Town of East Bridgewater
Insurance Advisory Committee
January 23, 2020

First…who are your advisors?

NFP?

(National Financial Partners)

NFP

Simple Is the New Smart

We are a leading insurance broker and consultant that provides employee benefits, property & casualty, retirement, and individual insurance and wealth management solutions. With unparalleled industry knowledge and a personal commitment to each client's goals, we make the complex simple, creating solutions that are direct and results-driven.

Over **50,000** corporate clients

Over **150** offices across the United States

4,800+ employees

6 international offices across the U.K., Puerto Rico & Canada

We Are Municipal Experts!

- Over 400 Clients in Mass. Alone
- Over 90 Municipal Clients and Growing!
- Advisor to 4 JPA's
- Clients in this Area: Marion, Mattapoisett, Carver, Lakeville, Old Colony Reg. Voc-Tech, Abington, Old Rochester RSD, North Attleborough, Raynham, New Bedford

Experts With All Municipal Employee benefits

- Health Insurance
- Life Insurance

(Mass. Statutory and Supplemental)

- Dental Insurance
- Vision Insurance
- LTD/STD
- Long-term Care Insurance

Account Executives

Ken Lombardi – LIA, over 40 years' exp.

Edd Byrnes – LIA, Underwriter, over 40 years' exp.

Joy Layden – Broker, over 20 years' exp.

Kevin Paicos – Broker, 40 yrs. as TA/TM, 15 yrs. Ins.

Co-insurance	Your share of the costs of a covered health care service, calculated as a percent (for example, 20 percent) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20 percent would be $20. The health insurance or plan pays the rest of the allowed amount.
Copayment	A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
Deductible	The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.
Integrated deducible	A medical or drug payment that you make, which counts toward a single deductible (combines medical and pharmaceutical).
Explanation of Benefits (EOB)	A statement sent by your health insurance company explaining what medical treatments and / or services were paid for on your behalf. An EOB typically describes: • the payee, the payer and the patient • the service performed, the date of the service, the description and / or insurer's code for the service, the name of the person or place that provided the service, and the name of the patient • the doctor's fee, what the insurer allows, and the amount initially claimed by the doctor or hospital, minus any reductions applied by the insurer • the amount the patient is responsible for • adjustment reasons, adjustment codes
Flexible spending accounts (FSAs)	A benefit plan that lets workers put pre-tax dollars in special accounts to help pay medical costs, child care and other health services. Unused funds do not carry over, so it's important to plan carefully. The IRS determines what expenses are covered. You can check what expenses are covered by visiting the IRS website.
Guarantee issue	The amount which a policy is offered to an applicant without regard to health status.
Health savings accounts (HSAs)	A bank account that lets people put money aside, tax-free, to save and pay for health care expenses. The Internal Revenue Service (IRS) limits who can open and put money into an HSA. May only be coupled with a High Deductible Health Plan.
High-deductible health plan	A type of health plan defined by the IRS that lets people save money tax-free in health savings accounts.
In-network	The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services. Plan members usually pay less when using an in-network provider because the cost to the health plan is lower.

COMMONLY USED TERMS CONT'D

Out-of-pocket	Out-of-pocket refers to the amount of money you are required to pay for health care services. Some plans have out-of-pocket maximums, after which the plan pays 100 percent of a member's health care costs. Deductibles and copayments are examples of out-of-pocket costs.
Primary care physician	The main doctor who takes care of you.
Qualifying event	A qualifying event is when health plan members have a major change in their life, such as a marriage, divorce, adoption or birth of a child. Such events make them eligible to change their insurance coverage outside of the normal enrollment period.
Annual pharmacy deductible	An amount you pay each year or prescription drugs before your insurance pays.
COBRA	A health insurance plan, required by law, that allows eligible employees to continue on their employer-sponsored health plan after they have left that employer, for a specified period of time, and at their own cost.
Contributory share	The amount you pay for your insurance premium, usually expressed as a % of the full premium.
Covered services/medications	A health care service or medication (subject to the formulary) which the insurance plan will pay for.
Inpatient medical care	Medical care you receive if you must stay overnight. Ex. – delivering a baby, major surgery.
Outpatient medical care	Medical care you receive that does not require an overnight stay – i.e. you are discharged the same day.
Open enrollment	The time when you can re-enroll in the health plan you are already in or choose to enroll in another health plan. You can usually do this without waiting periods or proof of insurance.
Mass Health	The name of the Medicaid program in Mass. that pays medical expenses for qualified individuals (disabled/low income).
Medically necessary	Medically necessary services, supplies, or drugs are those that prevent, diagnose, stop the worsening of, improve, correct, cure, or treat a medical condition that endangers your life, causes suffering or pain, causes physical deformity or malfunction, may cause or worsen a disability, or could result in making you very sick.

