Marketing and Expansion Feasibility Study

San Joaquin Valley Insurance Authority

Compiled by

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Gallagher Benefit Services, Inc.
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Part I – Expanding the San Joaquin Valley Insurance Authority

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Executive Summary

San Joaquin Valley Insurance Authority is a Joint Powers Authority organized under the laws of the state of California. The Authority currently provides medical benefits to the County of Fresno (self-funded PPO and Minimum Premium HMO) and the County of Tulare (self-funded PPO). The Authority is governed by a Board of Directors made up of publically elected representatives from each member County. The Authority began operations in December 2009 and has recently issued renewal offerings to both member counties for the plan year 2011. The Board of Directors of the Authority, as well as the respective Board of Supervisors for each county has approved the renewal offering.

The management responsibilities of the Authority are currently being shared by staff from each of counties. These management duties include, but are not limited to: Executive Director duties; Legal and regulatory review and Bookkeeping and Auditing functions. The San Joaquin Valley Insurance Authority has formed a strategic alliance with Gallagher Benefit Services, a wholly-owned subsidiary of Arthur J Gallagher Co, for the purpose of providing first class benefits consulting, actuarial and design services to its target market.

The market for alternative options in the public sector is extremely broad. Currently there are few programs available that are specifically tailored and targeted to the unique needs of the public sector. The San Joaquin Valley Insurance Authority has enjoyed outstanding initial success and believes our value proposition will resonate within the tight-knit population of public entities.

Situation Analysis

San Joaquin Valley Insurance Authority is entering its second year of operation. The interest for its services has been higher than expected with many different public entities expressing a desire to learn more about the Authority. Several prospective members have already requested a proposal for inclusion in the Authority. Along with the interest already generated, marketing will be critical for generating customers and visibility for the Authority. The basic market need is for additional options for public entities. The San Joaquin Valley Insurance Authority meets this market need with a quality and cost advantage for this underserved population.

Market Summary

Gallagher Benefit Services has extensive knowledge about the public entity marketplace and have collected significant amounts of information regarding the common attributes of the ideal customers. This information will be used to continually research the specific needs of the customers and determine how they can be better served and communicated with.

Market Needs

San Joaquin Valley Insurance Authority is providing its current membership with medical benefits, offered in a flexible manner to meet the each member county's specific needs. SJVIA will fulfill the following benefits that are important to its current customers as well as positioning the Authority for targeted growth.

- **Flexibility:** every entity has unique needs and, assuming they fit the SJVIA risk profile, SJVIA will be able to satisfy all of them.
- **Quality Products:** employee benefits are of critical importance. Through SJVIA's partnership with Gallagher Benefit Services we are able to offer a state-of-the-art benefits offerings.
- **Good Advice:** SJVIA and Gallagher Benefit Services offers a wide range of consulting services that allows it to determine the individual entity's needs and then tailor its service to meet these needs.

Market Trends

The health care delivery system has undergone significant changes over the last ten years. The industry as a whole has seen significant consolidation and a reduction in viable, meaningful alternatives – especially in the public sector. The consolidation has occurred primarily as a way for companies to remain profitable despite significant increases in health care costs.

Another way that the industry has dealt with rising costs has been increased adoption of the managed care. Managed care was specifically designed as a way to offer a foundation of base of health care while keeping costs within reason. Regardless how the industry has changed and tried to adapt to the significant increases in costs, more and more public entities are actively researching alternatives and welcoming options.

Market Growth

The market for a thoughtful, viable alternative for public entities in Central California is remarkably large. Budget constraints and uncertainty are incentivizing entities to look at all options. The San Joaquin Valley Insurance Authority is well positioned to leverage the initial successes and strong stakeholder relationships of the program in order to capture additional market share.

SWOT (Strengths, Weakness, Opportunities, Threats) Analysis

The following SWOT analysis captures the key strengths and weaknesses within the company and describes the opportunities and threats facing the San Joaquin Valley Insurance Authority.

Strengths

- Lowest imbedded fixed costs on the market
- Strong relationships with stake-holder partners.
- GBS's strong experience in the public entity sector.
- Exceptional industry insight and resources.

