INSURANCE ADVISORY BOARD MINUTES
City of Fort Lauderdale
100 North Andrews Avenue
8th Floor Conference Room
Wednesday, October 6, 2010– 8:00 a.m.

Board Members	Meeting Attendance	1/10 – 12/10 Cumulative Attendance P	A
Joseph Cobo, Chair	P	9	0
Mark Schwartz, Vice Chair	P	6	3
Joe Piechura, Sr.	P	8	1
Jim Drake	P	7	2
Charles Grimsley	P	9	0
Steve Botkin	P	7	2

Staff and Guest

Matthew Cobb, Risk Management Coordinator
Denny Stone, Employee Benefits Coordinator
Guy Hine, Risk Manager
Michael Walker, Procurement & Contracts Manager
Lloyd Rhodes, City's Outside Benefit Consultant

As of this date, there are 6 members of this Board, and all 6 are appointed, which means that 4 would constitute a quorum.

Roll Call

The meeting was called to order by Chair Joseph Cobo at approximately 8:00 a.m.

Communications to City Commission

Nothing to report.

Approval of Minutes

Motion made by Mr. Drake and seconded by Mr. Piechura to approve the minutes of the September 1, 2010 meeting. Board unanimously approved.

Unfinished Business

None.

New Business

Mr. Grimsley entered the meeting at approximately 8:09 a.m.

Dental Plan

Mr. Stone stated that the results of a four-month group dental RFP process are being brought before this Board for their approval. He explained that prior to the RFP, MetLife had suggested a 30% increase to the City's dental rates. Yet, an RFP was issued, and bids were received at less than the current rates.

Mr. Stone stated there were slightly over 1400 members in the Dental Plan, and 57% were in the DHMO due to the lower cost which is borne in it's entirety by the Teamsters. The Evaluation Committee consisted of John Sherman, Administrator for the Teamsters; Tim Ashmore, a member of the Federation; and Denny Stone, Employee Benefits Coordinator. A best and final meeting was held on September 10, 2010, and four finalists (Aetna, Solstice, Humana and MetLife) provided their presentations. Overall, responses were received from 11 companies, and a total of 36 plans were analyzed, ranked, and voted upon.

Mr. Stone explained how the four companies and their plans had been ranked. The companies had been asked to try and match the current plan, along with an alternative plan to provide an incentive to use the DPPO network dentists.

Mr. Rhodes explained that they had also requested the proposals with implants and without implants. The DHMO has changes, but the key is that the Evaluation Committee selected a plan that called for DPPO out-of-network benefit reductions and this was due to the impact on the rates. The plan currently in place is the "Cadillac of all Cadillacs." Costs were reduced, but the plan is vibrant compared to other groups in the marketplace.

Mr. Stone stated that $967,000 is spent yearly on the two plans, which is a result of a three-year rate guaranty (2007 – 2010). On the "best and final, "they went back to the group and asked for a three-year rate guarantee. Aetna would only provide a two-year rate guaranty, and therefore, everyone had to be compared on a two-year basis.

Mr. Stone said there were slight adjustments to co-pays on both the DHMO and the DPPO. The Committee chose Humana with their implants versus Humana without the implants. He proceeded to explain some of the benefits provided under the plan. A DPPO plan with a $100 deductible when using out-of-network coverages was selected. The cap on the PPO remains at $1500 per year, and the DHMO is not capped.

Mr. Rhodes added that the plan included orthodontia for both adults and children. He explained that MetLife only provided the existing plan and did not provide alternates, and therefore, were not competitive. Mr. Rhodes stated that the City had kept dental rates the same for 6-7 years.

Mr. Grimsley asked how this compared to the costs incurred last year. Mr. Rhodes explained that the three-year rate guaranty was the same. Costs are now coming in the same as the costs for the last three years.

Mr. Stone stated that one of the other issues pertained to references. He stated that Humana has good public entity references in Southeast Florida, and had retained their current large public entity accounts for the last 10-15 years. This scored high with the Evaluation Committee.

Motion made by Mr. Grimsley and seconded by Mr. Piechura to approve the Dental Plan as presented by the Selection Committee. Motion approved unanimously.

