Manatee County School District
Impasse Hearing
January 25, 2017

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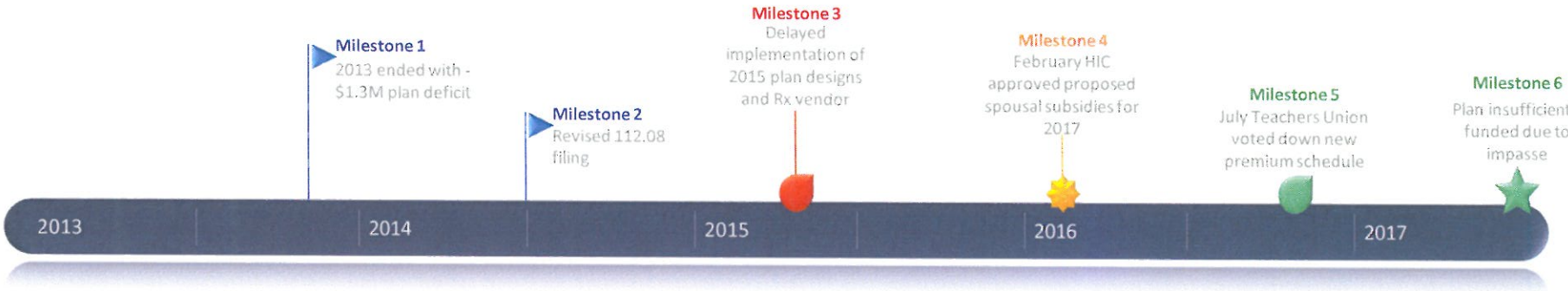
2013-2017 Timeline



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2013

- 2012 premium equivalents were maintained for the 2013 plan year
- Aon and Manatee County Schools began their partnership in the summer of 2013
- At that point, Manatee was offering employees 4 different medical plan options
  - ✓ These plans were not priced to accurately reflect the true cost or align with the actuarial value
    - Example: The richest plan design was the second least costly option
- Manatee expressed concerns with pharmacy vendor, Catamaran. Aon negotiated better terms with Catamaran to maintain relationship for the short term

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2014

- 2013 premium equivalents and plan designs were maintained for the 2014 plan year
- Manatee experienced a spike in pharmacy claims, although the increase coincided with a change in processing platforms, Catamaran insisted it was not related. This resulted in a Request For Information to acquire an alternate pharmacy vendor.
- **Aon completed the 2013 - 112.08 filing, the first since establishing a partnership with SDMC. The filing was completed on a plan year basis, resulting in a -$1.3M fund balance deficit. At this time the State provided correspondence that SDMC would not be approved to continue a self-funded health plan in 2015**
- **Aon submitted a second 112.08 filing with data through June, to align appropriately with the fiscal year per the statue requirements.** Due to the advanced collection of summer premiums – where the District collects July and August contributions in May and June, the reserve is prefunded for future expenses, inflating the balance and greatly improving the appearance of the fund at the time the filing is submitted to the State
- Manatee and Aon collaborated in redesigning the health plans and premium equivalents for 2015

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2015

- Due to delayed union ratification, the proposed 2015 plan designs and premiums were not implemented until April 2015
  - ✓ Employees experienced a 5% increase in medical premiums
  - ✓ As a result of the delay in implementation, the program was under funded for the first 3 months of the plan year
  - ✓ **In 2014-2015 the District made additional transfers to the fund, outside of the premium schedule, totaling $5,964,820**
- Envision, the new pharmacy vendor, was implemented in April of 2015 to align with the new plan designs. With increased copayments and other cost containment measures (prior authorization, step therapy, quantity limits, etc.) this restored Manatee's pharmacy experience to levels prior to the March 2014 platform migration with Catamaran
- Aon again submitted the 112.08 on a fiscal year basis, with the collection of summer premiums the plan continued to appear in compliance only due to the advanced collection of July and August premiums (see additional exhibit on slide 7)
- In the fall of 2015 the Health Insurance Committee began planning for the 2017 program

2016

- 2015 plan designs and premium equivalents were maintained for the 2016 plan year
  - ✓ The District agreed to make any additional transfers needed to cover program costs
  - ✓ **In 2015-2016 the District made additional transfers to the fund, outside of the premium schedule, totaling $4,900,000**
- The District advised Aon that, due to budget constraints, the District needed to keep their cost between $30-$35M for the 2017 plan year
  - ✓ Due to the significant change in spend from the District, Aon provided several subsidy options to meet the desired budget, the most effective option being an adjustment to dependent subsidies (see appendix for additional options proposed)
  - ✓ In order to maintain the employee and child(ren) subsidies, it was necessary to move from a 3 tier, to a 4 tier rate structure. This allowed for isolation of the spouses, who are also the most costly plan participants
  - ✓ **Proposed subsidies were agreed to and voted on by the Health Insurance Committee (HIC) in February 2016. In July 2016 Union representation indicated that the previously approved subsidies were no longer acceptable**
- Aon again submitted the 112.08 on a fiscal year basis, with the collection of summer premiums the plan continued to appear in compliance only due to the advanced collection of July and August premiums (see additional exhibit on page 7)