Weaknesses

- References for down-market expansion
- Length of time in operation

Opportunities

- Our target market has limited options currently available.
- The ability to spread costs over a larger customer base.
- Future strategic relationships developed as the Authority becomes more established.
- Ancillary offerings (dental, vision, life, LTD) utilizing the same model of aggressively driving fixed costs to the lowest levels available

Threats

- Government regulation.
- Significant changes in the cost structure of health insurance.
- Other JPA's forming
- Turnover of the elected Board of Supervisors at stakeholder's counties

Competition

Benefit programs for public entities and their employees comprise a multi-billion dollar industry that is highly competitive. Well-known national insurance companies like Prudential, Cigna, Aetna/US Healthcare, and the regional Blue Cross and Blue Shield companies seek the employer's dollar. In the public entity market space, the two primary options an entity has outside of a direct contract with carriers are CalPERS and CSAC-EIA

The San Joaquin Valley Insurance Authority strongly believes that a niche exists that is not well served with broad enough quality services by other pooled or JPA type arrangements. We have already demonstrated an ability to work with all partner constituents to insure the lowest possible fixed costs, thus saving our existing member counties substantial benefits dollars. By providing those quality services to an expanded population, at a fair price, SJVIA believes a competitive sales advantage exists that will permit attainment of the market goals sought.

Service Offering

Public entities now demand much more in the way of benefit options, funding alternatives, services and analysis than ever before. The San Joaquin Valley Insurance Authority and Gallagher Benefit Services have compiled an alliance of external providers, a service mix that includes: Benefits Plan Design and Pricing; Network Contracting Services, Actuarial Analysis; Consulting and Benchmarking Studies; Claims Management and Reporting; Ancillary Benefit Marketing; Quality Assurance, and Marketing Services.

Keys to Success

The keys to further success of the San Joaquin Valley Insurance Authority include:

1. **Product quality**. The plans and services provided by the San Joaquin Valley Insurance Authority and Gallagher Benefit Services are already state-of-the-art and reflect the lowest cost components of any public entity program currently available. The value added experience of the San Joaquin Valley Insurance Authority management team and its provider networks will ensure customer satisfaction. It is a necessity that clients maintain satisfaction both with service and plan cost.

2. **Marketing**. The San Joaquin Valley Insurance Authority and Gallagher Benefit Services will market directly to it's target demographic. After a time, it may prove beneficial to increase distribution channels. Initially, it will be necessary to establish name recognition among more established programs.

Critical Issues

The San Joaquin Valley Insurance Authority is in the initial stages of planning for growth. The critical issues that it faces are:

- Being careful to pursue carefully controlled growth where the potential new members fit the Authority's risk profile as well as subscribe to the Authority's vision. This will help ensure program cohesion.
- Protect stakeholder's interest while increasing market share. This will allow initial stakeholders to recoup start-up costs while utilizing the economies of ever-larger numbers to drive down fixed costs.

Part II – Governance and Management of the San Joaquin Valley Insurance Authority

- Governance
  - Founders Option
  - Congressional Option
  - Democratic Option
- Board of Directors Make-Up and Responsibilities

- Management
  - Staffing the SJVIA

The first Governance Model option called the "Founders" option includes the original proposal of leaving binding authority with the founding members. New member agencies are given non-voting seats on the Board of Directors.

However there are multiple choices for sub-governance entities. Sub-governance implies a different more diffuse decision-making structure at the program level while fundamental policy and management decisions rest with the Board of Directors.

The second option the "Congressional" or Blended Option opens up membership on the Board of Directors' to new members of the authority. However votes by the Board of Directors are weighted based on the size of the new member agencies as they join. The original founders Fresno County and Tulare County retain their four and three votes respectively on matters within the jurisdiction of the Board.

As in the case of the "Founders" option there are multiple options for sub-governance program level decisions.

The "Democratic Option" (small 'd') assumes a one agency one vote structure for the Board of Directors and carries out that same model through the sub-governance structure.

