needed to so we ended up collecting more than we needed.

Michael asked if there was a specific reason that we increased the cost of claims 8% and Candace explained that this is an increase in medical costs and that the next presentation of the Employee Benefits Trust would go into more detail on that. The average increase nationally is 8%. We are

putting in a buffer for increased medical claims costs. We increase the cost of claims estimate while at the same time bringing the balance of the fund down. We don't want to have funds held in the trust, because once they go into the trust fund, they cannot be taken out to use elsewhere. You can contribute less in future years, but once the dollars are in the trust fund, you cannot take them out.

Chair Freeman asked if Candace knows what the amount of savings reprieve for those department rates would be. Candace does not have those specifics, but could get them. She indicated that the rates were already calculated into the departments base budgets and it is a one-time savings. She also indicated that the departments would not actually see the savings, as the City General Fund has the savings. Although the better the General Fund does, the less pressure on departments for budget reductions, etc.

Chair Freemen introduced the Employee Benefits Trust Fund (EBT) presentation by Janice Ashley, Employee Benefits Administrator. Jan explained the EBT fund functions for the new members of the board. The EBT provides benefits for full-time and part-time benefit eligible employees, eligible dependents, as well as retirees and their eligible family members, in certain programs. These programs include a medical and prescription drug program with three benefit plans available. We also introduced a Medicare Part D Prescription Drug program in 2017 to retirees (and individuals) who are Medicare eligible and participating in the City's retiree medical plans.

We have stop-loss medical insurance that provides protection for medical and prescription drug claims over $300,000 per claimant annually. We provide dental; vision care benefits; health and dependent care flexible spending accounts; an EAP program fully funded by the City; basic group term life insurance and accidental death and dismemberment insurance (City funded) for full-time employees, supplemental life insurance (employee funded if chosen) for full and part-time benefit eligible employees and eligible families;; business travel/commuter death insurance (City funded) for full-time employees; short-term disability insurance (employee funded if chosen) for full-time employees and long-term disability insurance (City funded) for sworn officers and elected officials.

In addition to those benefits, we are very proud as a City to be leading edge with our Employee Wellness Center and Wellness Programs since 2014. Active employees and dependents can receive primary and preventive care services free of charge at the Wellness Center and can participate in various Wellness Programs. By the end of 2016, the Wellness Center had 3,900 unique patients (an average of 75 new patients per month). The average utilization rate at the Wellness Center was 66% monthly. Chronic conditions managed and treated include high cholesterol (5.2%), High Blood Pressure (3.9%), and diabetes (3.7%). Those three conditions are important to note as they are at the base of what could potentially be long-term high medical costs if not managed.

The City contracts with a third-party provider/management company at the Wellness Center. Nicole Stec is our City of Mesa Employee Health and Wellness Manager and coordinates and manages all of our Health and Wellness Initiatives. In 2016, we have had 1,150 participants in over 70 classes and 10 disease management programs. In the last three months, a Wellness Digital Platform pilot was introduced to 500 employees using digital equipment/fitness devices, mobile apps, and other health education tools. We hope to expand this program to all City employees in 2018.

Linee asked if the Health and Wellness Program impacted the stop-loss rates. Jan stated that it has not had the ability to impact the claims, although it was taken into account when we were provided quotes and it was noted that it may have potential to reduce large claims.

Kelly noted that the tracking of improvements in health, weight loss, and possible diagnosis and claims to see if they have been reduced over time would be an option. Jan specified that due to HIPAA regulations, we are not able to share certain information. We are however trying to look at 'de-identified" population statistics as long as it has no connectivity to individuals. Patients must have comfort that everything at the Health and Wellness Center stays there and does not link them directly and individually to their health plan.

Michael asked how the long-term disability insurance works with PSPRS retiree/retirement disability and Jan explained that it is a supplemental disability insurance that is offset by the state retirement funding for sworn or elected officials. It has a minimum benefit of $100 per month and is a secondary and not a primary protection in terms of long-term disability. It is fully City funded and any benefit would be taxable to the employee.

Kelly asked if the $1.6M expense reference on the EBT report was the amount for the Wellness Center. Jan confirmed and noted that we will be anticipating $1.7M this year and $1.8 M for FY 17/18. Kelly noted that the Wellness Program could eventually reduce claims and Jan agreed that this was a possible benefit of the Wellness Program.