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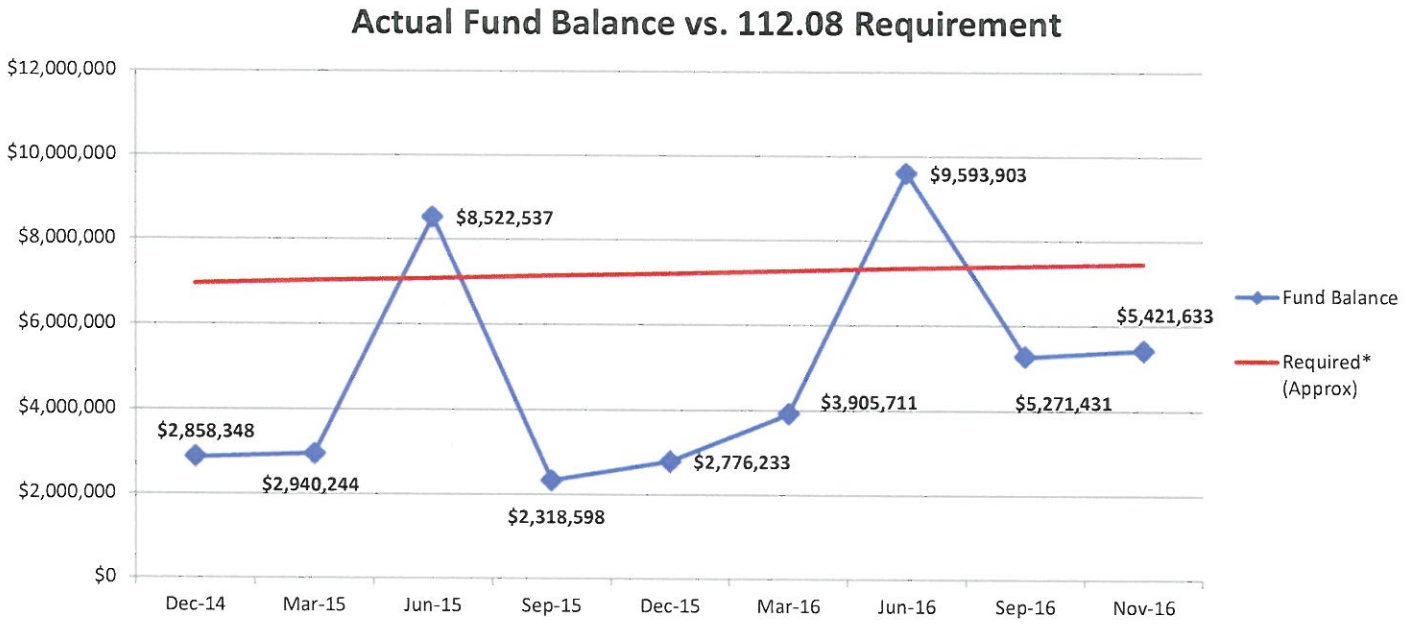
Cost Reduction Strategies

- Dependent Audit
- Compass Wellness Program
- Limit Acupuncture Benefits
- Rx Changes
- Plan Design Options
- Contribution Modeling
- Investigated Moving Fully-Insured

112.08 Fund Balance



- As of November 2016 SDMC's fund balance is $5.4M, well below the required average of $7.2M
- In terms of Aon's other self-funded School Districts, Lee, Escambia & Miami-Dade Counties, maintain the required funding throughout the year at or above the 60 day requirement. Sarasota and Pinellas Schools both recently went self-funded. They are still working to build their required reserves. Indian River Schools in a new Aon client. We are working with them to establish a plan with the State. Hillsborough, Volusia, and Clay County are all fully insured, no fund is required.