Fundamental Decisions of the Board of Directors

Regardless of the structure selected for the make-up of the Board of Directors there are fundamental decisions that are recommended to be maintained at the Board level. They include:

- Appointment of Authority Positions or Employees
- Adoption of Agency Budget
- Approve modifications of SJVIA bylaws and other governing documents as appropriate
- Select and Approve Principal Consultants
- Exercise Decision Making Authority over matters of Litigation
- Execute final approval of all contracts, agreements and insurance programs
- Adopt or approve rate structures for all SJVIA sponsored plans

The term sub-governance means that decisions not reserved to the Board of Directors would migrate to the program level. For our purposes programs would include self-funded preferred provider medical plans, health maintenance organization medical plans, insured medical plans, reinsurance, other benefit plans such as dental or vision plans if offered through the SJVIA.

In the case of PPO plans, if there are multiple plans involving multiple agencies the PPO Program would have its own committee to make decisions regarding the elements and structure of the program (plans).

Governance Model Options Table

At the end of this report there is a two page table that graphically describes the governance options described in this part. The first page describes various ways the authority of the Board of Directors may be exercised. It also lists the fundamental decisions that would reside with the Board regardless of the make-up of the Board. This page also describes the Banking Model and Pooled Risk Model.

In the case of the Banking Model there is no need for a sub-governance structure. Fundamental decisions are made by the Board and since each member essentially "self-funds" its own claims each member has the authority to structure most of the elements of its desired benefit plan or plans.

The Pooled Model is more complex. Individual agency decisions can have an effect on the experience of everyone in the pool. For these reason among others pooled programs will be subject to experience rating by the SJVIA based on actuarial analysis. The latter means that rates will be periodically adopted by the SJIVA that may set result in different percentage changes in future premiums paid by different members of that particular program.

Just as you have been provided options on voting structure at the Board of Directors membership level page two offers a variety of both voting options and retention options for the Board of Directors on decisions to be made or recommended by program participants.

For example the Board of Directors could retain the authority to select multiple options from which program members could select a vendor, a stop loss limit or premium. Or the program members could be allowed to make their own preferred selections of a vendor, a stop loss limit or premium levels and the Board of Directors would have the ability to ratify or veto that recommendation. The third example would allow the program committee to make the final decision on their own. These examples may appear easier to follow on page two of the attached table.

Recommendation
Tulare County staff would generally recommend the blended option. It allows new members the ability to vote on matters that affect the SJVIA. It reserves some specified voting power to the founding members who are likely to continue to be the largest members of the agency in the foreseeable future.

It allows program participants to make their own decisions regarding the programs they participate in. However it gives the founding members a voice at the table even if the founding member is not a plan participant. Finally, the Board of Directors may exercise veto of a proposed plan or program if it is not deemed in the best interest of the SJVIA. This would allow the program members the opportunity to resubmit a plan/program of their choosing rather than having one dictated by the Board.

There are valid arguments in support of each of the various options. Staff will be prepared to respond to questions regarding these options.

Governance Model Options			
Elements of Governance v Options	**Founders Option (Central Authority)**	**Congressional Option (Blended Option)**	**Democratic Option (One Entity One Vote)**
Board of Directors	• Founding Counties Retain Voting Authority on Board Matters. • New members are granted non-voting seats on the Board of Directors regardless of size of agency	1. Founding Counties retain Voting weight of 4 for Fresno and 3 for Tulare County. 2. New entities receive voting weight based on size of entity: • Less than 1000 employees – 1 vote • 1000 – 3000 employees - 2 votes • 3000+ - 3 votes 3. Each entities' votes may exercised by one or more entity members participating in Board meetings.	• All Agencies exercise one vote each on matters before the Board of Directors (CSAC-EIA model)
Matters For Board of Directors	• Appointment of Authority Positions or Employees • Adoption of Agency Budget		