COMMONLY USED TERMS CONT'D

Medicare	Medicare is the Federal health insurance program for people who are 65 or older, younger people with qualifying disabilities, and people with end-stage renal disease. Municipal employees who retired prior to April, 1985 are not eligible since they did not pay into the Medicare system.
Preventative care	Services you may receive that have disease prevention as their focus. Many of these services are fully covered and not subject to co-pays or deductibles. Ex. annual physical, PAP smears, immunizations.
Prior authorization	Prior authorization, also called "prior permission," is the approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. Some drugs are covered only if you get prior authorization.
Referral	Permission to use health service providers in the insurer's network, that you must obtain prior to using those services, in order to be sure the insurer will pay for them. Common provision with HMO plans.

AND SPEAKING OF MEDICARE…..

OK…let’s talk about how

your Employee Group Health Insurance Plan works….

Who can be on the plan?

- Employees of the Town who work an average of 20 hours per week (MGL Ch. 32b). [18.75 hours on GIC]
- Dependent children and spouses of the enrolled employee.
- Certain elected officials IF they are pension eligible (they receive a Town “salary” unless barred by by-law or regulation.
- Retirees of the Town (both Medicare qualified and not Medicare qualified).
- COBRA participants.

What are the Parts of Your Plan?

The Employer

- makes a set of promises to provide a health plan and pay part of the cost (MGL Ch. 32b)
- must be at least 50% of premium but can be higher if approved by ballot, Town Meeting, or collective bargaining (MGL Ch. 150e)
- must provide a PPO for employees living out-of the area

The Health Care Provider

- The doctor, hospital, clinic or other service provider
- Agrees to provide services for a negotiated discount with the insurance company, and agrees o accept a negotiated fee.

The Insurance Company (“Carrier”)

- Agrees to pay for covered health services, according to a “Schedule of Benefits”.
- The Schedule of Benefits establishes co-pays, deductibles, benefit levels etc. and is negotiable.
- MIIA is a municipal collaborative authorized by special legislation
- Carriers may or may not provide administrative services for payment of claims and may or may not assume risk of claims

Beneficiaries of Health Plan (the employee/dependents)

- Eligible employees/dependents receive services according to the Schedule of Benefits and agree to pay a share of the premium/working rate (if self-insured), and related ‘cost shares” such as co-pays, deductibles, etc.

What are the Components of Your Premium?

The “CAR”

How your plan works

The "CAR"

Claims – usually costs 80% of the total premium collected (employer/employee share) if the rates are set correctly.

Administration – usually costs between 10-15% of claims cost; is provided by carrier for a fully insured plan but must be procured for a self-insured plan.

