ktp advisors

38 Washington Square
Newport, RI 02840
www.ktpadvisors.com

Reducing Retiree Health Care Costs and Liabilities

A Municipal Case Study

Presented to:

NESGFOA.org
New England States Government Finance Officers' Association

Barry Eyre
Vice President, Business Development
(401) 490-9365
beyre@ktpadvisors.com

Guest Speaker:
Jay Condon
City of Brockton
Chief Financial Officer

KEEPING THE PROMISE

☆retiree/re•tir•ee - (ri-tah
A person who has retired fr
in a carefree state without
A wise and experienced p
Origin: 1940-45, America

Roadmap to Savings

1. Legal framework in MA
2. Political background in Brockton
3. Medicare program and competitive landscape
4. Maximizing federal subsidies - EGWP vs. RDS
5. Request for Proposals
   a) Potential Issues
   b) Considerations
6. Outcomes in Brockton
7. Greenfield, MA
   a) 7 years of renewal history with EGWP
8. Applicably to other jurisdictions
9. Ancillary benefits – OPEB reduction
10. Competitive procurement

Legal Frame Work in Massachusetts

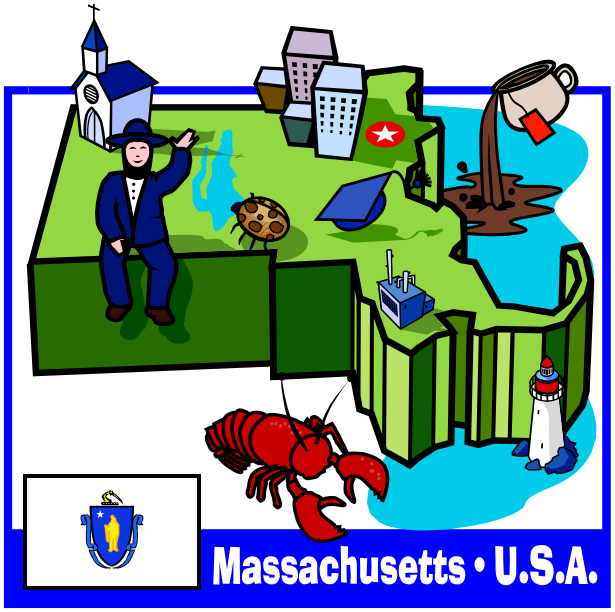
Prior to 2011 there were only two options to change Health Insurance:

1. **Traditional Collective Bargaining**

   - Not practical for bargaining health plan design because of the need to bargain union by union.
   - Bargaining typically focused only on percentage split of cost.

2. **Coalition Bargaining Under MGL 32B, Section 19, which was not widely used**

   - Municipalities resisted because it separated health benefit bargaining from wage bargaining and because it gave retirees, who otherwise did not enjoy collective bargaining rights, a seat at the table.
   - Unions often resisted because the coalition is structured with a weighted vote per union according to membership plus 10 percent to retirees, and this often disproportionately advantaged one or two large unions, especially teachers.



Legal Frame Work in Massachusetts

In 2011, the state passed municipal health reform legislation sections 21-23 of MGL Ch. 32B, establishing two separate paths with limited collective bargaining:

1. **Enroll in the state sponsored Group Insurance Commission**

2. **Establish new local plans whose benefit structure is based on GIC plan benchmarks**

Both options provide for a highly structured, accelerated, coalition process for implementation, with collective bargaining limited in time and agenda.

Legal Frame Work in Massachusetts

MGL Sec 21-23 is not a popular option with unions because:

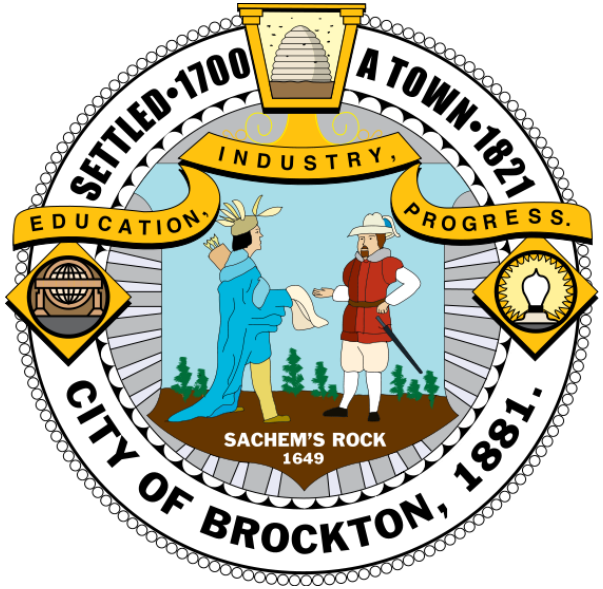
1. The savings achieved by the municipality is driven primarily by cost shifting to the employees and retirees
2. Unions have little control of or influence on plan design
3. It's an all or nothing decision for retirees and actives

