



CITY OF KIRKLAND
Human Resources Department
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MEMORANDUM

To: City Council
From: William R. Kenny, Human Resources Director
Date: September 9, 2010
Subject: CITY OF KIRKLAND MEDICAL BENEFITS PROGRAM

Over the past couple of years the City's medical benefits have been under review by the Human Resources Department, as well as our Medical Benefits Committee. During this time we have completed a due diligence assessment or study of options, while closely watching the changes that are occurring with our current provider of medical benefits, the Association of Washington Cities (AWC).

RECOMMEDATION:

It is our recommendation to move the City from the AWC medical benefit plans to self-insuring our medical and directly contracting our ancillary benefits (vision, dental, EAP, etc.) effective January 1, 2011. This move will help to maintain the cities benefits goals by allowing us to "control our destiny," abide by our collective bargaining agreements in providing "substantially equivalent" benefits, as well as place the City in a better position to increase consumer awareness and manage benefits costs.

BACKGROUND DISCUSSION:

Through discussion with the benefits committee, negotiations with our unions, and working closely with our broker, we have developed the "PRIME" medical plan. This plan is a self-insured plan that offers our employees "substantially equivalent" benefits, complies with the Affordable Care Act (Health Care Reform) requirements and will allow the City to more effectively control costs and benefit levels in future years. Commitments from carriers to accomplish this have been secured.

During the Study Session Council will also be provided the following:

- Discussion of due diligence study
- What options are available and were examined in the market
- Explanation of self-funding, how it works and the components
- Comparable other surrounding cities who are self-funded
- Discussion of "PRIME" medical plan
- Discussion of dental, vision, and EAP coverage
- Recommendation justification and associated costs

During the course of the due diligence study, Human Resources has been providing Council updates through issue papers. The latest issue paper is attached to offer a more complete background of the process that has been undertaken.



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MEMORANDUM

To: City Council

From: William R. Kenny, Human Resources Director

Date: February 23, 2010

Subject: Medical Benefits Strategies

As stated in previous Reading File and strategy updates, the City's medical benefits have been under review by the Human Resources Department, as well as our Medical Benefits Committee, with a cross-section of employee and Union representatives.

In keeping with this theme, we have spent the last couple of years completing a due diligence assessment or study of options, while closely watching the changes that are occurring with our current provider of medical benefits, the Association of Washington Cities (AWC).

Key Messages:
<ul style="list-style-type: none">○ AWC Regence Plans A&B not offered after December 31, 2011 (except LEOFF 1)○ AWC PPO plans (three) will replace Plans A&B, with a well city discount○ Unions have been provided notice and the Medical Benefits Committee was re-convened○ "Substantially Equivalent Benefits" (plan design and network) required per Union CBAs○ Due Diligence Study of options completed and recommendations developing

Council Direction Requested:
<ul style="list-style-type: none">○ Best option would seem to be going to a (Limited Risk) Self Funded Medical Program○ Change could be as early as July 1, 2010 and recommended not later than January 1, 2011○ Cost containment and "Control Own Destiny" goals are greater with Self Funded Program○ Alternative would be to stay with AWC and convert to PPO for 2011 (or 2012 latest)

Background

Kirkland has made a concerted effort over the past few years to move the majority of City employee's medical coverage from Regence Plan A to Plan B. This was a strategy to help contain the City's benefit costs in an environment of spiraling medical premium rates.

We were also able to get language in our negotiated collective bargaining agreements (CBAs) that provides, even mid-term of the agreements, for a due diligence study of the medical programs, associated costs and identification of other health options available to the City of Kirkland. Obviously, the Unions were hesitant to “pre-agree” to potential unknown changes but did agree to language that provides for exploring options toward “substantially equivalent benefits” and allowing for future changes. The CBAs also provides for (impacts) bargaining of any major changes.

In 2008 we received notice from AWC that they would be eliminating Regence Plan A and Regence Plan B and converting to three PPO plans effective at the end of 2011. The stated reason for the elimination is that the plans are no longer actuarially efficient for the Trust to continue to offer. It is noted that most other multi-employer trusts and medical plans have made or are making similar decisions and are or have moved to a PPO platform.

It might first be helpful to clarify what a PPO is - in contrast to our current Regence Plan A and B (known as a fully funded or POS / Point of Service medical program):

PPO –“... a managed care organization of medical doctors, hospitals, and other health care providers who have covenanted with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients....