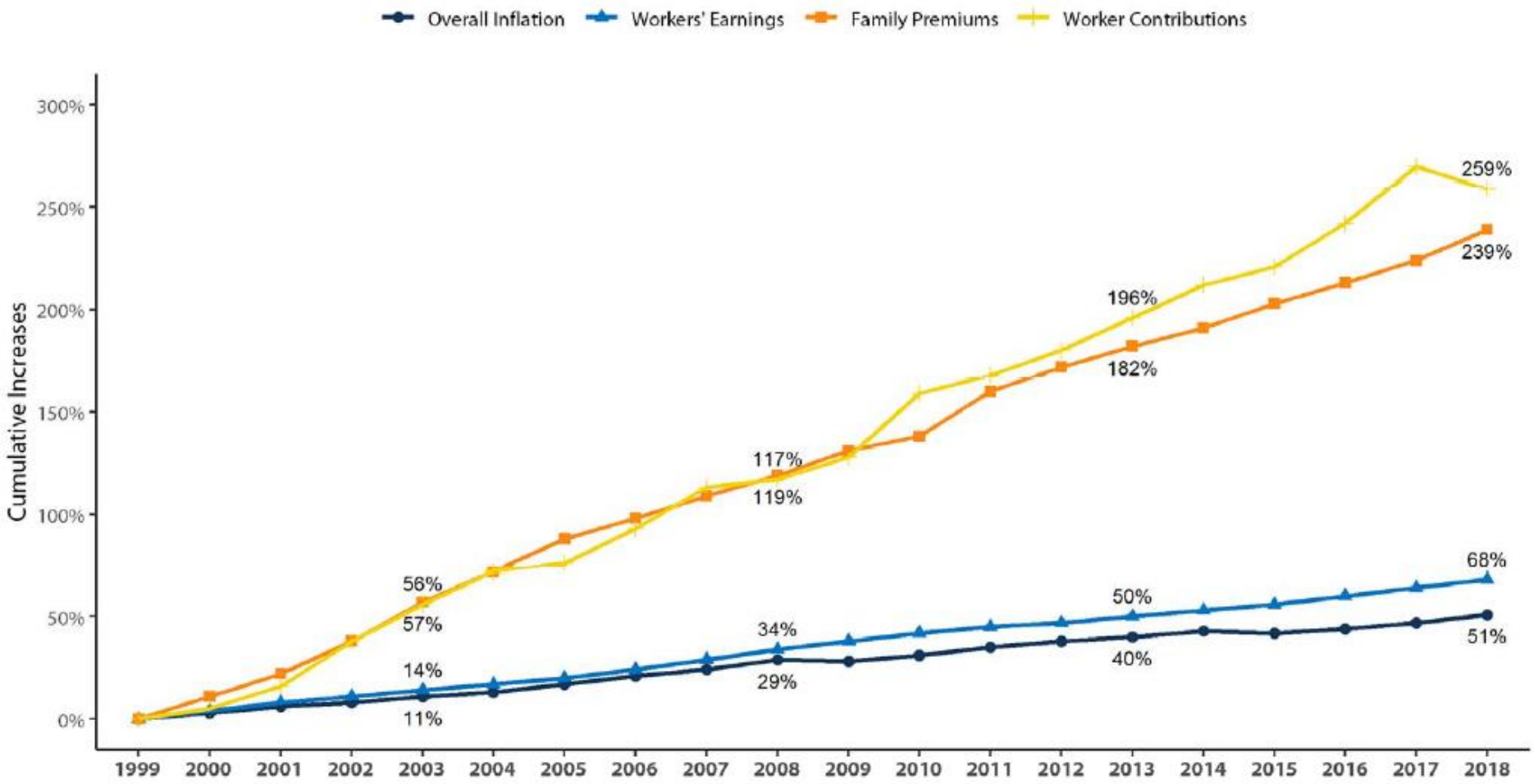
Risk – costs about 5%; the carrier (fully insured) or the Town (self-insured) cannot assume the risk of paying 100% of claims as any individual claim can be extremely high (easily in excess of $100,000) and there can be several large claims in any given policy year (fiscal year July 1 – June 30). Carrier or Town must purchase insurance called Stop-Loss insurance to provide payment for claims over a specified amount. May be an amount for a singly claim per year (specific) or for total annual claims over a set amount (aggregate). The insurance cost is the premium paid for the insurance and is part of the premium or working rate.