Jan covered the sources of funding for the EBT, including: contributions from City department budgets; employee, retiree, and COBRA premiums; state retirement system subsidies (ASRS or PSPRS); Medicare Part D drug subsidy reimbursements (EGWP) as of 1/1/17 anticipated to be more than $600,000 annually (this takes the place of the RDS program which will have a final pay out to us of approximately $300,000 to $450,000 this year); Pharmacy Benefit Management brand drug rebates (pharmacy is 25-30% of our total spend);

Linee asked if the Medicare Part D would impact costs to departments. Jan indicated that it would not.

Michael asked what percentage of the brands have generic alternatives. Jan indicated that there are still a large number of brands that don't yet have generic alternatives, although a lot of patents expired in 14/15 which was a banner year and the pipeline for generics is much slimmer today. The specialty drugs currently coming to market bring a very high price tag. We do have a very high generic participation rate; approximately 87% of drugs being dispensed were generic. The dispensed as written penalty requires the patient to pay the difference in cost between generic and name brand. This helps to encourage generic participation.

Michael asked why costs were high if so many generics were being used and Jan mentioned that there are specialty brand drugs, such as the Hepatitis C drug that costs $80,000 for a twelve-week therapy. Kelly stated that some chemotherapy drugs are very costly as well. Jan said that we want these drugs to come to market because some are life-saving. It is a complex arena and our PBM contract provides research and review of the pipeline, price points, FDA regulations, etc. to ensure the right drug gets to the right patient at the right time. We definitely need these experts to assist us in this regard.

We also receive administrative credits and performance guarantees; stop-loss insurance reimbursements received on claimants over $300,000 in a calendar year (on average we have received in the last two years between $1.0 -1-5M). In 2015 we received just over $2M in reimbursements. That amount of reimbursement was for 9 claimants in 2015 and for 11 claimants in 2016. Relatively few claimants, but severe cases. We had a big jump in *severe* claimants in 2015, while in 2016 we had more claimants that were not as severe. Lastly, trust investment income is another source of funding for EBT.

Potential impacts for the FY17/18 EBT:

- Continued frequency and severity of high dollar medical claimants (greater than $150,000). We have 34 claimants in 2016 that were over $150,000. There have been increases in the $100,000 - $150,000 range in the last two years. These will not meet the stop loss reimbursement.

Michael asked if these included both active employees and retirees. Jan confirmed that both were included: approximately two-thirds from active employee population and one-third from the retiree population.

- Diagnostic drivers:
    - complex cancers (between 50-60% of the high dollar claimants)
    - cardiac/stroke/vascular/neurological

Kelly asked if there were tracking mechanisms within the Wellness Program to help catch the various diseases early such as cardiovascular issues. Jan indicated that screenings and referrals are the objective of the Wellness Center to help catch things like complex cancers in the early stages so that we don't have Stage 4 and beyond diagnosis.

Jan stated that we are also seeing an increase in the total medical plan members. We are seeing approximately a 2% increase attributed in part to our increasing retiree population - employees who are eligible to retire and they are being replaced in the active employee population. The Affordable Care Act has also mandated that everyone must have coverage and this could be a reason we see the family member increases which have been the highest amount of increase as compared to employees themselves.

Michael asked if coverage for retirees remains until they are Medicare eligible or until they are deceased. Jan indicated that it is a lifetime benefit until deceased. They transfer to Medicare in a primary role at age 65 and the EBT is secondary coverage after that. We can see those numbers drop dramatically when a retiree moves into that Medicare primary coverage – we are paying on average approximately 20% of the allowed liability while Medicare is paying approximately 80%.

Michael asked if the retiree pays the same premium and Jan stated that they pay slightly less because they must participate in Medicare Part A and B and pay a premium to the federal government for Part B. So we give them a slight discount on their premium of $100 per month. Otherwise it is the same plan design and the same premiums. They also get a slightly different subsidy from the retirement system – it goes down when Medicare comes into play.

