COMMONWEALTH of VIRGINIA

SARA REDDING WILSON
DIRECTOR

Department of Human Resource Management

101 N. 14TH STREET
JAMES MONROE BUILDING, 12TH FLOOR
RICHMOND, VIRGINIA 23219
(804) 225-2131
(TTY) 711

November 2, 2015

The Honorable J. Chris Jones, Chairman, House Appropriations Committee
The Honorable Walter A. Stosch, Co-Chairman, Senate Finance Committee
The Honorable Charles J. Colgan, Co-Chairman, Senate Finance Committee

Subject: Review of the Public Employee Health Programs in the Commonwealth

The attached report is pursuant to Chapter 665, Item 82.H of the 2015 Virginia Acts of the General Assembly.

Please contact me if there are any questions.

Sincerely,

Gene Raney

Gene Raney
Director, Office of Health Benefits

cc: The Honorable Nancy Rodrigues, Secretary of Administration
Sara R. Wilson, Director, Department of Human Resource Management

Review of the Public Employee Health Programs in the Commonwealth

Virginia Department of Human Resource Management
November 2, 2015

TABLE OF CONTENTS

REPORT REQUEST

The attached report was prepared jointly by Aon and the Department of Human Resource Management (DHRM) to address the mandate outlined in the Virginia act noted below.

2015 Virginia Acts of the Assembly, Chapter 665

ITEM 82.

H.1. The Department of Human Resource Management shall conduct a comprehensive review of the public employee health programs in the Commonwealth. The Department shall provide a report detailing the findings and recommendations to the chairmen of the House Appropriations Committee and Senate Finance Committee by October 31, 2015.

2. As part of the review, the Department shall conduct an actuarial review of the impact on the state, the school boards, and other political subdivisions, from including the employees, and their dependents, of local governments including local school divisions in the state employee health program or in one statewide pooled plan for employees of political subdivisions.

3. Local school boards and localities shall provide information to the Department as requested for the actuarial analysis.

4. The review shall also include an examination of The Local Choice program's policies, including its pooling and rating methodology, to determine whether overall improvements may be made to the program, with a specific goal of trying to increase The Local Choice program's appeal among rural school divisions and local governments. During this effort, the Department shall hold a series of meetings with stakeholders to educate them about The Local Choice program and solicit their feedback.

5. The Director of the Department of Planning and Budget is authorized to transfer up to $250,000 general fund from program 757 (agency 995, Central Appropriations) from unobligated balances from prior year appropriation to the Department of Human Resource Management as needed to fund the review and outreach efforts.

EXECUTIVE SUMMARY

This report pursuant to the Act is comprised of five sections:

- Report Request, which contains the provisions of the Act authorizing this report.
- Executive Summary, which addresses both actuarial findings and The Local Choice (TLC) Stakeholder meeting results.
- Section A, which addresses Item 82.H.2 of the Act.
- Section B, which addresses Item 82.H.4 of the Act.
- Section C, Appendix, which provides lengthy supporting documentation and detail referenced in Sections A and B.

Scope

The scope of the report, which included extensive data gathering from over 500 entities, data verification, actuarial analysis, garnering of TLC stakeholder feedback, and synthesis of collected data, required a tight timeline and a rigorously managed process.

- Section A preparation required localities to provide a complete data set which was necessary for actuarial analysis by a clearly defined deadline. Deadlines were extended to maximize the response rate. Not all localities responded and not all data submitted was complete. Follow ups were conducted in the time available to increase the amount of usable data and credibility of findings. The report is based on the usable data submitted as described in the section detail.
- Section B preparation required holding stakeholder feedback meetings. These were held in July 2015 at eight locations. Although attendance by non-TLC entities was encouraged by stakeholder associations, relatively few non-TLC entities attended. Participant feedback was valuable.

Findings

The findings of this report identify:

- Local entities' budget and benefit structures vary widely.
- Localities currently have a range of stand-alone and TLC options.
- Decisions to join the state or TLC plans are local ones with varying fiscal impacts.

Summary of Actuarial Analysis

Data for 336 state and local government entities was used in the development of this report, representing 47% of total entities. Another 184 entities submitted data that was not used, representing 26% of total entities.

Actual claim experience adjusted for benefit differences, enrollment, premium, and contribution data for a sample of the school and local government population, including TLC and non-TLC entities, were compared against both State and TLC plans. The results of that comparison under a confidence level of 95% as detailed in the report are as follows:

Findings

State Plan Comparison Basis (COVA Care Basic and Expanded Dental)

- The expected medical and prescription drug claim cost is slightly lower than the state plan cost
- The expected dental claim cost is lower than the state plan cost
- A majority of the sample entities' employer costs would increase and employee cost would decrease under the state plan based upon current (lower) employer contribution levels
- Separate rating pools may provide different rates for the state plan than for the local subdivisions

TLC Plan Comparison Basis (Key Advantage (KA) Expanded with Expanded Dental)

- The expected medical and prescription drug claim cost for non-TLC entities is lower than the current TLC population plan cost
- The expected dental claims cost for non-TLC entities is higher than the current TLC population plan cost

Summary of TLC Program Review

Eight stakeholder meetings were held in July 2015 throughout the state. A total of 108 entities were represented in these meetings, 75 of which were TLC groups and 33 of which were not. Out of the discussions at these meetings, the following recommendations are proposed.

DHRM recommends:

1. *That it follow up with Anthem on wait times in Tidewater with potential subsequent communication with TLC participants in that region*—in response to a concern about specialist office visit wait times
2. *That it provide reports to groups to ensure accuracy of data before the Affordable Care Act (ACA) mandate reports are filed*—in response to requests from TLC groups to be able to review the accuracy of data
3. *That it communicate to TLC groups on the impact of the ACA excise tax as guidelines are developed*—in response to concerns about the impact of the excise tax on TLC plan design

4. *Maintaining the level of the existing TLC High Deductible Health Plan (HDHP) deductible*—in response to discussion about lowering the HDHP deductible

5. *That gap plans not be included in the TLC plan offerings*—in response to a request to gap plans

6. *That it inform regional plans of the opportunity during the next TLC procurement process*—in response to a concern about the lack of regional alternatives to the statewide plan offerings

7. *No change to current plan provisions regarding hearing aids and laboratory charges, meaning that TLC should not include coverage for hearing aids and should continue to include laboratory charges in deductible requirements*—in response to a request for these changes

8. *Maintaining the current TLC coverage options for retirees not eligible for Medicare, which do not include a separate plan*—in response to discussion about implementing a separate plan for non-Medicare retirees only

9. *Maintaining the current TLC Medicare retiree offerings, which do not include coverage for Medicare Part D*—in response to discussion about adding prescription drug coverage for Medicare retirees

10. *Maintaining the current process for TLC extended coverage, in which each group administers its own extended coverage*—in response to requests that TLC administer extended coverage, which is similar to COBRA coverage

11. *That TLC implement extended coverage training sessions for TLC group benefits administrators*—in response to requests that TLC administer extended coverage, which is similar to COBRA coverage

12. *That additional cost and benefit analysis be conducted before further consideration is given to designing and implementing a TLC shared service center*—in response to discussion about whether to implement a shared service center that would provide administrative support for TLC groups

13. *Providing additional utilization reporting to TLC groups*—in response to requests for this reporting

14. *That it will complete enhancements allowing TLC benefits administrators access to the eligibility system by the end of February 2016 and allowing employees to make elections directly after June 2016*—in response to questions about when these enhancements will be completed

15. *That at the next scheduled procurement, DHRM will solicit bids for a second tier of coverage options to include an unbundled approach, and subsequently implement an option to include unbundling if it is found to be practical*—in response to discussions about unbundling medical, dental and vision plans

16. *That TLC provide ongoing education to current and prospective groups on TLC premium rate development*—in response to questions about how the premium rates are developed

17. *Implementing the following requirements in FY 2018:*

    - *Reduce the minimum 80% employer contributions to employee only coverage to 70%. This relaxation will provide relief, but still provide protection against an adverse impact upon financial results*

    - *Maintain the 75% of eligible employees' participation level, but exclude those participating in other TLC or state employee plans from the participation percentage calculation*

    - *Modify the Virginia Administrative Code as necessary*—in response to discussion about relaxing current minimum employer contributions and participation requirements

18. *That individual groups be permitted to limit spousal coverage for their employees*—in response to discussion about limiting spousal coverage

19. *That individual groups be allowed to require higher contributions for working spouses beginning after the next procurement ends, assuming that the successful bidder is capable of administering this function*—in response to discussion about limiting spousal coverage

20. *That the Adverse Experience Adjustment (AEA) protection be maintained without modification*—in response to questions to better understand AEA provisions

21. *Having the actuaries develop an alternate rate structure for review*—in response to questions about the number of rate tiers

22. *Educating groups on the annual review process of stop loss levels*—in response to a question about how stop loss coverage works

23. *Applying the one-plan restriction to groups of 15 or fewer employees, which is lower than the current threshold of 25 or fewer employees*—in response to discussion about allowing groups with 25 employees or less to offer more than one plan option

24. *Marketing the opportunity for feedback at the annual open forum TLC regional review meetings to encourage attendance*—in response to interest in implementing opportunities to provide feedback on TLC

25. *Maintaining the current quote practice, which is to only provide quotes to groups that explicitly request them*—in response to a question about whether responding to the data request in the actuarial portion of this study would result in an unsolicited bid from TLC

26. *Allowing individual groups to implement their own incentive programs apart from TLC*—in response to interest about developing wellness programs for TLC

27. *Continuing the current CommonHealth discount program, and working with current vendor partners to communicate available discount programs to TLC groups and participants*—in response to discussion about discounts for health-related services and activities

28. *Implementing a pilot TLC diabetes Value-Based Insurance Design (VBID) program in FY 2018*— in response to discussion about VBID programs

SECTION A

Actuarial Analysis of Rate Impact on the State Plan and Local Entities

SECTION A

The Commonwealth of Virginia Department of Human Resource Management (DHRM) asked Aon to complete an updated actuarial analysis of the viability and financial impact of bringing the school and local government employees into the state health plan-thereby creating a state-wide health benefit plan. Aon completed a similar analysis in 2013. This analysis was expanded from the 2013 study to also include the impact to the entities from both an employer and employee perspective and comparison to costs for The Local Choice plan. This report provides the results of our analysis and describes the data, assumptions and methods used to complete the analysis.

I. Background

Health Benefits Current State

Local. Virginia School Districts and Local Governments ("Local Entities") whose total compensation policy is to offer group health benefits to employees and dependents currently have two primary options that are entirely under their controlling authority:

- **Stand-Alone Plan.** They may enter into an entity specific contract with a health benefits insurance carrier under a fully insured or self-insured arrangement. Plan design and cost components are negotiated solely between the entity and carrier. The financial risk to the entity is defined by the contract terms, but normally the risk and costs are primarily based on the entity's claims experience. Typically this is an arrangement favored by larger employee groups (1000+ employees) as the financial risk is more predictable, and the entity maintains complete control over benefit design.

- **TLC.** They may participate in the Commonwealth's The Local Choice (TLC) program. TLC has control of the plan design options, underwriting and employee contribution parameters and price rules. The decision to participate under the rules is under the local entity's controlling authority. The TLC Plan pools the claims experience, and assumes some financial risk to preclude large swings in annual premium. Typically, this program is favored by smaller entities whose claims experience is less predictable and, for budgetary purposes, want to avoid wide swings in annual plan premium.

State. Virginia State Government employees are covered by the state employee plan which provides coverage only for employees of state government entities. This includes part-or full-time, salaried, classified employees; or regular, full-time or part-time salaried faculty. Eligible dependents also may be covered. Employee contribution requirements vary based on full or part time status.

Potential State-wide Plan or Expanded TLC Plan

The state's budget bill contains a provision which requires DHRM to conduct a study as to the viability of bringing the Commonwealth's school and local government employees into the state health plan. To address the requirement, DHRM asked Aon to perform a review of the health costs of the school and local government populations.
This study includes the following:

- The impact to the state plan medical and dental claim costs if the school and local government population is included

- The impact to the TLC medical and dental claims costs if the non-TLC school and local government population is included
- The impact to the individual sample entities medical plan costs if they joined the state plan from both an employer and an employee perspective
- The impact of including local entities in the state-wide plan with a single pool
- The impact of including local entities in the state-wide plan with a separate pool
- An outline of considerations in implementing a state-wide plan if DHRM decides to do so

II. Analysis

Actual claim experience (adjusted for benefit differences), enrollment, premium, and contribution data for a sample of the school and local government population (includes TLC and non-TLC entities) was compared against both State and TLC plans. The results of that comparison are as follows:

State Plan Comparison Basis (COVA Care Basic and Expanded Dental)

- The expected medical and prescription drug claim cost is slightly lower than the state plan cost
- The expected dental claim cost is lower than the state plan cost
- A majority of the sample entities' employer costs would increase under the state plan with the current state employer/employee cost share split
- A majority of the sample entities' employee costs would decrease under the state plan with the current state employer/employee cost share split
- Separate rating pools may provide different rates for the state plan than the local subdivisions.

TLC Plan Comparison Basis (Key Advantage (KA) Expanded and Expanded Dental)

- The expected medical and prescription drug claim cost for non-TLC entities is lower than the current TLC population plan cost
- The expected dental claims cost for non-TLC entities is higher than the current TLC population plan cost

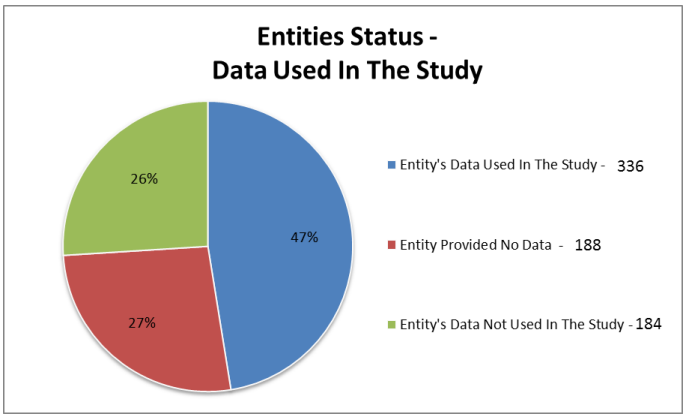
It is important to note that the sample did not cover all potential entities to whom the plan could be available, and even within the sample there is potential variability in costs. **In determining whether to allow the schools and local government to join the plan, the state should strongly note and consider the potential for these cost variations. In addition, consideration should be given to the other important fiscal implementation issues outlined in a subsequent section**.

Population Sampling

School and local government data used in the analysis is based on information provided for Aon's use by the entities. The data used in the study represents a subset of all potential state and local government

exposure, about 47% of school and local government entities. The sample medical and prescription drug data includes 203,593 average enrolled employees and 380,715 average enrolled members for plan years 2013 and 2014. We are unable to determine the portion of all potential employees or members since this information is not available for those entities that did not submit data. Due to incomplete data submissions or other issues, a subset of the sample entities was used for the dental claims cost comparison and the impact to the local entities.

While the sample data is used to determine the relative cost difference between the populations, it is important to note that costs for the entities without data could be materially different and could impact the results of the study.



Comparison of FY 2016 Cost Estimates – State Plan Basis (COVA Care Basic)

To evaluate the difference between the estimated population costs, Aon compared the costs for the population on a FY 2016 basis. We received claims, premiums and enrollment data for medical, prescription drugs, dental, and vision coverages. For purposes of this analysis, we focused on the review of the medical, prescription drug, and dental experience. In the results below, vision was not included. Vision represents approximately 2% of the state's plan health (medical, prescription drugs, dental, and vision) costs. The inclusion of vision would not materially impact the results or the financial outcome of the analysis.

The state benefit plan cost was based on the medical and prescription drug and dental costs inherent in the FY 2016 actuarial budget rate for the COVA Care Basic Plan with the expanded dental option. Aon calculated estimated FY 2016 medical and prescription drug and dental cost estimates on a per member per month (PMPM) basis from the sample school and government data (as described in the Methodology and Assumptions section below) and compared this estimate to the state COVA Care Basic Plan and expanded dental PMPM costs. Table 1 summarizes the results for the aggregate populations.

Table 1

Estimated FY 2016 Cost PMPM						
	Medical and Prescription Drugs			Dental		
	School/Gov't	State Plan	Difference	School/Gov't	State Plan	Difference
Low Trend	$444	$464	(4.2%)	$26.97	$30.55	(11.7%)
Best Estimate Trend	$454	$464	(2.0%)	$27.61	$30.55	(9.6%)
High Trend	$465	$464	0.3%	$28.26	$30.55	(7.5%)
Average Enrolled Members	380,715	195,483		294,651	195,483	

As shown in Table 1, the estimated medical and prescription drug plan PMPM cost for the sample school and government population adjusted for benefit differences is within 4% of the estimated FY 2016 cost for the state plan under a range of trend assumptions. Under best estimate trend assumptions, the sample cost is approximately 2% lower than the state plan cost.

For dental, the estimated plan PMPM cost for the sample school and government population is lower than the estimated FY 2016 cost for the state plan under a range of trend assumptions (7.5% to 11.7% lower).

The School/Gov't column contains information for the sampled local entities and represents the estimated cost for those entities (on a COVA Care benefit basis) whether they are combined with the state plan or are in a separate statewide pool. For example, under Table 1, if the sample schools/government were under a separate rating pool, that pool's rates would be 2.0% lower than the state plan. Under all scenarios, State plan rates are the baseline. As the political subdivisions individual experience and rates varies widely, this is an average of the sample. A universal conclusion on locality by locality impact is not possible, since all of the needed data is not available. Individual impact is addressed in subsequent detail in the report and shows distributions versus the state plan under various scenarios.

Statistical analysis was performed on the medical and prescription drug sample results to test the reasonableness of the estimated cost, with an acceptable margin of error. Specifically, we tested whether the $454 PMPM average cost is a reasonable cost estimate for the sample population given the variation in costs by entity. From the statistical analysis, we determined with 95% confidence that $454 PMPM is a reasonable estimate of the aggregate sample entity cost.

In addition to the expected average cost of the sample population, it is important to understand the potential variability in the average cost and the potential range of reasonable cost outcomes. Therefore, a statistical confidence interval was developed to show the range of reasonable outcomes. From the analysis, we determined with 95% confidence that the average aggregate cost of the sample school and government plans would be between $334 PMPM and $575 PMPM (assuming best estimate trend assumptions).

Cost comparisons for Schools vs. Government and TLC vs. non-TLC entities are shown in Table 2 below. For medical and prescription drug, the PMPM cost are similar for the schools and local government sample entities based on the survey data collected ($452 PMPM vs $457 PMPM). There is a greater variation in the cost estimates for TLC and non-TLC groups ($479 PMPM vs $451 PMPM). For dental, PMPM costs also vary both between school and local government entities and TLC and non-TLC entities.