Cost of Money/Profit – cost about 5%; the carrier must cover the cost of all claims as they are presented for payment. Sometimes, claims will be higher than total premium collected. This is usually temporary until next month's premium is collected, but sometimes the carrier will pay-out more for claims in a given policy year than they collected. A fully insured plan provides payment for all claims irrespective of premium paid. The carrier also wishes to make a profit for the year and that margin is part of the premium. Self-insured plans do not contain that factor.

Why do Medical Costs Increase so Rapidly and Drive premiums Up Every Year?

MEDICAL COST DRIVERS

Cumulative Increases in Family Premiums, Worker Contributions to Family Premiums, Inflation, and Workers' Earnings, 1999-2018



SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2018; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2018 (April to April).

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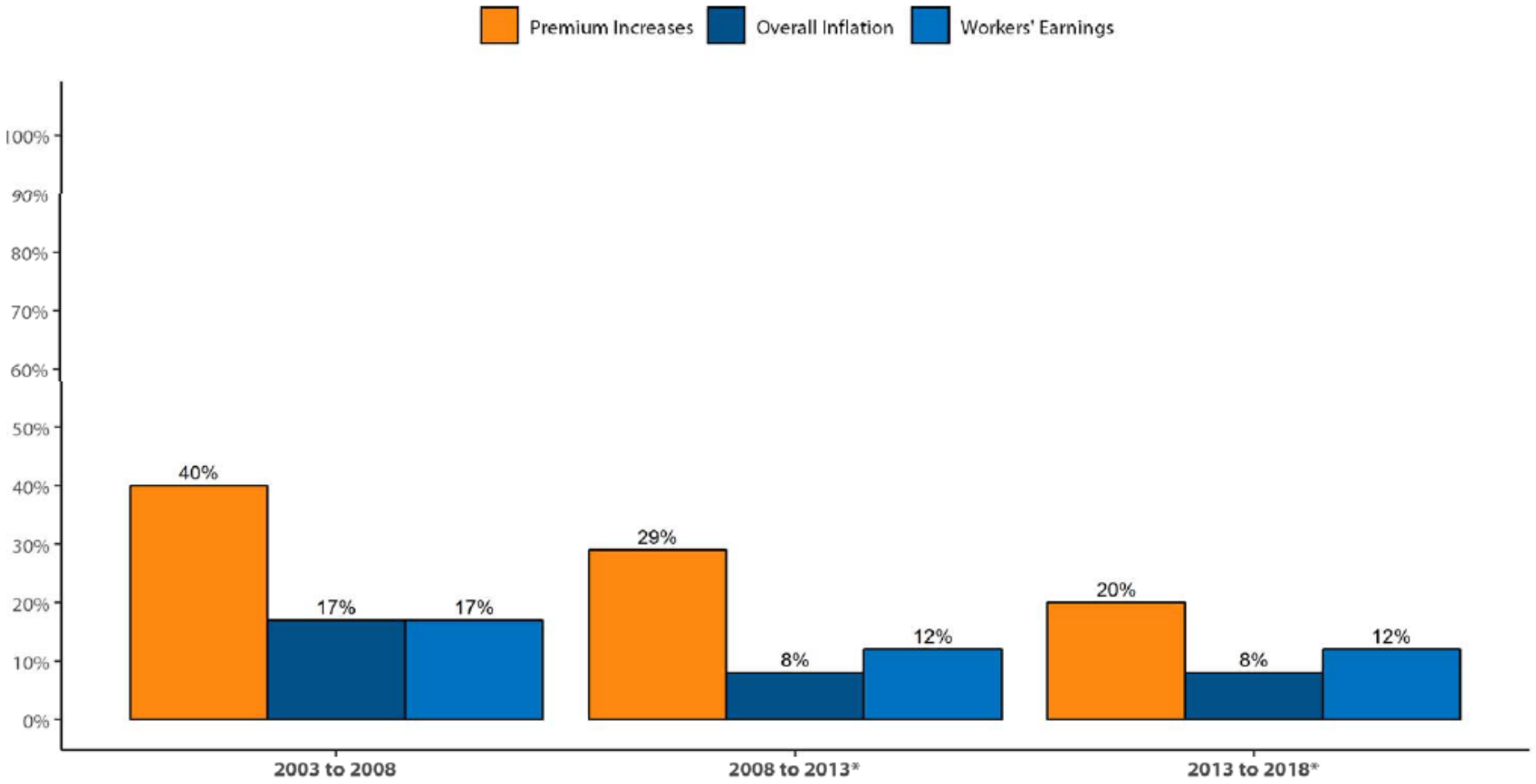
MEDICAL COST DRIVERS

