Healthcare Planning Committee
Tentative Minutes
February 20, 2024

1. Call to Order: Billeter called the meeting to order at 3:00 pm. Present: Gillingham, Daub (3:05), County Engineer Ciesiel, Director of Court Services Cindy Bergstrom, Egyed, Reising, Jacinto, Baker, Gallagher, Grobe and Billeter. Absent: Dan Miller and Gallick

   Alternates Not Present: Brodzik, Troye and Mark Miller
2. Approval of minutes – January 16, 2024: No Motion minutes not presented.
3. Public Comment: None
4. Old Business:
   A. Discussion & Review of Previous Topics: Billeter not much to report here but wanted to let the committee know that the aggregate report came in at .8, which is excellent. Reising asked if Billeter knew what our reserve was at this time. Billeter shared he didn't look this month but last month when he checked it was 1.78 million.

   B. Replacements for Retiree: Billeter stated we haven't heard any details on this so he will have a conversation with the Sheriff regarding this.
5. New Business
   A. Introduction to M3: Zach Rice from M3 is really excited to be here. I know we've been working closely with Amanda in HR, just in terms of getting integrated and kind of connected with all the vendors and partners and Group Administrators. Rice shared one of the big things is doing an early shop just in terms of looking outsides the market of where you are all today.

   Rice discusses various considerations for Ogle County, including evaluating different healthcare models such as self-funded, fully insured, or bundled models with carrier partners like Blue Cross or UnitedHealthcare. M3 plans to gather updated census data and have discussions with carrier partners to inform their decision. Rice also mentioned putting certain data analytics projects on hold until they decide whether to stick with their current Group Administrators or explore other options. Overall, they express excitement about the partnership and mention having a good existing relationship with Group Administrators.

   Rice also shared their role in overseeing medical benefits and exploring ancillary programs and compliance issues. They express interest in conducting a thorough review of current practices to identify potential improvements and alternative administration methods. They emphasize the importance of maintaining the quality and accessibility of benefits while also considering financial impacts and streamlining processes. They aim to gather census data by the end of the month to potentially make changes, although they acknowledge challenges in aligning renewal and stop-loss windows. They seek to understand the rationale behind current structures and consider potential changes with a focus on weighing pros and cons.

   Gallagher asked when you take on new clients, do you see a lot of transition initially when you review their stuff or is it more just tweaking kind of what they have?

   You know, I can definitely go both ways. I would say sometimes we walk into situations where yeah, there needs to be some pretty significant changes right away. I would say we've had a lot

of success in the last 18 months with moving groups to some of our other carrier partners and seeing some pretty significant savings and not a drop in the access or benefit level, it’s really about what the market is going to dictate. That's why we thought one of the first things we wanted to look at is an early shop, just to look at, you guys have been self-funded for quite some time, and I'm a big proponent of self-funding. However, it also comes out if you're able to have a fully insured premium that's going to be coming in well below what your expected claims are, especially from a mass claim standpoint, that's something that we're going to run down and present. So I think some of it's also just figuring out, you know, from an onboarding perspective, you know, Amanda and her team, where can we help maybe take some lift off of their plate, with Group Administrators, you know, seeing some of the vendors that they've put in place, getting a better idea of with a host care, some of these additional services, you know, are they bringing the value that we feel like they should be bringing.

Daub asked what Rice saw as the advantages being self-funded where and he shared it really does provide for more flexibility and control. Those are some of the really great things I like about self-funded. I would say, from a fully insured perspective, especially from a budgeting standpoint, there's some upside, you know, what your fixed number is going to be, depending on again, what carriers are going to step up to the plate and show financial savings against a self-funded plan. But overall, if you're self-funded, knowing you're doing the right things, and you know, what the workforce is, your membership is fairly healthy, and we're able to do things to control prescription drug costs, chronic conditions, stepped in with large claims that self-funding is a great solution.

Reising asked if Rice sees an issues with lasers deductibles and if we can get rid of them. Rice expressed most stop-loss contracts that we would look at in self-funded world would be no new lasers. However, any existing lasers would still probably have to stay on. There's negotiations that can take place there. And when we look at the stop loss market, we have a stop-loss consortium through a partnership of ours, where we've got some really good relationships there some markets that we can see what that looks like Blue Cross, there's typically not going to be lasers on a Blue Cross stop-loss contract and definitely from a phone insurance standpoint, you wouldn't have lasers.

Billeter stated regarding fully insured plans, one of our primary concerns revolves around securing an attractive initial premium and then a significant increase when it comes time for renewal. Have you observed any notable trends this year in terms of rate hikes and Rice replied he thought the projected increases is around 9%, across the board. Rice shared they would probably look to do a not to exceed a certain percentage but we probably won’t be seeing multiple year rate guarantees. Rice shared once we have that census in and get things going I would say by the March meeting maybe we could actually have some potential numbers to discuss.

Gillingham asked Rice if he would be attending all of the meetings and he replied he will come as often as we will have him. Rice asked the committee what they would like to see things enhanced, stay the same or make big changes. Gallagher commented he thought there are several misconceptions among employees about the current state of affairs within the group, which has been struggling to find direction over the past couple of years. Gallagher believes that M3 is well-suited for the job based on their recent presentation and the clarity they bring to the table. In the past Gallagher shared there were concerns about the lack of clear and trustworthy information, noting that the proposed changes could lead to cost savings. Additionally, they highlight the need

for better communication with employees to provide clarity about the organization's status compared to others.

Rice asked when I look at your guys stop loss contract. The way it's written is you have $100,000 specific deductible and then a $75,000 aggregate and specific. Is that correct or is it flipped, because when I look at this report, and it shows that $100,000 aggregate that would make me think that you have $100,000 aggregating spec, and a $75,000. Billeter stated he wasn't sure and Rice said he would find out. The committee shared this is what some of the issues where from the previous broker they would provide reports but the committee didn't know how to interpret the data. The committee asks Rice if there is a way we can run through the reports and how to properly read them. Rice expressed he was happy to do that and spoke to even being able to do lunch and learns with different providers.

B. Monthly Reports: .8 Aggregate report for last month.

C. Project Updates: Jacinto shared the wellness program's structure and its impact on rates were reviewed, particularly concerning new hires joining after the enrollment period. It was noted that historically, new hires are unable to participate in the wellness program were still given wellness rates. It has been proposed to modify the program for these new hires, but conversations with Genesis, the wellness program provider, revealed they hadn't been involved much in the process. They appreciated being consulted and offered insights. However, due to timing constraints and the complexity of implementing changes, it was decided to defer significant alterations until 2024 to ensure readiness and avoid financial implications. The goal remains to foster a culture of wellness and genuine behavior change rather than merely going through the motions.

Jacinto also shared another issue being looked into is the insurance opt-out program, which is currently part of union contracts and pays out approximately $40,000 to $45,000 annually. The process currently involves employees automatically receiving money in January for not having insurance, without any active involvement from them. Jacinto suggests that employees should have more participation by signing an opt-out document to qualify for the payout. However, there have been instances where employees were unaware of why they received the money. There's a proposal to revise the process for 2024, aiming to increase employee engagement and ownership. The committee members discussed possible options and stated they will need to decide with M3 what the best plan is for Ogle County.

6. With no further business Billeter adjourned the meeting. Time: 3:19 p.m.

Respectfully submitted,
June Jacobs