A preferred provider organization is a subscription-based medical care arrangement. A membership allows a substantial discount below their regularly charged rates from the designated professionals partnered with the organization. Preferred provider organizations themselves earn money by charging an access fee to the insurance company for the use of their network (unlike the usual insurance with premiums and corresponding payments paid either in full or partially by the insurance provider to the medical doctor). They negotiate with providers to set fee schedules, and handle disputes between insurers and providers....

Other features of a preferred provider organization generally include utilization review, where representatives of the insurer or administrator review the records of treatments provided to verify that they are appropriate for the condition being treated rather than largely or solely being performed to increase the amount of reimbursement due....” [Wikipedia]

To employees and their families, the key to the quality of care is the provider network – i.e. how inclusive the provider network is and, specifically, if their individual health care providers are members.

Due Diligence Study

In order to assure a prudent due diligence study, the Benefits Committee utilized the services of Alliant / ClearPoint to analyze options for the city within the medical benefits marketplace.

There are four options that are generally available to an employer. We reviewed each of these as part of the due diligence study. Those four options are:

- 1) contracting directly with insurance carriers,
- 2) moving to another multi-employer trust,

- 3) staying with AWC
- 4) initiating a Self Funded medical program

Previous Council Reading Files have provided more detailed discussion of these options and the pros and cons for each.

A lack of specific City of Kirkland claims data has represented a significant problem in looking at options. AWC does not provide access to the claims experience data to individual participating members. Because of this, we have been unable to provide exact claims data to potential carriers in order to secure quotes.

Rates are typically set through a combination of factors including employee population size, employee and family demographics and previous claim experience (actual costs). With our small employee population and lack of specific claims experience information, potential carriers initially either declined to quote or have come up with quotes significantly higher than our current costs.

As discussed further in the “Risk Management” section below, working with Alliant / ClearPoint, we were able to creatively mitigate this lack of Kirkland specific claims data by providing carriers with reasonable experience information utilizing known claims data from comparable jurisdictions and our own demographics. Even with this, carriers have tended to quote rates higher than current AWC rates (...Premera quoted, for example, 50% higher than current premium costs).

With the remaining options of either staying with AWC or moving to another multi-employer trust, both approaches result in a conversion to a PPO plan design. (It is noted that many of the other large multi-employer trusts, such as the PEBB state program or Union trusts, such as the Teamsters, are already in a PPO format). Therefore, coupled with a continuing increase in costs (...either through an immediately higher premium or as a result of a lack of ability to affect or control “trend” regarding escalating premium costs), it is not really a question of if Kirkland should move to a PPO platform but rather “when?” and “which one...?”

Competing Interests

Reconciling competing interests has been a challenging endeavor in this approach. All employers today are critically concerned in regard to the escalating costs associated with medical benefit programs. This is balanced with the needs of employees and their families, who are most interested in the benefit plan design and the provider network which is available to them. This has proven to be even more-so true for City of Kirkland employees. The Unions are concerned about change from current benefit levels and any efforts toward increasing their members’ out-of-pocket expenses (cost-sharing) – hence the emphasis on assuring substantially equivalent benefits.

In order to attempt to balance these competing interests, and provide an “apples to apples” comparison to AWC’s current (Plans A&B) and AWC’s future (PPO) programs, the study of options was initiated with some clear initial parameters:

- 1) Plan design within a PPO framework
- 2) Substantially similar benefit levels
- 3) Substantially similar provider network
- 4) Preventative benefit component

- 5) Deductible and out-of pocket similar to the AWC PPO
- 6) Ability to manage costs and reduce “trend”
- 7) Ability to “control our own destiny”

Given all considerations, a “limited risk” Self Funded medical program would seem to provide the best prospect of meeting Kirkland’s interests and reconciling these competing interests.

What Is Self Funding?

An employer who operates a Self Funded health plan assumes the financial risk for providing health care benefits for its employees. Self Funded plans differ from fully insured plans in that employers do not pay monthly premiums for health care, however they do pay the claims cost for the services that employees actually receive and the costs to administer the program.

