MEETING MINUTES
COMMITTEE OF THE BOARD (COB)
May 19, 2009

PRESENT:

Board of Education: Elona Street-Stewart, Kazoua Kong-Thao, John Brodrick, Anne Carroll
Tom Goldstein joined the meeting at 5:16 p.m.
Tom Conlon joined the meeting at 5:25 p.m.
Keith Hardy joined the meeting at 5:47 p.m.

Staff: Superintendent Carstarphen, Teresa Rogers, Terri Bopp, Theresa Nistler

Other: Steve Clausen, Deloitte

I. **CALL TO ORDER**
The meeting was called to order at 5:04 p.m.

II. **AGENDA**
There was only one agenda item, an update on the health care renewal process.

1. Update on Health Care Renewal Process

The purpose of the meeting was to provide the Board with an update on the Health Care RFP process. The RFP was released on February 26. There was a mandatory bidder's conference on March 11 with proposals due March 26. The Labor Management Committee (LMC) evaluation meetings occurred in April. The recommendation will be presented to the COB on May 19 with an effective date would be January 1, 2010.

The objectives of the RFP were competitive overall cost and value; a comprehensive broad provider network; plan options and design to allow for choice; quality services was critical; health improvement and wellness components to mitigate cost and ensure the health of the staff and, finally, that care management programs be embedded in the program. The evaluation criteria included the listed objectives along with the product offering, plan administration, flexibility and customer service options. The target for approval is the Board meeting of June 16.

Other goals of RFP included:
- Offering a copayment plan with an aggregate value of benefits similar to the current Distinction plan)
- Multiple plan design options
- Alternative funding options
- Flexible Spending Account (FSA) administration

The guiding principals were access, value and cost. Three proposals were received (Health Partners, BCBS of MN and PEIP). The LMC was looking for a partner that could demonstrate a philosophy aimed at improving the health of participants. To ensure continuity a three year financial commitment was requested. The LMC was also looking for a plan that recognized the value of the patient doctor relationship and a plan of benefits designed with the future in mind. To make a change from the current plan provider there would need to have been substantial financial reasons or the marketplace had to have changed.

The plan design addressed such things as:
- Meeting the negotiated value of the benefits agreed to in the labor relations process
- Providing meaningful choice for participants to consider with limits to financial out-of-pocket costs

- Providing alternatives to more traditional plan design that has a long-term approach allowing savings to cover future health care expenses
- Emphasizing preventive care no matter what plan is chosen (each plan pays 100%) and
- Providing incentives to complete and participate in wellness initiatives (health risk assessment and wellness program).

Choice was important with clearly defined and understandable levels to allow for making a selection among the offerings. The proposals also provided for programs that allow individuals to begin to accumulate funds for future health care expenses. The design incorporates enough differences from a value standpoint that people can look at it and be able to make a decision based on their current needs.

Clarification was provided on an HSA (Health Savings Account) which is a savings account with the account belonging fully and completely to the individual and an HRA (Health Reimbursement Account) which is a fund of money set aside by an individual to cover medical costs within a specific period of time (one year), monies not used are lost to the individual at the end of the defined time period.

Mr. Clausen then went on to review a summary of the plan design outlining three options the LMC provided to bidders as a basis of what was desired for the district plans. He provided a more detailed plan descriptions to Board members. He clarified that under the obligations of the aggregated value the proposals had to come as close as possible to Option 1, the other options are options and the union agreements allow for tweaking the options without having to go through negotiations or agreements.

He then moved on to a financial overview. There were good responses from all three respondents. Health Partners and BCBS of MN provided multi-year rate caps. Health Partners proposed approximately a 3% increase in health care costs in 2010. BCBS' proposal was around a 1% in overall aggregate increase. The PEIP program was comparable to the existing financial situation (no increase) but a different plan design structure. There are some value differences in the overall premiums and HP and BCBS both provided, second and third year guarantees. PEIP cannot provide multiple year guarantees, they are not large enough and SPPS is too large to enable them to do so. HP's cap was not to exceed 9.0% in 2011 and 9.5% in 2012. BCBS was 10.0% in 2011 and 11.0% in 2012. All three proposals were strong relative to finances. The district is leaning more toward Health Partners because of the caps involved.

These are major changes in the plan offerings and communication will be key. The psychology around the plans is change; it is a consumer model. Another benefit is that one of the options might be attractive to the retiree pre-Medicare group.

QUESTIONS/DISCUSSION:

- How different are the evaluation criteria from the last round? The LMC looked at what was used previously as a starting point and then updated criteria based on what current needs were and what was considered important.
- Were the plan design options part of the RFP? The LMC defined the type of plans to be used and released those requirements with the RFP.
- Did all RFP respondents come up with plans that addressed the plan design? They were very similar but not identical. Health Partners matched option 1 (their traditional plan) and they can do options 2 and 3 as well. BCBS can also do all three options. The PEIP program has some limitations to it; they have only certain plan designs which can be offered. They offered three options they were not exactly like the "plan design" but they came close and similar, close enough for comparability.
- Is there any way to ensure lesser amounts than the caps (worst case scenario)? There is no requirement for the District to participate in year 2 or 3 with HP; their figure is just a cap. The contract will be a one year contract and they have provided a cap out for years 2 and 3.

- Why do insurance companies provide caps, are they "gaming" the district? The second and third year caps were requested so the first year did not come in very low with a significant increase in the second year. When they propose a cap they are considering trends in health care. The current trend is about 8.5-9.0%. The other component is the provider community; hospitals and physicians are negotiating their reimbursement contract terms with the health plans and they are looking at reimbursement increases of 4.5-6.0%. So, if all else remained the same costs would go up 4.5-6.0%. The insurance caps are not unrealistic amounts if a good job has been done in negotiating the premium and expense relationship in the first year.
- If the District goes with Health Partners, is it obligated to be with them for three years? No, it just provides the district with a known second and third year increase.
- If the employee numbers change the numbers shown would change as well? Yes, the figures shown are based on a static number; current participation in the current plans. The one known is the obligations relative to union contracts and the contributions the district has agreed to in those.
- With the recommended version, if that is approved, should there be a shift in Federal health care or State is there a provision built in to address those kinds of major shifts. Yes.
- If a significant number of people choose to shift to option 2 (less costly premiums) what happens? Individuals select their plan annually; the district will only pay that premium for the plan selections. Is there a reason to incent people or is there an advantage to the district to have people choose a plan with a more costly premium? The goal would be to education people on the value of the alternatives.

Administration stated that based on the analysis of the RFP responses, the LMC would recommend accepting the Health Partners proposal. The rates would be brought forward for Board action at the June Board meeting.

MOTION: Ms. Carroll moved, seconded by Mr. Brodrick, that the Committee of the Board recommend that the Board of Education accept the report on the health care renewal process and that it approve the administrative recommendation to accept the Health Partners proposal.

Motion passed 6 in favor with Mr. Hardy abstaining.

Mr. Clausen also provided a brief legislative process update on the legislation relative to a mandatory health insurance pool for all school districts in the State of Minnesota. Versions of the bill passed both the House and the Senate. It went to conference committee to reconcile differences where it was reconciled and tabled and not brought to the floor for a vote before the adjournment. Therefore the bill is dead for the session. It may be reintroduced at the next session because it has gone through the conference committee process and has been reconciled.

III. ADJOURNMENT

MOTION: Ms. Kong-Thao moved the meeting adjourn; seconded by Ms. Carroll.

Motion passed.

The meeting adjourned at 5:55 p.m.

Respectfully submitted,
Marilyn Polsfuss
Assistant Clerk