Stop-Loss Insurance

Mr. Rhodes stated that AvMed had not finalized numbers regarding the stop-loss insurance at this time, but wanted to review where they stood in the process. He believes they are close to a final commitment. The self-funded health plan is administered by AvMed. He proceeded to give historic information back to 2003 when they began with a $150,000 cap. He explained that stop-loss insurance is not experience rated, and is governed by trends and the marketplace. The process with AvMed has been that the re-insurance company must have an approved relationship with AvMed to authorize them to pay claims. This entails the sharing of confidential information with respect to discounts provided by AvMed. By having such knowledge, the re-insurance tends to be more competitive. Each year, AvMed shops for re-insurance among carriers that are approved for business.

Mr. Rhodes stated that 2009 was the worst year with seven claims. Mr. Stone stated that year also had over 50 claims that were over $50,000. Most were cancer claims and were due to a “blip” and US Fire took a bath. This year large claims seem to have adjusted downward, even though there are four claims hovering around $200,000.

Mr. Rhodes further stated that Vista is the managing general underwriter for Companion Life Insurance Company, and were also the managing general underwriter for the previous carrier, US Fire. A switch was made to Companion in 2010 after looking at 17 different proposals, some of which included increasing the lifetime maximum for the self-funded health plan. Effective January 1st, Health Care Reform requires that a lifetime maximum has to be unlimited, but there could still be an annual maximum benefit as low as $750,000. Currently, the annual maximum is $2 million. By 2014, everything has to be unlimited. He explained the present annual cap is illustrated as $1.8 million, which includes the specific deductible of $200,000. This is based on being incurred in 12 months, and paid in 15 months, which is considered a good contract. He proceeded to show a chart of monthly rates. There is an underwriting fee for Charles Borden & Associates, which is a firm that works with AvMed to underwrite the risk.

Mr. Rhodes stated that last year at the time of the renewal, there was a “laser” which means there was a member who was on an organ transplant list. Instead of a $200,000 limit, the limit was $275,000. The $275,000 with Companion will be retained. Mr. Stone proceeded to explain some of the costs that such individuals incur.

Mr. Stone stated that if an individual reaches that cap this year, they would have to begin all over the following year.

Mr. Rhodes further stated that one of the things making it difficult to get a timely renewal on the re-insurance was the fact that reinsurance carriers are not willing to commit until late in the year. He explained that he had a commitment that the rates shown were firm, but the disclosure requirements would only go through the end of August. Coming before the Board now would provide more time for review and approval.

Mr. Rhodes stated there were two proposals being considered. They are recommending that the City raise the individual stop-loss level from $200,000 to $225,000 in order to mitigate the re-insurance premium impact.

Mr. Stone referred the Board to the historic information provided to them.

Mr. Rhodes explained some of the information in the columns provided on the chart. He stated they will work on meeting Health Care Reform compliance in 2014, thereby avoiding increases in costs at this time.

Mr. Grimsley asked why a company would put out so many different proposals. Mr. Rhodes proceeded to explain some of the specific proposals. The bottom line is that initially the City was looking at a 28% increase, and therefore, they wanted to review all available options and see what the impact of Health Care Reform would be with respect to the different maximums. He stated that re-insurance companies will only guaranty for one year, but this is the last year without an RFP for AvMed, it is their preference to work with re-insurance companies either owned by the TPA or approved by the TPA. Otherwise, the City could be open to potential liability.

Mr. Stone stated that the carrier the City had used for a number of years was Combined Insurance which had been purchased by United Health Care.

Mr. Grimsley stated that he understood different programs could be tailored for specific clients, but the plans being recommended all have premium increases. He noticed that Vista had three programs showing premium reductions, and asked why those were not being considered.

Mr. Rhodes explained that they were increasing the stop-loss level to $250,000.

It was asked if there was a difference in the new Federally mandated utilization charges and internal charges. Mr. Rhodes stated the biggest difference is preventative care measures, which include colonoscopies. Mr. Stone stated that some biometrics were also included. The other change is that on January 1st the dependent child age limit of 26-year age limit will be instituted.

Mr. Rhodes stated that insurance companies are presently using 1.5% to 2% of employee insured premiums to adjust upwards for Health Care Reform, which includes the maximum benefit change and the other proposed changes. Everything has been included in their projections for 2010, including the re-insurance.

It was suggested that when a presentation is made to the City Commission that they provide different math showing the premium to stop-loss caps. Mr. Rhodes explained that a claims to savings ratio would be done. The only potential change will be the “laser.” The premium rates would remain the same. He asked for direction in regard to approving this proposal as long as there are no changes. He had hoped for a conditional recommendation to move forward with the approval.