The basic components of a well-established Self-Funded Plan would include:

- 1) Third Party Administrator (Eligibility & Claims Processing)
- 2) Plan Design (Actuarially prudent – note: “substantially equivalent” requirement)
- 3) Provider Network (Health care services and provider discounts)
- 4) Stop Loss Insurance (Risk Limitation or Cap)
- 5) Reserves and Rate Stabilization Fund (Assure adequate funding and cost containment)

To limit their liability most employers purchase Stop Loss insurance. The Stop Loss insurer agrees to reimburse the employer for health care costs that reaches certain individual and/or aggregate thresholds (for example, \$100,000 monthly per individual and \$3.8 mm annual aggregate) in exchange for premium payments on the Stop Loss coverage. Generally, the lower the threshold amount, the higher the premium.

Risk Management

Self-Funded programs are not totally without risk, but the risks can be minimized. As noted, having good Stop Loss coverage in place, with appropriate limits, is a key component of managing the risk.

As part of the due diligence study, we were able to do an actuarial analysis to predict our “Expected Liability” utilizing known claims data from comparable jurisdictions, coupled with a cross reference to our own demographics. This helps to overcome the issue of a lack of claims data from AWC and is best thought of as a base line average of anticipated claims.

To alleviate the volatility of claims, the Expected Liability average was then converted into a “Maximum Liability” (98% reliability factor). Stop Loss coverage would be put into place at this level.

Reserves and Rate Stabilization are tools to assure the adequate dollars are in place to pay both fixed costs and claims.

“Reserves” are built during the first year and do not necessitate a cash infusion. Typically, employers are in a position to “save” money in the first 12 months while self-funding. This occurs because claims payments for services in one month are not processed until the second or third month. For example, should Kirkland go to a Self Funded program, in the early months of the transition period, medical claims and provider billings “run-in” subsequent to when the service is

actually delivered. Additionally, AWC would remain liable for services prior to the transition period, regardless of when paid. This allows reserves to build. (Please see Illustrative Example – Attachment 1)

The “Rate Stabilization” fund provides that anticipated costs remain constant for say a two year period, while providing an actuarially prudent hedge against “trend” in the second year. This is important, especially with a biennium budget. This helps to assure that overall costs are predictable and new cash infusions are not necessary.

“Control your own Destiny”

Performance measurement and management by information are powerful tools. With a Self Funded Program, cost containment options are different than with a fully funded program, such as AWC or direct contracting with a carrier. With Fully Funded programs, premium cost-sharing with employees is the only viable option toward cost containment and consumer managed care. Within Self Funded models, utilization and severity analysis are possible on an ongoing basis, and such elements as plan design, deductibles and out-of-pocket are variables within one’s own control. Both the employer and the employees are in a greater position to influence and drive the type of care and the cost of it.

Typically, an employer would put into place a “Benefits Committee” (much like our current MEBT model) with both employee and management representation. If costs on a specific item are growing at an actuarially inappropriate rate, they can be specifically addressed. For example, if employees are over-utilizing Emergency Rooms, an alternative clinic or health care approach, or even a higher deductible, can be applied to that specific benefit to reduce utilization and to control cost.

Additionally, over-time, the employer can gather and analyze claims data to be responsive with provider or plan design changes or other modifications to meet utilization.

Further, the Self Funded model currently being used as a base line has a significant “preventive” component (annual physical, well-child, etc). This can be leveraged with the City’s current wellness and health risk assessment efforts.

Questions deserving consideration

How would this be funded – won’t it cost more?

When a conversion / transition is made to Self Funded, the employer is able to build reserves. Because fixed costs can be anticipated and claims costs have a gradual run-in, the additional cash can be retained as reserves against future claim costs. This alleviates the need for up-front cash.

By contributing even at current levels of cost (i.e. the amount that AWC premiums currently cost the City of Kirkland, which is approximately \$5.1 mm), nearly \$1.3 mm in reserves and rate stabilization could be achieved by the end of the first year. While no-one can assure claims cost, this assessment is based upon reasonably prudent actuarial analysis and risk factors.

Even with “trend” increases, this should assure that sufficient monies are being reserved to meet claims costs for a biennium budget, without additional annual adjustment. (Please see Illustrative Example – Attachment #1)

What is “trend?”

Each year medical services cost more. Premium increases are correspondingly increased even more. However, depending upon an employer’s approach, there can be a big difference in how much more. For example, in recent years, AWC has averaged 10% premium increases (and even more than that in prior years.) Contrast that with some of our neighbors such as Bellevue and Redmond, who are Self-Funded, and have averaged closer to 6% cost increases. In some years they have had 0% increases in cost (Redmond – 2009, Bellevue – 2008) and Everett, Renton and others have enjoyed similar successes.