	• Approve modifications of SJVIA bylaws and other governing documents as appropriate • Select and Approve Principal Consultants • Exercise Decision Making Authority over matters of Litigation • Execute final approval of all contracts, agreements and insurance programs • Adopt or approve rate structures for all SJVIA sponsored plans		
Program Types	Banking Model: Shared fixed cost contracts, shared risk reinsurance contracts, underpinned by self-insured first dollar liability, which is the present model for the authority. Pooled Risk Model: Programs with pooled risk continue to leverage fixed costs and reinsurance premiums. Participating entities premiums and claims are pooled together and rates are set based on the overall experience of the pool. Risk sharing can vary within a pool based on the specific stop loss limit for each entity. Those limits are based on credibility assessments of each participating group. Future premiums are adjusted based on loss experience.		
Elements of Governance v Options	**Founders Option (Central Authority)**	**Congressional Option (Blended Option)**	**Democratic Option (One Entity One Vote)**
Banking Model	Board of Directors Approval	Board of Directors Approval	Board of Directors Approval
Program Elements	Banking model members may set their own benefit structures establishing evidence of coverage statements and benefits tailored to their specifications subject to law.		
Pooled Model - Sub-governance structure (Committee) comprised of participants in the pool.	1. Pooled risk programs must be sponsored by a founding member of the SJVIA. 2. All program participants have weighted vote: • Less than 1000 employees – 1 vote • 1000 – 3000 employees - 2 votes • 3000+ - 3 votes	1. Program does not require sponsorship by founding member of SJVIA 2. Each participant entity has one vote 3. Participating Founding members may veto committee decision 4. Tulare County and Fresno County part of Sub-governance group but if not program participant serve as non-voting member.	1. Program does not require sponsorship by founding member of SJVIA 2. Only program participants have voting powers and each entity has one vote
Pooled Model - Program Elements 1. Program Vendor selections 2. Stop Loss	Program participants select from options approved by the Board of Directors	Pooled Program participants submit recommendations Ratified or vetoed by Board of Directors	Selected by vote of Pooled Program members Only program

Limits 3. Adoption of Premiums			participants have voting powers and each entity has one vote
Elements of Governance v Options	**Founders Option (Central Authority)**	**Congressional Option (Blended Option)**	**Democratic Option (One Entity One Vote)**
Pooled Model-Evidence of Coverage	Pooled model members with 1000 and more subscribers may set their own benefit structures establishing evidence of coverage statements and benefits tailored to their specifications subject to law. Pooled model members with less than 1000 subscribers shall submit their proposed benefit structures and evidence of coverage schedule for approval by the Board of Directors. Plans mimicking an insured plan from a national health insurance provider shall be approved subject to ability of the authority's third party administrator to administer such structured benefit plan.		

Management of the San Joaquin Valley Insurance Authority

The management responsibilities of the Authority are currently being shared by staff from each of member counties. Additionally, the SJVIA has formed a strategic alliance with Gallagher Benefit Services for the purpose of benefits consulting, actuarial and program design services. As the Authority grows in membership (both member lives as well as member entities) it will become necessary to provide dedicated staff rather than utilize the entities resources. Imbedded in the rating structure is a SJVIA management fee which is being collected and reimbursed to the counties upon receipt of billed hours for the services provided. Growth of the member base of the SJVIA will allow more funds to be available for these dedicated positions. Member growth may also provide an opportunity for the founding member entities to recoup monies spent during the formation of the SJVIA.

Part III – Marketing Strategy of the San Joaquin Valley Insurance Authority

- Mission
- Objectives/Goals
- Target Market
- Positioning
- Sales Forecast

Mission

The mission of the San Joaquin Valley Insurance Authority is to be the premier benefits plan for public entities in the Central Valley of California. We will accomplish this by consistently demonstrating for our member entities the lowest fixed costs, the most aggressive claims management and the best service available of any benefits plan.

Objectives/Goals

Through focused, strategic growth to increase market share for the San Joaquin Valley Insurance Authority to 25,000 medical employee lives by calendar year 2014. Our goal is also to establish ancillary programs for distribution by 2012.

Target Market

The target market for growing the San Joaquin Valley Insurance Authority will be Counties, Cities, Special Districts and, possibly, School Districts. As previously mentioned, this market demographic shares common interests and challenges and has seen the available options primarily limited to CalPERS and CSAC-EIA Health

Positioning

Gallagher Benefit Services, in conjunction with the management team of the San Joaquin Valley Insurance Authority, would establish an aggressive, but targeted, approach to marketing the program to interested entities. After direction from the management team as well as the Board of Directors, GBS would identify potential candidates and approach them with plan information as well as the value proposition of the Authority. Careful consideration would be give to demographic data, claims experience and "synergy" factors to make sure all Authority members share common goals and philosophies.

