**Sumner County SIB Trust**
**Employee Health Self-Funded**
**Dual-Option Information Meeting Transcript**
**February 2013**
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## Opening Remarks:

## Healthcare Overall:

Most of us have heard about health care reform and what it will and will not do for several years now. It is important the participants covered under the Sumner County SIB Trust be able to filter out what they hear that does not apply to them or their coverage. Much of the reform that affects the Sumner County self-funded trust has already been added to the plan and the associated increase in cost anticipated. Much of what you hear going forward will not impact your coverage, and if it does, it will be several years before that happens. So how can you tell?

There are three basic groups when considering the health care reform acts. The first group is called "individual." This means that someone is not offered coverage by their employer or is self-employed and they must secure coverage themselves. This is often done through an agent or directly with an insurance company. The second group is called, "small group." This is people who are offered coverage through their employer and the size of the group is between two employees and 100 or 200 employees, depending on the state in which you live. The third group is, "large group." This would be employer offered coverage with over 200 employees in the group. As a member of the Sumner County SIB Trust, you are considered to be in the third group, "large group."

Since you are in the large group category, as stated earlier, much of the change required has already occurred and the associated costs anticipated. That means that what you are hearing currently about new changes will not affect the cost of this program. Some of the changes that affected your plan were increasing dependent coverage for children up to age 26, no lifetime caps on coverage and expanded wellness benefits with no copays.

Not only are you in a large group, you are also in a self-funded large group which is a further safe-harbor from some of the health care reform mandates. It is important that each participant understand the importance of being self-funded as opposed to "fully insured." First, fully insured means that the employee purchases insurance from an insurance company. The employer pays the insurance company a set premium and the insurance company pays claims, regardless of the amount. If the claims are greater than the premium, the insurance company loses money. If the claims are less, the insurance company makes money. Under this arrangement the insurance company will almost always take in more premium than they pay out. Also, the employer has very little control over coverage changes.

The Sumner County SIB Trust, being self-funded, is not insured by Blue Cross Blue Shield of Tennessee. The Trust pays Blue Cross to do two things; pay claims and provide a network. Blue Cross cannot lose money on this program. All of the risk is on the Trust. But, if there are good claims years the Trust keeps the money, not Blue Cross, or any other insurance company they may hire. For a set fee, per employee per month, Blue Cross pays claims that are incurred by members of the Trust at hospitals, doctor's offices, and drugs purchased at retail pharmacies. The money for these claims is paid out of the Trust's bank account. Blue Cross also supplies a "network." The network negotiates discounts with hospitals, doctors and other medical professionals. These discounts significantly lower the cost of care to the Trust. Being self-funded allows the Trust to make changes in coverage whenever it is decided that it would be in everyone's best interests to do so. This is almost impossible under a "fully insured" arrangement. Being self-funded is a major benefit to those who are covered under this plan.

When the government passed health care reform, one of their objectives was to cover everyone. To accomplish that, everyone must also purchase insurance. With this in place the government, as part of the reform, decided to include rules that made it difficult for insurance companies to take advantage of the consumer. To add that protection they included a rule that said that any insurance company that sold a policy to a large group must spend eighty-five cents of every dollar on claims. They are allowed to keep fifteen-cents of each dollar to pay for everything they do to offer and administrate the policy. Under the Sumner County Self-Funded Trust, that fifteen cents is only $ 0.0377. That means that over $0.96 of every dollar set aside in the Trust is used to pay claims on its members. Not $0.85. That is phenomenal.

Consumers will experience another series of price shocks later this year when some see their premiums skyrocket thanks to the Affordable Care Act.

The reason: In crafting government designed healthcare reform legislation ignored virtually every actuarial principle governing rational insurance pricing. Premiums will soon reflect that disregard—indeed; premiums and health care costs are already reflecting it.

Central to healthcare reform are requirements that health insurers (1) accept everyone who applies (guaranteed issue), (2) cannot charge more based on serious medical conditions (modified community rating), and (3) include numerous coverage mandates that force insurance to pay for many often uncovered medical conditions.

Under guaranteed issue people are incentivized to forego buying a policy until they get sick and need coverage (and then drop the policy after they get well).

