Arthur J. Gallagher & Co.
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SJVIA
San Joaquin Valley Insurance Authority

Results of Internal Gallagher Audit and Recommendations

January 1, 2013-October 31, 2015

GALLAGHER BENEFIT SERVICES | DECEMBER 30, 2015

SJVIA Cash Flow Contributing Factors

Background:

Gallagher recently conducted a thorough review and audit of all premium and claims data from 2013 to the present.
Since the inception of the SJVIA, Gallagher has compiled plan information in order to track attributes for reporting and plan performance reviews. This information comes in many forms from several sources and is consolidated into one internal Gallagher document (Plan Cost Summary). During this recent review process, all sources that feed the Gallagher Plan Cost Summary were rechecked directly and compared to verify the following information:

- Enrollment Data – Confirm the enrollment data (total number of plan participants in each one of the plans for each of the member entities) to insure enrollment been properly verified. *Gallagher requested enrollment information (by entity, by plan and by coverage tier) from Hourglass. Gallagher then compared this verified source data with the Gallagher Plan Cost Summary. The source for this data was provided by Hourglass and represented the actual enrollment and eligibility for each group.*
- Premium Rates – Confirm the proper premium rates have been billed for each of the plans at each of the member entities. *The source data for this was the actual billed rates as agreed upon and noted in the individual entities participation agreement with the SJVIA. Gallagher further verified that the actual rates billed equaled the previous premium rates adjusted by the SJVIA Board approved renewal action.*
- Claims – Confirm all claims (by year, by entity, by plan) during the review period to insure that eligible claims have been reported and paid. *The source for this data was Anthem Blue Cross for the Minimum Premium HMO and the Anthem PPO, Blue Shield of California and HealthNow Administrators for the City of Tulare and US Script for the prescription drug claims.*
- Stop Loss and Other Reimbursements –Confirm that reimbursements from the excess reinsurance carriers and other sources have been paid. *The source for this data was Anthem Blue Cross for Minimum Premium HMO charges in excess of $400,000 (non-capitated claims), HM Life and Benefitmall for PPO claims in excess of $450,000. Gallagher also verified Capitation refund amounts with Anthem Blue Cross as well as Rx rebates with US Script.*

Results of the review/audit:

The internal review conducted by Gallagher supported the accuracy, within reasonable limits, of the Plan Cost Summary used for the reporting and renewal functions. ***This review is available for internal use and discussion only.***

Pertinent items to be discussed:

1. Reserves: The beginning reserve for the 2013 plan year (ending 2012) was calculated at $12.0 million. From the source data, ending and beginning reserves were calculated thereafter through 10/31/2015 (for the 2013, 2014 and 2015 plan years). As shown below, ending the 2014 plan year and going into the current year (2015), the beginning reserve was calculated to be $12.25 million, not including the approximate $1 million in the HMO reserve held by Anthem. Clearly, the 2015 plan year beginning reserve of $12.25 million was appropriate to support the renewal according to underwriting calculations and based upon past performance. The HMO plan has experienced unusually high claims during the 2015 year to date and as a result, the HMO reserves alone have been depleted from $1.5 million positive to $7.7 negative, a $9.2 million delta. The reserve calculation assumes all premiums are paid through October 2015.

Reserve Calculations: 01/01/2013 through 10/31/2015

		2012	2013	2014	2015 (thru 10/31)
Beginning	PPO	N/A	$5,964,118	$10,005,185	$10,689,372
Beginning	HMO	N/A	$6,038,546	$4,193,084	$1,558,568
Total Beginning		N/A	$12,002,664	$14,198,269	$12,247,940
Ending	PPO	$5,964,118	$10,005,185	$10,689,372	$10,456,083
Ending	HMO	$6,038,546	$4,193,084	$1,558,568	-$7,681,730
Total Ending		$12,002,664	$14,198,269	$12,247,940	$2,774,353

2. HMO claims activity in 2015: The SJVIA HMO is currently showing a deficit of $9,240,298 (Total Premium less Total Expenses) YTD for 2015. The County of Fresno is responsible for $6,538,573 and the County of Tulare is responsible for $1,427,489. Combined, the two Counties make up $8.0 million of the total $9.2 million shortfall. The claims during this time period have exceeded 2014 claims costs and 2015 claims projections. As an example, for the 2015 renewal projection, using the standard SJVIA approved renewal rating methodology, HMO claims for the 2015 calendar year were anticipated to be:
    - Capitation $276.05 Per Member Per Month
    - Non-Capitated Medical Claims $419.03 PEPM
    - Rx Claims $147.82 PEPM

    Using the above projections, the total projected claims through 10/31/2015 would be $40,868,849.