MGL Sec 21-23 is not popular with Municipalities because:

1. GIC requires a minimum three year commitment
2. Plan design is completely removed from the municipality (GIC) or nearly so
3. Premiums are set by the GIC and not known before the deadline to renew
4. A great deal of control is shifted from the municipal level to the GIC

Political Background in Brockton

- ✓ In February 2012, the city council rejected the mayor's proposal for the city to implement the new health insurance reform legislation by establishing GIC like plans without enrolling directly in GIC
- ✓ Projected savings was approximately $7.2M per year, for total costs
- ✓ After the council's action, the administration entered into good faith negotiations with the collective bargaining units to try to achieve a similar level of savings.
- ✓ The city and its unions agreed to bargain as if Section 19 coalition bargaining were in place, to see if agreement would be reached
- ✓ KTP Advisors was engaged to access savings potential for the Medicare eligible retiree population (1900 retirees) as a component of the overall savings target.



Political Background in Brockton

The city and its unions reached agreement in October, 2012. Key elements to save an estimated $6.7 million:

1. Formal acceptance of Section 19 for the period of January 1, 2013 through June 30, 2017- an automatic sunset of coalition bargaining unless the parties agree to extend

2. Plan design for active employees and retirees who are not Medicare eligible to continue on self-insured basis, with higher co-pays, but no deductibles as under the GIC like plans

3. Competitively bid, fully insured benefits, for Medicare eligible retirees with greater savings but similar benefits to current plans

National Medicare Network Highly Competitive

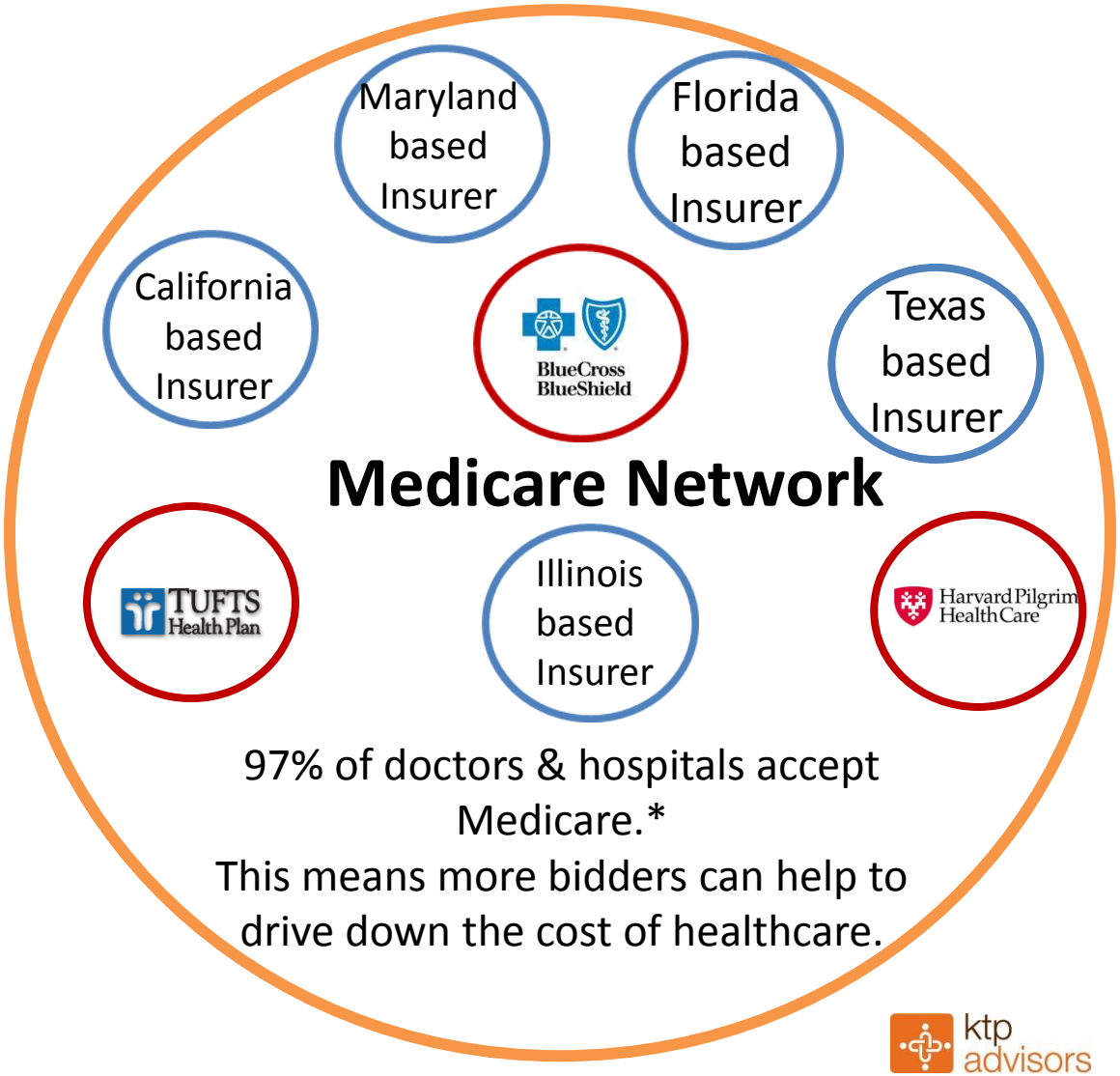
Medicare retirees do not need local carriers and networks to access their doctors