In order to position ourselves in the marketplace and "build our brand", The San Joaquin Valley Insurance Authority will reiterate our mission of "*consistently demonstrating for our member entities the lowest fixed costs, the most aggressive claims management and the best service available of any benefits plan*" in all of our marketing efforts. It is these attributes that already set the SJVIA apart from competitors and we will strive to educate potential members going forward.

In addition to this targeted positioning approach it may be desirable to build awareness by exhibiting at various public entity functions such as CalPELRA, PARMA, CASBO, etc. Ideally, SJVIA could also become a presenter/speaker at these meetings.

Sales Forecast

We will begin external marketing efforts December 2010 for July 2011 (and later) effective dates. We will have the necessary infrastructure in place to identify suitable candidates for inclusion in the SJVIA as well as accurately and prudently determine cost parameters for groups of 50 and above. Since July and January are the months which most public entities (other than School Districts) renew their benefits programs, these months represent our greatest potential for increasing membership. Gallagher Benefit Services and the San Joaquin Valley Insurance Authority would anticipate an increase of membership by 500 employee lives for July 1, 2011 effective dates. Through effective marketing, we would anticipate an additional 2,000 employees lives for January 1, 2012 effective dates.

Part IV – Underwriting Methodology of the San Joaquin Valley Insurance Authority

- New Groups
  - Small Group Considerations
- Renewal

Underwriting Methodology for Groups Entering the SJVIA

"Each entity entering the SJVIA will be evaluated and initially rated based on their specific claims experience and demographics. Entities without claims information (typically less than 200 lives or those entities exiting CalPERS) will be evaluated based on manual rates".

During the initial evaluation and underwriting phase of new Public Entities wishing to join the SJVIA, several criteria are carefully reviewed and recommendations are made. Once a decision to offer coverage within the SJVIA is made, formal rating can begin.

Initially, extensive demographic material is collected including age, gender, dependent status, total members, etc. Additionally, plan design material is collected and a comprehensive matrix of plans to be offered is generated. Overall plan costs are then calculated for both the current year as well as the suggested renewal for the in-force carriers.
Next, the SJVIA will review any claims information provided for all lines of coverage. This review will evaluate claims both on an annual basis as well as a rolling 12 month period. Enrollment information is also collected and reviewed at this stage. Consideration is given to any stop-loss (or pooling) reimbursements and enrollment is lagged to properly weight the most recent enrollment figures. Finally, a claims rate on a composite PEPM is generated for the period(s) that claims information is available.

At this point, SJVIA will project claims for the initial 12 month contract period using the PEPM claims rate generated in Step 2 (above). The PEPM claims rate is inflated for medical trend (SJVIA uses an amalgam of trend projections/calculations from several industry resources). This trended medical claims rate is then applied to the current enrollment in order to arrive at an annual projected claims total on a mature claims basis. Finally, claims lag is factored and projected immature claims as well as projected reserves are determined.

Once the claims are projected, the fixed costs of the program are added. These fixed costs include excess reinsurance premiums, administration fees from the carriers and claims paying entities, consulting fees, SJVIA fees, etc. Combining the total fixed costs with the projected claims costs give a total plan costs on a PEPM basis. Multiplying the projected total cost (PEPM) times the current enrollment, times twelve months, will give a total annual plan cost.
Finally, the total monthly and annual plan costs are converted to monthly premiums based on the entities current plan structure, the current contribution strategy and current tier structure.

Small Group Rating Methodology for Groups Entering the SJVIA

It is imperative that new groups into the pool are not "uninsurable", meaning no other carrier or pool will take them at the highest rate charged by the SJVIA. The SJVIA must avoid being what is often called "the insurer of last resort".

The requirements below must be met also in order for the two- and three-year rate guarantees to operate properly. This pool and others that do not impose sound first-year underwriting are highly vulnerable to anti-selection.

The first-year underwriting rules, if adopted, will also relieve the amount of surplus needed at start up. Consequently, the rules provide protection against the misconception that an accumulated surplus can always overcome anti-selection.