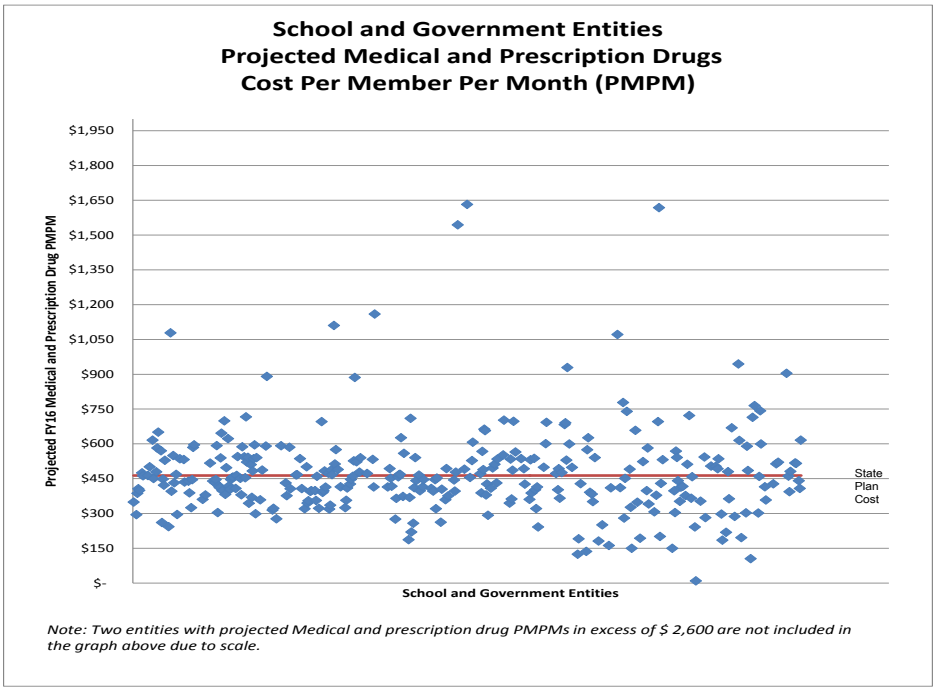
Table 2

Estimated FY 2016 Cost PMPM								
	Medical and Prescription Drugs				Dental			
	Schools	Gov't	Total	State Plan	Schools	Gov't	Total	State Plan
TLC	$467	$490	$479		$28.47	$21.23	$25.34	
Non-TLC	$451	$452	$451		$30.75	$25.96	$28.19	
Total	$452	$457	$454	$464	$30.21	$25.15	$27.61	$30.55
Average Enrolled Members	211,389	169,326	380,715	195,483	143,842	150,809	294,651	195,483

Note: Some of the schools' data is reflected in the government columns on the chart because school and county government data was submitted on a combined basis.

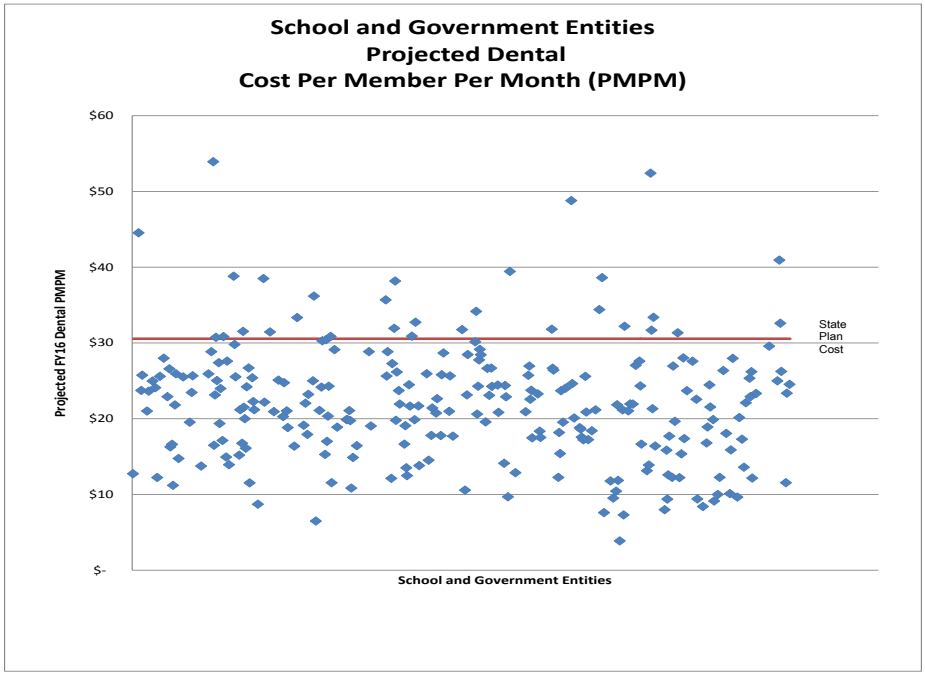
In addition, estimated costs varied significantly between the individual entities within the sample as shown in Tables 3A and 3B. While the average medical and prescription drug cost is approximately $454 PMPM, estimated costs ranged from $9 PMPM (entity with one employee) to $2,687 PMPM for the sample entities. Dental PMPMs, while substantially lower than medical, also show a wide range of cost across the sample entities. See Tables 3A and 3B.

TABLE 3A



Note: Two entities with projected Medical and prescription drug PMPMs in excess of $ 2,600 are not included in the graph above due to scale.

TABLE 3B



Demographic Comparison

A comparison of the demographic characteristics of the populations shows that the sample local entities have a slightly lower average age and a higher female mix vs. the state plan. Based on Aon estimates for expected cost differences due to age/gender, this age/gender mix suggests a lower cost for the combined schools and local government population vs. the state plan. This lower demographic cost impact could be a potential driver of the cost differential shown in Table 1. Larger variations exist between the state plan and the school and government segments of the sample population. See Table 4**.**

Table 4

Demographic Comparison - Enrolled Employees				
	Schools	**Government**	**Total**	**State Plan**
Average Age	46.6	47.7	47.1	47.7
Female % of Total	77.1%	45.4%	61.6%	53.5%
Age/Gender Variance	1.004	0.963	0.984	1.000

Aggregation/Migration Impact

The sample school and local government population reflected in the medical and prescription drug comparison data is approximately twice the size of the state plan population on an average enrolled member basis. If the entire sample population was aggregated with the state plan, it would make up about 66% of the new combined population. At this level of exposure, each 1% point difference between the sample population experience and the state plan would produce a 0.66% cost impact for the new blended population costs vs. the current state plan costs. Potential migration impacts are show in Table 5 for both medical/prescription drug and dental coverages. For example, under the high trend assumption for medical and prescription drug claims, costs for the school and government population are estimated to be in line with the state plan (approximately 0.3% higher – See Table 1). If the entire sample population joined the state plan at this cost level, the new blended state plan cost would be approximately $465 PMPM, a 0.2% increase vs. the current state plan costs. Similarly, at the upper limit of the confidence interval for medical and prescription drug claims, costs for the school and local government population are estimated to be $575 PMPM, 24% higher than the state plan. If the entire sample population joined the state plan at this cost level, the new blended state plan cost would be approximately $537 PMPM, a 15.9% increase vs. the current state plan costs.

The sample school and local government population reflected in the dental comparison data is approximately 1.5 times the size of the state plan population on an average enrolled member basis. While dental PMPM costs are substantially lower than medical and prescription drugs PMPM costs on a pure dollar basis, the sample schools and local government entity cost variance vs. the state plan is higher on a percentage basis. As such, the potential inclusion of this population produces a larger variance on a percentage basis. See Table 5.

Table 5

Estimated FY 2016 Cost PMPM								
	Medical and Prescription Drugs				Dental			
	New Entrants	State Plan	New Total	Vs. State Plan	New Entrants	State Plan	New Total	Vs. State Plan
Total Sample	$454	$464	$458	(1.3%)	$27.61	$30.55	$28.79	(5.8%)
Average Enrolled Members	380,715	195,483	576,198	194.8%	294,651	195,483	490,134	150.7%
Total Sample - Low Trend	$444	$464	$451	(2.8%)	$26.97	$30.55	$28.40	(7.0%)
Average Enrolled Members	380,715	195,483	576,198	194.8%	294,651	195,483	490,134	150.7%
Total Sample - High Trend	$465	$464	$465	0.2%	$28.26	$30.55	$29.18	(4.5%)
Average Enrolled Members	380,715	195,483	576,198	194.8%	294,651	195,483	490,134	150.7%
Total Sample - High CI Limit	$575	$464	$537	15.9%				
Average Enrolled Members	380,715	195,483	576,198	194.8%				

Comparison of FY 2016 Cost Estimates – TLC Plan Basis (KA Expanded)

As part of the review of TLC, we compared the costs of the non-TLC entities' plans to TLC's KA Expanded plan. The TLC comparison is different than the state plan comparison for a few reasons:

- **Underwriting Parameters.** The TLC program has underwriting parameters that apply to each entity separately, while the state plan aggregates all claims experience to determine one set of rates that are used for the entire state government population. These TLC underwriting parameters include some credibility applied to the entities' own claim experience based on the size of the entity.

- **Contribution Parameters.** While there are contribution parameters under TLC, each entity does have a certain degree of flexibility in determining the contributions appropriate for their population, while the state program has one set of contributions used for the entire state government population.

- **Size.** The TLC program is generally elected by smaller entities. The FY 2016 average enrollment per TLC entity is 104 employees with less than 5% of these entities having more than 500 employees. Given the relatively small size of most entities in TLC and the individual underwriting that is applied to each entity, a manual rate may be used in the underwriting process for each plan.

To evaluate the difference between the estimated population costs, Aon compared the costs for the population on a FY 2016 basis. The TLC comparison was based on the medical and prescription drug and dental costs inherent in the FY 2016 manual rate for the KA Expanded Plan with the expanded dental option. Similar to the state plan comparison, for purposes of this analysis, we focused on the review of the medical, prescription drug, and dental experience. Aon calculated estimated FY 2016 medical and prescription drug and dental cost estimates on a per member per month (PMPM) basis from the sample school and government data (as described in the Methodology and Assumptions section) and compared this estimate to the KA Expanded Plan and expanded dental PMPM manual rates. The following table summarizes the results for the TLC and non-TLC entities combined:

Table 6

Estimated FY 2016 Cost PMPM						
	Medical and Prescription Drugs			Dental		
	School/Gov't	KA Expanded	Difference	School/Gov't	KA Expanded	Difference
Low Trend	$457	$394	16.1%	$25.23	$21.28	18.6%
Best Estimate Trend	$468	$394	18.9%	$25.83	$21.28	21.4%
High Trend	$479	$394	21.7%	$26.44	$21.28	24.3%
Average Enrolled Members	380,715	41,502		294,651	41,502	

Table 6 shows a comparison of the benefit-adjusted PMPM costs of the entities to the manual rates of TLC's KA Expanded plan and expanded dental. However, it is important to note that the manual rate is one component of the final rate for TLC program participants. Entity experience and other adjustment factors are combined with this manual rate to produce the final rate charged to the group. Therefore, the more meaningful comparison is the benefit adjusted cost for TLC vs. non-TLC entities, both converted to the KA Expanded benefit basis. The comparison shows a lower medical and prescription drug PMPM cost for the non-TLC population vs. the current TLC population ($465 PMPM vs $493 PMPM). For dental, the analysis shows a higher PMPM cost for the non-TLC population vs. the current TLC population ($26.37 PMPM vs $23.70 PMPM).

Table 7

Estimated FY 2016 Cost PMPM								
	Medical and Prescription Drugs				Dental			
	Schools	Gov't	Total	KA Expanded Manual Rate	Schools	Gov't	Total	Expanded Dental Manual Rate
TLC	$480	$505	$493		$26.63	$19.86	$23.70	
Non-TLC	$464	$465	$465		$28.77	$24.29	$26.37	
Total	$466	$471	$468	$394	$28.26	$23.53	$25.83	$21.28
Average Enrolled Members	211,389	169,326	380,715		143,842	150,809	294,651	

Given that the TLC program has been more attractive to smaller sized entities, it is also prudent to examine how the costs differ by entity size, as it may be a better indication of the cost profile of groups likely to join TLC. As shown in Table 8 below, the benefit adjusted medical and prescription drug PMPM cost of the non-TLC entities with less than 250 employees is lower than the cost of all current TLC entities ($448 PMPM vs. $493 PMPM). Conversely, the cost for the TLC entities with less than 250 employees is higher than the cost of all current TLC entities ($527 PMPM vs. $493 PMPM). For dental, both TLC and non-TLC entities with less than 250 enrolled employees have lower dental PMPM costs vs. all current TLC entities.

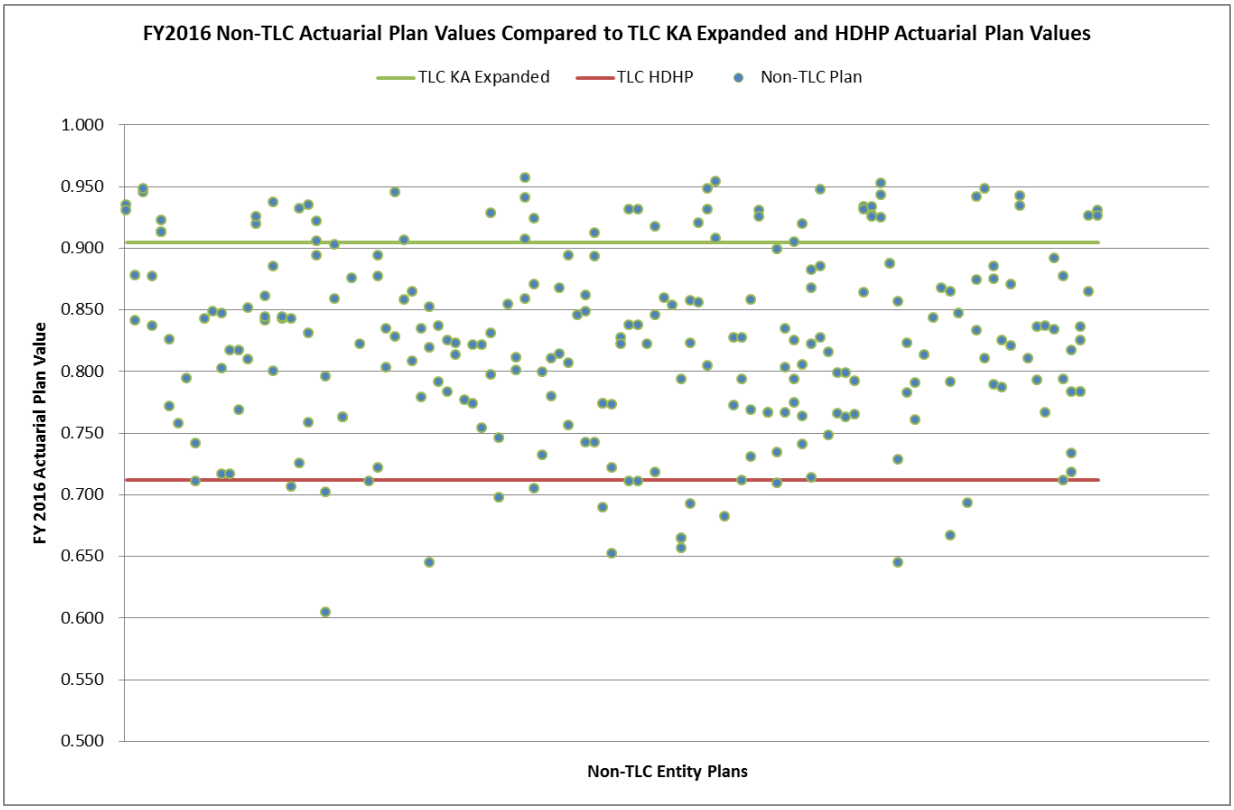
Table 8

Estimated FY 2016 Cost PMPM						
	Medical and Prescription Drugs			Dental		
	TLC	Non-TLC	TLC - All Entities	TLC	Non-TLC	TLC - All Entities
Entities < 250 Employees	$527	$448	$493	$19.59	$20.57	$23.70
Average Enrolled Members	18,893	7,203		19,023	5,237	
Number of Local Entities	156	30		146	20	

Given that there are underwriting guidelines and contribution methodology flexibility, one of the key considerations for new entities entering the TLC program is the plan availability and relative richness compared to the entities' current plan offerings. Relative richness of plan offering is determined by comparing actuarial values between the plans (where actuarial value is the portion of total cost paid by the plan). The actuarial values are developed using the Aon relative value model. As shown on the chart

below, most of the non-TLC entity plans have actuarial values that fall between TLC's KA Expanded plan and TLC's HDHP, the richest and leanest TLC plans, respectively. Of the 254 non-TLC plans valued in the study, 21 plans have values below (less rich than) TLC's HDHP and 50 plans have values above (more rich than) the KA Expanded plan. In most cases, these outlier plans are with entities that offer more than one plan option to their employees. See Table 9.

Table 9



Impact to the Entities – Joining the State Plan

While it is important to understand the impact to the state plan risk pool/expected claims, it is also important to consider how a state-wide plan might impact the school and local government entities from both an employer and an employee perspective. For purposes of comparison, current entity plan premiums and contributions were compared to the FY16 COVA Care Basic and Expanded Dental premium and contributions. FY 2016 State plan premium and contributions were not adjusted for the impact of a potential combined risk pool. We analyzed the medical and prescription drug premium and contribution data as submitted with the study from three different perspectives:

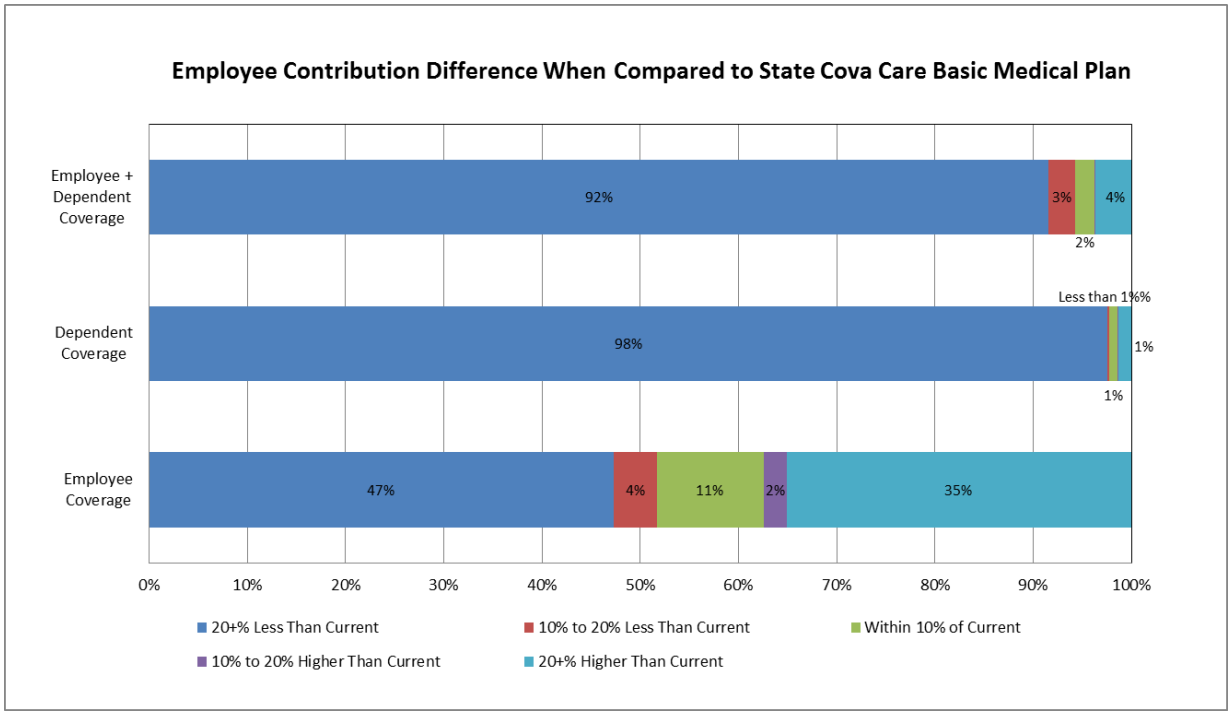
- **Employee Contributions.** How employee contributions vary for both employee and dependents as compared to the state COVA Care Basic plan
- **Employee Cost.** How the total employee costs (i.e., employee contributions plus employee out-of-pocket medical and prescription drug expenses) compare to the state COVA Care Basic plan

- **Employer Cost.** How the employers' net cost (i.e., premiums minus employee contributions) compare to the state COVA Care Basic plan

Employer and employee cost sharing splits varied across the sampled entities/plans. Based on enrollment, the following chart shows the distribution of the difference in Projected FY 2016 employee contributions for the schools and local government entities vs. the COVA Care Basic plan. The plans are grouped into ranges as defined on the bottom of the chart, where the range represents the percentage difference between the entity contributions and the state plan contributions. The percentages inside the bars on the chart reflect the percentage of plans that fall into each of the percentage change ranges.

