Genesee County

August 19, 2020

Presentation of Medical Plan Procurement Results to Board of Commissioners

Response to Public Session Questions/Comments

Public Questions

1) Question/Comment from Sharon Gregory call

There are about 400 current employees paying into a VEBA for the past 14 years that has been used to pay for current retiree healthcare (through payroll deduction). This money is not in our own account or (in) our own names, plus our regular deductions for our own healthcare. Many of us have paid ~30K-$40K, and when we retire many of the 400 employees will go onto Medicare and have to pay for that as well. Many of us are wondering how we are going to get back the benefits that we've paid into the county. The VEBA account is run dry, the County is funding it with general fund dollars. Why is the income from the VEBA not mentioned or included in the Plante Moran presentation for funding the retiree's healthcare?

Answer

The VEBA (Voluntary Employees' Beneficiary Association) A Voluntary Employees' Beneficiary is a type of tax-exempt trust used by its members and eligible dependents to pay for eligible medical expenses. The plan is typically funded by an employer. In the case of Genesee County, its VEBA included employee contributions. Such contributions are not owned by individuals and the trust assets must be exclusively used to pay costs incurred by the Plan. The purview of the work completed by Plante Moran Group Benefit Advisors (PMGBA) did not encompass any analysis of the VEBA, its past, present, or future assets. PMGBA was retained for the purpose of evaluating all benefit plans, vendors administering the plans, and developing alternatives to provide such benefits by the County. As a result of the work completed by PMGBA, the County will make decisions on future plan operations and vendors.

2) Question/Comment from Ken Emigh as provided through PDF

Answer

Based on the information provided, Mr. Emigh, the retired employee, has Medicare coverage primary with with the County's supplemental coverage for himself. His dependents, spouse and granddaughter, are covered as non-Medicare participants because of their age.

The work performed by PMGBA did not include any changes to the eligibility provisions of the plan. Any changes to plan administration will be communicated in advance of making the plans effective.

3) Question/Comment from Michael Glasson

Are retiree dependents covered for their lifetimes as survivors? Are dental or vision care affected by the proposed plan?

Answer
To the question of lifetime coverage for surviving dependents, we will defer to the County as any response has potential legal ramifications.

To the question on dental or vision plans being affected, the analysis presented by PMGBA did not incorporate or impact the dental or vision plans.

4) Question/Comment from Vyvyan Warren

If you change from BCBS to Aetna, will out of state retirees be covered as in the past?

Answer
Any change to Aetna does not impact in or out of state coverage. The Aetna Medicare Advantage plan recommended is a national PPO with what is referred to as a "passive PPO". This means the level of benefits provided is the same in and out of network. Please understand, it does not mean an individual's cost will be the same in and out of network, only that the application of how any claim payment is determined is uniform. For example, an in-network service might be subject to a 10% coinsurance paid by the individual. If that in-network provider charges $100 for that service, the individual would be responsible for $10.

By contrast, an out of network provider might change $120 for the exact same service. This means the individual would be responsible for $12, which is 10% of the charge.

The plan is administered at the same benefit level, but the amount due by the individual is different.

5) Question/Comment from Mr./Ms./Mrs. Blanchard

I would like to see Blue Cross Blue Shield Medicare Advantage plan offered to us.

Answer
One of the options presented to the County includes BC. For the BC Medicare Advantage plan to be made available, the County would need to select BC as its administrator for all active, pre-65, and Medicare retiree benefits.

We note, the Medicare Advantage plans outlined in the materials from Aetna and BC are based on the same plan design.

6) Question/Comment from Diane Conley

Has anyone thought to forego the post retirement 13th check disbursement when the 8% goal is reached as we did in 2019 to fund retirees health benefits? How much did that equal last year and can this rule be changed? If so, by whom? Was this considered in your review and recommendations?

Answer

The analysis and recommendations done by PMGBA did not include any evaluation or recommendations on any post retirement 13th check.

Genesee County Fiscal Services Answer

The 13th check disbursement is done through the Genesee County Employees' Retirement System. If a change was made to forego the 13th check, those funds would remain in the pension system to fund the pension payments to retirees. The retiree health benefits are paid out of the VEBA (Voluntary Employees' Beneficiary Association) Fund which is an entirely separate plan.