Sample Guidelines for Small Group Underwriting

Only Full Time employees (30 or more hours per week) will be covered.
Maximum rate = 2 x Manual Rate

<u>Group Size 10 to 50 Full Time employees on Payroll</u>

- Must have 85% participation; decline otherwise.
- Applicants must complete short-form questionnaire; decline otherwise. Experience will not be used. Medical conditions may result in a decline also.
- One plan only.

<u>Group Size 51 to 99 Full Time employees on Payroll</u>

- Must have 80% participation; decline otherwise.
- Experience will be used, subject to underwriting judgment.
- Applicants must complete short-form questionnaire in lieu of experience; Maximum rate otherwise.
- One plan only.

<u>Group Size 100+ Full Time employees on Payroll</u>

- Must have 75% participation; decline otherwise.
- Experience will be used, when available, subject to underwriting judgment.
- Group will be accepted at Maximum rate without experience.
- No more than two plan choices.

Renewal Rating Methodology

"After the third year in the SJVIA, each member entity is evaluated in order to determine their claims experience in relation to the overall claims experience of the SJVIA. Once this evaluation is complete, adjustments will be made to further decrease or increase the premium rate from what the program renewal requires. Public Entities who entered the program without any credible claim experience will undergo this assessment after their second year in the SJVIA."

Each year, SJVIA will establish the overall program renewal for the upcoming plan year by aggregating the total plan claims, projecting trended claims, applying fixed costs, adjusting projected reserves and setting final rates as described above. During the member entities first two renewals, the member entity will receive the overall pool increase.
When a member entity has been in the program for 3 years (2 years for those entities without claims information) several factors will be evaluated to apply a group-specific adjustment to the overall plan renewal. Initially, the individual entities variance must be identified. After the *variance* is calculated, an adjustment to the program renewal can be made.

Variance
The individual entities variance will be the difference between the loss ratio of the individual entity and the loss ratio of the entire program. This variance can be reflected either as a positive number (individual entity I has a loss ratio *greater* than the entire program) or a negative number (individual entity I has a loss ratio *lower* than the entire program).
The overall program's loss ratio is established by dividing the incurred claims (less any stop-loss reimbursements) by the total program premiums collected. If the total incurred claims are $70,000,000 and the total program premiums are $100,000,000 than the overall program's loss ratio is 70%.

Next, the individual entities loss ratio is established. Incurred claims for each entity will include an adjustment for large claims using pooling points that are graduated based on group size. This ensures that smaller groups are not overly penalized due to large "shock" claims. This graduated scale suggests recommended pooling points from $100,000 (for groups less than 500 employees) to $450,000 (for groups 3,500 employees and above). Additionally, the three years claims experience is weighted 28% for the first year, 33% for the second year and 39% for the most recent year. This insures that all years in the experience period will have a significant impact on results while providing additional weight to the most recent years. This may positively reflect the impact of any cost management efforts implemented early in the experience period.
Each group's experience will be considered 100% credible for loss ratio determination. This is because the multiple-year experience period increases credibility (i.e., 200 life employer's experience over three years equals 600 Life years) and the pooling mechanism is customized by group size.

Once the loss ratio and variance have been determined, group-specific adjustments will be determined.

Adjustments

Upon the third renewal (second for manually rated groups), each group may qualify for an adjustment to the pool renewal. Entities receiving an adjustment cannot qualify again until the second renewal after the adjustment has been applied. Groups can receive, at maximum, an adjustment every other year.

The Corridor will vary based on the entities size in relationship to the pool's overall size, subject to a minimum and a maximum. The minimum and maximum corridors have been determined based on statistical testing for groups with weights currently existing in the SJVIA program. As membership grows, these weights will change and a re-evaluation of the corridor as well as minimum and maximum limits may be adjusted.

If an entity is determined to warrant an adjustment, that adjustment will be 100% of the Variance (entity loss ration minus program loss ratio) less the Corridor.

Part V – Summary

The identified market for the services provided by the San Joaquin Valley Insurance Authority is extremely broad. There has already been heightened awareness regarding the products and services offered by the SJVIA with many different public entities expressing a desire to learn more about the Authority. Several prospective members have already requested a proposal for inclusion in the Authority.. The current economic conditions demand additional options for public entities. The San Joaquin Valley Insurance Authority meets this market need with quality and a cost advantage for this underserved population