KEEPING THE PROMISE

Medicare is a national network that can be used by any insurance company approved by Medicare.

There is no need to rely on a locally based insurance company to access the network.

The retiree can access the network in all states.



*Source: Center for Medicare and Medicaid Services (CMS).

Optimize Federal Subsidies Critical to Cost Savings

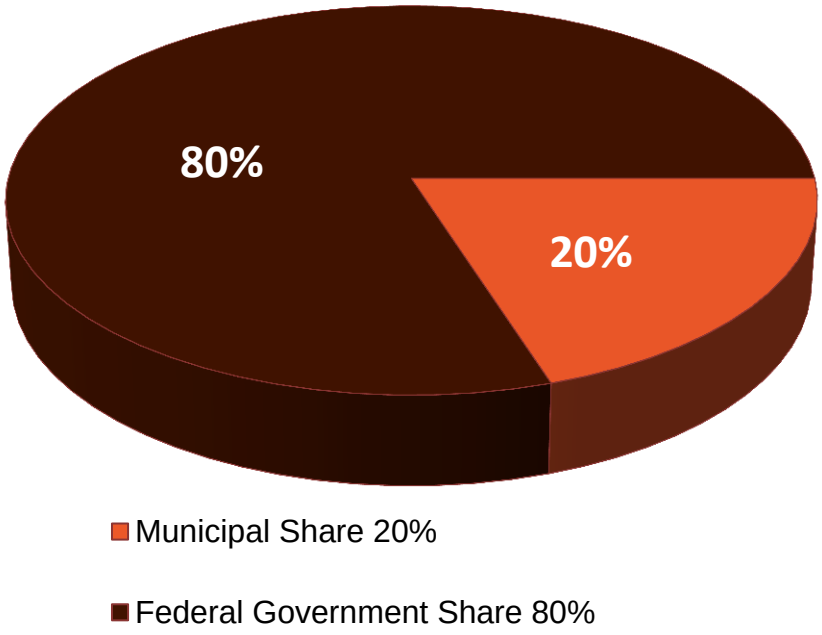
Most communities access the Retiree Drugs Subsidy (RDS). There is a much better subsidy program. Employer Group Waiver Plans (EGWP) offer a higher base subsidy than the RDS.