    The actual net HMO claims for the period 1/1/2015 – 9/30/2015 are:
    - Capitation $276.05 PEPM
    - Non-Capitated Medical Claims $479.15 PEPM
    - Rx Claims $198.49 PEPM

    Using the above net claims costs, the total claims through 10/31/2015 are $46,240,677. Claims through 10/31/2015 are $5,371,828 ***greater*** than projected.

    These claim cost components represent an increase over 2014 of 26.48% (Non-Capitated Medical Claims) and 29.57% (Rx Claims). One item of note, Gallagher has identified 92 claims over $50,000 (through 10/31/2015) in 2015. For comparison, in 2014 there were only 65 claims over $50,000. Gallagher is currently working with Anthem Blue Cross to identify the source and possible reasons for this increase in larger claims. Additionally, GBS is looking at the following:

    - HMO Claims Payment in Excess of Projections
    - Community Hospital Lab Charges
    - Cap on Rx Claims (result of ACA) and Specialty Drugs
    - Why the Rx has increased at such an alarming rate over trend

Renewal Projection and Pricing

Beginning in 2012, the SJVIA began to employ a shared-risk, blended renewal methodology. Prior to that time, the Fixed Cost Components of the SJVIA program were shared but the entities (County of Fresno and County of Tulare) developed rates and renewal action based on their individual claims experience.

Gallagher Benefit Services has conducted the renewal claims projection and proposed rate action underwriting since the inception of the SJVIA using actuarially verified guidelines. These guidelines have been discussed, reviewed and accepted by SJVIA staff and the SJVIA Board of Directors.

Beginning in 2012, for each shared-risk renewal, GBS first determines the upcoming year's anticipated total plan costs. These costs include both a Fixed Cost component and a Claims Projection.

Fixed Costs Components:

- *Administration Fee – the fee (on a Per Employee Per Month basis) for Anthem to administer the claims adjudication process. Includes the fee charged to access the Anthem Blue Cross network of providers to ensure that eligible charges are subject to the steepest discounts available. This network discount analysis was recently reevaluated and confirmed by the SJVIA during a review of responses to a Request for Proposals for network discount.*
- *Excess Re-Insurance Fee – The SJVIA has elected to purchase excess reinsurance to indemnify the Authority should an individual claim become excessive. The Authority purchases a policy that reimburses once a PPO claim reaches $450,000 and when an HMO claim reaches $400,000.*
- *ACA Fees*
- *Various Other Administrative Fees*

The Fixed Costs for the SJVIA, both as a dollar amount and as a percentage of total plan costs, are the lowest of any program currently in existence. For example, the Affordable Care Act sets a maximum of 15% of total plan costs attributable to administrative costs. The Fixed Costs for the SJVIA PPO have averaged between 8-9% while the HMO has averaged 11%.

Claims Projection:

Due to the size and makeup of the SJVIA covered population, actuaries consider the SJVIA claims experience to be 100% credible. That is, the current claims of this population will have a direct relationship to what the future claims will be. Each July, Gallagher reviews claims activity (most recent 12 or 18 months), adjusts for any excess reimbursement payments and applies an agreed upon and appropriate medical inflationary trend increase in order to project claims for the upcoming renewal period. This claims projection (on a Per Employee Per Month – PEPM basis) is calculated for both the PPO and HMO and shown in the final renewal ratified and accepted by the Board.

The following table demonstrates GBS's claims projection (developed 6 months prior to the start of the plan year) versus actual claims for each of the blended renewal years:

Plan Year	*Plan*	*GBS Claims Projection*	*Actual Claims*
2012	*HMO*	*$674.55 PEPM*	*$706.20 PEPM*
2012	*PPO*	*$562.95 PEPM*	*$533.45 PEPM*
2012	*Combined*	*$628.50 PEPM*	*$629.83 PEPM*
2013	*HMO*	*$774.36 PEPM*	*$768.03 PEPM*
2013	*PPO*	*$611.23 PEPM*	*$544.29 PEPM*
2013	*Combined*	*$703.73 PEPM*	*$672.61 PEPM*
2014	*HMO*	*$820.51 PEPM*	*$802.49 PEPM*
2014	*PPO*	*$585.05 PEPM*	*$614.39 PEPM*
2014	*Combined*	*$721.99 PEPM*	*$720.68 PEPM*
2015	*HMO*	*$842.91 PEPM*	*$953.69 PEPM*
2015	*PPO*	*$657.02 PEPM*	*$691.21 PEPM*
2015	*Combined*	*$762.78 PEPM*	*$821.19 PEPM*