While healthcare reform imposes a financial penalty—or tax—to discourage people from gaming the system, at $95 a year initially it is too low to be a real disincentive. Many will simply not buy insurance and pay the lower tax…until they need coverage. The result will be insurance pools that are smaller and sicker, and therefore more expensive.

Many actuaries, including the international consulting firm Oliver Wyman, are now predicting an average increase of roughly 50% in premiums for some in the individual market; for the same coverage.

Small employers will likely see a significant increase, though not as large as the individual market, which will be the hardest hit.

Large employer groups will be less affected, at least initially, because the law does not include, in most of its language, employers that self-insure, like Sumner County.

Although healthcare reform proponents repeatedly claimed that health-insurance premiums for a family would be $2,500 lower by the end of 2012, they are actually about $3,000 higher—a spread of about $5,500 per family.

## So how does this affect the Sumner County Trust participants?

1. Most all of the reform mandates that apply to the Trust have already been implemented.
2. The next change will come in 2014 when the Trust cannot require any preexisting conditions on new people added to the plan.
3. Another challenge will come when the state finally sets up an insurance exchange. There will be a cost to the Trust to comply with this mandate. As of now Tennessee has not chosen to set up a state exchange but has elected to allow the federal government to run the exchange. The issue, however, is that the federal government is not prepared to do so and there isn't enough funding within the reform act. Even if this is set up, it again only affects the first two groups, individuals and small group, not the Trust. The Trust will not be directly affected until 2017. The indirect affect is that exchanges will likely raise the cost of health care, which is paid for directly by the Trust.
4. The largest impact to the Trust will be the increased cost of medical services and products and the shortage of primary care doctors.

## What has the Trust done to prepare for these issues?

1. On-site clinics. Since the Trust implemented on-site clinics several years ago, they have already established a trusting relationship with several local doctors. Many in the community who are not part of the Trust will have problems finding a primary care doctor or, if they do have a doctor, there will be long waits for appointments. Trust participants will likely have continued access and short wait times.
2. Several participants over the years have taken advantage of the wellness and chronic care services offered at the clinics. In order to increase that participation, a new wellness incentive is being established. That is the purpose of this Dual Option Program. For it to work, the majority of participants will have to embrace the concept of

becoming involved in their health, and the cost of being involved in their health. This program addresses both.

3. It is important to remember that the Sumner County SIB Trust is not an insurance company. It is self-insured, meaning that every claim created by those who participate is paid for by funds set aside by the County and employee contributions. These dollars are sent directly to hospitals, doctors, ancillary providers and drug stores. None of these dollars are sent to an insurance company and no commissions are paid to agents or brokers. Through June 30, 2013 the Trust is estimated to pay $15.1 million for medical and $2.5 million for drugs directly to these institutions. In addition, the Trust will pay approximately $762,000 in fixed costs to BCBS for claims paying services. An additional $2.5 million will be paid for the operation of the on-site clinics. If the clinic funds were placed back in the BCBS plan, that number would increase from $2.5 million to $3.5 million. The estimated total cost to the Trust will be $21 million dollars. That is about $12,400 per employee per year.

## Side by Side Comparison

One of the handouts is labeled **Standard Plan vs. Preferred Plan**. You will note that the middle two columns labeled Preferred in network and Preferred out of network are the same benefits as you have currently. The Standard Plan on the right hand side generally has an out of pocket that is three times greater than the out of pocket in the Preferred Plan. There are two differences. First the emergency room copay under the Standard Plan is only $50 higher, not three times. The Rx, or drug copays, is two times higher, not three.

It is important to note that regardless if you are in the Preferred or Standard Plans, what is taken out of your pay check will be the same. There are two things to note however. First, if the employee, the spouse, or, the employee and the spouse use tobacco products, there will be an additional surcharge that will be taken out of your check. Details can be found in the Frequently Asked Question handout. Second, if the Trust determines that additional funding is needed beginning in August of 2013 there could be an increase in what is taken out of your check, however, both plans will increase the same and the deduction will remain the same for both plans.

Again, no one will be placed in the Standard Plan until July 1, 2014, over a year from now. That placement will be based on compliance with participation. This will be explained in detail later.