Cumulative Premium Increases, Inflation, and Earnings for Covered Workers with Family Coverage, 2003-2018



* Percentage change in family premium is statistically different from previous five year period shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2003-2018; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2003-2018 (April to April).

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But…WHY?

HEALTHCARE TREND

The cost to provide healthcare services changes constantly. Some expenses such as surgical costs increase because of new, better, and sometimes, more expensive medical technologies, which doctors and hospitals can access. Other expenses, such as durable medical equipment, decrease because of cheaper materials. The annual change in healthcare cost is known as trend, which is the sum of all changes in cost throughout the healthcare industry. Healthcare trend affects employers, care providers, insurance companies, and policyholders. This trend varies by geography, but the way in which it affects employers does not change. For example, two employers in a similar geography are likely to experience very similar annual trends, even with differing occupational profiles. This occurs because healthcare trend is the change expected in claims cost before any employer initiatives, such as modifications in plan design changes or implementing health and productivity programs.

The 2019 national trend is expected to be the same as 2018, a 6.5% growth rate.

Each of the following can affect trend:

- Price inflation or deflation Medical cost drivers
- Healthcare service utilization
- Aging of the covered population
- Leveraging effect of deductibles and copays
- Variations in provider treatment patterns
- Changes in federal or state legislation
- Improvements in medical technology and drug therapies
- Consolidation of healthcare providers
- Cost shifting (from public payers, such as Medicare, to private plans)

MEDICAL COST DRIVERS

But to be a Bit More Specific….

1. Direct to Consumer Advertising for drugs – creates consumer demand for Dx visits and thus services/drugs.
   - 109 scrips/visits in 1994
   - 146 scrips per visit in 1999
   - Drug company advertising in 1990 - $55 million
   - Drug company advertising in 2000 – 2.5 billion!

2. Technology
   - Advances are continual, advertised (like drugs), and extremely costly.
   - New machines purchased by hospitals/clinics must be “fed” to pay cost of purchase (Canada has 3 PET scanners/US has 250 – BCBS source).
   - Drug coated stents are $3,000 more expensive than regular stents – benefit is unclear however.
   - Back fusions increased 137% in past ten years (surgeons get paid much more for a fusion than a decompression.

