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Municipal Healthcare Financing Collective-MHFC

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Agenda

1. What is the MHFC?
2. Unique advantages for Municipalities
3. Real Time Risk Management
4. Real-world examples and success stories
5. Q&A session to address your questions

Municipal Healthcare Financing Collective
MHFC

Founding Members

- **NYSAC**
  - Steve Acquario, Executive Director- sacquario@nysac.org
  - Mark Lavigne, Deputy Director- mlavigne@nysac.org
  - Patrick Cummings, Attorney- PCummings@nysac.org
- **Columbia County-approximately 615 enrolled**
  - PJ Keeler, Treasurer- pj.keeler@columbiacountyny.com
  - James Breig, Controller- jamesbreig@columbiacountyny.com
- **Ulster County-approximately 1200 enrolled**
  - Dawn Spader-Personnel Director- dspa@co.ulster.ny.us
  - Kevin Roach- Employee Benefits Administrator- kroa@co.ulster.ny
  - Clinton Johnson-County Attorney-cjoh@co.ulster.ny.us
- **Yates County-approximately 170 enrolled**
  - Jessica Mullins-County Administrator- jessica.mullins@yatescountyny.gov
  - Kerry Brennan-Director of Human Resources- kerry.brennan@yatescountyny.gov

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What is the MHFC?

Simply a Member owned stop loss captive

Who can join the MHFC?

- Any fully insured Municipality (over 100 eligibles)
- Any currently self funded Municipality

Stop Loss Captive Definition: an insurance arrangement where employers form a captive (a member-owned insurance entity) to collectively purchase stop loss coverage that protects them against unexpectedly large health claims.

What are benefits of a Municipal Captive

Advantages of a stop loss captive vs a stand-alone arrangement

- **Control**: Member-driven governance that allows decisions about stop loss plan structure and risk management.
  - Current members are Columbia, Ulster and Yates County with a total of 2007 employees
- **Risk Pooling and Cost Stability:** reduces volatility and absorbs bad years vs high variability of standalone contract
  - Stop Loss Premium is underwritten by individual Municipality
- **Full Transparency of all data and costs:** Allows for data driven decisions and proactive risk management strategies
- **Collaboration and Shared best practices**

Why come together with the MHFC?

Provides Control, Autonomy and Leverage

- **Control**: allows decisions about stop loss plan structure and risk management.
  - Introduced Clinical Real Time Risk Management of High Cost Claims
- **Autonomy:** Members maintain autonomy with their existing plan design, eligibility, union negotiated terms, contributions, and risk tolerance
  - You keep your existing Medical Carrier/TPA, PBM-no change required
  - Full Transparency of all data and costs
  - Stop Loss Premium is underwritten by individual Municipality
- **Leverage:** 62 Counties would be the desire of any carrier
  - Allows Municipalities currently in a fully insured model to consider self-funding their health plan under a protective stop loss environment
  - Underwritten to breakeven vs stand alone carrier keep gain
  - Provides Financial stability with predictable costs and protection from market volatility
  - Any Underwriting gains are returned to the members
- **Results in Long-term Savings:** Ability to outperform commercial stop loss trends

Simple “Standalone” Stop Loss vs. Captives Illustration

*premiums + collateral, funds that are “at risk” if experience is unfavorable

Autonomy in risk management philosophy

- Each member chooses their own stop loss deductible and if they want aggregate coverage(guarantees max liability)
- Underwriting gain returned to members on a pro-rata basis

Captive Variations

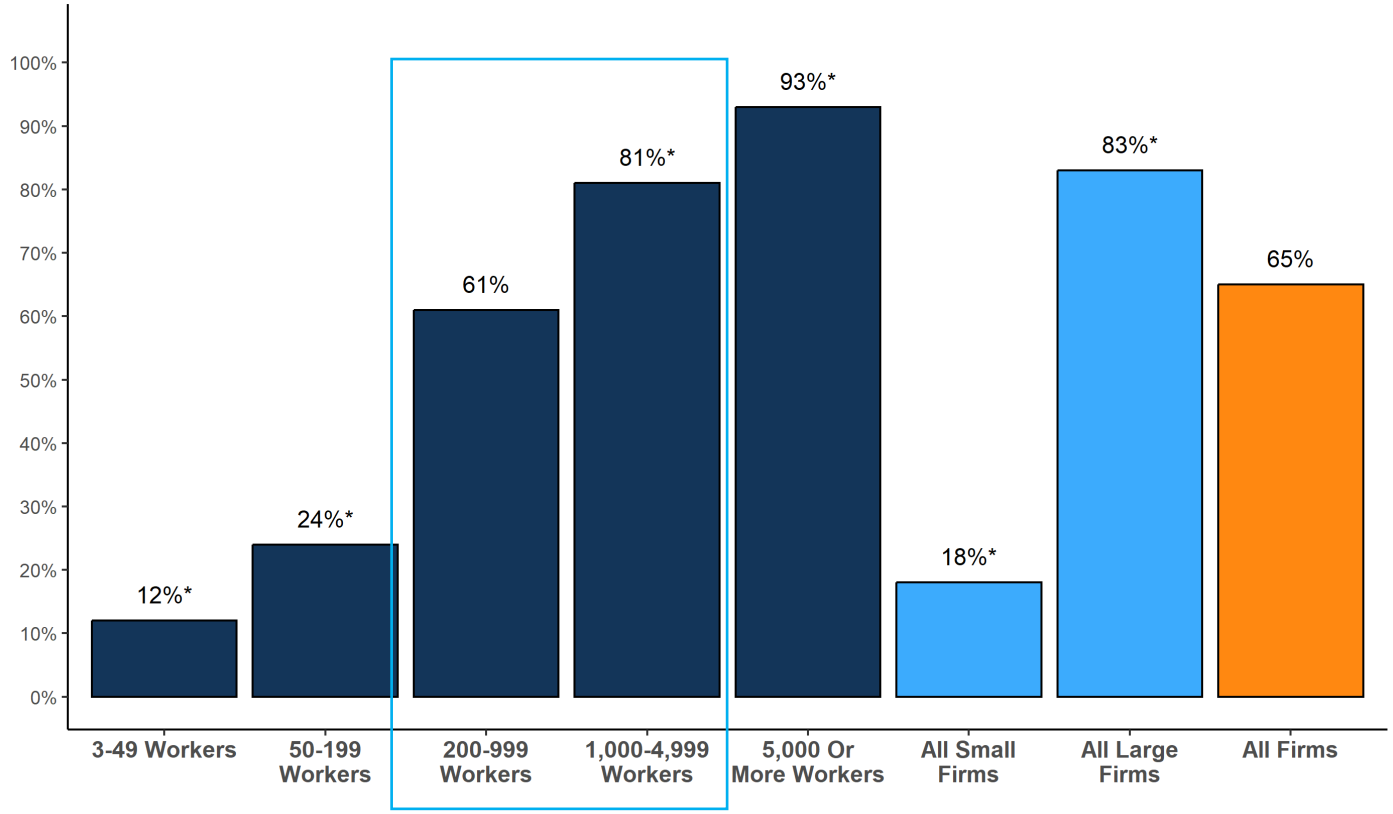
- Homogonous: all one type of industry risk. E.g. higher education, not-for-profits, municipalities, etc…
- Heterogeneous: mix of employer types & industries.