Employer Group Waiver Plan		Retiree Drug Subsidy
(Average Per Retiree Per Year Subsidy)		*(Average Per Retiree Per Year Subsidy)*
$650	>	$510

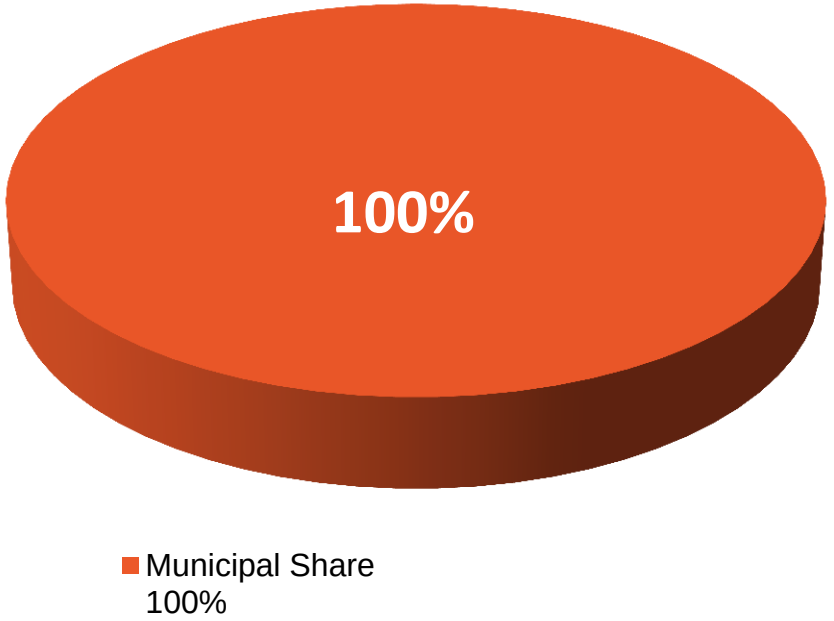
Employer Group Waiver Plan pays for 80% of drug costs over $6,773
Retiree Drug Subsidy pays nothing over $6,773

KEEPING THE PROMISE

EGWP Pays for 80% of Cost Over $6,773



Municipality pays 100% of costs over $6,773 with the RDS



Example: if a retiree has drug expenditures of $20,000, the EGWP pays: ($20,000-6,773) X 80% = $10,581.60 in extra subsidy. The RDS would pay $0.00.

Because the Number of Expensive Drugs is Increasing the EGWP is Getting More Attractive to Municipalities

KEEPING THE PROMISE

Drug Name	Most Common Indication	Days Supply	Plan Cost (1)	Course of Therapy (or) Annual Cost	MAX RDS SUBSIDY (2)	EGWP SUBSIDY (3)	EGWP SAVINGS OVER RDS
INCIVEK	HEPATITIS	28	$16,796.41	$50,389.23	$1,757.00	$35,574.38	$33,817.38
REVLIMID	CANCER	21	$8,101.07	$97,212.84	$1,757.00	$73,033.27	$71,276.27
SUTENT	CANCER	30	$7,906.13	$94,873.56	$1,757.00	$71,161.85	$69,404.85
GLEEVEC	CANCER	30	$6,010.14	$72,121.68	$1,757.00	$52,960.34	$51,203.34
HUMIRA	INFLAMMATORY CONDITIONS	28	$5,937.62	$71,251.44	$1,757.00	$52,264.15	$50,507.15
ZYTIGA	CANCER	30	$5,673.81	$68,085.72	$1,757.00	$49,731.58	$47,974.58
TOBI	INFECTIONS	28	$5,353.17	$32,119.02	$1,757.00	$20,958.22	$19,201.22
TARCEVA	CANCER	30	$4,890.07	$58,680.84	$1,757.00	$42,207.67	$40,450.67
VICTRELIS	HEPATITIS	28	$4,537.20	$49,909.20	$1,757.00	$35,190.36	$33,433.36
XYREM	MISC SPECIALTY CONDITIONS	27	$4,499.27	$53,991.24	$1,757.00	$38,455.99	$36,698.99
GILENYA	MULTIPLE SCLEROSIS	28	$4,139.45	$49,673.40	$1,757.00	$35,001.72	$33,244.72
COPAXONE	MULTIPLE SCLEROSIS	30	$4,115.77	$49,389.24	$1,757.00	$34,774.39	$33,017.39
SPRYCEL	CANCER	30	$4,060.63	$48,727.56	$1,757.00	$34,245.05	$32,488.05
ENBREL	INFLAMMATORY CONDITIONS	28	$3,727.06	$44,724.72	$1,757.00	$31,042.78	$29,285.78
REBIF	MULTIPLE SCLEROSIS	28	$3,483.27	$41,799.24	$1,757.00	$28,702.39	$26,945.39
AVONEX	MULTIPLE SCLEROSIS	28	$3,359.82	$40,317.84	$1,757.00	$27,517.27	$25,760.27
PEGASYS	HEPATITIS	28	$2,531.33	$30,375.96	$1,757.00	$19,563.77	$17,806.77
PULMOZYME	RESPIRATORY CONDITIONS	30	$2,323.81	$27,885.72	$1,757.00	$17,571.58	$15,814.58