Not to suggest that technology

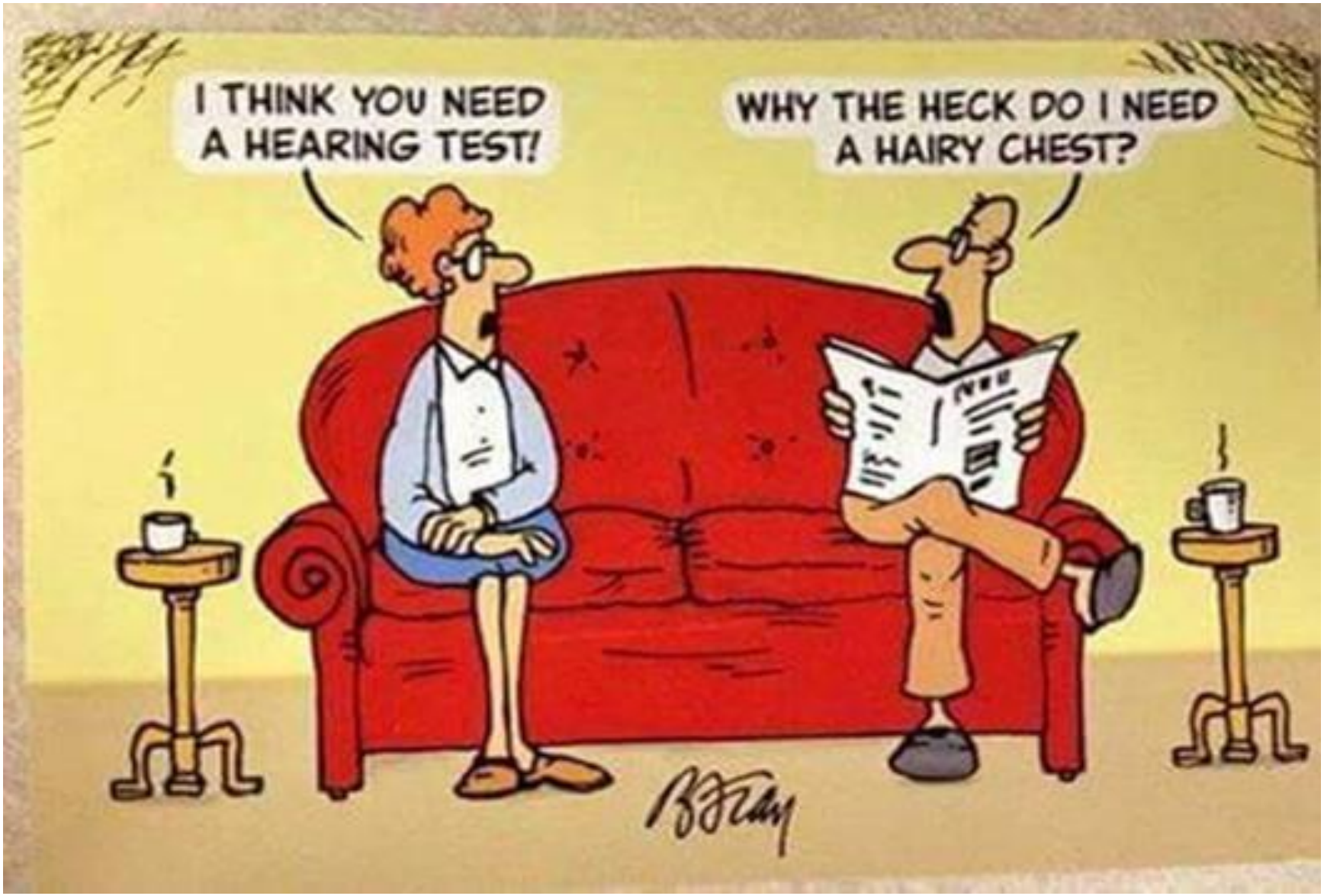
does not have its place….


A busy night at Stone Henge
as workers move all the stones
forward one hour...

Medical cost drivers (con't.)

3. Aging/Growing US population
   - US population growth from 1993-2013 = $269 billion increase in medical spending (JAMA source).
   - Aging population (Baby Boomers?) from 1993-2013 = $137.5 billion increase in medical spending (JAMA source).

Medical cost drivers (con't.)



Medical cost drivers (con't.)

4. State and Federal Mandates
   - HIPPA
   - ACA
   - Increased Psych. Benefits
   - Impact of Terrorism
   - Malpractice awards and lack of gov't. reform.
   - Tension between political parties about health care reform and how it will impact carriers/providers.