The last thing about this comparison concerns in and out of network benefits. For 2013-2014 the Preferred Plan will have, as it does now, out of network coverage. Beginning on July 1, 2014 the out of network benefit on the Preferred Plan will go away. Coverage can only be obtained by staying in network after that date. Since you are in the Blue Cross “P” or Preferred Network, it will be difficult to find a hospital or doctor that is not in this network. We will discuss this later. Beginning July 1, 2014 those that are placed in the Standard Plan will have access to out of network providers; however, there will not be a cap of what you will have to pay.

## Step by Step Process

Certain aspects of this program are time sensitive and it is important that you act by certain dates, as included in the attached material.

Some of the basics are:

1. Every covered employee, retiree and their covered spouse must have a Health Risk Assessment blood draw completed between February 1, 2013 and June 30, 2013 at one of the CareHere remote locations listed on the schedule. Children, regardless of age do not have to comply. There will be 52 separate events and they must be by appointment. The appointment can be made on the website, www.carehere.com or by phone at 1-877-423-1330. You may use CareHere for the required follow-up or your own primary care physician. Follow up at CareHere costs nothing, follow up with your own physician will have regular plan costs associated and it is your responsibility to get all completed forms back to CareHere by the deadline.
2. Beginning July 1, 2013 there will be two plans available. A Preferred Plan; this plan is the same coverage as you currently have. A Standard Plan; creates out-of-pocket expense equal to three times the Preferred Plan, except for emergency room visits-a $50 increase in co-pay, and the pharmacy is only two-times more, not three. No one will be placed in the Standard Plan effective July 1, 2013. The first time anyone will be eligible for the Standard Plan will be July 1, 2014, over a year away.
3. Which plan you are placed in will be determined by your participation in a plan of care should your blood work indicate a concern with five specific findings. Please refer to the attached literature. It should be emphasized that your placement will be based on participation, not outcome, and that determination will be made by a physician, not the Trust or the County. The first time this determination will be made will be March 1, 2014, over a year away.

## Q&A Handout

You were given a hand out labeled “Frequently Asked Questions.” That document has already changed and will continue to change as new questions are posed, or, changes or corrections are made. This document can be accessed at your county benefits website, http://finance.sumnertn.org/services/Employee_insurance_benefits_(1) or the BOE benefits website, www.sumnerschools.org/benefits. Since the beginning of these introductory meetings there have been an additional 130 questions asked that will be placed on the site once all of the answers have been obtained and verified.

There are a few things I want to highlight that are listed on this handout.

**No Show Charge**

Due to a significant increase in patients not showing up for appointments at the CareHere clinics it has become necessary to charge a "no show" fee. There were over 1,200 missed appointments last year. When you go to your regular doctor their office is seeing four to five patients at a time. When one of those patients doesn't show up the financial impact is not significant. However, at the CareHere clinic, in order to give the patient the care intended, the doctor sees one patient at a time. When that patient doesn't show up everything sits for twenty minutes, during which time the cost does not stop. The doctor is still being paid, other support staff is still being paid and there is the overhead that still has to be paid. In other words, it is costly when someone makes an appointment and doesn't show up or cancel the appointment. The other part of the problem is tardiness for the appointment. The average cost to the Trust for an appointment will run about $80. Considering that there were over 1,200 missed appointments last year that cost the Trust about $96,000. Keep in mind that you are the Trust. That $96,000 came out of your benefit fund. To try to cut down on these missed appointments the Trust has added a "no show" charge. It went into effect February 1, 2013. Each individual or family is given one missed appointment each year with no penalty. After that there will be a $50 charge for not canceling an appointment 12 hours prior to the appointment. If you are over 10 minutes late, it will be considered a missed appointment and the same charge will apply. You may pay the charge at the Shafer Clinic with any means other than cash. Until the charge is paid clinic services will be suspended. It is easy to cancel an appointment on line by simply going to the schedule and clicking delete by your appointment. The change is immediate. If you do not have access to a computer you can also call at 1-877-423-1330. If there is a serious event that causes the missed appointment you should also contact the clinic to discuss.