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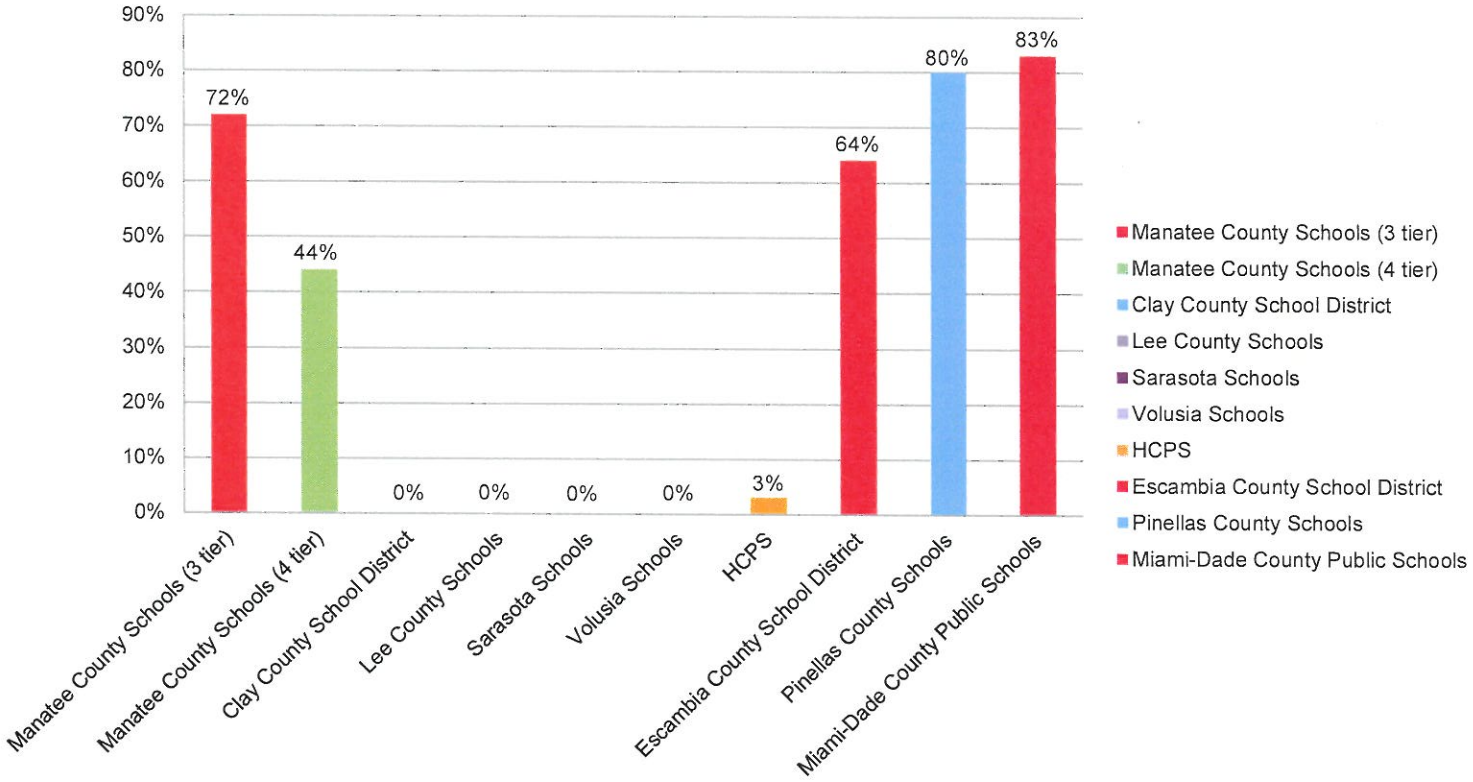
School District of Manatee County

Benchmarking Results - Current Aon Florida School District Clients

School District	# of Employees	Funding Type	2016 Employer Premium PEPY	2017 Total Monthly Spouse Premium	2017 Employer Contribution to Spouse Premium	% Employer Contributes to Spouse Coverage
Manatee County Schools	4,300	Self-Funded	$8,288	$458 (3-tier) $631 (4-tier)	$330 (3-tier) $275 (4-tier)	72% (3-tier) 44% (4-tier)
Clay County School District	2,400	Fully-Insured	$5,170	$532	$0	0%*
Lee County Schools	11,000	Self-Funded	$6,372	$725	$0	0%*
Sarasota Schools	4,700	Self-Funded	$7,874	$701	$0	0%*
Volusia Schools	6,700	Fully-Insured	$8,294	$637	$0	0%*
HCPS	22,686	Fully-Insured	$6,987	$551	$17	3%
Escambia County School District	4,050	Self-Funded	$6,123	$540	$348	64%
Pinellas County Schools	10,500	Self-Funded	$8,639	$455	$364	80%
Miami-Dade County Public Schools	33,000	Self-Funded	$9,432	$928	$770	83%

**Defined Contribution*

% Employer Contributes to Spouse Coverage



- Under the Affordable Care Act only children are considered to be qualified dependents, not spouses.
- In the last several years there has been an increase in employer groups removing spouses from coverage due to the availability for spouses to seek coverage elsewhere; other employer coverage, exchanges, etc.