7) Question/Comment from Carole Mattoon

Presently with HAP, they reside in Arizona for part of the year. With the new Aetna Medicare Advantage program do we still have the same limitations where you must have an in-network Dr. and a referral, or can we go to any doctor in the US? Will we have Out-of-pocket expenses (deductibles, copays, etc.) and what will they be? Will the out-of-pocket costs change? Will the dental and eyeglasses still be covered?

Answer

The Aetna Medicare Advantage plan being proposed and recommended will be based upon a different network of doctors and hospitals than what is in the HAP network. That said, many of the same doctors and hospitals you are using will be in the new network too, but HAPs network and Aetna's network are not identical.

If this approach is adopted, you will be in a PPO and not an HMO, if that's what you are in now. With the PPO you will not need to get referrals and you can opt to go in or out of network as you wish. Furthermore, the Aetna Medicare Advantage program travels with you and includes doctors and hospitals nationwide – including Arizona.

Benefit designs for pre and post 65 retirees are being consolidated from many different plans to three different plans. The plan that will be available is based on the plan in which you are currently enrolled. As noted in the presentation, any retiree design changes are between 1%and 3% in total value and it may mean there are some differences in plan design elements like deductibles, copays, and coinsurance. That said, some plans may actually have slight

improvements too. It all depends on the plan in which you are currently enrolled. More specific information about the plans is being provided.

The dental and vision care benefits are not impacted by the proposed/recommended medical plan and vendor changes.

8) Question/Comment form Colleen Soto

Do all Medicare employees have to use 98point6 virtual appointments? The employee/retiree prefers face-to-face appointments. Can I still meet my PCP face to face? Please define "stop-loss" insurance. Can I still use my preferred pharmacy, I do not approve of Express Scripts. I do not approve of these changes to my health plan.

Answers
98point6 is a feature that will only be offered to active and pre-Medicare retirees, not Medicare retirees. For Medicare retirees, virtual consults will be made available through the selected Medicare Advantage carrier, i.e., Aetna. The use of virtual consults for actives, pre-Medicare retirees, and Medicare retirees will be voluntary.

You may continue to see your personal physician through traditional face to face appointments.

Stop-loss is a risk protection management technique used by most benefit plans. It protects the plan and plan sponsor from the negative cost impact that can be caused by extremely high claims on any one individual. Right now, the County has a $170,000 individual stop loss feature. The recommendations include moving to a $200,000 stop loss level because it represents the better balance of protection and cost to the plan.

The Pharmacy benefits as recommended will remain with Express Scripts, the current vendor. Express Scripts helps develop the network of pharmacies that you may use to fill your prescriptions. Barring changes at Express Scripts, you will be able to continue using your current pharmacy. The recommendations provided by PMGBA do not include changing the network of pharmacies that individuals may use.

Board Questions

1) Can PM provide answers to the questions under public comment?

   Yes, see the above answers.

2) Is there somewhere Genesee can get a booklet for the overview of the Aetna program?

Yes, PMGBA will provide the information to HR for posting.

3) Current retirees are asking how this change would affect the pre-retiree and post-retiree current coverage with the 3 current options available?
We have provided a key that provides the mapping of current plan designs to proposed plan designs.

4) "Our ability to identify ourselves w/ what group we're in as a retiree" – is that based on deductible and medical coverage needed?
The group you are is generally defined by a plan suffix number, e.g. 019, 1000, 1003, etc. Each plan suffix may have different plan deductibles, coinsurance, and prescription copay tier. To help people determine which plan they are in we are providing a detailed summary of the plan designs for the current and recommended plans. If you need additional assistance to determine your plan it is best to contact the HR department.

5) Page 43 - #2, 3, 4 & 5 "CMM, Master medical". Depending on their deductible level & their prescription plan – does that identify what plan they should be moved into?

Yes. The information provided shows the current and the plan to which individuals will map too.

6) Major Medical – does that come in under "CMM"?

Yes. CMM mean Comprehensive Major Medical.

7) Can we get a breakdown of current retiree list against the proposed 3 plans showing a checkbook (spreadsheet) so we can see the plans at a glance?