Overall we have seen rate increases for both the City and employees on our medical plans at an 8% level so we have budgeted those premiums for January 1, 2017 and we expect to see an 8% increase in 2018 as well. Candace will speak to the final number of contributions into the plan. We have also reviewed the plan designs to shift some cost from the trust to the employees on the highest cost plan which is the Copay Plan. We increased the copays contained in that plan this year. For example, it was traditionally a $20 copay for a primary office visit and now it is a $25 copay and a $40 specialty office visit copay. These copays are more benchmarked to other similar plans in the marketplace This did cause some concerns from employees who are now paying more for an office visit than before. However, it was the right thing to do and necessary under the current environment.

Candace mentioned that copays have not increased on our plans for many years, approximately 15-17 years.

Linee asked if employees can contribute to a flex spending account to cover copays and Jan confirmed that we maintain flexible spending accounts with the maximum allowable contributions each year so that employees can utilize that. We are seeing a slightly higher amount of contributions to these accounts. We see between $1.2 - 1.3M contributed by employees to the FSA accounts on an annual basis. We will be reviewing at the end of this year for 2018 to see what types of plan design changes might be recommended in terms of deductibles, co-insurance as well to help mitigate some of the costs.

Another issue is that we do not know what is going to happen to the Affordable Care Act. It could be repealed, replaced, or repaired. We don't know when or what. It will have a financial impact on fees and taxes; it will have an impact on compliance reporting, and on plan design and eligibility compliance. If there is still an individual mandate for employees that will have an impact on their eligibility and participation rate. Will employers still have a mandate? We don't know. Will some of the conditions already required still be valid (to age 26 coverage, pre-existing condition coverage, unlimited coverage over lifetime)? If not, we will need to decide what we want to do about those

items, if anything. If there is no repeal or change, we can expect in 2017 and going into 2018 that we do have these basic compliance obligations right now. This includes a federal excise tax that is in the $25,000 category. The 1095 reporting process is very complex and time consuming and we are still underway on that.

Linee asked what the top two issues are that make the 1095 reporting complex. Jan stated that you must report who was eligible for coverage, who enrolled for coverage, what sort of coverage they had in terms of how much they had to pay for it. We have to prove minimum essential coverage, an affordable level of coverage in terms of premiums, and who was covered in it. This must be reported on all employees and their dependents for every month of the year. All of those parameters make programing the reporting complex.

Jan indicated that the "Cadillac Tax" which has been postponed from 2018 to 2020 may go away if the ACA is repealed; however, if ACA is replaced then the purpose of the Cadillac tax (which was revenue) will potentially have to be replaced. Jan asked if there were any questions, and when none turned the presentation over to Candace.

Candace presented the EBT Fund Financial Update and FY 17/18 Funding Recommendations Report noting that the benefit plans are managed on the calendar year and this is the only fund out of the three trusts that the employees pay into as well. The rates are changed only once a year for the plans, and we have an open enrollment period. Our enrollment period is in October so the rates are set by September. Looking forward to the 17/18 fiscal year, we are actually looking at the budget side and not the rate side. We focus on what the City contribution should be so that we can set our City budget for adoption. Of course, when the premiums go up, they go up for both the City and the employees. If you look at the report, you can see where we had some increases in claims. This report has been converted to fiscal year for budgets. In FY14/15 we had an 11.8% increase in claims and then in FY15/16, 18%. Unfortunately, this was not just a peak, it was actually resetting the base. We project in FY 16/17 it is in line with that higher base. We are back to the national average of 8% increases. We had a few years where we were below the national average because of some cost containment measure that we were able to put in place. We put some caps on out-of-network costs and also balanced out the plans and the premiums.

Looking at next year on the graphs, you can see where the claims have risen. For fund balance purposes, we do not have a particular set fund balance that we look at in this fund. You can see on the cash flow graph that we do look at the expenses and because we only want to make modifications to the rates once a year, we project quite a bit into the future what those expenses will be so that we can maintain an appropriate fund balance to cover those expenses. Over those last two years where we had the double-digit increases in claims, it just so happens that we had built our fund balance up due to the cost containment measures the previous two years and we were able to handle that. It was actually about a $10M decrease from where we thought the fund balance would be to where we ended after those two years. We thought that we were appropriately sized as far as fund balance and we did not need to catch up, so we agreed to maintain that fund balance. We are forecasting it to go down over the next couple of years as we get our rates into alignment. We are looking at a national average for our rate increases, although we had thought that last year would be an 8% increase and then we would go back down to 5-6%; we are now not seeing that. We continued to have another year of double-digit increases so we are now forecasting at the 8% each year.