(1) Actual Cost of individual Rx based on Number of Days Supply
(2) Max RDS Subsidy is 28% of the per retiree prescription costs between $325 and $6,600, this example assumes one retiree takes only this drug
(3) $650 Base Subsidy plus 80% of per retiree prescription costs in excess of $6,733.75

Alternative Strategies for EGWP Produce Big Differences in Savings

KEEPING THE PROMISE

By splitting the retiree benefit, self funding the medical and fully insuring the Rx (Strategy II below), a large portion of the savings from the EGWP pays administrative and advisory fees that could be completely eliminated by fully insuring the entire benefit (Strategy I below).

Strategy I - Fully Insure Both the Medical & Pharmacy Benefits

$70 PMPM EGWP
$25 PMPM Admin Fees
$5 PMPM Other Savings

	Fully Insured	Self Funded
Medical		
Pharmacy		

Strategy 1 Net Savings = $100 PMPM*

Pros/Cons

- ✓ Eliminates risk of all medical and pharmacy claims
- ✓ Eliminates all administrative fees
- ✓ Reduces advisory fees to just the non Medicare lives
- ✓ Maximizes the savings from the EGWP

Strategy II - Split the Medical & Pharmacy Benefits

$70 PMPM EGWP
($25) PMPM Admin Fees

	Fully Insured	Self Funded
Medical		
Pharmacy		

Strategy 1 Net Savings = $45 PMPM*

Pros/Cons

- ✓ Eliminates risk of pharmacy claims ONLY
- ✗ Exposed to large medical claims
- ✗ Still pay the admin fee to the carrier on retirees and actives
- ✗ Still pay advisory fee on retirees and actives
- ✓ Maximizes the savings from the EGWP

*Actual level of savings will vary based on plan design consideration

Potential RFP Issues: Ensuring a Level Field for Bidding and Avoiding Pitfalls

Matching plans can be tricky. It is important that you really understand what you are offering.

Example: RDS and EGWP plans must be Part D compliant. Certain classes of drugs are not Part D compliant, but might be covered by your collective bargain agreements. To avoid disruption, the cost of these non Part D drugs must be covered by the responders to the RFP, or the bids will not be comparable.

Example: Access to certain tiers of drugs may be restricted causing out of pockets cost to increase. To minimize disruption, it is important that retirees are able to access the drugs they are prescribed for similar costs even if they are classified on different tiers from the incumbent.

A properly structured RFP will ensure that the bids are comparable and match the desired level of benefits.

RFP Considerations

Collapsing multiple plans to one reduces overhead and management costs. Also, this eliminates adverse selection problem and results in a lower quote. But this will require some change in benefit levels.

Which plan to match? The plan with the most retirees will generate least disruption. Need to understand the nature of disruption.

Cheaper plans often have higher out of pockets (co pays/deductibles). A plan with a higher premium may have lower net cost to the retirees.

It is possible to leave cheaper HMOs in place. However, they will need to be closed to new retirees.

Big Cost Savings for Brockton & Retirees

KEEPING THE PROMISE

	Net results for City of Brockton & Brockton Retirees
Prior Plans (Blended) Cost PMPM	$482
Monthly RDS Subsidy	$47
Prior Plan Cost Net of RDS	$435
New Plan Cost PMPM	$331
TOTAL ANNUAL SAVINGS	$2,375,920
City Savings	21%
Retiree Savings	31%

The city of Brockton & their Medicare eligible retirees save **$2,375,920** per year and are now fully insured.

7 Years of EGWP Renewal History in Greenfield, MA

KEEPING THE PROMISE

	2005	2006	2007	2008	2009	2010	2011	2012	2013
Total Premium for Medicare Eligible Retirees	$422.85	$317.07	$273.00	$290.00	$307.00	$325.00	$332.00	$330.00	$337.00
Percent Change		-25.0%	-13.9%	6.2%	5.9%	5.9%	2.2%	-0.6%	2.1%

- Greenfield implemented the same strategy as Brockton 7 years ago. Since then, Greenfield's average renewal rate has been **-2.4%**.
- EGWP is NOT a new subsidy program. It was created by the Medicare Modernization Act of 2003, which went into effect in January 2006.