MEDICAL COST DRIVERS

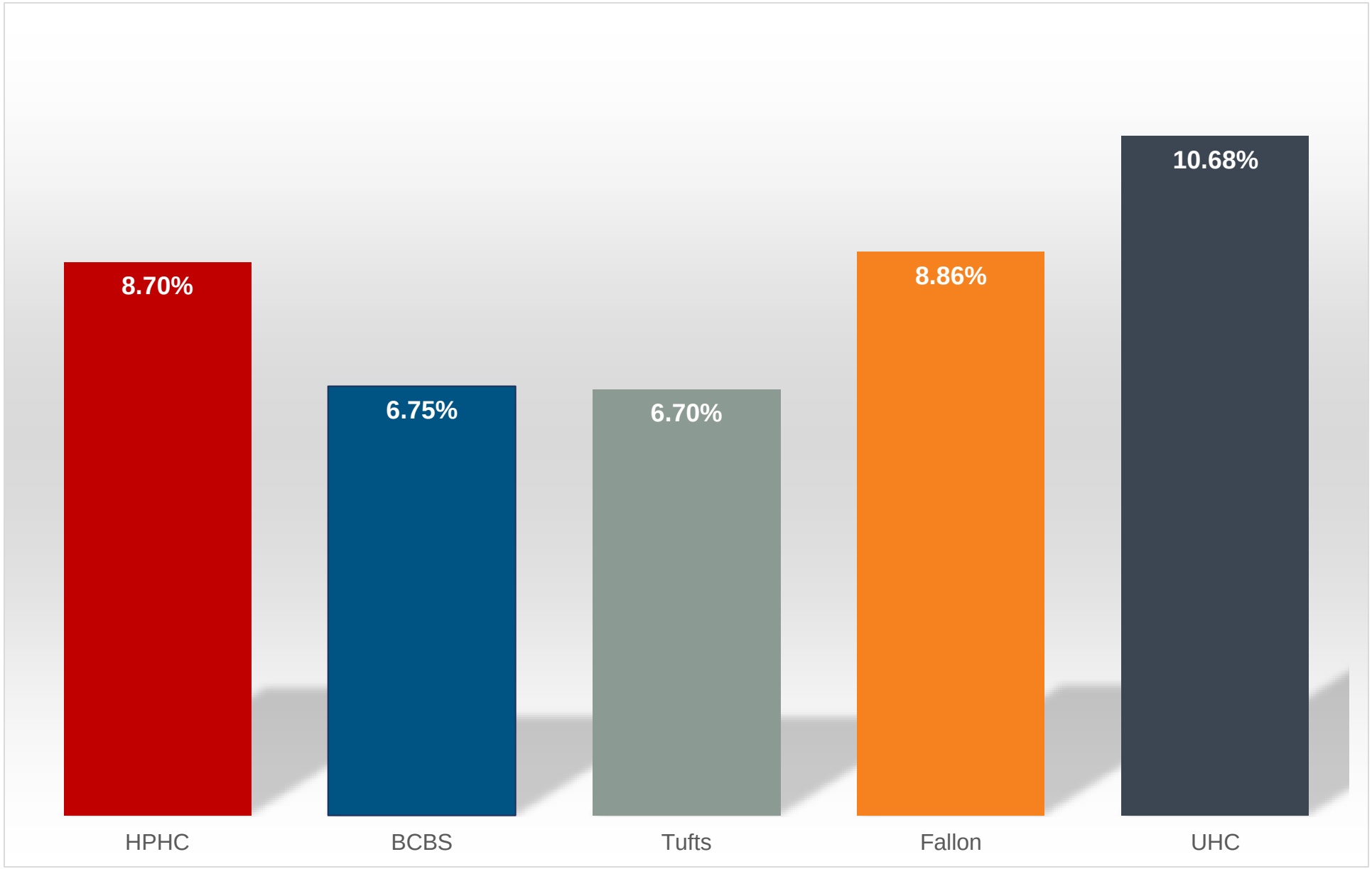
But of all factors increasing spending, the single largest factor by far was increased prices and intensity of use by consumers.

That caused an increase in spending from 1993-2013 of 50% or $583.5 billion!

And what does the health insurance industry

think will happen in the future?