Additionally, each year the Stop Loss premium may also increase. Again that is driven by the number of times that claims exceed maximum liability, either based upon unusual individual or aggregate experience. While there is only a 2% prospect of this occurring, the Rate Stabilization fund would provide adequate safeguard against the need for additional cash infusion, cover any trend increases, as well as provide predictability as to the total cost of a medical program.

What are factors that would jeopardize a Self Funded Plan?

Most Self Funded programs are successful. Very occasionally, you may hear about one that is not successful and that organization would then go back to a different medical program. While rare, there are some “lessons learned” in those instances. Generally, one or more of the following have occurred, when there are problems with Self Funded medical programs:

- 1) Inadequate Stop Loss Coverage
- 2) Too small of a group or “high cost / high risk” demographics
- 3) Incomplete or improper actuarial analysis
- 4) Too rich plan design
- 5) Not managing by information / adjusting to utilization
- 6) Reserves or Rate Stabilization set too thin
- 7) Treating Reserves or Rate Stabilization as “cash”

How will we know if we are reserving enough / too much?

First Choice Health would provide Third Party Administrative services. This will provide ongoing claims and experience data. Alliant / ClearPoint will then provide analytical, underwriting, key metrics analysis, risk measures and severity reports based upon actual Kirkland data.

Externally, the State of Washington provides an annual audit and detailed actuarial assessment of reserve levels and the adequacy of those reserves. Internally, a Benefits Committee will also provide a consumer-driven approach to managed health care, based upon composite information.

What about Group Health and other Insurances?

Group Health is an HMO and, by law, we would continue to offer Group Health as an option under this scenario. The Self Funded program basically replaces Regence Plans A and B. Other insurances such as Vision and Dental, as well as our FSA/125 Plan, etc. would continue to be offered at current levels, and would be generally unaffected.

It should also be identified that we would also have very significant opportunities as to Prescription Drugs access and cost. This approach allows for greater volume purchasing, pricing transparency and formulary management, resulting in lower costs.

What about employee cost-sharing?

Each of our Collective Bargaining Agreements has language that provide for the ability to change medical programs, with certain requirements. The basic tenant is “substantially equivalent.” The language of the AFSCME Agreement serves as an example:

ARTICLE 15 – HEALTH & WELFARE

15.1 MAINTENANCE OF BENEFITS

Medical and Dental Insurance - The Employer may self-insure medical and/or dental insurance coverage or select a new medical and/or dental insurance plan and shall make every possible effort to maintain substantially equivalent benefits. The Employer and the Union shall meet to explore alternative insurance coverage prior to selecting any new medical and/or dental insurance plan in order to maintain substantially equivalent benefits at a reasonable cost. The Employer recognizes its responsibility to bargain with the union the impact of those decisions.....

Participation in benefits shall be consistent with Article 15.2 of this Agreement and the trusts and Plans described below.

15.2 HEALTH AND LIFE INSURANCE

Medical Insurance - the Employer shall pay each month one hundred percent (100%) of the premium necessary for the purchase of employee coverage and one hundred percent (100%) of the premium necessary for the purchase of dependent coverage under the Association of Washington Cities Regence Medical Plan B or Group Health Plan 2 for each employee of the bargaining unit.

Changes in insurance carrier shall be subject to Article 15.1....

Obviously, a change to a Self Funded Program will represent a significant “leap of faith” for our employees and their families. Additionally, to the Unions, it is their perspective that the components of benefit plan design, provider network and member cost are all elements of “substantially equivalent benefits.”

It is a very significant question as to Union receptivity if this type of a change in programs (Self Funded) could be accomplished if employee cost-sharing was concurrently proposed.

Again, it is believed and recommended that the cost containment potential for the City of Kirkland is in the greater ability to “Control our own Destiny.”