This Approach Also Has Positive OPEB Implications

Significant benefit for EGWP subsidy over RDS

GASB has ruled indicated that the RDS subsidy should not be included as part of the OPEB valuation.

The reason is that the RDS subsidy is considered general governmental revenue and as such is not earmarked towards the funding of OPEB benefits.

Because Employer Group Waiver Plan (EGWP) subsidies directly reduce your plan costs, shifting from the RDS to an EGWP can reduce your costs, OPEB liability and your ARC.

This shift was a major contributor to the State of Connecticut's recent $8.7 billion reduction in its OPEB liability.

OPEB liability reduction from transitioning to an EGWP depends on cost share percentages, but can be in the range of 12 to 15%, all else being equal.

Higher Subsidies

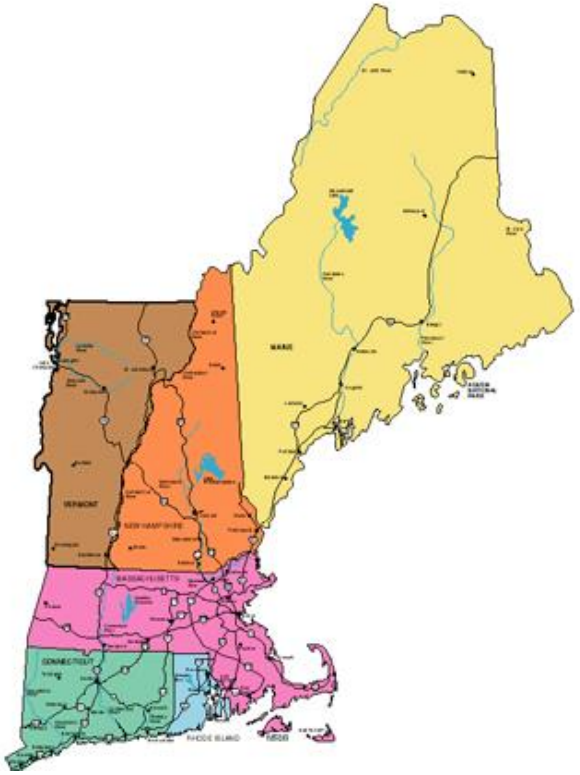
Lower OPEB

Applicability to Other Jurisdictions

Because Medicare is a federal program, the strategies outlined here can be implemented in all states.

The insurance companies that specialize in this type of product do business in all the New England states.

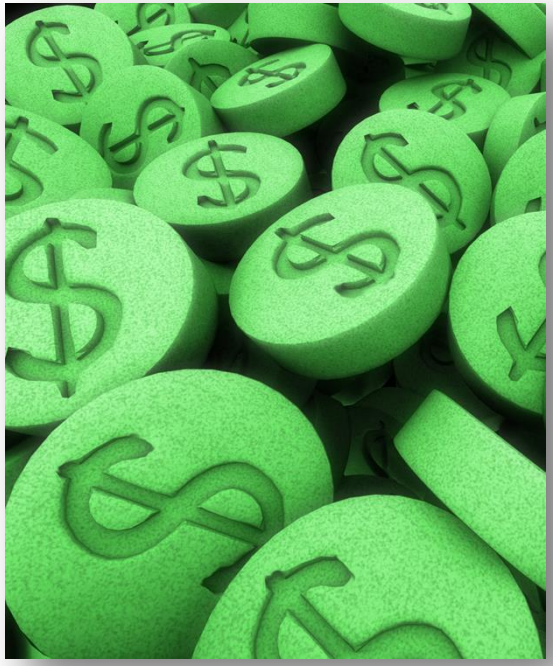
This strategy is a rare win/win. Union groups have been very receptive to this strategy as it can be used to offset the cost of active employee healthcare costs increase as seen in Brockton.



High Market Share + Lack of Regular Bidding = High Prices

There is a high level of market concentration for insurance in the New England States[1]:

- Connecticut 66%
- Maine 88%
- Massachusetts 67%
- New Hampshire 75%
- Rhode Island 95%
- Vermont 90%



Most municipalities do not regularly bid out their health insurance business. The incumbent provider often retains business by default after some low intensity negotiation over a renewal.

Given the high level of market concentration and lack of regular competitive procurement, incumbent providers have little incentive to sharpen their pencils to retain business.

A credible threat of losing the business is the only way to make sure you are getting the best deal possible.

[1] Market share of two largest providers. Source: Center for American progress.