The bottom bar compares contributions paid for employee only coverage; the middle bar compares contributions paid for dependent coverage; and the top bar compares the average employee contribution for employee and dependent coverage combined (based on a weighted average of enrollment by coverage tier) for each entity.

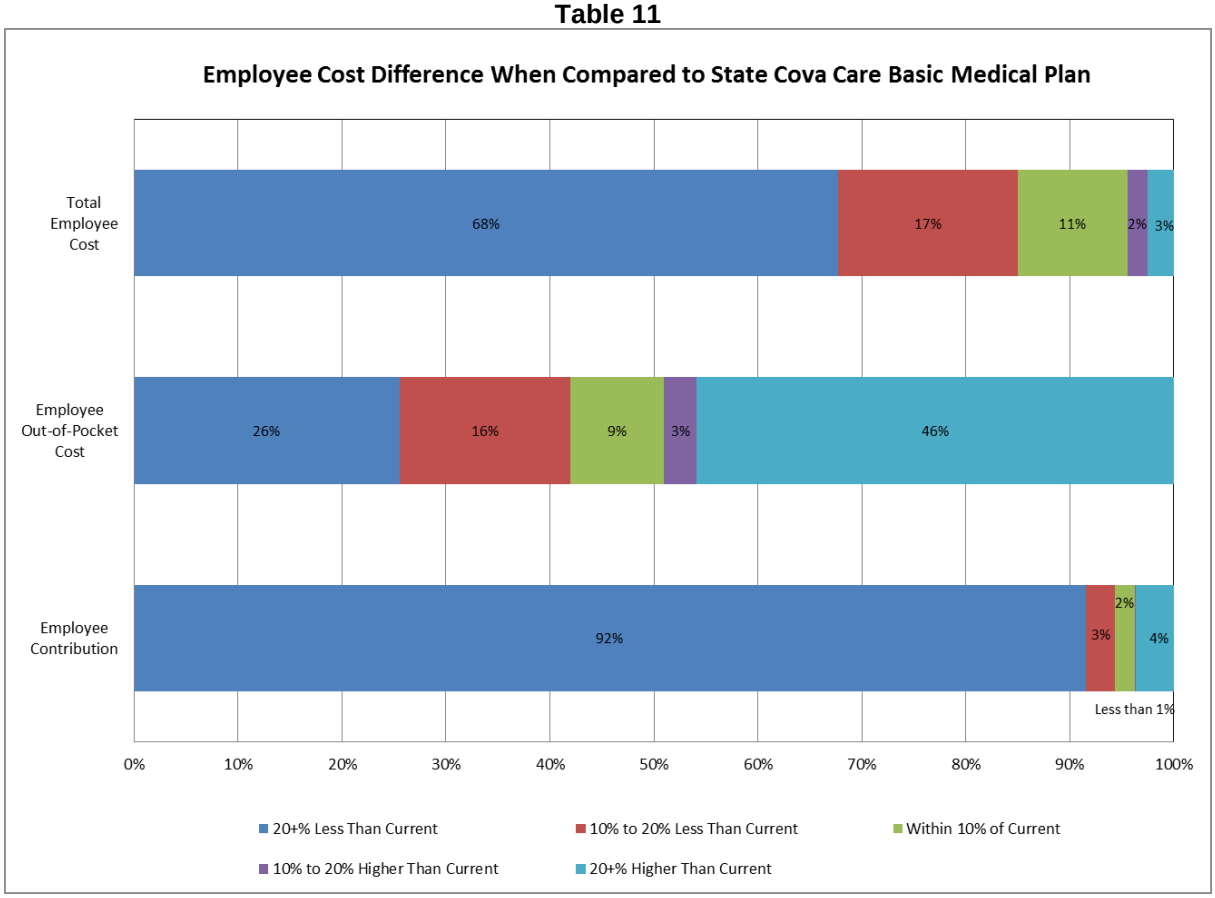
Table 10



As shown on the chart above, employee contribution differences vary across the plans. For employee only coverage, approximately 47% of employees would pay 20+% less for the COVA Care Basic plan than they would under their current plan option and 35% of employees would pay 20+% more for the COVA Care Basic plan than they would under their current plan option. However, for dependent coverage, approximately 98% of the dependent contributions would be 20+% less under the state's COVA Care Basic plan, suggesting that the state plans may subsidize dependents more generously. This dependent coverage difference drives the combined employee and dependent contributions (as reflected in the top bar on the chart) for the schools and local government entities to be much lower than the state's COVA Care Basic plan.

Employee contributions are only a portion of what plan participants pay for medical and prescription drug coverage. Plan participants also pay a portion of their medical and prescription drug expenses through copays, deductibles, and coinsurance, referred to as out-of-pocket (OOP) costs. Based on enrollment, the following chart shows the distribution of the difference in Projected FY 2016 employee OOP costs for the schools and local government entities vs. the COVA Care Basic plan. The plans are grouped into ranges based on cost differential, similar to the contribution chart. The bottom bar compares the average employee contribution including dependents (from Table 10 above); the middle bar compares the OOP cost for employee and dependents combined; and the top bar compares the total employee cost (employee contributions plus OOP costs).

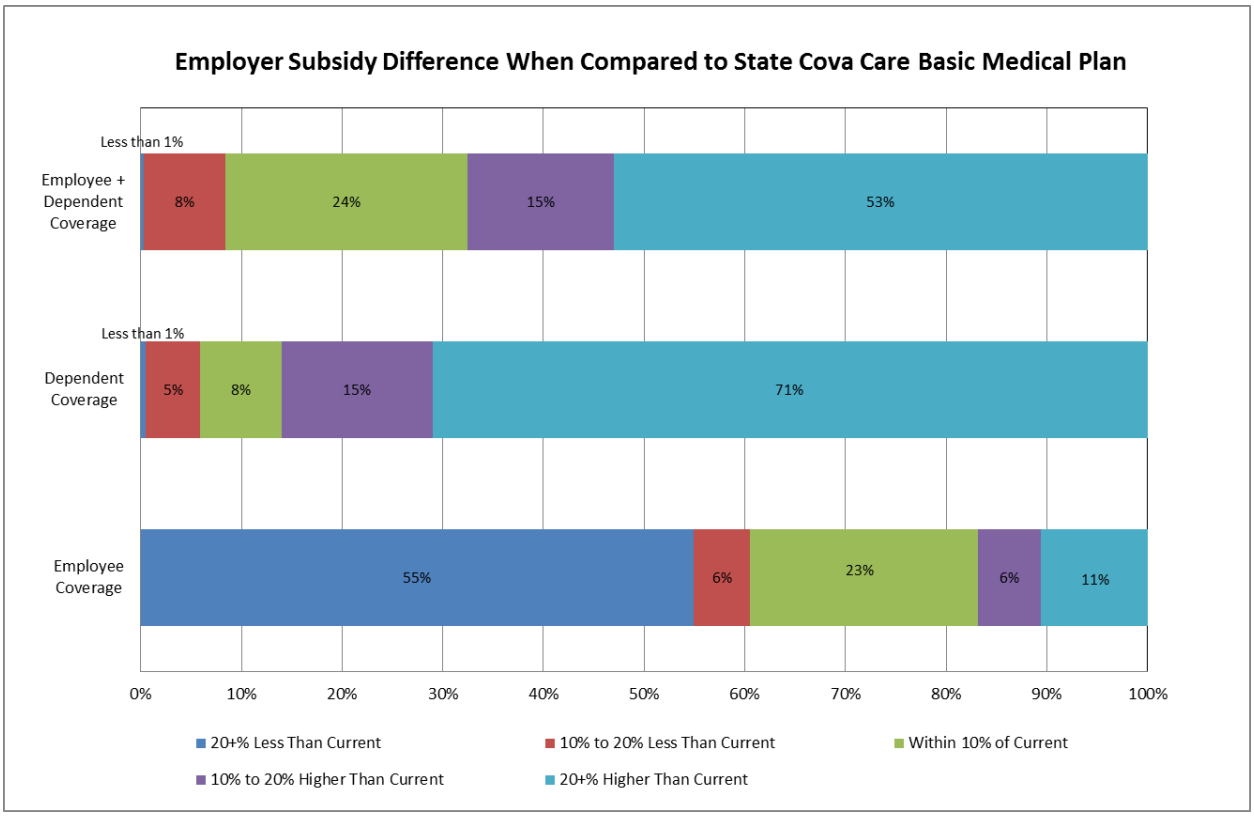
Table 11



As the study data reflects the full spectrum of plan offerings at the schools and local government entities (some richer than COVA Care Basic and some leaner), there is a fair amount of variability in the OOP costs compared to the COVA Care Basic plan. However, when the contribution and OOP impacts are combined to reflect a total employee cost, the analysis does show that a large majority of plan participants would pay lower overall costs to participate in the state COVA Care Basic plan vs. their current plan election (as reflected on the top bar in Table11 above).

In assessing the impact to the schools and local government entities, the net cost impact to the employers (i.e., the employer subsidy) is also considered. Based on enrollment, the following chart shows the distribution of the difference in Projected FY 2016 employer subsidies for the schools and local government entities vs. the COVA Care Basic plan. The plans are grouped into ranges based on cost differential as defined on the prior charts. The bottom bar compares the employer subsidy for employee coverage only; the middle bar compares the employer subsidy for dependent coverage; and the top bar compares the average employer subsidy for employees for employee and dependent coverage combined (based on a weighted average of enrollment by coverage tier) for each entity.

Table 12



Based on the comparison of employee contributions and OOP cost, the state COVA Care Basic program may offer savings to employees of schools and local governments. The lower employee cost is partially due to a shift in cost from the employee to the employer, particularly for dependents. Total employer subsidies would be higher under the state COVA Care Basic plan for approximately 70% of plan participants. See Table 12.

In determining whether to allow the schools and local government to join the plan, the state should strongly consider not only the impact to the state plan, but also the impact to the individual entities.

Impact to the Entities – Joining the TLC Program

An analysis of the impact to the employee/entity for joining the TLC program is not included in this analysis. Due to the TLC-specific underwriting dynamic/formula and contribution setting flexibility inherit in the TLC program, entity-specific TLC premium rates and contributions could not be determined.

Implementation Considerations / Program Protections

The focus of this section is a potential combined state plan. TLC operates independently with underwriting guidelines and other risk mitigating protections. Therefore, we limited our review to implementation risks/considerations for the state plan.

If the Commonwealth does allow school and local government employees into the state plan, there are a number of issues to consider. The analysis completed shows that the cost of the sample population is slightly lower than the state plan cost. The margin of error for the analysis has also been described. Some implementation considerations / protections are outlined below to help ensure that the cost result achieved would be in line with the expected results and to limit adverse impact to the cost of the current state plan. The tightest controls will afford the most protection against adverse financial impact.

General Selection Considerations

If the state plan is made optional, it may not attract a broad mix of exposure as represented in the sample data from the group of all eligible entities. The entities could compare the cost of the state plan benefit offering vs. what they can negotiate independently in the market and may only choose the state plan if it provides a lower cost than other options available. As a result the state plan may get a disproportionate share of higher cost entities. This is referred to as the selection impact.

To demonstrate the potential impact, the entities in the sample were segmented into quartiles based on estimated cost. Entities are ranked from lowest to highest based on estimated cost. The 1st quartile represents the 25% of entities with the lowest cost, while the 4th quartile represents the 25% of entities with the highest cost. See Table 13A and 13B below and additional detail in Appendix A Tables 17A and 17B.

Table 13A

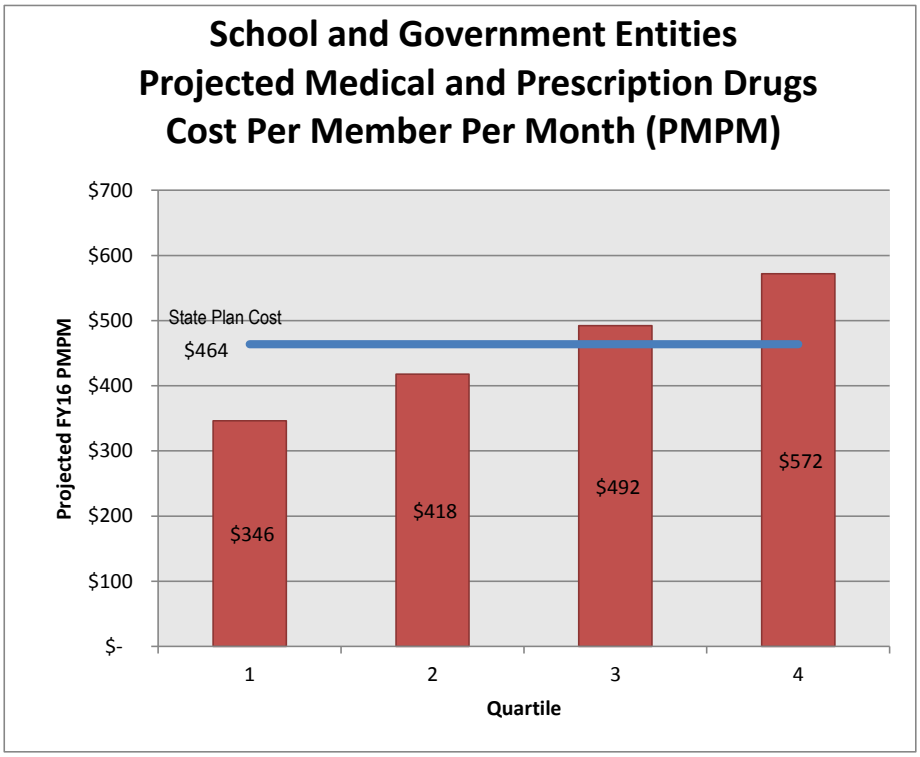
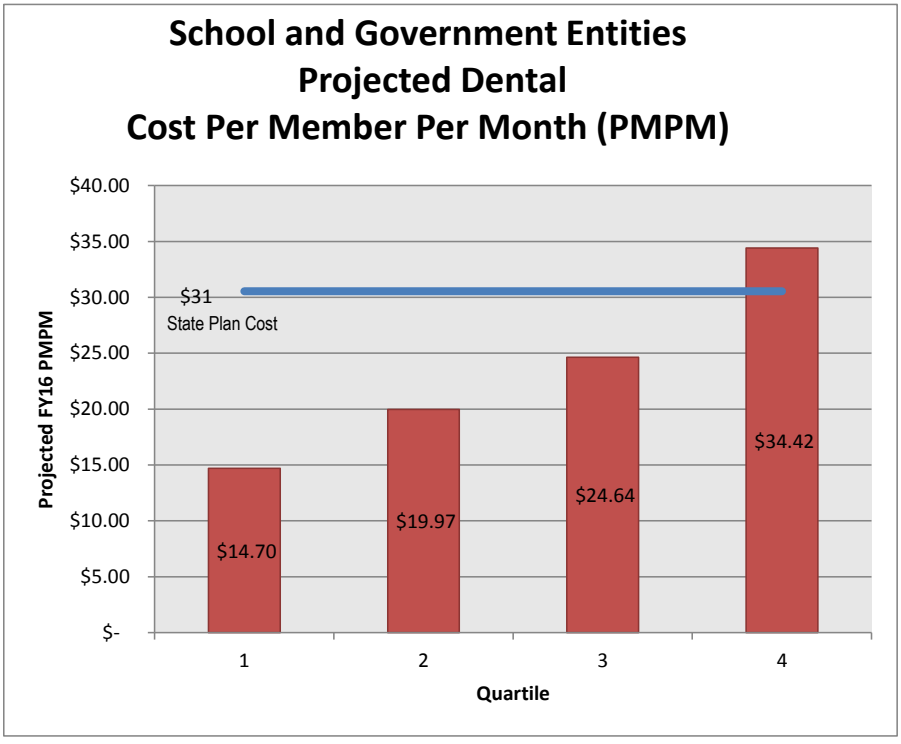


Table 13B



For the highest cost quartile, estimated medical and prescription drug benefit costs are approximately 26% higher than the sample average and 23% higher than the state plan costs. If only the highest cost sample entities joined the plan, the new state plan aggregate medical and prescription drug cost would increase by about 5.6% based on the enrollment in the highest cost quartile in the sample population. By contrast, if only the lowest cost sample entities joined the plan, the new state plan aggregate medical and prescription drug cost would decrease by about 5.1%. The dental costs would also increase with only the highest cost entities joining the state plan and decrease with only the lowest cost entities joining the state plan. See Table 14 below.

Table 14

Estimated FY 2016 Cost PMPM								
	Medical and Prescription Drugs				Dental			
	New Entrants	State Plan	New Total	Vs. State Plan	New Entrants	State Plan	New Total	Vs. State Plan
Highest Cost Quartile	$572	$464	$490	5.6%	$34.42	$30.55	$32.15	5.2%
Average Enrolled Members	62,265	195,483	257,749	31.9%	137,691	195,483	333,175	70.4%
Number of Local Entities	80				65			
Lowest Cost Quartile	$346	$464	$440	(5.1%)	$14.70	$30.55	$28.09	(8.1%)
Average Enrolled Members	49,724	195,483	245,207	25.4%	36,029	195,483	231,512	18.4%
Number of Local Entities	79				64			

The focus of this portion of the analysis is to assess the cost impact to the state plan if the school and local government entities are allowed to join. In the current state, smaller school and local government entities with insured arrangements pay a premium that includes insurer retention costs for administration, premium tax, and profit/risk charge. For smaller groups this retention charge can be 15% to 20% of the total premium (based on minimum loss ratio requirements of the Affordable Care Act). This compares to a typical administrative cost load of about 5% in the state's self-insured programs. For these entities, the difference in administration costs / loads can produce savings, even if the underlying claim costs are higher in the self-insured cost pool. [Note: The assessment of the cost impact from the local entity point of view is included as a separate section of this report.] To demonstrate the potential impact to the state plan, the entities in the sample were segmented based on the average group size (average enrolled employees). See Tables 15A and 15B below and additional detail in Appendix A Tables 18A and 18B.