**Smoking Cessation Charge**

If you are placed on the Standard Plan due to the continued use of tobacco products there will be a monthly surcharge in addition to your benefit payroll deduction. The charge will be $50 per month, per tobacco user. If the employee and their spouse are on the Standard Plan and only one uses tobacco, there will only be a $50 charge. If both the employee and the spouse use tobacco there will be a $100 per month surcharge. These surcharges will continue to be deducted as long as you are on the Standard Plan, even if you stop using tobacco mid-year. The surcharges will be collected through payroll deduction.

It has been asked why tobacco use is singled out for a surcharge when other factors like obesity also causes serious health related expense. Tobacco use is the only issue that the federal government allows to be treated this way. Other factors besides tobacco use could well become eligible for surcharges as more data is released. We are not aware of any pending changes in the near future. A recent Associated Press story pointed out that the new health reform law allows insurance companies who sell to individuals to charge for tobacco use. The article stated that a 60 year old smoker could pay as much as $5,100 on top of their premium under the new government passed legislation. The Trust is charging $600.

There are more details concerning this issue in the Frequently Asked Questions document on-line.

**Change in Annual Deductible Accumulation Period**

Your current deductible and out of pocket expenses are accumulated from January through December, or a calendar year. The Trust benefits plan runs from July to June, or a fiscal year. Most government programs and budgets operate on a fiscal year. Because the deductible year and the plan year are different it is always an issue when changes have to be made. To make the process simpler and more efficient a decision was made to move the deductible and out of pocket accumulation period to match the fiscal year plan period of July to June. In order not to penalize the plan participant a decision was made to extend, a onetime event, the accumulation period from twelve months to eighteen months. That means that beginning last January 1, 2013 your deductible and out of pocket accumulation began and it will continue through June 30, 2014, or eighteen months. That makes it more likely that you will be reimbursed after meeting your deductible and out of pocket expenses. This is an excellent additional benefit. Beginning July 1, 2014 your accumulation period will be from July 1, 2014 to June 30, 2015, and the same each year thereafter.

**In-Network vs. Out-of-Network**

Both the Preferred Plan and the Standard Plan use the same BCBS of Tennessee Preferred or "P" network. This is the broadest network available and contains most every hospital and doctor. It is difficult for a hospital or doctor to refuse to be in this network because BCBS is so large. Still, it is possible for you to find a doctor or group of specialists that are not in the network. The best rule is to ask if they are in the network when the appointment is made and then ask again when you arrive at the appointment and before services are rendered.

If you are admitted to a hospital, this process can become more complicated. There are certain groups that operate out of a hospital that are not directly owned or managed by the hospital. The most common groups are anesthesiologists and emergency room doctors. These two groups are sometimes self-contained and owned and operated by an outside corporation. For this reason they may choose not to be a part of the same network as the hospital.

BCBS of Tennessee takes the position, in determining if the group is in or out of network, that is if the group is "hospital based" they are considered in-network even if they have not signed a contract with the network. Hospital based means that the group is primarily using the hospital as a base for their operations. This is a determination that is made by BCBS of Tennessee based on their conversations with the hospital. For this reason you should speak with the hospital to get a determination about any groups or physician services that are not "in-network." Be aware that this is your sole responsibility, not the doctor that sets up the admission. The most common group or doctor that is not in-network is a surgeon. Surgeons often have privileges at several facilities. They may or may not be in the same network as all of the hospitals where they operate. Over 85% of hospital admissions are scheduled well in advance. You should have sufficient time to speak with the hospital admissions office. You are advised to do so.

For those times when you have an emergency you should not be held responsible for actions over which you have no control. If you are in an accident and you are taken to the nearest hospital, which may not be in your network, you should not be penalized for a decision over

which you had no control. Under these circumstances your admission at the emergency room should be considered in-network. Once you are stabilized and can be transported you may be requested to transfer to an in-network facility.

The last issue concerning in and out of network centers around out of state medical care. First you should know that Blue Cross Blue Shield of Tennessee is a state run and owned entity. There is not a national Blue Cross Blue Shield company. Instead, each state has a company and it is independently run. There are a few cases where some state groups have joined together, but for the most part they are all individually run. There is a national Blue Cross Association and through this group there is a benefit called the “Blue Card.” There is an explanation of this program in your benefit material. If you are out of state you simply need to ask if the hospital, doctor or other medical professional or service is in that states Blue Cross Blue Shield plan. If they are it is the same as their being in your network in Tennessee.