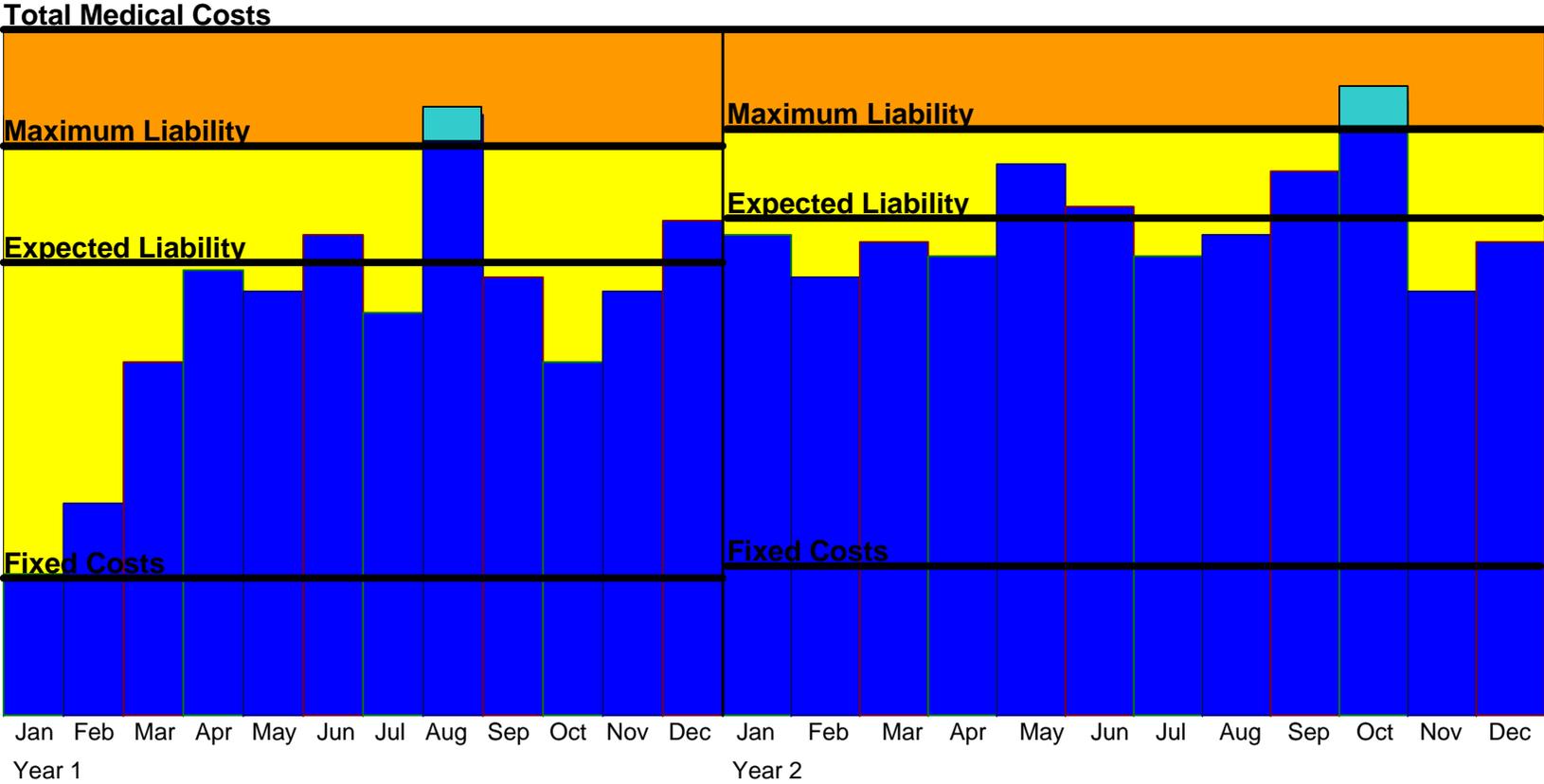
Conclusion

The opportunity to realize a positive change in medical programs (at a time when change is necessitated) is important for a variety of reasons. It is also noteworthy that the options available to the City of Kirkland become less with the passage of time.

This Reading File presents Self Funded as an option for Council's consideration, and one that does reconcile multiple competing interests. It also meets many of the goals necessitated by the City of Kirkland's understandable budget and financial concerns.

It is hoped that this Reading File represents an opportunity for Council discussion and direction, on a matter that is critical to our City as well as to its employees and their families.

How do we build reserves? -Illustrative Example



- Reserve Accumulation
- Rate Stabilization Fund
- Fix Costs + Actual Claims
- Aggregate Stop Loss Claim