Table 15A

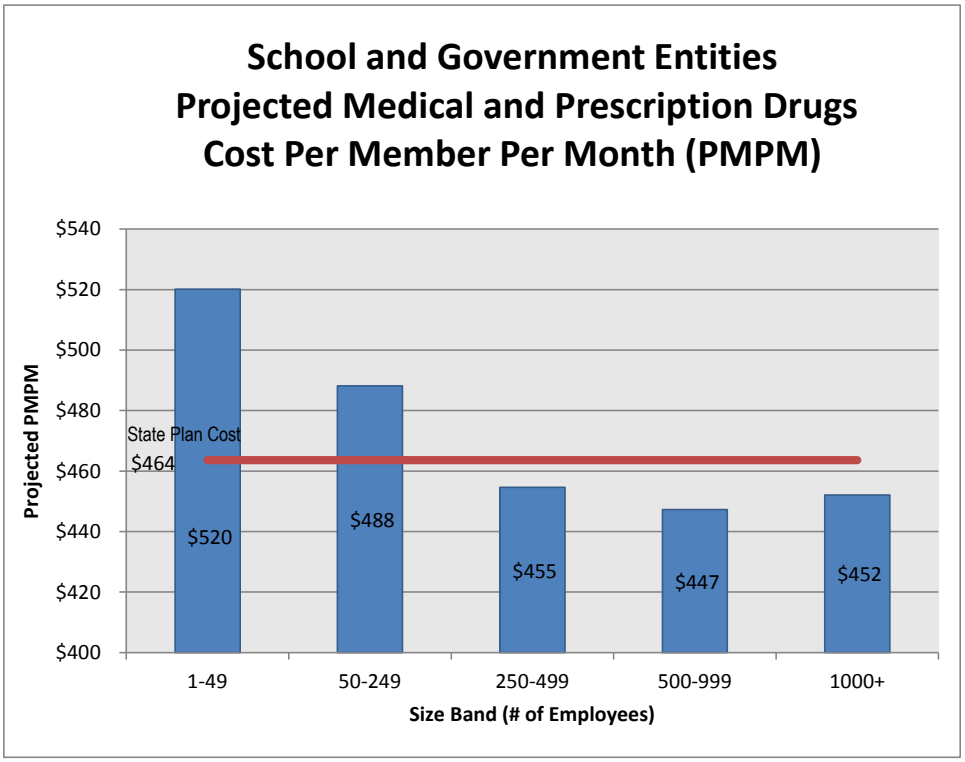
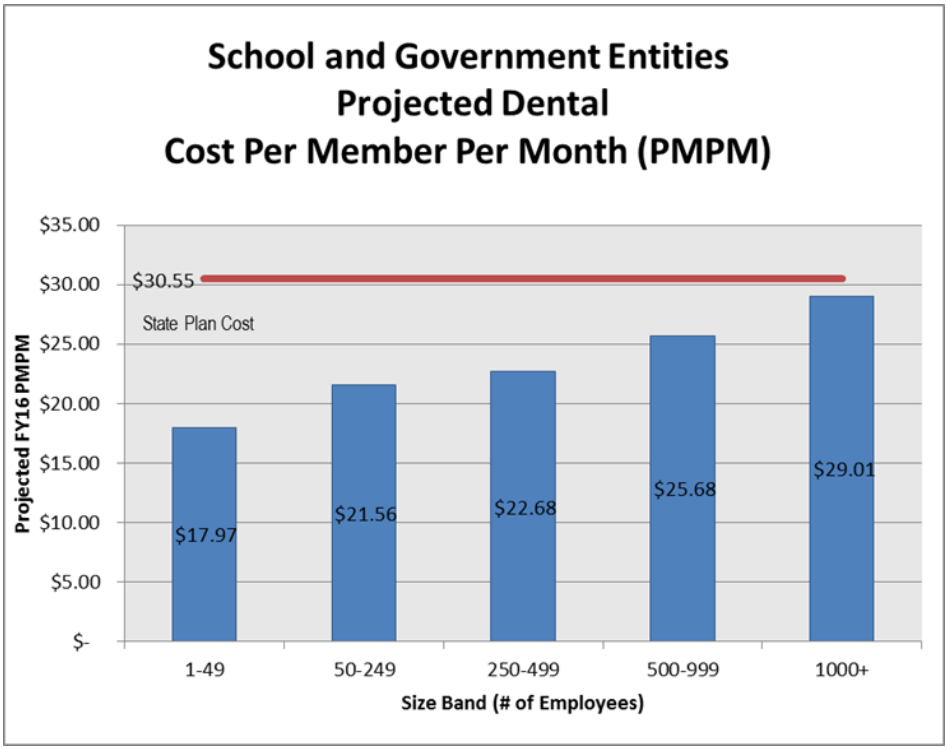


Table 15B



If only the sample entities with < 250 employees joined the plan, the new state plan aggregate medical and prescription drug cost would increase by about 0.7% while the dental cost would decrease by about 3.4%. See Table 16.

Table 16

Estimated FY 2016 Cost PMPM								
	Medical and Prescription Drugs				Dental			
	New Entrants	State Plan	New Total	Vs. State Plan	New Entrants	State Plan	New Total	Vs. State Plan
Entities < 250 Employees	$491	$464	$467	0.7%	$21.17	$30.55	$29.52	(3.4%)
Average Enrolled Members	26,096	195,483	221,580	13.3%	24,261	195,483	219,744	12.4%
Number of Local Entities	186				166			

The state may wish to implement certain protections for the state plan to mitigate the effect of selection on the state plan pool experience. The effect of selection is the primary challenge of an insurance mechanism that competes with more sophisticated risk attributers in the marketplace, as purchasers will look to take advantage of rates that do not fully reflect their risk, and are therefore underpriced on an expected cost basis.

Potential Protections

- **State Plan Becomes Mandatory.** All school and local government entities would be offered the state plan with rates and similar, preferably identical contribution parameters determined by DHRM. There would be one combined risk pool. All other plans including TLC would be eliminated. This option offers the most protection against adverse impact due to entity selection dynamics.

- **State Plan is Optional with Three Year Lock-in / Lock-out.** Entities opting to join the state plan would become part of one combined risk pool with rates and contribution parameters determined by the state. Entities opting to join must stay in for 3 years. Entities opting not to join or to leave the state plan would be locked out for 3 years. This option helps to mitigate potential volatility due to population fluctuation and selection impact as entities "shop" the market. The local entities would still have the ability to obtain external coverage.

- **State Plan is Mandatory or Optional with Adjusted Community Rating Basis**. Entities joining the state plan would comprise a separate risk pool. A simplified underwriting approach could be used to adjust for demographic variations between groups. The state would determine base rates and contribution parameters. This could be implemented on either a mandatory or optional basis with the considerations as outlined above. The current state plan and its risk pool would not be impacted.

- **State Plan is Optional with TLC-like Underwriting Control Structure**. Entities joining the state plan would comprise a separate risk pool. Premium rates would be determined via underwriting guidelines similar to those which exist in the current TLC framework; underwriting varies by group size and some protection is offered against high cost claim exposure. The current state plan and its risk pool would not be impacted.

Additional Considerations

- **Loss of Autonomy In Benefit Plan Management.** Schools and local governments currently have authority for benefit design determination, contribution setting and contracting with health

plan benefit insurance carriers. Entities joining the state plan would have to accept state plan design and contribution parameters. They would no longer be allowed to choose design or set entity specific contributions outside of any underwriting requirements that are established.

- **State Plan Contingency Reserve.** Currently the state holds a claims contingency reserve that is approximately 8% of incurred claims for its self-insured health benefit plans. The dollar amount of the reserve held would need to increase as enrollment in the state plan and potential claim exposure increased.

- **State Plan Contribution Split.** State plan contributions for coverage, especially the dependent rate tiers, are higher than locality contributions. Locality dependent participation in the employer plan is lower than the state dependent participation ratio.

    - If the localities are combined with the state plan, and the state plan contribution formula applies:

        - More locality dependents will opt to enter the plan, and increase total cost per entity over current costs.

        - Absent increased dependent participation, employer cost will increase to fund the higher state formula contribution levels.

        - The additional employer contribution cost will have to be absorbed by the state or locality.

III. Data

Aon used the following information to conduct the analysis:

- Paid medical, prescription drug, and dental claims by enrollee type (active, cobra, pre-65 retiree) and benefit plan option for calendar years 2013 and 2014 for each entity

    - If an entity switched carriers or joined TLC at some point during this time period, the claims data received may be limited to the experience with the latest carrier

- Medical, prescription drug, and dental enrollment by enrollee type (active, cobra, pre-65 retiree) and benefit plan option for calendar years 2013 and 2014 for each entity

- 2015 census information for the local entities and the state plan

- FY 2016 budget expected medical and prescription drug claim costs for the state plan (COVA Care Basic plan excluding dental benefits)

- FY 2016 budget expected dental claims costs for the state plan (expanded dental)

- Current medical, prescription drug, and dental plan design information with comments about changes in design reflected in the claims data submitted for each entity

- Current medical and prescription drug premium and contribution rates for each entity and plan

The source of the information varied by entity:

- For Non-TLC school and local government plans included in the study: Claims and enrollment data was provided by the medical and prescription drug vendor. Census, plan design, premium, and contribution information was provided by the entity.

- For TLC school and local government plans included in the study: Claims, enrollment, and census data was provided by Anthem. Plan design, premium, and contribution information were provided by the entities and confirmed through state provided documents.

Data for 336 school and local government entities was used in the development of the medical and prescription drug cost vs. a total local entity count of 708. Data for 184 entities was provided but not used in the study due to an incomplete data submission or other issues. Note that data for 18 of the school and local government entities was combined with other entities in the same county and could not be separated. Therefore, in some of the result summaries, the entity count will total 318. A subset of these entities was used for dental claims cost comparisons and the impact to the entities due to missing or incomplete data submissions.

Aon reviewed the data for reasonableness and consistency. We do make several key assumptions about the data as noted in the Methodology and Assumptions section below.

We relied on the accuracy and completeness of the data and information provided by the entities and vendors to develop our analysis. If the data or the information is not accurate or incomplete, the results may be different.

IV. Methodology and Assumptions

- For each entity, historical medical, prescription drug, and dental costs for each year of data provided were trended to FY 2016 and adjusted for benefit differences using Aon Actuarial Value tool to make them comparable to the state plan or TLC plan benefits. Results for 2013 and 2014 were blended with 67% weight on calendar year 2014. Results were aggregated across the entities.

- To develop a consistent comparison between the school and local government sample data in the analysis and the FY 2016 State COVA Care Basic or TLC KA Expanded plan medical and prescription drug cost and expanded dental plan estimates, we did the following before aggregating the data.

    - All entities' plan designs as well as the current state COVA Care Basic/TLC KA Expanded and expanded dental plans were evaluated using the same actuarial value model with the same underlying assumptions. The benefit ratios for the combined medical and prescription drug benefits and separate dental benefits were used.

    - The historical medical, prescription drug, and dental claims were trended forward from the respective experience mid-points to the mid-point of the projection period (1/1/2016) based on selected annual medical, prescription drug, and dental trends.

    - Historical claims were adjusted to the levels of the current state COVA Care Basic/TLC KA Expanded and expanded dental plans using the benefit ratio results from the actuarial value model.

  - Total claims were converted to a per member per month (PMPM) basis.

- Medical, prescription drug, and dental trends were developed from FY 2013 – FY 2015 claim experience for the state and TLC plans. The best estimate trend assumptions for medical, prescription drug, and dental based on the experience were 5.0%, 10.0%, and 4.0% respectively. High and low estimates used for sensitivity testing were set equal to best estimate +/- 1%.

- Only entities with at least 12 months of experience data were included in the analysis. If an entity offered multiple plan options or switched plan options, each plan option had to have at least 2 months of experience to be included in the analysis.

- The first two months of claims experience for any plan with less than 24 months of experience was excluded from the study.

- Active, cobra, and pre-65 retirees are included in the analysis (as available), consistent with the pricing population base for the state COVA Care Basic Plan.

- Only medical, prescription drug, and dental claims are included in the analysis.

  - Vision claim, enrollment, plan design, premiums, and contribution data was received for some plans/entities. Based on the inconsistent format of the data received, the difference in PMPM between entities with mandatory (combined medical/vision) benefit election and voluntary (separate medical/vision) benefit election, and the relatively low cost of vision cost, we exclude vision as a part of the study. For the state plan, vision represents approximately 2% of the total health plan (medical, prescription drug, dental and vision) costs; therefore, any differences in vision plan costs will not have a material impact of the total costs of the overall program.

- Due to the incomplete dental information received for survey participants, the populations reflected in the medical and prescription drug cost comparison and the dental cost comparison are different. Therefore, total expected PMPM costs cannot be derived by adding the medical/prescription drug PMPM costs and the dental PMPM costs together.

- Current demographic information was summarized for entities that provided the complete census information on enrollment, date of birth, and gender. Age, for purposes of demographic comparisons, is calculated as of 7/1/2016. We excluded the Kaiser demographic information from the comparison as there were limited Kaiser claim data available for use in the cost comparison.

- For entities that provided historical plan design information, we matched the plan designs with the claim experience splits. For TLC groups, we had 2013 and 2014 calendar year plan designs. For entities that only provided the most recent plan designs, we assumed that the historical claims reflected the benefits in the most recent design for each benefit plan option.

- Entity claim data was adjusted to approximate the benefit levels of the state COVA Care Basic or TLC KA Expanded plan and expanded dental plans using actuarial benefit ratios from the actuarial value model. No adjustment was made for potential changes in utilization for changes in benefit level. No adjustment was made for cost structure difference due to network discounts or network utilization differences. No adjustment was made for differences in demographics.

- Medical and pharmacy premium and employee contribution data received from the entities was trended to FY2016 and compared to the state COVA Care Basic plan.

  - Retiree plans were not included in this part of the analysis

- Employee out-of-pocket costs were estimated under each medical and pharmacy plan by backing out an assumed retention load for expenses, dividing the remaining cost by the actuarial value to estimate total claims costs before plan provisions are applied, and subtracting the estimated plan claims cost from this number.

  - An entity that had more than 500 enrolled employees was assumed to be self-insured with a retention or expenses of 5%. An entity with 500 or fewer enrolled employees was assumed to be fully-insured with a retention of 18%.

- Comparisons of premiums and employee contributions were done at the plan level rather than the entity level. Within an entity, there may be both winners and losers as compared to the COVA Care Basic plan.

- Entity data used may vary for portions of the study based on completeness of data received for that portion of the analysis. For example, if an entity did not provide medical and prescription drug claim data along with plan design information for the study, it was excluded from all portions of the study. However, if an entity only supplied these pieces of information it was included for the state plan cost impact.

The school and local government data used in the study does not represent all potential exposure as data was not available or not usable for all entities. We have assumed the data provided is a representative sample for comparison purposes.

We believe that the assumptions used in completion of the analysis are reasonable.

V. Limitations

It should be noted that Aon's conclusions are based on certain assumptions that appear reasonable at this time. Actual experience may vary from projected experience, and this difference may be material. The information contained in this document, including any enclosures, has been prepared for DHRM for the purpose of evaluating the viability and impact of a State-wide Schools and Local Government health benefit plan. The information may not be appropriate for any other purpose. This report is intended for the sole use of DHRM. Reliance on information contained within this report by anyone for other than the intended purposes puts the relying entity at risk of being misled because of confusion or failure to understand applicable assumptions, methodologies, or limitations of the report's conclusions. To the extent this information is provided to third parties, the document should be distributed in its entirety. We strongly recommend that any use and interpretation of the data be supported by a certain level of expertise in actuarial science and rate development to avoid misinterpretation of the data presented.

VI. Conclusion

Based on analysis using actual experience data for a sample of the school and local government population, the expected cost is slightly lower than the state plan and the schools and local government employees would likely experience a lower cost for coverage with some of that cost being shifted to the employer. However, the sample did not cover all potential entities to whom the plan could be available, and even within the sample there is potential variability in costs. In determining whether to allow the schools and local government to join the plan, the state should strongly note and consider the potential

for these cost variations and the implication of costs to employers, including the administrative component. In addition, consideration should be given to the other implementation issues outlined above.

SECTION B

The Local Choice (TLC) Stakeholder Meeting Overview

The Local Choice (TLC) Stakeholder Meeting Overview

Introduction

The 2015 Virginia Acts of the Assembly, Chapter 65, Item 82, required the Department of Human Resource Management (DHRM) to hold a series of meetings with stakeholders to educate them about The Local Choice (TLC) program and solicit their feedback.

During the weeks of July 6th and July 13th, DHRM conducted stakeholder meetings in Abingdon, Annandale, Alberta, Chester, Fredericksburg, Portsmouth, Roanoke and Staunton.

Most entities sent multiple representatives to these sessions. In addition, Anthem and Aon representatives participated at every session. In some sessions, local brokers also participated.

The following chart shows individual group participation by location:

	Number of Entities	
	TLC Groups	**Non-TLC Groups**
Abingdon	16	0
Alberta	3	0
Annandale	5	3
Chester	8	6
Fredericksburg	8	0
Portsmouth	7	6
Roanoke	14	8
Staunton	14	10
TOTAL (108)	75	33

Each session included a detailed slide presentation on TLC that outlined its history, key provisions, administrative capabilities, and foundational underwriting requirements and practices. The presentation was followed by an interactive question and answer period. Based on knowledge of the program and its participants, facilitators from Aon and DHRM presented topics to elicit discussion regarding what attendees considered to be attractive TLC features, areas for improvement, and barriers to joining TLC. These questions led to additional inquiries and comments. The discussions are summarized in this report, along with feedback and DHRM recommendations.

Discussion focused on subjects included in ten different categories:

- Provider Network
- Compliance with Affordable Care Act (ACA)
- Benefit Plan Offerings
- Plan Provisions
- Retiree Plans
- Administration
- Underwriting
- Participant Education and Feedback Opportunities
- Purpose of Actuarial Study
- Wellness

Feedback and Recommendations

Provider Network

Provider networks were mentioned by participants at two meetings. Generally, respondents liked the breadth of the provider network administered by Anthem. No specific comments were made regarding the Kaiser network.

A concern was expressed at the Portsmouth meeting regarding specialist office visit "wait times" in the Tidewater region.

Recommendation 1

DHRM recommends that it follow up with Anthem on wait times in Tidewater with potential subsequent communication with TLC participants in that region.

DHRM has already shared the concern about wait times in the Tidewater region with Anthem management.

Compliance with Affordable Care Act (ACA)

Compliance with the ACA was discussed at several meetings. Three general topics emerged in this category: reinsurance fees, reporting and the excise tax.

Reinsurance Fees

Reinsurance fees were discussed by participants at three meetings. Participants expressed appreciation that TLC was handling payment of ACA reinsurance fees on their behalf.

Reporting

Reporting was brought up by participants at three of the meetings. Participants expressed appreciation for the services currently and to be provided with respect to ACA employer mandate reporting. Overall,

both TLC and non-TLC groups saw the ACA reporting service as an attractive feature, but wanted the ability to review the accuracy of reports before filing.

Recommendation 2

DHRM recommends that it provide reports to groups to ensure accuracy of data before the ACA mandate reports are filed.

This process will begin in Fall 2015 when the January-September information will be sent to groups for review. TLC groups must provide certain information to DHRM to facilitate completion of the report, and this has been communicated to all groups.

Excise Tax

The excise tax was discussed at two meetings. Participants expressed concern about its impact on TLC plan design.

The excise tax is an annual tax on high-cost employer-sponsored health coverage that exceeds a pre-determined threshold. It is scheduled to begin in 2018. It is also known as the "Cadillac" tax. The federal government is still developing excise tax guidelines.

Recommendation 3

DHRM recommends that it communicate to TLC groups on the impact of the ACA excise tax as guidelines are developed.

The United States Department of Health and Human Services (HHS) will need to provide more guidance regarding the excise tax formula.

Benefit Plan Offerings

Benefit plan offerings were discussed at several meetings. Four general topics emerged in this category: the Preferred Provider Organization (PPO) network, the High Deductible Health Plan (HDHP) options, gap plans and regional plans.

TLC offers a choice of five self-insured plan options: Key Advantage Expanded, Key Advantage 250, Key Advantage 500, Key Advantage 1000, and the TLC High Deductible Health Plan. Additionally, a fully insured Kaiser Health Maintenance Organization (HMO) plan is available in Northern Virginia.

Public sector total compensation strategies often offer relatively high value health and retirement plans for attracting and retaining skilled workers to counter the private sector advantage of higher direct salary compensation. Since the TLC program offers a selection of benefit plans with different actuarial values, individual groups have numerous options affording the opportunity to mitigate proposed increases by choosing a lower value, less costly plan.

PPO Network

Participants at two meetings said that they liked the Preferred Provider Organization (PPO) network platform offered by self-funded TLC plans, in part because of its national scope, out-of-network benefits,

and provision that no Primary Care Physician (PCP) referral is required before receiving care from a specialist or other provider.

HDHP Options

The concept of decreasing the current HDHP deductible was mentioned at two meetings. Several participants considered the high deductible level as a barrier to increased participation in the HDHP.

HDHP plans were introduced to the market over 15 years ago and have become increasingly more prevalent as health plan benefit offerings. The 2015 Aon Employer Survey indicates that 63% of State and Local Governments polled either have an HDHP in place or will add one in the next three to five years.

By design, these plans:

- **Provide Cost Savings through increased cost sharing provisions.** Typically, these plans have an individual deductible in excess of the highest non-HDHP TLC plan deductible, which is Key Advantage 1000. This deductible level produces lower premiums while still protecting participants from catastrophic medical expense through coverage coupled with a defined out-of-pocket maximum expense level. Generally, the plans pay 70—100% and the employees pay the remainder. The premise behind the increased employee cost sharing, including the deductible and any applicable coinsurance, is to encourage appropriate utilization of services and to seek cost-effective providers when care is necessary.