Yes, this will be provided.

8) On page 6, total cost of 2021 plan $29M – page 29 shows cost of $21,971,000 – is that showing the difference between implementing your program?

No, page 6 costs of $29,043,969 refer to the total costs projected for calendar year 2021 for all actives, pre-65 retirees, and post-65/Medicare retirees.

The costs illustrated on page 29 of $21,971,331 are the calendar year 2021 costs (not 2020 costs as noted, this typo has been corrected and an updated copy has been sent to the County). This represents the 2021 costs for just the actives and pre-65 retirees.

The recommended plan with Meritain and Aetna results in total savings of $6,841,722 applicable to all actives, pre-65 retirees and post-65/Medicare retirees (see page 8).

The recommended savings applicable to only actives and pre-65 retirees (does not include Medicare retirees) under the Meritain/Quantum plan is $2,719,472 as illustrated on page 29.

9) How long of a turn around would it be to have the vendors in place and be able to have retirees in the system?

We are proposing to have changes in place for a January 1, 2021 effective date. In order to implement the solutions recommended by January 1, 2021, we need to have a decision made no later than September 10, 2020.

9) Email questions/comments from Margaret DesRosier-Frechette:

1) Do NOT tell your retirees who gave so much for our insurance through our life of retirement, to save a buck or two to get an advantage plan and have us get rid of our medicare.

Answer
Medicare Advantage plans are built on Medicare. In fact, enrolling in a Medicare Advantage plan requires a participant to be enrolled in Medicare Parts A and B. Medicare Advantage plans wrap Medicare Parts A, B, and C (supplemental coverage) into one package. Furthermore, the Medicare Advantage plans being considered by the County are passive PPOs meaning you can see any doctor that accepts Medicare and is willing to submit claims to the Medicare Advantage carrier (i.e., Aetna).

2) We have no limit of coverage with Medicare, can see any doctor we want, without having to have a referral and for those of us who have plenty of medical problems, we can call and get in the same day with regular medicare.

Answer
The Medicare Advantage plans being considered by the County do not restrict same day appointments. Any limitation in this regard would be based on the doctor's availability or willingness to schedule same day appointments.

3) Why would you get Aetna with only a $170,000 limit when most of us retirees have that with one visit in the hospital and then what? we get stuck with thousands of dollars of further services. Who has that kind of money?

Answer
The $170,000 referenced in the study is the stop-loss insurance purchased by the County to protect itself from catastrophic loss in the event of a serious illness or accident. The $170,000 is not something that is relevant to how retirees experience their benefits. Both the pre-Medicare plans and the Medicare Advantage plans being considered by the County cap a retiree's annual out-of-pocket costs at much, much lower amounts. The County will be positing plan design summaries where retirees can see the annual out-of-pocket limits. For example, the Medicare Advantage plans being considered limit medical expenses to $1,100 per person per year.

4) We need a supplemental as we have always had and not an advantage plan. As mentioned previously, Medicare Advantage plans include supplemental coverage.

Answer
As mentioned previously, Medicare Advantage plans include supplemental coverage.

5) If we refuse to give up our Medicare A&B for this advantage plan, can we still have the Express Scripts Part D? Or are we going to get screwed on that too?

Answer
In order to continue coverage with the County, you must retain your Medicare A & B. This entitlement is not something the County or any other organization can require you to forfeit. As mentioned previously, Medicare Advantage plans require you to also be enrolled in Medicare Parts A and B. The Express Scripts arrangement for Medicare Part D will remain with modest changes to co-payments.

6) Why take always the cheapest, remember the cheapest is NOT ALWAYS THE BEST. Take the Blue Cross, middle ground cost and give us what we are used to. the almighty buck should not be the reason for the change totally when the cost of the Blue Cross is not that much more.

Answer
With respect to the Medicare Advantage plans, there are very minor differences between the Aetna and Blue Cross arrangements. The Blue Cross solution being considered by the County is also a Medicare Advantage plan. Furthermore, all Medicare Advantage plans are governed and regulated by the federal government, so each carrier plays by the same rules. Lastly, Aetna has a higher star rating assigned to their Medicare Advantage plans meaning they are recognized by the federal government as being a higher quality solution.