The above table reveals two things:

1) *Gallagher has historically been very successful in projecting the claims for each of the plans.*
2) *The SJVIA HMO has experienced unpredictably high claims in plan year 2016*

Final Rating Action

Once the Fixed Costs are identified and the Claims are projected, Gallagher can anticipate total costs for the upcoming rating period. Using the enrollment from the final month of the claims measurement period, the SJVIA can determine what the appropriate rate action should be. Gallagher determines this rate action

individually for the PPO, individually for the HMO and finally on a "whole-case" basis for both plans combined. From 2012 through 2015, the direction from the Board of the SJVIA was to blend the PPO and HMO and have one rate action for all of the SJVIA benefit plans. Beginning with the 2016 SJVIA renewal, the Board elected to issue separate rate actions. The PPO will experience a 4.9% increase while the HMO will experience an 11.7% or 13.1% increase (depending on member entity). These bifurcated renewal increases are still partially blended to smooth the overall projected rate increase.

3. Kaiser Migration: At the January 1, 2015 renewal effective date, 433 Anthem plan participants migrated off the Anthem BC PPO (self-insured) and HMO (minimum premium) plans and moved to the Kaiser plan, a fully insured plan. The 2015 renewal had been projected and rates were set during the 2014 plan year using 2014 enrollment/experience and in advance of the 2015 open enrollment and without foreknowledge of how many employees would migrate to Kaiser.

   The consequence of this amount of migration can be summarized that 433 employees no longer paid premium into the SJVIA Anthem plans as of January 1, 2015, however runout claims were paid for the next several months on those employees who left in favor of Kaiser. Effectively no revenue would come in but claims money would flow out. The estimated runout claims that would have been paid directly from the reserve for medical and Rx claims are estimated at approximately $484,157. GBS has projected this cost by taking actual claims rates for Non-Capitated medical claims and Rx claims from calendar year 2014 (there is no need to include Capitated costs as they are no longer being charged) on a Per Member Per Month basis and (conservatively) anticipating 2 months of runout claims. This IBNR payment has had a direct impact on the total reserve balance.

   It is anticipated (per the open enrollment results for the County of Fresno) that > 400 more employees will be migrating to Kaiser effective 1/1/2016 which will have an additional impact to the reserve balance.

4. Timing of Accounts Receivables: The data that Gallagher uses in all of our reporting functions to the SJVIA (monthly claims reports, renewal projections and recommendations, etc) originates from various sources. Regardless of the source utilized, the assumption for Gallagher's reports is that all entities that have reported enrollment, the corresponding premium for that enrollment has been received by the SJVIA. For example, if the reports show that the County of Fresno had 4,000 employees covered in the month of January, GBS anticipates that the premium for those 4,000 January County of Fresno employees has been received by the SJVIA. If the premium for January is not received by SJVIA in January, then the cash on hand will not reflect that premium. It is technically still part of the assets of the SJVIA (as an account receivable) but it is not available as cash on hand as it has not yet been remitted.

   Since first notified by the SJVIA of the cash flow issue, Gallagher Benefit Services has been concerned about a disconnect related to the timing of the County of Fresno's premium contributions. It is Gallagher's understanding that the County of Fresno pays premiums 2 pay periods (4 weeks) in arrears (i.e. the County of Fresno pays premium for members covered for the month of July by August XX). This payment schedule will, by design, always present the potential for cash flow issues. The claims are paid by the SJVIA for covered members on a daily (or weekly) basis. If claims for County of Fresno members are paid in July, but premium is not received by the SJVIA for those members until August, the impact to cash flow is evident.

   The County of Fresno recently noted that they had "advanced" the SJVIA $1,000,000 towards their premium obligation. It is our understanding that this "advance" actually brings the County from 2 pay periods in arrears to 1.5 pay periods in arrears. The impact to cash flow is slightly mitigated by this

reduction in arrears, however the underlying issue remains. Until the County of Fresno pays for claims on their membership with premium for that month, this cash flow issue will continue.

Gallagher understands that the City of Modesto has traditionally paid in arrears as well. The City of Modesto has the majority of its members covered by Kaiser and as such, would have very little impact to cash flow by paying in arrears. Additionally, the City of Modesto has recently notified the SJVIA that they will begin paying current premiums by the 10th of each month. This change in premium remittance will eliminate any cash flow issues with the City of Modesto for 2016 and beyond.