- **Promote Consumerism/Better Health Choices.** The effectiveness of these plans is heightened when coupled with tax-advantaged accounts known as Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs). To qualify as an HDHP and permit the use of HSAs or HRAs, a plan must have minimum individual and family deductibles of $1,300 and $2,600, respectively.

  Enrollment in an HDHP allows the member to set up a personal HSA through a bank or other financial institution, which can be used to help pay health care expenses or save for retirement. HSAs were created as part of Medicare reform legislation in 2003. HSA funds used to pay for qualified medical expenses are tax free, and interest earned in the account is also tax free. Funds in an HSA are portable; they can be moved to another HSA. HRAs are similar to HSAs but are not portable. Both HSAs and HRAs can be rolled over for use in the next plan year. The TLC HDHP meets federal requirements and is HSA compatible, which allows a participant to set up an HSA with his/her financial institution of choice or one selected by the employer plan sponsor.

- **Help avoid the ACA excise tax.** The ACA imposes a surcharge on plans that exceed specific cost thresholds. Guidance indicates that the tax will be 40% of the cost in excess of the proscribed level. Regulations on the excise tax have not been issued and are now projected by the IRS for release in 2016.

Recommendation 4

DHRM recommends maintaining the level of the existing TLC High Deductible Health Plan (HDHP) deductible.

The TLC HDHP has a one person deductible of $2,800 and a family deductible of $5,600, which are respectively $1,500 and $3,000 higher than the minimum allowable deductible levels set by the federal

government. However, if deductible amounts were lowered, it would increase plan premiums. This, in turn, could increase vulnerability to the ACA excise tax and reduce the advantages of funding with an HSA or HRA.

Furthermore, every TLC group has the option of electing a Key Advantage plan from the standard TLC plan menu. These plans have varying deductible levels that are lower than the HDHP. For example, Key Advantage 1000 has a $1,000 deductible. There is no benefit in offering multiple plans if they are too similar in cost or benefit levels.

Gap Plans

The possibility of offering gap plans was discussed at one session.

These "employee pay all" plans can be offered at significant group discounts when they are endorsed by the employer. Gap plans have the potential to mitigate the impact of the HDHP deductible and high out-of-pocket maximum levels. They are not tax advantaged like HSAs or HRAs, but they can be part of a strategy to encourage HDHP enrollment. They typically limit coverage for specific expenses, such as hospital charges or those related to a single disease such as cancer.

Recommendation 5

DHRM recommends that gap plans not be included in the TLC plan offerings.

Nothing in TLC administrative procedures would prevent a local employer from entering into such an arrangement on its own. Decisions to implement gap plan options should be based on local fiscal and workforce management considerations, which will vary tremendously from group to group. These products are widely available in the open market. Individual groups can easily purchase these plans on their own without increasing the TLC administrative costs.

Regional Plans

The lack of regional alternatives to the statewide Anthem plans was noted in one session.

Outside of the Kaiser Health Plan in Northern Virginia, there are no other regional plans offered by TLC. Generally, competition leads to enhanced program and benefit plan design and to improved pricing. Regional carriers/health plans are eligible to participate in TLC competitive bids, but the response over recent bid cycles has been minimal and uncompetitive. Regional carriers often offer fully-insured, for-profit plans, which are frequently more expensive than TLC options. In this environment, some carriers may anticipate that relatively few TLC participants would elect their plan, and therefore choose not to submit a bid.

Recommendation 6

DHRM recommends that it inform regional plans of the opportunity during the next TLC procurement process.

Plan Provisions

In two sessions, participants discussed the possibility of adding coverage for hearing aids and excluding laboratory charges from the deductibles.

Changing these provisions is not seen as something that would either fuel or prohibit TLC member growth. However, these changes would, to some extent, increase the TLC plan's risk of exposure to the ACA excise tax.

Recommendation 7

DHRM recommends no change to current plan provisions regarding hearing aids and laboratory charges, meaning that TLC should not include coverage for hearing aids and should continue to include laboratory charges in deductible requirements.

Retiree Plans

Retiree plans were discussed at one meeting. Participants identified two areas of interest: a separate plan for retirees who were not eligible for Medicare and a desire for prescription drug coverage through Advantage 65, TLC's retiree Medicare supplemental plan.

Separate Plan for Retirees not Eligible for Medicare

In one session, participants discussed whether a separate plan could be implemented to provide coverage for non-Medicare retirees only.

This separate plan for retirees not eligible for Medicare would be available from a participant's retirement date until Medicare eligibility is reached. Because of the high degree of risk involved, the separate plan would need to be fully insured.

This type of plan is seldom offered in the commercial market, because it is generally cost prohibitive. This would be true for a separate non-Medicare retiree plan for the current TLC group. Claim costs for these retirees in the TLC population are 1.85 times those for active employees. This is consistent with recent industry and TLC-specific actuarial studies, which generally find the claim cost for non-Medicare-eligible retirees to be approximately twice the active employee claim cost.

All participating TLC groups may currently offer non-Medicare retiree coverage. Groups with fewer than 50 employees may offer only on a blended rate basis and larger groups have a choice of either a blended or stand-alone rate. When groups choose the higher cost stand-alone rate, it increases their exposure to adverse selection, because the retirees who would find this coverage attractive would be those most likely to incur high claims.

As a result of the higher costs, it is necessary for TLC to increase premiums if coverage for non-Medicare retirees is selected. Currently, the blended rate increases all premiums for active employees and non-Medicare retirees by 2% over the discrete active premium rate. The stand-alone rate does not materially affect active employee rates. Instead, it charges non-Medicare retirees approximately twice the active premium rate for the same coverage.

Recommendation 8

DHRM recommends maintaining the current TLC coverage options for retirees not eligible for Medicare, which do not include a separate plan.

A separate plan would be cost prohibitive and unpopular.

Prescription Drug Coverage for Medicare Retirees

Participants at one meeting discussed the possibility of adding prescription drug coverage to the retiree Medicare supplemental plan, Advantage 65.

Primary interest in this concept came from groups located in Northern Virginia who were more familiar with the Kaiser Medicare Advantage Health Maintenance Organization (HMO) plan. This plan is already available to Kaiser TLC retiree participants outside of the TLC Program. Since this is a Medicare Advantage Plan, it does not coordinate with any Medicare-primary (Medicare retiree) plan options offered by DHRM to either TLC or state program participants.

TLC groups that offer coverage to non-Medicare retirees may also elect to provide coverage to their Medicare retirees, with no required employer contribution. Currently, this Medicare supplemental product includes coverage secondary to Medicare Parts A (hospital) and B (medical). Since the introduction of Medicare Part D (outpatient prescription drug coverage) in 2006, TLC has not offered prescription drug coverage to Medicare-eligible retirees.

Medicare Part D coverage offered through group plans is governed by Medicare. This creates many administrative issues in ensuring that Medicare's oversight is reflected in the plans' eligibility. This usually requires administration by a Pharmacy Benefits Manager, which communicates with Medicare and then reports back to individual groups to update their eligibility systems. This can be a complex process requiring manual intervention. For TLC, with 340 participating employer groups, it is anticipated that the difficulty would be greatly increased. This would require significant additional TLC administrative staffing with associated costs.

In addition, due to TLC's relatively small size, compared to some national plans, and high-cost Medicare population, TLC's Medicare Part D premium would be higher than many available to all Medicare beneficiaries through Medicare.gov. Since the introduction of Medicare Part D, there have been many and varying Part D choices available to all Medicare beneficiaries—generally around 50 drug plans, not including Medicare Advantage options. Other than the perception that it is more convenient, administration by TLC is not likely the most cost effective solution for this population.

Recommendation 9

DHRM recommends maintaining the current TLC Medicare retiree offerings, which do not include coverage for Medicare Part D.

Administration

Participants referenced TLC administration at every meeting. Discussions involved the following five topics: the TLC program manager, the Public Health Service Act extended coverage administration, a TLC shared service center, utilization reporting, and eligibility and enrollment.

TLC Program Manager

At every meeting, TLC participants expressed great appreciation for the TLC program manager. The current program manager has held this position for 16 years and has close relationships with participating groups. As described by attendees, he is called upon frequently to provide guidance regarding the TLC Program, as well as other legislative requirements associated with health plans. Participants indicated

their appreciation for his knowledge and assistance, and consider him to be an invaluable resource. Also, TLC participants generally expressed overall satisfaction with TLC administration. The high level of this satisfaction is evidenced by the 99% TLC group retention rate.

Public Health Service Act Extended Coverage (Similar to Consolidated Omnibus Budget Reconciliation Act—COBRA) Administration

At two meetings, participants requested that TLC administer extended coverage.

TLC currently provides groups with the tools to administer extended coverage by making available notice formats that comply with Department of Labor standards. Differences in TLC plan options among 340 groups and billing mechanisms (direct versus group billing) present many specific challenges to centralized administration of extended coverage, even after initial enrollment, and would require a great deal of additional staffing to accomplish. This would be cost prohibitive.

Recommendation 10

DHRM recommends maintaining the current process for TLC extended coverage, in which each group administers its own extended coverage.

Recommendation 11

DHRM recommends that TLC implement extended coverage training sessions for TLC group benefits administrators.

This will improve the extended coverage process by enhancing the existing administrative support provided by TLC.

Shared Service Center

At all sessions, attendees were asked by the meeting facilitator whether they would be interested in access to a shared service center that would provide administrative support related to their TLC health plan coverage. It was noted that there would be some additional cost for this service. Some attendees expressed interest, but were concerned about any associated cost.

Recommendation 12

DHRM recommends that additional cost and benefit analysis be conducted before further consideration is given to designing and implementing a TLC shared service center.

The value of, cost for, and level of interest by groups in this type of service is unclear at this time.

Utilization Reporting

Participants at two sessions expressed interest in receiving group specific and overall TLC utilization results.

Utilization reporting could provide useful information from which to develop effective communication strategies to drive change toward healthier behaviors.

Recommendation 13

DHRM will provide additional utilization reporting to TLC groups.

DHRM will work with TLC's third party administrators to determine what additional data can be captured and reported to TLC entities. Changes to the report package will be communicated to TLC participants.

Eligibility and Enrollment

Participants at two meetings asked when TLC's planned improvements to its eligibility system will be implemented.

These planned improvements will allow TLC group benefits administrators access to the eligibility system in February 2016, and will eventually allow TLC employees to make elections directly through a self-service portal. TLC employees will not be able to make elections directly until after DHRM completes an ongoing project to migrate its Personnel Management Information System from a Unisys mainframe to a server environment. This migration is scheduled to be completed in June 2016.

Recommendation 14

DHRM will complete enhancements allowing TLC benefits administrators access to the eligibility system by the end of February 2016 and allowing employees to make elections directly after June 2016.

Underwriting

At almost every meeting, participants discussed underwriting. The following eight topics were raised: benefit plan packaging and bundling, premium rate development, contribution levels and minimum participation requirements, limiting spousal coverage, adverse experience adjustment (AEA) protection, rate tier alternatives, stop loss coverage and small group options.

TLC operates under a complex set of guidelines based upon actuarial and underwriting principles and pooling practices designed to ensure its fiscal viability. The majority of these are in place to address the phenomena of "adverse selection."

At the individual level, adverse selection occurs when plan provisions do not properly control eligibility for the plan. If limitations are not put in place to mitigate adverse selection, participants can enroll when they need coverage and disenroll when they are healthy, thereby creating a population of only unhealthy participants. This results in the need for an expensive and potentially unsustainable premium in order to fund the high health care costs of the plan.

In TLC's multiple employer plan context, adverse selection occurs when groups are able to leave and rejoin the plan with no accountability for a prior deficit position.

Successful large self-insured plans establish underwriting rules to incent long term participation, which reduces the risk of adverse selection. For a statewide local employer choice plan like TLC, it is critical to implement specific underwriting rules to ensure sustainability and financial viability.

Multiple employer plans that deviate from this approach typically become fiscally unsound and fail. A fundamental reason for TLC's longevity and success is its adherence to critical underwriting principles.

Benefit Plan Packaging and Bundling

Participants at five sessions discussed unbundling medical, dental and vision plans.

Currently, the TLC premium covers the cost of bundled medical, dental and vision benefits. This bundled approach is a safeguard against adverse selection by spreading the risk over the entire group, which is consistent with sound underwriting practices. Bundling ensures a higher level of enrollment and more competitive administrative costs from the third party administrators.

For example, if vision benefits were unbundled, it is certain that participants with vision assistance needs will select them. Subsequent premiums will need to be adjusted to match the higher risk, thereby making the coverage unaffordable and less attractive.

Conversely, to reduce their overall benefit cost, employers are increasingly offering ancillary benefit plans like dental or vision on an unbundled basis, with different levels of subsidy. In some cases, these are offered on a voluntary, or "employee pay all" basis, which shift the cost to participants. To meet the market demand, but limit the impact of adverse selection, insurance carriers have imposed minimum participation levels for these unbundled plans. Participation requirements vary, but typically range between 25% and 50% of eligible employees participating in the medical plan.

Recommendation 15

DHRM recommends that at the next scheduled procurement, DHRM will solicit bids for a second tier of coverage options to include an unbundled approach, and subsequently implement an option to include unbundling if it is found to be practical.

The first package of coverage options in the procurement should include the current bundled grouping of medical, dental and vision plans. The second package should offer unbundled dental and vision plans. The stand-alone dental and vision premium costs are typically higher than similar benefits under a bundled program. However, the opportunity to participate only in TLC medical benefits could be attractive to entities not currently offering dental and vision benefits. If priced appropriately, this would not impact the fiscal soundness of the TLC program and may attract additional groups and maintain current high retention levels. Deferring to the next scheduled procurement would not jeopardize existing contracts, would provide appropriate lead time to alter current vendor systems and would allow adequate time to evaluate all options and interested vendors. If it were found to be impractical, unbundling would not be implemented.

Premium Rate Development

Participants at two meetings asked how TLC premium rates are developed.

Underwriting guidelines are used in premium development to institute a regimen of consistency and protection against adverse selection. Consequently, they provide the foundation for overall lower premium levels; opportunity for membership growth; and persistency, which is the percentage of groups that annually renew.

To address TLC premium rate development, it is necessary to understand the following variables: Credibility/Claim Experience, Retention (Administrative Expense), Commissions, Participation Requirements and TLC Underwriting Outcomes.

Credibility/Claim Experience

For groups with less than 300 eligible employees, both TLC and insurance companies use a blend of actual account specific claim experience and a manual pooled rate to develop premium rates. As the employee size of the group increases, so does the credibility or reliability of the group's claim experience. Claim volatility is greater with smaller groups, which is tempered by the blending of actual claim experience and insurance pool rates.

TLC credibility tables and blended rate usage are consistent with insurance company standards. In addition, TLC does not adjust rates for tobacco usage, which is more favorable to premium rate setting for prospective and incumbent TLC groups.

Retention (Administrative Expense)

According to ACA requirements, administrative expense levels are to be capped for fully-insured premium rates. For groups with less than 100 eligible employees, administrative expense levels cannot exceed 20% of the total premium. This means that 80% of the premium is to be used for claim payment. TLC is self-insured, except for the Kaiser HMO. TLC uses a much smaller retention level, currently approximately 6%, in its rate setting process, leaving approximately 94% of TLC premium for claim payments. This results in more favorable rates for TLC entities in most competitive marketing situations.

Commissions

Insurance carriers build a commission (e.g., a broker's fee) into their small business rates, which is generally between 3—5%. Since TLC does not pay a commission, it provides an automatic 3—5% savings, resulting in lower costs to groups and participants.

Participation Requirements

Participation requirements can vary by plan. They are implemented to create a reasonable mix of insurance risk in every group, reducing adverse selection. Without minimum participation requirements, there is a greater risk that more unhealthy than healthy employees will enroll. This would result in premium levels that are insufficient to cover costs. Contribution levels and minimum participation requirements are also underwriting standards that were discussed by participants and will be addressed more fully later in the report.

TLC Underwriting Outcomes

The low annual premium rate increases, persistency and new business close rates are clear indicators that TLC is an extremely attractive offering in Virginia, particularly in the small and medium group marketplace.

Insurance carriers generally set a target persistency rate of 85—92% of their book of business. Historically, TLC's persistency rates have averaged 99%, significantly exceeding industry goals.

Annual industry rate increases for small businesses have ranged between 8—10% over the past five years, which is an average of approximately 70% higher than the TLC premium adjustments. TLC rate increases over the past five years have averaged 5.3%.

TLC has consistently had excellent results in closing new business. Insurance companies typically have a goal of closing approximately 10% of new business quotes. TLC closed 32% during the past year, which beat the typical industry-wide goal by 320%.

Recommendation 16

DHRM recommends that TLC provide ongoing education to current and prospective groups on TLC premium rate development.

Contribution Levels and Minimum Participation Requirements

At almost all the meetings, participants asked about the possibility of relaxing current minimum employer contributions and participation requirements.

Current TLC regulations require a minimum of 80% employer subsidy of employee-only cost. In addition, unless 75% of eligible employees participate, employers must make a 20% minimum contribution toward dependent costs.

These levels were established to ensure an appropriate mix of insurance risk to mitigate the effect of adverse selection. Based on TLC financial and participation results, they have been effective.

The current rules can be especially costly to organizations in certain circumstances. Spouses who are enrolled in another employer's plan are, in general, included in the eligibility count when calculating the participation rate. For some groups, satisfying this requirement has become problematic.

The most dramatic TLC example involved a participating southwestern Virginia school system with over 300 employees. It had a large number of employees whose spouses covered them through their own employer's plan and, consequently, had waived TLC coverage. By including all in the eligibility calculation, the entity did not meet the 75% minimum participation level. If entities fail to meet the 75% participation threshold, TLC underwriting mandates a minimum employer contribution for dependents of 20%. For this school group, the 20% requirement would increase the employer's costs by over $200,000. If excluding spouses enrolled in another TLC group's plan or the state plan from the calculation were permitted, this group would have met the participation requirement and avoided the additional contribution requirement.

Recommendation 17

DHRM recommends implementing the following requirements in FY 2018:

- *Reduce the minimum 80% employer contributions to employee only coverage to 70%. This relaxation will provide relief, but still provide protection against an adverse impact upon financial results.*

- *Maintain the 75% of eligible employees' participation level, but exclude those participating in other TLC or state employee plans from the participation percentage calculation.*

- *Modify the Virginia Administrative Code as necessary.*

This solution cannot be extended to non-TLC, non-State Employee Health Benefits Program participants because there is no reliable method to verify enrollment.

Limiting Spousal Coverage

The topic of limiting spousal coverage was mentioned during four of the meetings and is related to "Contribution Levels and Minimum Participation Requirements."

There is a growing trend for employers to limit coverage, or require higher contributions, for working spouses who have available health coverage under another plan. Recently, some employers, including the University of Virginia, have eliminated coverage for working spouses covered by their employers' plans.

Although limiting or eliminating spousal coverage may be a source of cost savings, it will be a likely source of participant dissatisfaction. Some TLC groups appear willing to consider limiting spousal coverage or require higher contributions for spouses as a cost-saving measure, while others are not.

Providing individual TLC groups with the eligibility option to limit spousal coverage will accommodate a wider market. TLC could not implement higher contributions for spouses until after the next procurement.

Recommendation 18

DHRM recommends that individual groups be permitted to limit spousal coverage for their employees.

Recommendation 19

DHRM recommends that individual groups be allowed to require higher contributions for working spouses beginning after the next procurement ends, assuming that the successful bidder is capable of administering this function.

Because some groups are unlikely to favor this approach, whether to implement a surcharge for spousal coverage will also be a choice for individual groups.

Adverse Experience Adjustment (AEA) Protection

Participants asked questions to better understand the AEA provisions at two meetings.

Since the TLC program is self-funded, it is necessary to protect participating groups from losses related to another participating employer leaving the program in a deficit position. To provide this protection, TLC imposes an AEA when it is warranted.

Only terminating groups are subject to AEA and no adjustment is applied if no deficit exists. The end result is that no participating group will be penalized for losses created by a terminating group. Because of this, the AEA provides a competitive advantage to the TLC program.