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TOTAL PLAN INFORMATION (Paid Basis)

	2013	2014	2015	2016 YTD[1]
Enrollment	4,667	4,476	4,699	4,734
Medical Claims	$26.4M	$27.2M	$31.6M	$28.9M
Pharmacy Claims	$11.1M	$13.1M	$12.2M	$11.0M
Total Plan Cost[2]	$40.5M	$43.4M	$49.2M	$44.1M
Claims > $50,000	$10.1M	$10.2M	$13.2M	$12.0M
Number of Claimants > $50,000	90	85	113	101
Claims > $400,000	$1.6M	$1.9M	$1.9M	$3.0M
Number of Claimants > $400,000	3	3	3	4

CONTRIBUTIONS

	2013	2014	2015	2016 YTD[1]
Total Plan Cost[2]	$40.5M	$43.4M	$49.2M	$44.1M
Subscriber Contributions	$13.5M	$12.9M	$13.5M	$12.2M
Spouses (Active Only)	$2.7M	$2.5M	$2.6M	$2.4M
District Responsibility	$27.0M	$30.5M	$35.7M	$31.9M

	2017 (MEA at 3-Tier Rates)		2017 (MEA at 4-Tier Rates)	
	Total Dollars	Percent	Total Dollars	Percent
Subscriber Contributions	$14.2M	27.5%	$16.4M	31.8%
District Responsibility	$37.4M	72.5%	$35.2M	68.2%

CLAIMANT TYPE INFORMATION

	2013	2014	2015	2016 YTD[1]
Distribution by Member Type				
Subscribers	50.6%	50.9%	50.9%	51.2%
Spouses	19.3%	19.1%	18.8%	18.6%
Children	30.1%	30.0%	30.3%	30.2%
Relationship Factor				
Subscribers	100.0%	100.0%	100.0%	100.0%
Spouses	103.7%	94.1%	138.9%	119.9%
Children	46.0%	48.3%	35.4%	67.1%

SPOUSE LARGE CLAIMANTS

	2013	2014	2015	2016 YTD[1]
Claims > $50,000	$2.6M	$1.9M	$5.4M	$3.2M
% Of Total Claims > $50,000	*25.5%*	*18.9%*	*41.0%*	*26.9%*
Number of Claimants > $50,000	26	21	41	31
% Of Total Claimants > $50,000	*28.9%*	*24.7%*	*36.3%*	*30.7%*
Claims > $400,000	$0.0M	$0.0M	$1.4M	$0.4M
% Of Total Claims > $400,000	*0.0%*	*0.0%*	*72.2%*	*14.4%*
Number of Claimants > $400,000	0	0	2	1
% Of Total Claimants > $400,000	*0.0%*	*0.0%*	*66.7%*	*25.0%*

Notes:

1. 2016 YTD = Through November 2016
2. Includes fixed expenses from HIC fund summary
3. See projected medical trend definition
4. SDMC Experienced trend through May of appropriate year

Data Sources:

I. Large claim reports for plan years 2013 though 2016 YTD (through November) provided by Florida Blue.
II. Enrollment and membership counts for January 2013 through November 2016 provided by Florida Blue.
III. Medical paid claims for January 2013 through November 2016 provided by Florida Blue.
IV. Medical incurred claims for January 2013 through November 2016 were developed by Aon based on claim lag reports provided by Florida Blue.
V. Pharmacy paid claims for January 2013 through March 2015 provided by Catamaran.
VI. Pharmacy paid claims for April 2015 through November 2015 provided by EnvisionRx.

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Definitions

- **Actuarial Value:** *Actuarial Value is the percentage of total health care costs expected to be paid by the plan after deductibles, coinsurance, and copays are applied. It is complementary to the out-of-pocket percentage.*

- **Trend:** *The trends are intended to represent the underlying cost trend of each health care delivery type. They include the two general drivers of cost trend: price increases and utilization increases. These two broad categories are driven by more specific trend components such as general and medical inflation, changes in mix of services, aging of the total population (albeit a very small portion), technology, malpractice, cost shifting from nonpaying individuals and other external influences.*
  - ✓ Slight adjustments are considered to reflect plan designs, geography and other client specific demographics

Appendix

- Other Strategy Options – October 2015
- Self-Funded to Fully Insured – November 2015
- Trend Statement – April 2016