Estimated Industry Trends 2019



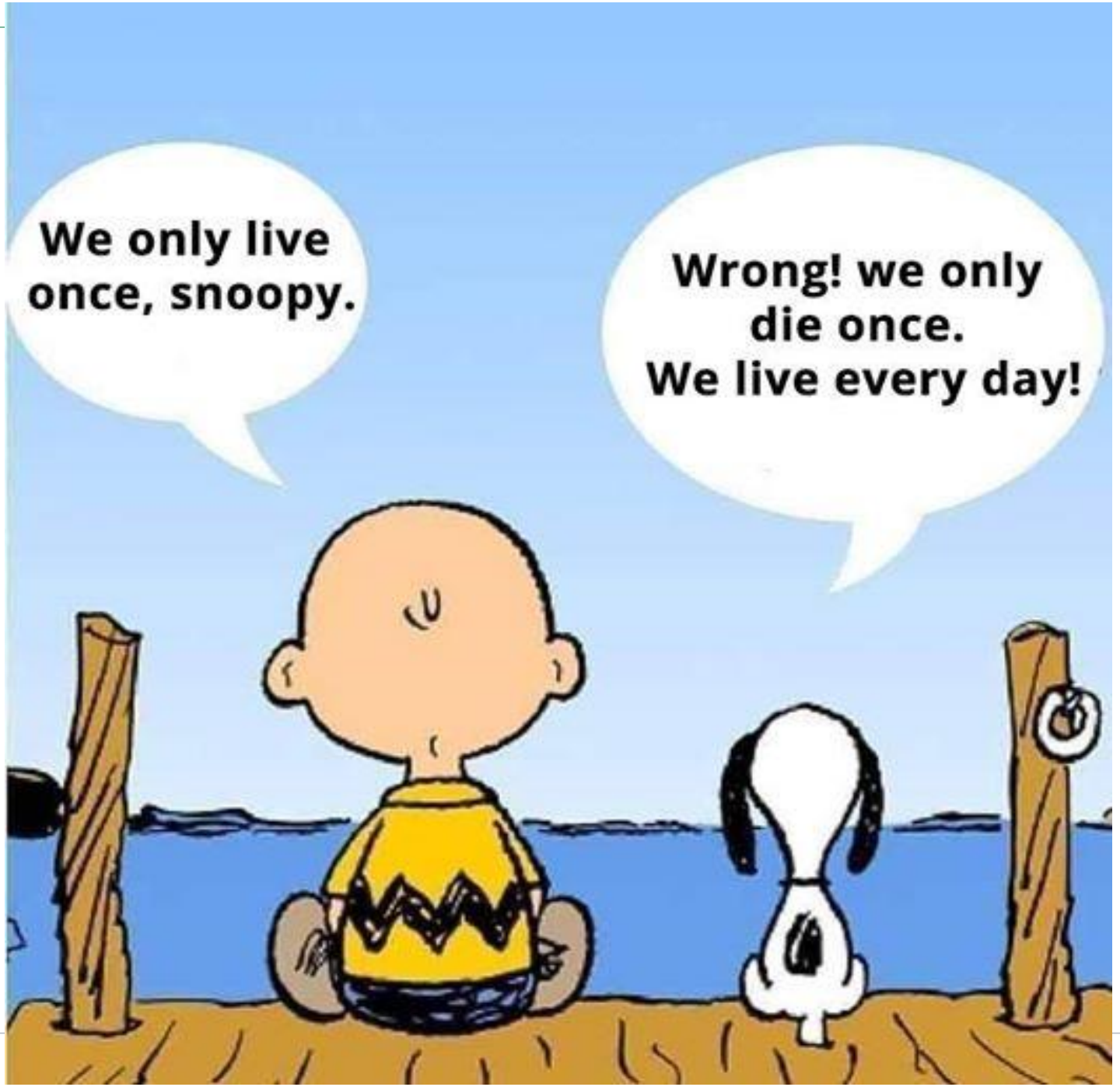
But these trends are things we can't control….

Right?

Wrong – there are PLENTY of things you can proactively do

To control rising health care costs at the local level!!

See you next time!! ☺


We only live once, snoopy.
Wrong! we only die once. We live every day!