For a withdrawing group with over 300 employees, the AEA is equal to the actual employer losses for the immediate past plan year. For groups smaller than 300 employees, the AEA is based on the group's percent of participation in the pool applied to any total pool losses for the immediate past plan year.

The AEA has been applied only 20 times in the 25-year history of TLC.

Recommendation 20

DHRM recommends that the Adverse Experience Adjustment (AEA) protection be maintained without modification.

Rate Tier Alternatives

At almost every session, participants discussed increasing the number of rate tiers.

Currently, TLC offers a three tier rate structure—Single, or Employee-Only; Dual, or Employee plus one dependent; and, Family, or Employee plus two or more eligible dependents.

Offering additional rate tiers will not affect the overall total cost, and the use of four or five tier structures is common in the marketplace. By stratifying costs according to a larger and more defined set of tiers, the pricing becomes more precise as it more closely aligns actual cost with the risk level. For example, the Dual tier could be expanded to Employee plus Spouse and Employee plus one Child. Likewise, the Family tier could be expanded to Employee plus Spouse and one or more Child(ren) and Employee plus two or more Children.

if the number of tiers are increased, some participants will see a premium increase, causing abrasion, and some will see a premium decrease. For example, if the Dual tier is split into two tiers, Employee plus Spouse will experience a higher premium, while Employee plus one Child will have a lower premium.

Recommendation 21

DHRM recommends having the actuaries develop an alternate rate structure for review.

If a decision is made to implement a new structure, it would be effective in Fiscal Year 2019, due to the intensive education and programming changes that would be required.

If any changes are to be adopted, amendment of the Code of Virginia and the Virginia Administrative Code will be required to permit expansion of the Employee, Dual and Employee and Family rate tiers to include additional dependent tiers.

Stop Loss Coverage

Stop Loss coverage was mentioned at one meeting in only a “how does it work” context. Generally, TLC participants were satisfied with the levels of protection and found the annual renewal changes to be reasonable.

This provision protects the experience of participating groups by limiting the amount individual catastrophic claims impact a group’s rate setting. Stop loss protection is provided for TLC participating groups, and attachment points, which are where stop loss protection begins, are based upon entity enrollment size. For example, groups with less than 300 covered employee lives have a $90,000 attachment point while larger groups with 1,500 covered employee lives have an attachment point of $175,000.

Attachment points are reviewed annually. TLC stop loss levels were developed in accordance with sound industry practices and pooling levels are appropriate and competitive based upon current individual entity size.

Recommendation 22

DHRM recommends educating groups on the annual review process of stop loss levels.

Small Group Options

The topic of allowing more than one plan option for groups of 25 employees or less was mentioned at one of the sessions. Generally, small-group meeting participants were satisfied with the current offerings.

All TLC groups select from the same plan menu consisting of four self-funded Key Advantage plans and a High Deductible Health Plan. Groups in Northern Virginia also have access to a fully-insured regional HMO underwritten by Kaiser Permanente. Employees in each self-funded plan also select either comprehensive dental or only diagnostic and preventive dental. Groups with 25 or less employees are currently limited to one benefit plan selection.

Offering additional plans to smaller groups could increase the opportunity for adverse selection because it increases the risk of self- interest selection over a very small population. Therefore, many carriers are reluctant to offer multiple plan choices to smaller groups.

In the market, the ability to offer more options for small groups is limited. It is difficult to determine the degree to which restricting the number of options for groups with 25 or less employees may deter small group TLC growth.

Recommendation 23

DHRM recommends applying the one-plan restriction to groups of 15 or fewer employees, which is lower than the current threshold of 25 or fewer employees.

This change is recommended in an effort to increase the attractiveness of the program to small groups. Groups with more than 15 employees will be allowed to elect at least two plans.

Participant Education and Feedback Opportunities

Participants at several meetings expressed interest in implementing opportunities to provide feedback about the TLC program.

Several options were discussed, including the establishment of a rotating advisory council comprised of human resource individuals from participating TLC entities, increasing non-TLC group participation at the annual TLC regional review meetings held each spring, and employing a survey to capture feedback.

Attendees were informed of the past and present methods used to garner feedback:

- **Advisory Board:** TLC has implemented advisory councils in the past with mixed results. They have not proven to be an effective feedback mechanism, because of the need to balance a manageable group size with representation of over 300 localities with a variety of statewide needs.

- **Surveys:** Surveys can provide useful feedback, but they are limited by responder interest and knowledge of the TLC program.

- **Annual forum**: The annual open forum TLC regional review meetings are well attended by TLC and non-TLC groups, and provide opportunity for two-way communication. Encouraging even greater attendance at the open forum may be an efficient way to further capitalize on an already productive practice. It appears that this setting would be the most effective means of offering stakeholders the opportunity to provide feedback.

Recommendation 24

DHRM recommends marketing the opportunity for feedback at the annual open forum TLC regional review meetings to encourage attendance.

Encouragement from the General Assembly and local entity stakeholders could also help to drive increased participation.

Purpose of Actuarial Study

A participant in one location asked whether responding to the data request for the actuarial portion of this study would result in an unsolicited bid from TLC.

TLC leadership reiterated that the mandated study had two purposes:

- To evaluate ways to improve TLC attractiveness for growth and retention purposes, and

- To determine the feasibility of a statewide insurance pool for multiple employer groups, either as a separate pool or part of the State Employee Health Benefits Program.

Meeting attendees were informed that TLC would welcome the opportunity to develop quotes for non-TLC groups, but would only do so after a request had been received.

Recommendation 25

DHRM recommends maintaining the current quote practice, which is to only provide quotes to groups that explicitly request them.

.

Wellness

At almost every meeting, participants expressed considerable interest in developing wellness programs under the TLC structure. Three specific topics were discussed: member engagement incentives, discount programs and Value-Based Insurance Design (VBID) programs.

Member Engagement Incentives

Creating incentives to drive member engagement was discussed in six meetings. Under this concept, members would receive cash incentives for completing specific tasks. Common examples include

providing incentives for members who complete health risk assessments, obtain annual physicals and participate in biometric screenings. All of these activities enhance members' understanding of their own health status, an important factor in promoting greater member accountability for their own health.

Prior to the implementation of an incentive program, significant thought must be given to selecting what behaviors and/or activities will result in a reward, and this thought should be based on the individual employer's circumstances.

Wellness programs have inherent up-front costs and results are not immediately realized, but are achieved over time. The typical wellness program has goals to drive employee accountability and behavior change, with measurable results emerging three to five years post-implementation.

Because of these dynamics, implementation of these programs is problematic for a multiple employer plan like TLC. In the short run, employer costs will increase, with the hope that they will go down over time as the health of participants improves. Groups may leave the TLC program at any time, and this could skew the results of member engagement incentives, and make it impossible to determine return on investment. As such, these incentives are better suited for single employer plans.

Recommendation 26

DHRM recommends allowing individual groups to implement their own incentive programs apart from TLC.

Discount Programs

Discount programs were discussed at one meeting. Participants wanted discounts for health-related services and activities, such as gym memberships.

Currently, the CommonHealth Program offers discounts for such things as gym memberships. In addition, insurance carriers or total population health management companies usually have discount programs as part of their product portfolios. These arrangements can be explored with current benefit plan administrators for potential access by TLC members.

Recommendation 27

DHRM recommends continuing the current CommonHealth discount program, and working with current vendor partners to communicate available discount programs to TLC groups and participants.

VBID (Value Base Incentive Design) Programs

VBID programs were discussed at two meetings.

VBID programs are designed to help improve health, lower long term costs and increase treatment compliance, by reducing employee costs for drugs, supplies, and services used to treat specific health conditions, such as diabetes. The concept is to increase compliance with recommended treatment regimens for specific conditions by reducing co-pays or other participant out-of-pocket costs for drugs and supplies.

It takes three to five years to assess whether a VBID program leads to improved aggregate health and reduced costs. Since VBID programs should consistently increase treatment compliance, they have excellent potential for direct and positive impact.

Recommendation 28

DHRM recommends implementing a pilot TLC diabetes VBID program in FY 2018.

A pilot VBID program should be attractive to groups that are considering TLC. Diabetes is alarmingly prevalent throughout Virginia and the United States. Because of its negative impact on population health and health plan costs, It is the appropriate disease state to address through this program. DHRM will develop the program and educate groups on its new benefit provision. This program will be closely monitored in subsequent plan years to determine its effectiveness and potential for further expansion.

SECTION C

APPENDIX

APPENDIX A

Entities Used in the Study

Accomack County
Albemarle Co Service Authority
Albemarle County
Albemarle County Schools
Alexandria City Schools
Alexandria Renew Enterprises
Alleghany County
Alleghany County School Board
Amherst County
Amherst County Service Authority
Appomattox County
Appomattox County Schools
Arlington County
Arlington County Schools
Assistive Technology Loan Fund Authority
Augusta County Schools
Bath County
Bath County Schools
Bedford County
Bedford County Schools
Big Stone Gap Redevelopment & Housing Authority
Blacksburg VPI Sanitation Authority
Bland County
Blue Ridge Behavioral Healthcare
Blue Ridge Regional Jail
Botetourt County Schools
Bristol City Schools
Brunswick County
Buchanan County Schools
Buckingham County
Campbell County
Campbell County Schools
Caroline County
Caroline County Schools
Carroll County
Carroll County Schools
Charles City Schools County Schools
Charlottesville City Schools
Chesapeake City Schools
Chesterfield County
Chesterfield County Schools
City of Alexandria
City of Bristol
City of Buena Vista
City of Charlottesville
City of Chesapeake
City of Colonial Heights
City of Covington
City of Danville
City of Emporia
City of Fairfax
City of Falls Church
City of Franklin
City of Fredericksburg
City of Galax
City of Hampton
City of Harrisonburg
City of Hopewell
City of Manassas
City of Manassas Park
City of Martinsville
City of Newport News
City of Norfolk
City of Norton
City of Petersburg
City of Poquoson
City of Portsmouth
City of Radford
City of Richmond
City of Roanoke
City of Staunton
City of Suffolk
City of Virginia Beach
City of Waynesboro
City of Williamsburg
City of Winchester
Clarke County
Clarke County Schools
Colonial Beach
Colonial Heights City Schools
Covington City Schools
Craig County
Culpeper County
Culpeper County Schools

APPENDIX A (Continued)

Entities Used in the Study (Continued)

Cumberland County
Cumberland County Schools
Danville City Schools
Dickenson County Schools
Dinwiddie County
District 19 Community Services
District Three Governmental Cooperative
Essex County
Essex County Schools
Fairfax County
Falls Church City Schools
Fauquier County Schools
Floyd County
Floyd County Schools
Fluvanna County
Franklin City Schools
Franklin County
Frederick County
Frederick County Schools
Fredericksburg City Schools
Galax City Schools
Giles County Schools
Gloucester County
Gloucester County Schools
Goochland County
Goochland County Schools
Goochland County Social Services
Grayson County School Board
Greene County
Greene County Schools
Greensville County
Greensville County Schools
Greensville County Water and Sewer Authority
Greensville-Emporia Department of Social Services
Halifax County
Halifax County Schools
Hampton City Schools
Hampton Roads Planning District Commission
Hanover County
Hanover County Schools
Harrisonburg City Schools
Harrisonburg-Rockingham Regional Sewer Authority
Henrico County
Henrico County Schools
Henry County
Henry County Schools
Henry County Service Authority
Highland County
Highlands Community Services
Hopewell City Schools
Hopewell Redevelopment & Housing Authority
Jackson River Technical Ctr
James City County
James City Schools County Schools
King George County
King George County Schools
King William County
Loudoun County
Loudoun County Schools
Louisa County
Louisa County Schools
Madison County
Madison County Schools
Manassas City Schools
Manassas Park City Schools
Marion Redevelopment & Housing Authority
Martinsville City Schools
Mathews County
Mathews County Schools
Middle Peninsula Planning District Commission
Middle Peninsula Regional Security Center
Middle Peninsula-Northern Neck Community Services
Middlesex County
Monacan Soil & Water Conservation District
Montgomery County
Montgomery County Schools
Montgomery Regional Solid Waste Authority
Nelson County
Nelson County Schools
New Kent County
New Kent County Schools
Newport News City Schools
Norfolk City Schools
Northampton County

APPENDIX A (Continued)

Entities Used in the Study (Continued)

Northampton County Schools
Northern Neck Planning District Commission
Northern Neck Soil & Water Conservation District
Northern Shenandoah Valley Regional Commission
Northumberland County
Northumberland County Schools
Norton City Schools
Orange County
Orange County Schools
Page County
Page County Schools
Pamunkey Regional Jail
Pamunkey Regional Library
Patrick County
Patrick County Schools
Petersburg City Schools
Piedmont Alcohol Safety Action Program
Piedmont Regional Juvenile Detention Center
Pittsylvania Co Svc Authority
Pittsylvania County
Pittsylvania County Schools
Powhatan County
Powhatan County Schools
Prince Edward County
Prince Edward County Schools
Prince George County
Prince George County Schools
Prince William County
Prince William County Schools
Prince William County Service Authority
Pulaski County
Radford City Schools
Rappahannock Area Comm Svcs
Rappahannock County
Rappahannock County Schools
Richmond City Schools
Richmond County
Riverside Regional Jail
Roanoke City Schools
Roanoke County
Roanoke County Schools
Roanoke Higher Education Authority
Roanoke River Service Authority
Rockbridge County
Rockingham County
Rockingham County Schools
Russell County Schools
Salem City Schools
Scott County
Scott County Schools
Scott County Soil & Water Conservation District
Shenandoah County
Shenandoah County Schools
Shenandoah Valley Juvenile Center
Smyth County Schools
Southampton County
Southampton County Schools
Spotsylvania County Schools
Stafford County
Stafford County Schools
Staunton City Schools
Suffolk City Schools
Surry County
Surry County Schools
Sussex County
Sussex County Schools
Tazewell County
Tazewell County - Service Authority
Tazewell County Schools
Three Rivers Soil & Water Conservation District
Tidewater Soil & Water Conservation District
Town of Abingdon
Town of Appomattox
Town of Ashland
Town of Bedford
Town of Berryville
Town of Blacksburg
Town of Blackstone
Town of Bluefield
Town of Boones Mill
Town of Boydton
Town of Broadway
Town of Burkeville
Town of Cedar Bluff

APPENDIX A (Continued)

Entities Used in the Study (Continued)

Town of Chase City
Town of Clarksville
Town of Clifton Forge
Town of Clintwood
Town of Coeburn
Town of Colonial Beach
Town of Courtland
Town of Culpeper
Town of Damascus
Town of Dayton
Town of Dublin
Town of Dumfries
Town of Edinburg
Town of Farmville
Town of Floyd
Town of Front Royal
Town of Gate City
Town of Glade Spring
Town of Gretna
Town of Grottoes
Town of Halifax
Town of Hamilton
Town of Haymarket
Town of Haysi
Town of Herndon
Town of Hillsville
Town of Kenbridge
Town of Kilmarnock
Town of La Crosse
Town of Lawrenceville
Town of Lebanon
Town of Leesburg
Town of Lovettsville
Town of Luray
Town of Marion
Town of McKenney
Town of Middleburg
Town of Mineral
Town of Montross
Town of Mount Jackson
Town of Narrows
Town of New Market
Town of Newsoms
Town of Orange
Town of Pearisburg
Town of Pembroke
Town of Pulaski
Town of Rich Creek
Town of Richlands
Town of Rocky Mount
Town of Round Hill
Town of Saint Paul
Town of Saltville
Town of Shenandoah
Town of South Boston
Town of South Hill
Town of Stanley
Town of Strasburg
Town of Tappahannock
Town of Tazewell
Town of Timberville
Town of Victoria
Town of Vienna
Town of Vinton
Town of Wakefield
Town of Warsaw
Town of Waverly
Town of Windsor
Town of Wise
Town of Woodstock
Town of Wytheville
Valley Community Services Bd
Virginia Beach City Schools
Warren County
Washington County Schools
Waynesboro City Schools
Westmoreland County
Williamsburg-James City Schools County Schools
Winchester City Schools
Wise County
Wythe County
Wythe County Schools
York County
York County Schools

APPENDIX A (Continued)

Entities With Some Data, Not Included in Study

Amelia County
Amelia County Schools
Amherst County Schools
Appalachian Juvenile Commission
Appomattox Regional Library System
Augusta County
Augusta County Public Service Auth
Bedford Regional Water Authority
Big Sandy Soil & Water Conservation District
Bland County Schools
Botetourt County
Bristol Redevelopment & Housing Authority
Bristol Virginia Utility Authority
Brunswick County Schools
Buckingham County Schools
Center for Innovative Technology
Central Shenandoah Planning District Commission
Central Virginia Alcohol Safety Action Program
Central Virginia Regional Jail
Central Virginia Waste Management Authority
Charlottesville-Albemarle Airport Authority
Chesapeake Redevelopment & Housing Authority
City of Lexington
City of Lynchburg
Clinch Valley Soil & Water Conservation District
Coeburn-Norton-Wise Regional Waste Water Trtmnt Auth
Craig County Schools
Craig-New Castle Public Service Authority
Crater District Area Agency on Aging
Crater Planning District Commission
Crater Youth Care Commission
Cumberland Mountain Community Services
Dan River Alcohol Safety Action Program
Danville Redevelopment & Housing Authority
Dickenson County
Dickenson County Department of Social Services
Dinwiddie County Water Authority
Eastern Shore Community Services
Fauquier County
Fluvanna County Schools
Franklin County Schools
Franklin Redevelopment and Housing Authority
Front Royal-Warren County Industrial Dev Auth
Giles County
Halifax County Service Authority
Hampton Redevelopment & Housing Authority
Hampton Roads Regional Jail
Handley Regional Library
Henricopolis Soil & Water Conservation District
Highland County Schools
Holston River Soil & Water Conservation District
Interstate Mining Compact Commission
Isle of Wight County
Isle of Wight County Schools
James River Soil & Water Conservation District
John Flannagan Water Authority
King and Queen County
King William County Schools
Lake Barcroft Watershed Improvement District
Lancaster County
Lancaster County Schools
Lee County
Lee County Department of Social Services
Lee County Public Service Authority
Lee County Redevelopment & Housing Authority
Lenowisco Planning District Commission
Lexington City Schools
Lonesome Pine Regional Library
Lunenburg County
Lunenburg County Schools
Lynchburg City Schools
Maggie Walker Governor's Sch For Govt/int'l Study
Massanutten Regional Library
Mecklenburg County
Mecklenburg County Schools
Middlesex County Schools
Mount Rogers Planning District Commission
New River Resource Authority
New River Soil & Water Conservation District
New River Valley Agency on Aging
New River Valley Community Services
New River Valley Juvenile Detention Home
New River Valley Planning District Commission
New River Valley Regional Jail

APPENDIX A (Continued)

Entities With Some Data, Not Included in Study (Continued)