We will keep watching the fund balance and if it continues to dip down, we may need to increase that percentage. We would really like to avoid double-digit increases for our employees on the premiums if possible. We are recommending that we anticipate an 8% increase in the City contribution for the FY17/18 based on the current premiums that we have today. For 17/18 that would be a six-month impact because we have the rates through 2017. It will be an 8% increase effective January 2018, going forward. The current estimate for the resulting contribution would be approximately $62.5M for FY 17/18 and that could vary as we go through the budget process depending on the rates and the

number of positions that we budget for. That would be the recommendation of staff going into the FY 17/18 budget year.

Chair Freemen asked if there were any questions. Kelly asked if there was anticipation that staff would increase next year and Candace indicated that this was not anticipated as departments were asked to look for reductions going into the 17/18 FY because of pressures that we have in the General Fund due to pensions.

Chair Freeman asked if the 8% increase would be passed on to the premiums and Candace stated that we would budget in 17/18 assuming a City contribution that would increase by 8% and then over the summer we would determine how that would be applied to the rates. Retiree and active employee rates are set separately as well as the different plans (Choice Plan, Copay Plan, etc.). This would not be the implementation of those increases but it would be at least the 8% increase on the City side and then we would look at how we would modify that in the rates.

Chair Freeman asked if that would then be rolled out to employees in October for open enrollment. Candace stated that it would actually be rolled out in September because we usually go to Council in September and notify Council of how we are implementing those increases, as we have more data at that point, and then open enrollment will start in October with the effective date in January.

This concluded the presentations and recommendations for the City contributions to the trust funds.

Michael made a motion that the board accept the recommendations from the OMB Self-Insurance Trust Fund Reports presented by Candace for all three funds (PPL, Workers' Compensation and EBT) to be recommended to City Council.

Chair Freeman and Jim Smith noted each of the recommendations on the OMB reports as follows:

Property & Public Liability Trust Fund: In order to fund PPL Fund expenses for FY17/18, staff recommends an FY16/17 City contribution of $4.8M to the PPL Fund, resulting in a year-end balance of $10.0M. Staff recommends including a $6.3M City contribution in the FY17/18 budget to achieve a minimum forecasted ending reserve balance of $10.0M.

Worker's Compensation Fund: Staff recommends the continuation of the current practice to adjust rates annually unless a significant change in expenses occurs. Staff recommends setting the rates for FY 17/18 at a level to achieve a targeted ending reserve balance sufficient to cover the annual expenses. For FY 17/18, the reserve target is $6.4M. The current estimate for the City contribution for FY 17/18 is $3.5M. The final budgeted contribution may vary slightly from the recommendation as the adjusted rates are applied to budgeted salaries and the budget process has not yet been completed.

Employee Benefits Trust Fund: Staff recommends the City contribution to the EBT Fund budgeted for FY 17/18 be based on current medical and dental premiums to be increased 8% in the benefit plan year 2018. The current estimate for the resulting City contribution is $62.5M. The increased premiums affect 6 months of the fiscal year. The final budgeted contribution amount may differ slightly as the estimated number of employees/retirees is further refined during the budget process.

Kelly seconded the motion to approve the recommendations. All were in favor.

The next item on the agenda presented by Jim Smith was to explain a motion that states the minutes of the meeting be approved by the Chairperson after they have been circulated to all members and any edits have been finalized. This authorizes the Board Chairperson to approve the minutes without the delay of another meeting a year later.

A motion was made by Kelly to authorize the Board Chairperson to approve the minutes after circulation to all board members. Michael seconded the motion. All were in favor.

Linee moved to adjourn. Kelly provided a second. All were in favor.

The meeting was adjourned at 9:48am.

Tracy Hurt 3/1/17 Mark A Freeman 3/1/2017

Tracy Hurt, Secretary to the Board Date Mark Freeman, Board Chairperson Date

c: Christopher J Brady, City Manager
DeeAnn Mickelsen, City Clerk
Mayor's Office
Self-Insurance Trust Funds Board Members