SJVIA Rate Action Since Inception

Below is a table showing the SJVIA rate action by year vs a consensus trend:

Year	*SJVIA Rate Action*	*Consensus Trend**	*Difference*
2012	*0%*	*8.5%*	
2013	*4.9%*	*7.5%*	*-35%*
2014	*5.3%*	*6.5%*	*-19%*
2015	*1.17%*	*6.8%*	*-83%*

**Consensus trend from PwC Health Research Institute*

Overall Plan Savings

In the first year of the SJVIA, the combined savings for the County of Fresno and the County of Tulare was in excess of $1.5 million over the fully-insured renewal offerings. Since then, if you were to apply the above consensus trend rate increases and compare that to the actual rate action for the SJVIA (see table below) the approximate total savings attributable to the Authority would be $6,494,872.

Renewal Year	2012 Claims PEPM	2012 Enrollment	2012 Total Claims Cost	2013 SJVIA Renewal	2013 Trend	*Savings over Trend*
2013	$629.83	98,193	$61,844,897	4.90%	7.50%	
				$64,875,297	$66,483,264	*$1,607,967*
Renewal Year	2013 Claims PEPM	2013 Enrollment	2013 Total Claims Cost	2014 SJVIA Renewal	2014 Trend	*Savings over Trend*
2014	$672.51	105,262	$70,789,748	5.30%	6.50%	
				$74,541,604	$75,391,081	*$849,477*
Renewal Year	2014 Claims PEPM	2014 Enrollment	2014 Total Claims Cost	2015 SJVIA Renewal	2015 Trend	*Savings over Trend*
2015	$720.68	109,848	$79,165,257	1.17%	6.80%	
				$80,511,066	$84,548,494	*$4,037,428*
			Total	$219,927,967	$226,422,840	*$6,494,872*

Conclusion:

As a result of the above review, Gallagher is confident in the methodology used and the reserves identified at any given point in time (all premiums received, for all eligible employees enrolled, less all fixed costs for all eligible employees enrolled, less all claims paid for all eligible employees enrolled).

By definition, the cash on hand at any point in time will fluctuate (sometime greatly based on claims activity and the timing of premium receivables) and may never equal exactly the amount calculated by Gallagher as reserves. To the extent that the claims activity mirrors the claims projections and all entities are paid current in their premiums, there would be no cause for concern relating to cash on hand. However, if claims begin spiking (as they have) and some entities are paying premiums in arrears (as they are) then cash on hand will diminish. If this trend continues, the potential for exhaustion of the claims reserve becomes very real.

Gallagher Recommendations:

- Gallagher recommends the SJVIA staff work with all entities to insure timely premium payments. As identified above, the formula for determining reserves (as well as impacting cash on hand) requires that all premiums be paid in a timely manner. Fixed costs and claims are being paid on those members and if premium has not been collected that will contribute any cash on hand discrepancy. It is Gallagher's belief that two entities currently are responsible for approximately $3.2 million in premium arrears (premium due but not yet received by SJVIA). Had this premium been paid timely it would have completely mitigated the recent "Line of Credit" issue facing the County of Fresno (and SJVIA).

- During our review, Gallagher validated all enrollment eligibility, all premium amounts, all claims payments and all excess reimbursements for accuracy. Since Gallagher does handle any of the below functions, we would recommend that the staff of the SJVIA review the following:
    - Billing
        - Eligibility by entity by plan – did the SJVIA bill the correct number of employees for each plan offered by each entity?
        - Premium billed by entity by plan - did the SJVIA bill the correct premium (by tier) for each plan offered by each entity?
        - Premium received by entity – Has the SJVIA received all premiums due for each plan offered by each entity?
            - If the SJVIA is in arrears, which entity(s) are late in paying? What is the total amount still due the SJVIA for those covered employees?
    - Payments
        - Fixed costs by entity - has the SJVIA paid all fixed costs due by entity?
            - If the SJVIA has paid out fixed costs for an entity but not yet received premium for that entity, cash on hand will be affected.
        - Claims reconciliation - has the SJVIA reconciled the amount of ACH (and check payment) transfers from the claims fund against the Gallagher verified amounts?
        - Excess Reinsurance/Rx rebate reimbursements – has the SJVIA received and accounted for all reimbursements (Stop Loss, HMO Pooling, HMO Capitation and Rx Rebates)?