Northern Neck Reg Voc Ctr
Northern Neck Regional Jail
Northern VA Transportation Authority
Nottoway County Schools
Peanut Soil & Water Conservation District
Pepper's Ferry Wastewater Treatment Authority
Peter Francisco Soil & Water Conservation District
Petersburg Redevelopment & Housing Authority
Peumansend Creek Regional Jail
Piedmont Regional Jail
Planning District One Behavioral Health Services
Poquoson City Schools
Portsmouth Redevelopment Housing
Prince William Soil & Water Conservation District
Pulaski County Schools
Rappahannock - Rapidan Regional Commission
Rappahannock Area Youth Srvs & Grp Home Comm
Rappahannock Juvenile Center
Region Ten Community Services Board
Richmond County Schools
Richmond Regional Planning District Commission
Roanoke Redevelopment & Housing Authority
Roanoke Valley - Alleghany Regional Commission
Rockbridge County Schools
RSW Regional Jail
Smith River Sports Complex
Smyth County
South Central Wastewater Authority
Southeastern Public Service Authority
Southside Community Services
Southside Planning District Commission
Southside Regional Jail Authority
Southwest Regional Recreation Authority
Southwest Virginia Regional Jail Authority
Spotsylvania County
Suffolk Redevelopment Housing Authority
Sussex Service Authority
Tazewell County Department of Social Services
Thomas Jefferson Planning District Commission
Thomas Jefferson Soil & Water Conservation District
Tidewater Youth Services Commission
Town of Altavista
Town of Amherst
Town of Appalachia
Town of Big Stone Gap
Town of Bowling Green
Town of Bridgewater
Town of Brookneal
Town of Buchanan
Town of Cape Charles
Town of Chatham
Town of Chilhowie
Town of Chincoteague
Town of Christiansburg
Town of Crewe
Town of Elkton
Town of Exmore
Town of Gordonsville
Town of Goshen
Town of Grundy
Town of Honaker
Town of Hurt
Town of Independence
Town of Independence
Town of Iron Gate
Town of Jarratt
Town of Jonesville
Town of Keysville
Town of Louisa
Town of Middletown
Town of Onancock
Town of Parksley
Town of Pennington Gap
Town of Purcellville
Town of Quantico
Town of Remington
Town of Scottsville
Town of Smithfield
Town of Stephens City
Town of Urbanna
Town of Warrenton
Town of Washington
Town of West Point
Tri-County/City Soil & Water Conservation District

APPENDIX A (Continued)

Entities With Some Data, Not Included in Study (Continued)

Upper Occoquan Service Authority
Virginia Biotechnology Research Park Authority
Virginia Coalfield Economic Development Authority
Virginia Peninsulas Public Service Authority
Virginia Resources Authority
Virginia's Region Local Government Council
Warren County Schools
Washington County
Waynesboro Redevelopment & Housing Authority
West Piedmont Planning District Commission
Western Tidewater Community Services
Western Tidewater Regional Jail
Western Virginia Water Authority
Westmoreland County Schools
Wise County Schools
Wytheville Redevelopment & Housing Authority

APPENDIX A (Continued)

Entities With No Data Submission

Accomack County Schools
Accomack/northampton Plan
Alexandria Red/hous Auth
Alleghany Highlands Comm Svcs
Amelia-Nottoway Technical Center
Anchor Commission
Appomattox River Water Auth
Bedford Public Library
Big Walker Soil & Water Conservation District
Brunswick Industrial Development Authority
Buchanan County
Buena Vista City Schools
Campbell Co Utilities & Svcs
Capital Region Airport Comm
Castlewood Water And Sewage Authority
Central Rappahannock Regional Library
Charles City County
Charlotte County
Charlotte County Schools
Charlottesville Red/hous Auth
Charlottesville/Albemarle Tech Edu Center
Chesapeake Bridge/tunnel
Chesapeake Red/hous Auth
Chesterfield County Health Center Commission
City of East Orange New Jersey
City of Fort Lauderdale
City of Mount Airy
City of Nashville
City of Palatka
City of Salem
Colonial Behavioral Health
Colonial Soil & Water Conservation District
Commonwealth Regional Council
Culpeper Soil And Water Conservation District
Cumberland Plateau Reg Housing
Daniel Boone Soil And Water Conservation District
Danville-Pittsylvania Community Services
Dinwiddie County Schools
Eastern Shore Public Library
Eastern Shore Soil & Water Conservation District
Economic Development Authority Of Henrico Co, Va
Emporia
Evergreen Soil And Water Conservation District
Fairfax City Schools
Fairfax County Schools
Fauquier Co Water & Sanitation Auth
Ferrum Water And Sewage Authority
Frederick Co Sanitation Auth
Giles County Public Service Authority
Grayson County
Hampton Newport News Community Services Board
Hampton Roads Sanitation Dist
Hampton Roads Transit
Harrisonburg Rockingham Community Services Board
Holston River Soil And Water Conservation District
Horizon Behavioral Health
Institute For Advanced Learning And Research
King and Queen County Schools
Lee County Schools
Lonesome Pine Soil And Water Conservation District
Loudoun County Sanitation Authority
Meherrin Regional Library
Meherrin River Regional Jail Authority
Mount Rogers Community Services Board
Nelson County Service Authority
New Horizons Technical Ctr
Norfolk Airport Authority
Norfolk Red/hous Auth
Northern Neck Regional Special Education Program
Northern Virginia Health Care Center
Northern Virginia Juvenile Detention Center
Northwestern Comm Svcs Bd
Nottoway County
NRV Regional Water Authority
Opportunity, Inc. of Hampton Roads
Peaks Of Otter Soil & Water Conservation District
Peninsula Airport Commission
Piedmont Community Services
Planning Dis One Behavioral Health Svcs
Portsmouth City Schools
Potomac And Rappahannock Transportation Comm
Potomac River Fisheries Comm
Prince William Soil & Water Conservation District
Rappahannock Juvenile Center

APPENDIX A (Continued)

Entities With No Data Submission (Continued)

Rappahannock Rapidan Regional Commission
Rappahannock Regional Jail
Richmond Metropolitan Transportation Authority
Richmond Redevelopment and Housing Authority
Rivanna Water & Sewer Auth
Robert E. Lee Soil And Water Conservation District
Rockbridge Area Comm Svc Bd
Rockbridge Area Social Service Dept
Rockbridge Co Public Svc Auth
Rockbridge Regional Library
Rowanty Vo-tech Center
Russell County
Russell County Public Service Authority
Scott County Public Service Authority
Scott County Redevelopment And Housing Authority
Shenandoah Valley Juvenile Center Commission
Shenandoah Valley Regional Airport Commission
Skyline Soil And Water Conservation District
Southside Reg Juvenile Group Home
Southside Regional Library Bd
Spotsylvania-Stafford-Fredericksburg Group Home Co
Staunton Red/hous Auth
Suffolk Redev & Housing Auth
Tazewell Soil And Water Conservation District
The Charles Pinckney Jones Memorial Library, Inc.
The Pruden Center For Industry And Technology
Town of Accomac
Town of Alberta
Town of Belle Haven
Town of Bloxom
Town of Boyce
Town of Boykins
Town of Branchville
Town of Brodnax
Town of Capron
Town of Charlotte Court House
Town of Cheriton
Town of Claremont
Town of Cleveland
Town of Clifton
Town of Clinchco
Town of Clinchport
Town of Columbia
Town of Craigsville
Town of Dendron
Town of Dillwyn
Town of Drakes Branch
Town of Duffield
Town of Dungannon
Town of Eastville
Town of Fincastle
Town of Fries
Town of Glasgow
Town of Glen Lyn
Town of Hallwood
Town of Hillsboro
Town of Irvington
Town of Ivor
Town of Keller
Town of Madison
Town of Melfa
Town of Monterey
Town of Mount Crawford
Town of Nassawadox
Town of New Castle
Town of Nickelsville
Town of Occoquan
Town of Onley
Town of Painter
Town of Pamplin
Town of Phenix
Town of Pocahontas
Town of Port Royal
Town of Pound
Town of Ridgeway
Town of Rural Retreat
Town of Saint Charles
Town of Saxis
Town of Scottsburg
Town of Spring Hope
Town of Stanardsville
Town of Stony Creek
Town of Stuart
Town of Surry

APPENDIX A (Continued)

Entities With No Data Submission (Continued)

Town of Tangier
Town of The Plains
Town of Toms Brook
Town of Troutdale
Town of Troutville
Town of Virgilina
Town of Wachapreague
Town of Weber City
Town of White Stone
Tri-county/city Soil And Water Conservation Dist.
Virginia Peninsula Regional Jail
Virginia School for the Deaf and Blind-Staunton
Washington Metropolitan Area Transit Commission
West Point
Western Virginia Regional Jail Authority
Western Virginia Water Authority
Wise County Public Service Authority
Wise County Redevelopment And Housing Authority
Woodway Water Authority
Wythe-Grayson Regional Library

APPENDIX B

Additional Cost Comparisons – State Plan Comparison Basis (COVA Care Basic and Expanded Dental)

Estimated Cost by Quartile

Table 17A

Estimated FY 2016 Medical and Prescription Drugs Cost PMPM				
Quartile	**Entity Count**	**Avg. Members**	**PMPM**	**Vs. Total**
1	79	49,724	$346	(23.8%)
2	79	161,238	$418	(8.0%)
3	80	107,487	$492	8.3%
4	80	62,265	$572	25.8%
Total	318	380,715	$454	

Table 17B

Estimated FY 2016 Dental Cost PMPM				
Quartile	**Entity Count**	**Avg. Members**	**PMPM**	**Vs. Total**
1	64	36,029	$14.70	(46.8%)
2	65	39,765	$19.97	(27.7%)
3	65	81,165	$24.64	(10.8%)
4	65	137,691	$34.42	24.6%
Total	259	294,651	$27.61	

Estimated Cost by Size Band (Average Members Count)

Table 18A

Estimated FY 2016 Medical and Prescription Drugs Cost PMPM				
Size Band	**Entity Count**	**Avg. Members**	**PMPM**	**Vs. Total**
1-49	80	2,104	$520	14.5%
50-249	106	23,992	$488	7.4%
250-499	52	30,339	$455	0.0%
500-999	34	44,115	$447	(1.6%)
1000+	46	280,165	$452	(0.5%)
Total	318	380,715	$454	

Table 18B

Estimated FY 2016 Dental Cost PMPM				
Size Band	**Entity Count**	**Avg. Members**	**PMPM**	**Vs. Total**
1-49	82	2,636	$17.97	(34.9%)
50-249	84	21,624	$21.56	(21.9%)
250-499	36	21,680	$22.68	(17.9%)
500-999	23	26,866	$25.68	(7.0%)
1000+	34	221,844	$29.01	5.1%
Total	259	294,651	$27.61	

Additional Census Comparison – Based on Snapshots provided by the entities

Table 19

Enrolled Employee Mix by Status			
	School/Gov't	**State Plan**	**Difference**
ACTIVE	91.3%	92.3%	(1.0%)
COBRA	0.3%	0.2%	0.1%
RETIREE	8.4%	7.5%	0.9%

APPENDIX C

TLC Highlights

The Local Choice Health Benefits Program (TLC) was created 25 years ago by an act of the Virginia General Assembly to assist political subdivisions in acquiring high quality, cost competitive health benefits for their employees. In 1989, the Department of Human Resource Management (DHRM) of the Commonwealth of Virginia began offering a self-funded health plan available exclusively to Virginia cities, counties, towns, schools and other political subdivisions.

Beginning with just over 100 participating groups in 1989, TLC has grown to 340 groups (more than 370 individual entities including sub-groups, each of which is eligible in its own right) covering more than 62,000 employees, family members and retirees. In just the last 10 years, group participation has grown by 69%.

Current employer groups range in size from one employee to over 1,600. Groups with fewer than 50 employees (our smallest pool) represent 58% of membership; groups between 50 and 300 employees (mid-pool) comprise 35% of the membership; and groups with greater than 300 employees (large pool) account for 7% of membership. Growth in all pools has remained relatively constant over the years, attesting to the value at each size level.

All groups are rated based on individual demographics such as age, sex, and location; and for medical and behavioral health as described below:

- Rates for the smallest pool are initially based on demographics only. At renewal, they are evaluated based on their demographics but also on the experience of that pool as a whole (community rating.)

- The mid-pool renewal rating evaluation is also based on group demographics, but on a sliding credibility scale, utilizing increasing credibility of each group's experience based on size. This is supplemented by experience of the entire pool to further spread the risk over the larger group.

- The large group category is evaluated based on its own demographics along with medical and behavioral health claims experience.

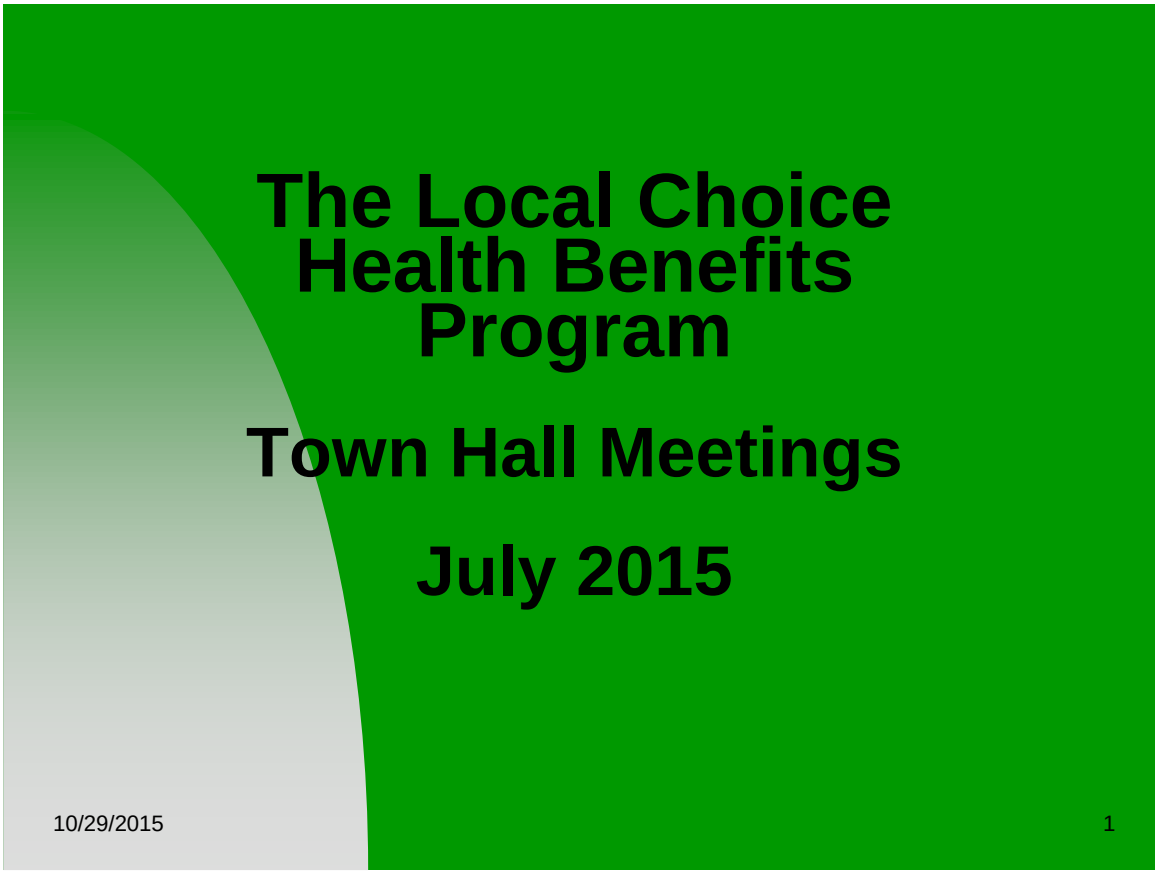
- Claims experience for dental and outpatient prescription drugs is pooled for all groups across all size categories. This takes much of the volatility of rate changes out of the equation for individual groups of all sizes.

Flexible, but sound, underwriting has allowed TLC to avoid adverse selection while maintaining a diverse menu of plan designs and competitive rates for its member groups. While offering five distinctively different self-funded plan options, TLC has been able to maintain an average rate adjustment for the past five years of 5.3% and 5.08% over the last 10 years.

APPENDIX D

The Local Choice Presentation

This presentation may be found online at
http://www.thelocalchoice.virginia.gov/documents/TLCProgramforGeneralAssembly.pptx



2015 Virginia Acts of the Assembly, Chapter 665

ITEM 82.

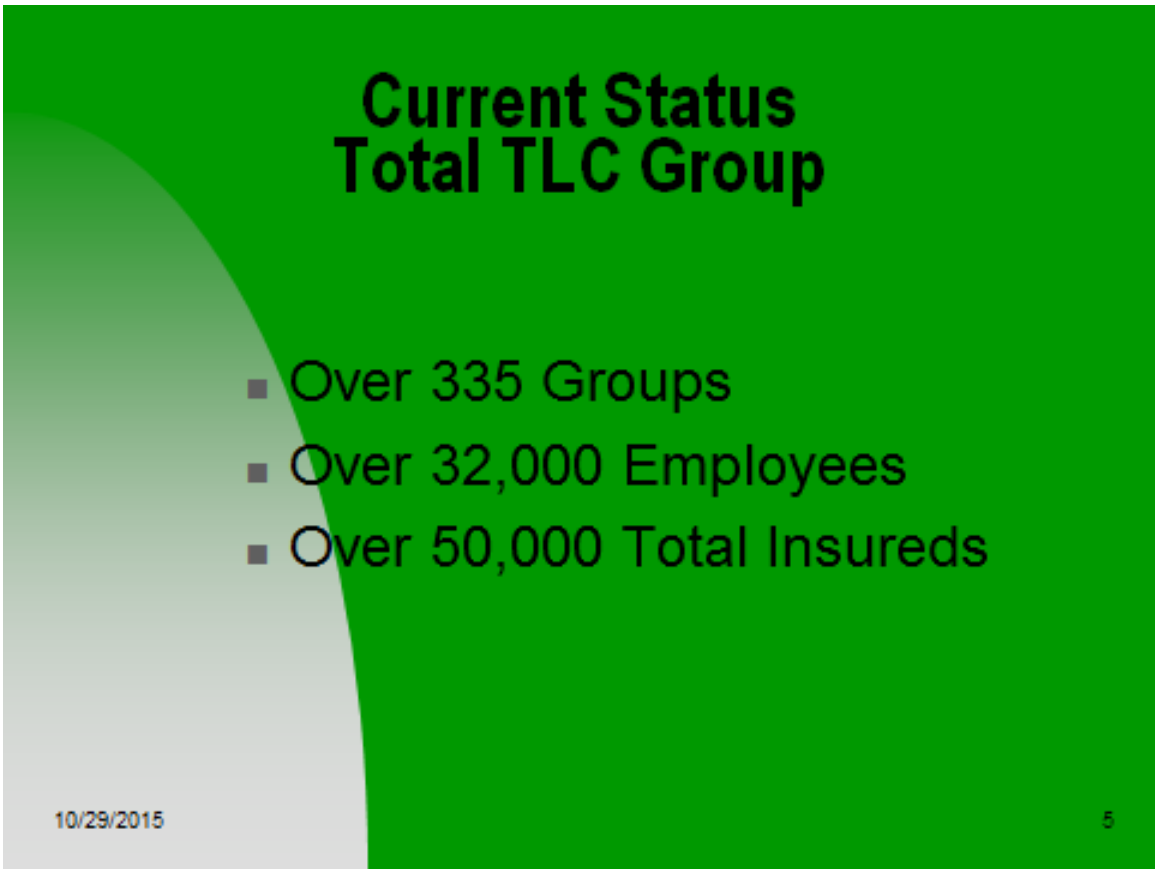
- H.1. The Department of Human Resource Management shall conduct a comprehensive review of the public employee health programs in the Commonwealth. The Department shall provide a report detailing the findings and recommendations to the chairmen of the House Appropriations Committee and Senate Finance Committee by October 31, 2015.
- 2. As part of the review, the Department shall conduct an actuarial review of the impact on the state, the school boards, and other political subdivisions, from including the employees, and their dependents, of local governments including local school divisions in the state employee health program or in one statewide pooled plan for employees of political subdivisions.
- 3. Local school boards and localities shall provide information to the Department as requested for the actuarial analysis.
- 4. The review shall also include an examination of The Local Choice program's policies, including its pooling and rating methodology, to determine whether overall improvements may be made to the program, with a specific goal of trying to increase The Local Choice program's appeal among rural school divisions and local governments. During this effort, the Department shall hold a series of meetings with stakeholders to educate them about The Local Choice program and solicit their feedback.
- 5. The Director of the Department of Planning and Budget is authorized to transfer up to $250,000 general fund from program 757 (agency 995, Central Appropriations) from unobligated balances from prior year appropriation to the Department of Human Resource Management as needed to fund the review and outreach efforts.