Motion made by Mr. Schwartz and seconded by Mr. Piechura that they move forward with the proposal.

Mr. Grimsley asked what is left to work on since only a draft is being presented. Mr. Rhodes stated that numbers had to be confirmed. Mr. Stone stated they were still looking at August claims. Mr. Grimsley asked about the deadline for finalization of the numbers. Mr. Rhodes believed final figures would be available by the end of the week.

Board unanimously approved.

Old/New Business

Crime Policy

Mr. Hine stated that at the Board's November meeting they would need to discuss the Crime Policy and whether it should be marketed or if they should negotiate with the current vendor.

Health Care

Mr. Stone stated staff is presently discussing with City management about Health Care. Last year, the City had a bad year with approximately 30 claims totaling $5.5 million. They had been at a 6% to 8% trend, and last year the trend went to about 20% - 25%. It has adjusted downward, and they are now looking at about 9.9%. They are looking at plan designs and premiums. He asked if the Board members had any thoughts regarding this matter. The City gives a defined contribution based on bargaining unit agreements, and the City's contribution represents about 89% of the funding of the program. Employee contributions would probably be re-adjusted.

Mr. Rhodes stated the marketing agreements call for a fixed-dollar amount which protects the City against fluctuations. This means the employees bear the full cost of changes required to keep the plan healthy. Currently, there are surpluses in the plan, but the projection is that they need to do something or they would be back to where they were in 2002/2003 regarding deficits. He reiterated there would be benefit changes, as well as contribution changes.

Mr. Schwartz asked what other large municipalities and employers were doing in this regard. Mr. Stone stated that Broward Schools increased dependent coverage last year significantly. Due to that, there were 200 new dependents joining the City's plan as of January 1st.

Mr. Rhodes stated that in the summer the County received a 29% increase from VISTA. Mr. Cobo stated the County and Schools needed to review all available options for a better program. Mr. Rhodes stated that an RFP had been done last year, and VISTA was kept. A new bid went out, and Humana had declined to quote since they were ranked second the previous year. It is between VISTA and AETNA, and it appears VISTA is getting the leading edge. There are going to be major changes with a 29% increase. They do not have the defined contribution arrangements the City has which call for a fixed dollar amount per employee.

Mr. Cobo asked if there is a way to charge more for dependent coverage. He asked if the flat amount per employee included dependent coverage and spouse coverage. Mr. Rhodes explained it is applied to each of the tiers offered. Some money is used to subsidize the dependent rate to make it more affordable.

Mr. Stone stated that single coverage is about $460 in value per month. The actual City contribution to Teamsters is $635 per month, firefighters are at $567 a month, and management is at $702 a month.

Mr. Rhodes stated that since the change in contributions is borne entirely by the employees, employees will bear changes.

Mr. Botkin stated that there has never been a disincentive regarding family coverage, but that could occur this year. Mr. Rhodes agreed. Mr. Botkin stated the presentation has to show that a fair rate was being proposed. Mr. Rhodes stated they are facing a new reality. In 2003 major changes had been made to the plan, but no other changes were made since then, except for those last April. He stated further that they were looking at double-digit trends. In order to maintain a healthy plan, changes will have to be made now and in the future.

Mr. Rhodes stated they are anticipating some additional savings in the new PBM, but they would not be realized for at least 6-7 months since it was mostly for rebates. Rebates are not paid until 90 days after the end of the quarter in which they are earned.

Mr. Cobo stated the premium charge would have to be directed to the user group using the plan to offset the charges. Mr. Rhodes stated the benefit reconfiguration would have to be put on the individuals using the plan, but efforts would have to be made to try and not dissuade them from using the plan. People need to use the plan to remain healthy.

It was stated that carriers offering consumer-driven plans started out with $1200 HSA deductibles with an increase to $1500, and are now at $1800 or more per year. They are seeing tremendous inside deductibles in the policies.

Mr. Hine stated that staff has been discussing the Wellness Program, along with the possibility of putting together a committee to be part of such discussions. He asked the Board to provide their input at the next meeting regarding this matter. Another challenge is that if any funds are going to be spent, the issue will have to be presented to the Commissioners.

Scheduled Board Meetings

The next scheduled Board meeting is November 3, 2010 at 8:00 a.m.

There being no other business to come before the Board, the meeting was adjourned at approximately 9:00 a.m.

Respectfully submitted,

Margaret A. Muhl
Recording Secretary