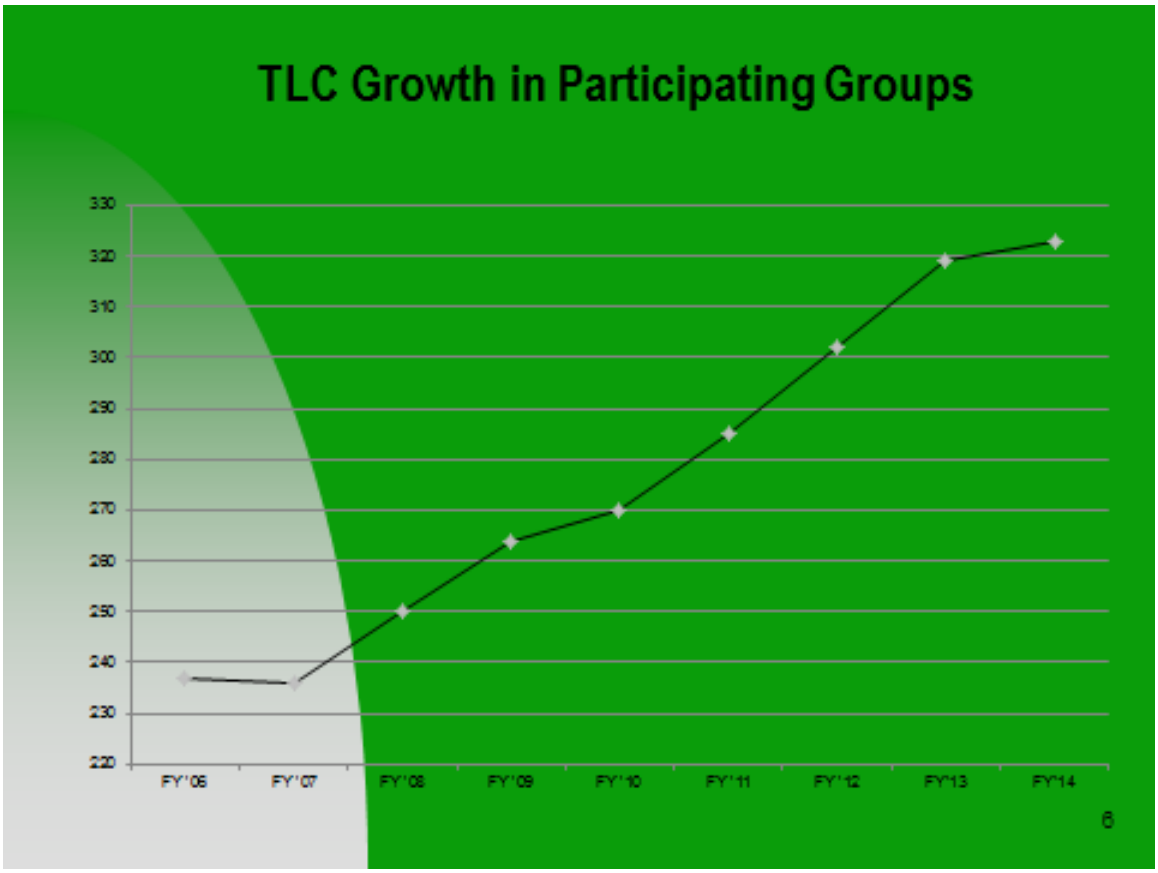
TLC

- Established by Legislature in 1990
- Self-Funded Program with a Fully Insured Regional Plan Options
- Exclusively for Schools and Political Subdivisions in Virginia
- Managed by DHRM
- Premium Represents Entire Funding

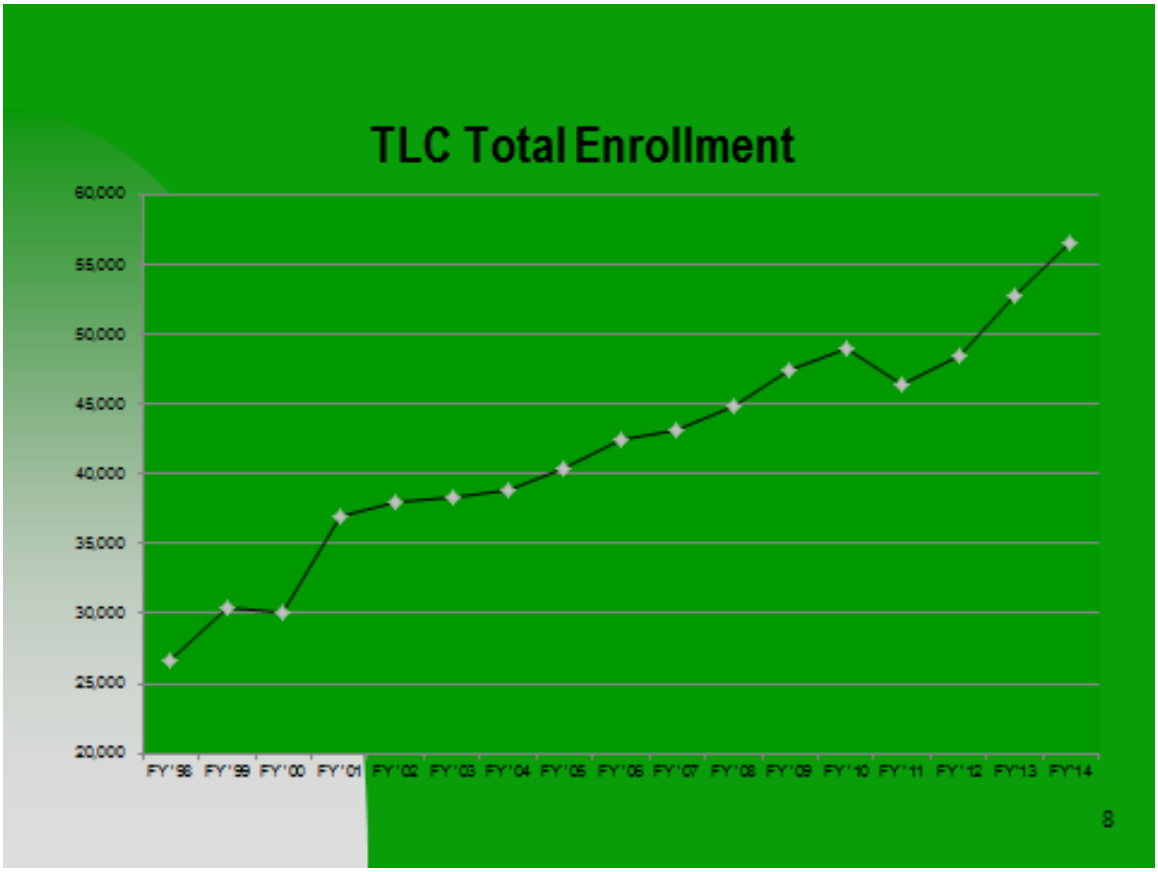
Effective Dates and Renewal Dates

- Groups May Join at Any Time During the Year but Must Renew on July 1 or October 1
- School Groups May Choose July 1 or October 1
- All Non-School Groups Renew on July 1


Current Status
Total TLC Group
Over 335 Groups
Over 32,000 Employees
Over 50,000 Total Insureds
10/29/2015
5


TLC Growth in Participating Groups
330
320
310
300
290
280
270
260
250
240
230
220
FY'06
FY'07
FY'08
FY'09
FY'10
FY'11
FY'12
FY'13
FY'14
6


TLC Employee Growth by Year
33,000
31,000
29,000
27,000
25,000
23,000
21,000
19,000
17,000
FY'98 FY'99 FY'00 FY'01 FY'02 FY'03 FY'04 FY'05 FY'06 FY'07 FY'08 FY'09 FY'10 FY'11 FY '12 FY'13 FY'14
7


TLC Total Enrollment
60,000
55,000
50,000
45,000
40,000
35,000
30,000
25,000
20,000
FY'98
FY'99
FY'00
FY'01
FY'02
FY'03
FY'04
FY'05
FY'06
FY'07
FY'08
FY'09
FY'10
FY'11
FY'12
FY'13
FY'14
8

TLC Groups by Congressional District

District	1	2	3	4	5	6	7	8	9	10	11
School	8	0	1	5	12	6	3	1	10	3	0
County	8	0	2	6	9	5	2	0	11	1	0
City/Town	11	2	5	7	20	24	6	1	36	7	5
Other Political Subdivision	12	3	17	17	19	12	11	1	54	2	4

Current Group Participation

- Current range from 1 to 1,600 Employees
- 58% fewer than 50 Employees
- 35% between 50 and 300 Employees
- 7% greater than 300 Employees
- 2014 Statewide Self-Funded Plan Cost - $316,596,872
- 2014 Fully Insured Regional Premium - $3,462,900

Self-Funded Plans Have Stop Loss Protection

Specific Stop Loss Protection is Provided for All Groups

Attachment Points	
Under 300	$90,000
300 to 999	$110,000
1000 to 1499	$150,000
1500 +	$175,000

Current Carriers and Plans

For Active Employees and Early Retirees

- S/F Administered by Anthem
  - Key Advantage Expanded
  - Key Advantage 250
  - Key Advantage 500
  - Key Advantage 1000
  - High Deductible Health Plan
- Fully Insured Administered by Kaiser
  - Regional HMO

Regional Plan

- Regional Plan Is Fully Insured with All Groups Paying the Same Rate Regardless of Location, Demographics or Experience
- At This Time, Kaiser Permanente HMO Offers our Only Regional Plan and is Available in Northern Virginia (Live or Work)

Plan Options

Groups with:	May Select:
1 to 25 employees	1 Plan
26 to 100 employees	Up to 2 Plans 2 KA or 1 KA and either HDHP or the regional plan
100 or more employees	Up to 4 Plans 2 KA plans + HDHP + the regional plan

Rating Pools

- In Addition to Group Demographics, TLC Groups are in 1 of 3 Pools

  - Community Rated - 1 to 49 EEs
  - Credibility Factor Rated – 50 to 299 EEs
  - 100% Credible Experience Rated – 300 + EEs

Community Rated or Pooled

- Experience for all 1 to 49 Employee Groups is Pooled Together
- Individual Group Experience is not a Factor in Rating
- Dental, Rx and Medicare Supplemental Components Are Fully Pooled

Credibility Factor Rated

Group Size	Credibility Factor
50 - 99	41% of group's medical experience
100 - 149	58% of group's medical experience
150 - 199	71% of group's medical experience
200 - 249	82% of group's medical experience
250 - 299	91% of group's medical experience

- Remainder of Experience Rate Comes From Pooling All Groups between 50 and 300 Employees
- Dental, Rx and Medicare Supplemental Products Are Fully Pooled

100% Credible Experience Rated

- Rating for 300+ Employee Groups Considers 100% of the Group's Med/Surg/MISA Experience
- Dental, Rx and Medicare Supplemental Products Are Fully Pooled

Pooled Benefits Statewide – Self-Funded

- Dental by Delta Dental through Anthem
- Rx by ESI through Anthem
- Medicare Eligible Retiree Coverage by Anthem

Retiree Coverage

Statewide, Self-Funded Plans

for

Medicare Eligible Retirees

(Administered by Anthem and Delta Dental)

- Advantage 65
- Advantage 65 with Dental/Vision
- Medicare Complementary available as grandfathered plan

(An Employer May Select Only 1)

Underwriting and Eligibility Requirements

- Group Must Be Created by or of an Act of GA
- No Minimum Participation Requirement
- 80% Minimum Employer Contribution for F/T Employees; 20% for Dependents
- 50% of F/T Employer Contribution Required for P/T Employees
- No Required Dependent Contribution if 75%+ Participation
- No Required Contribution for Retirees
- Employers May Fund from Average Plan Cost

Adverse Experience Adjustment Protection (AEA)

- Only Terminating Groups Are Accessed AEA
- No Adjustment Applied if No Deficit Exists
- 1 to 299 Based on Exposure % of Pool Losses
- 300+ Based on Actual Employer Plan Losses
- AEA Assures Current Member Groups Will Not Be Penalized for a Terminating Group's Losses

TLC Highlights

- Dedicated customer service unit
- Benefits similar to state employees
- Procurement Savings
- Multiple Plan Choices
- Shared Risk Concept
- Pool Protection

TLC Highlights

- State Benefits Eligibility System (BES)
- ACA Reporting Assistance
- Re-Insurance Fee Paid by TLC
- Low Administrative Costs
  200,000 + Insureds with State and TLC
- AEA Protection

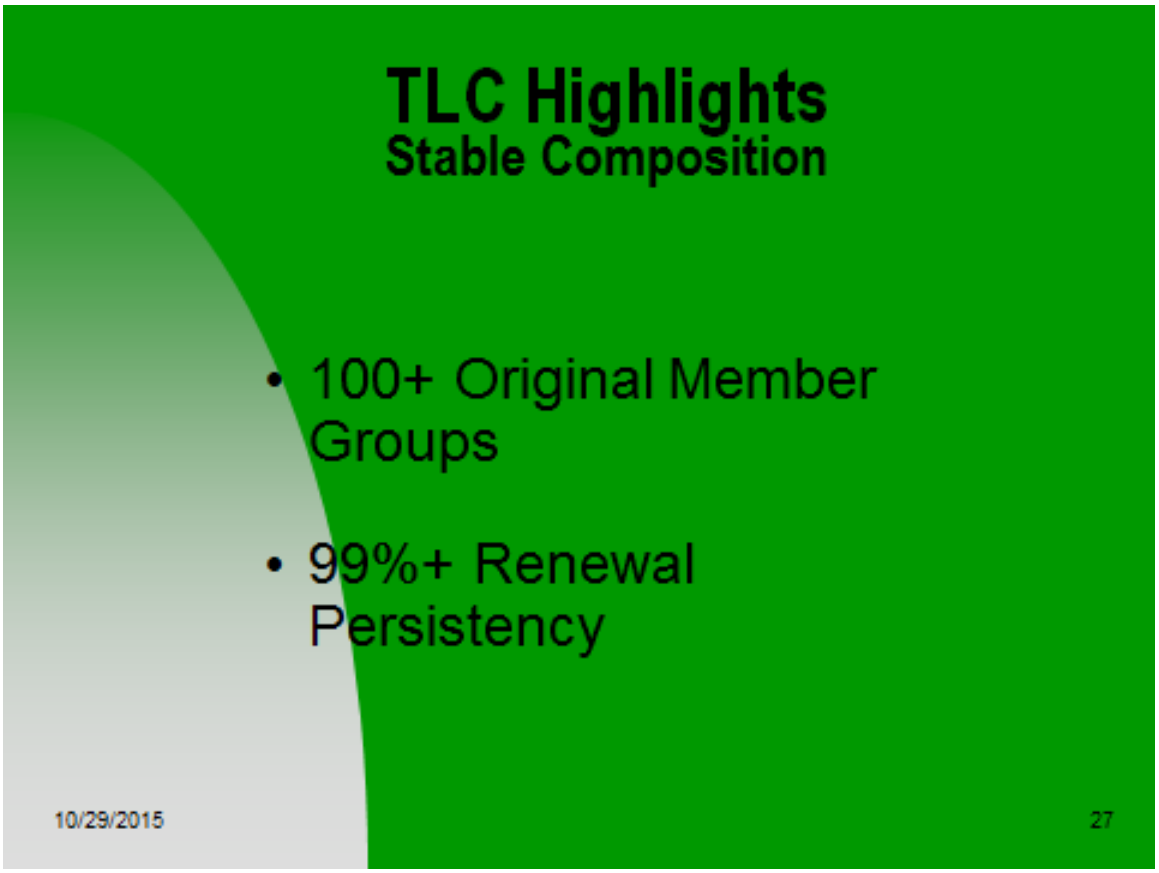
TLC Highlights

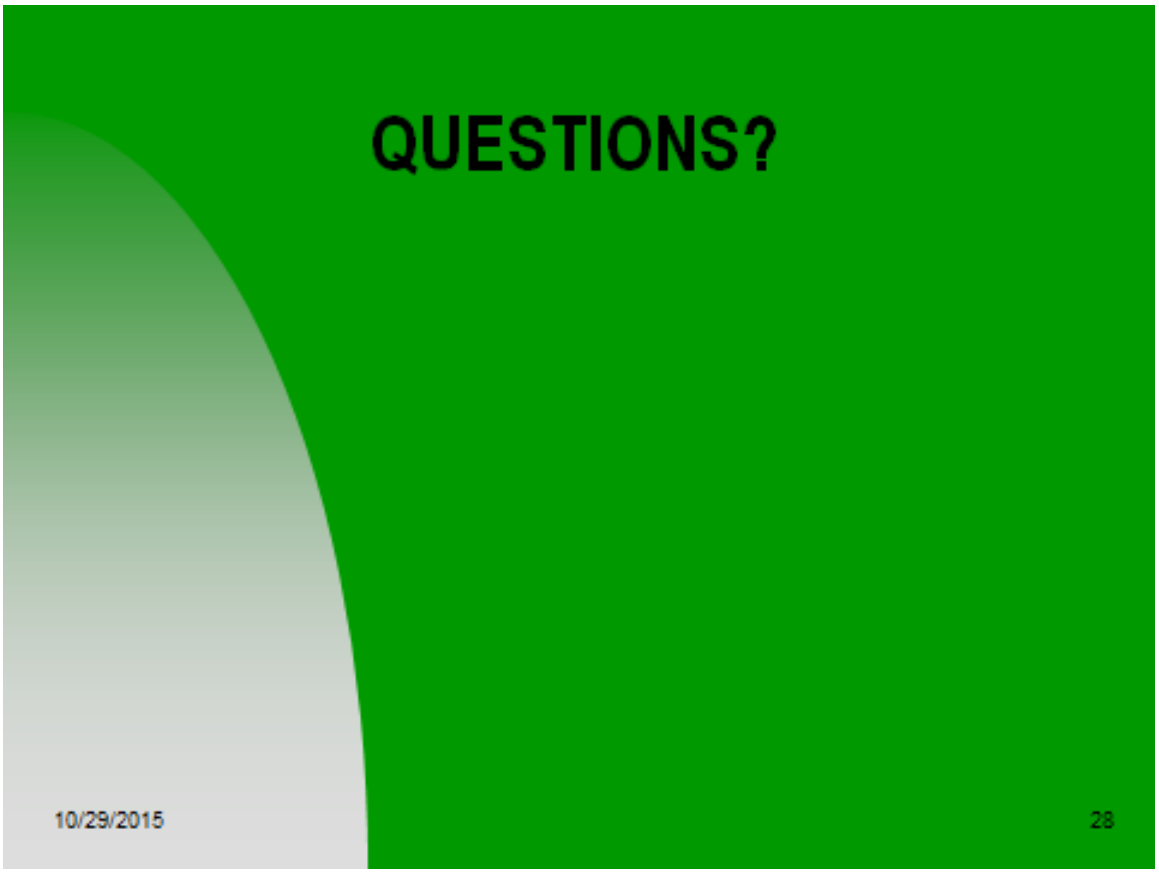
- Disease Management, EAP and Wellness Programs Included
- Minimum Performance Standards
- Large Provider Network
  - 95% Virginia Doctors
  - 100% Virginia Hospitals
- BlueCard
- No Referrals Required
- Substantial Network Discounts

TLC Highlights
Stable Premiums

Year	Rate Adjustment	Year	Rate Adjustment
2006	8.5%	2011	5%
2007	3.5%	2012	3%
2008	-1.8%	2013	6.6%
2009	7.2%	2014	5%
2010	6.9%	2015	6%

- 5 Year Avg. Adjustment 5.3%
- 10 Year Avg. Adjustment 5.08%


TLC Highlights
Stable Composition
• 100+ Original Member Groups
• 99%+ Renewal Persistency
10/29/2015
27


QUESTIONS?
10/29/2015
28

TLC Contact

Walter E. Norman
TLC Program Manager
101 N. 14th Street
13th Floor
Richmond, VA 23219

(804) 786-6460 Phone
(804) 371-0231 Fax
walter.norman@dhrm.virginia.gov
or
www.thelocalchoice.virginia.gov