Unique advantages for Municipalities

Both Fully Insured and Self Funded

Self-Funding Prevalence

Figure 10.1
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 2023



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2023

NYSAC
NEW YORK STATE
ASSOCIATION OF COUNTIES

MHFC Provides Municipal Control and Autonomy

MHFC	Alternatives (Trust, Article 47, etc.)
• *Vendor agnostic for medical & pharmacy*	• *Vendors selected by program*
• *Your Plan design , impacts budget*	• *Selected program plans, impacts rates*
• *Reserves established and held by Counties*	• *Reserves held by program*
• *No exit/termination barrier*	• *Potential for multi-year commitments*

Resilient Beginnings: Our Captives steady performance through unprecedented times

MHFC has Outperformed Industry Averages

*Aegis Annual Risk Medical Stop Loss Premium Survey					
Program Year	**Mthly Census**	**Average PEPM Rate**	**Change in Aver PEPM Rate (%)**	**ITD Change Aver PEPM Rate (%)**	**Industry Average Increase (%)***
2020	2039	$ 65.52	N/A	N/A	N/A
2021	2016	$ 68.61	4.7%	4.7%	11%-13%
2022	1957	$ 74.69	8.9%	6.8%	11%-14%
2023	1938	$ 84.55	13.2%	8.9%	10%-13%
2024	1929	$ 89.41	5.8%	8.1%	7%-16%
2025	2007	$ 93.99	5.1%	8.2%	

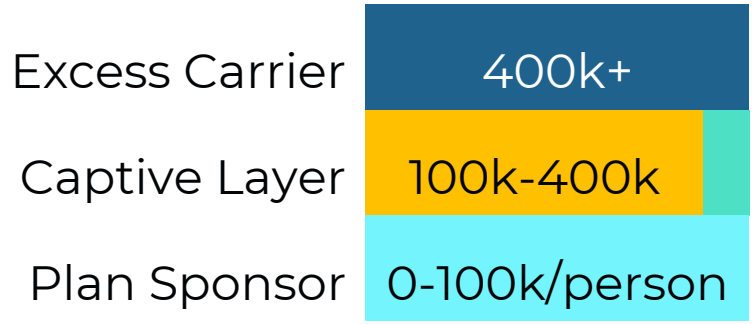
Growth History of our College Health4EDU Captive Program

Counties	Year	Enrolled EEs	Health Plan Budget	Prior Funding	PURPC (Rx)
Colgate University	2014	1,345	$16.3M	Insured	✓
Hamilton College	2014	640	$10.1M	Insured	✓
St. Lawrence University	2014	580	$9.0M	Insured	✓
LeMoyne College	2016	400	$6.1M	Insured	✓
Clarkson University	2018	530	$9.7M	Self-Funded	✓
Vassar College	2019	696	$16.2M	Insured	✓
Utica University	2020	340	$6.1M	Insured	✓
Dickinson College	2021	710	$11.3M	Self-Funded	✓
Bard College & Simon's Rock	2022	960	$18.4M	Self-Funded	✓
York College of PA	2022	494	9.7M	Self-Funded	✓
Albany College of Pharmacy	2023	160	$2.7M	Insured	✓
Niagara University	2023	411	$7.9M	Self-Funded	✓
Washington & Lee University	2023	913	$18.7M	Self-Funded	✓
Pratt Institute	2024	914	$22.1M	Insured	Jan 26
Teachers College of Columbia U.	2024	658	$18.6M	Insured	Jan 26
Gettysburg College	2025	592	$9.5M	Insured	Jan 26
St. John's College	2025	258	$4.9M	Self-Funded	Jan 26
Yeshiva University	2025	670	$21.3M	Self-Funded	Jan 26

Underwritten too Breakeven

Working as designed!

MHFC Captive (3 layers)



Year	Captive Inc (Loss)	Captive Prem Chg	Member Loss Ratio
2020	(159,321.64)		84%
2021	99,432.60	-4%	60%
2022	(159,108.96)	6%	82%
2023	295,514.48	10%	44%
2024	(180,977.14)	7%	80%

Real Time Risk Management

A Clinical approach

Clinical Oversight and Advocacy

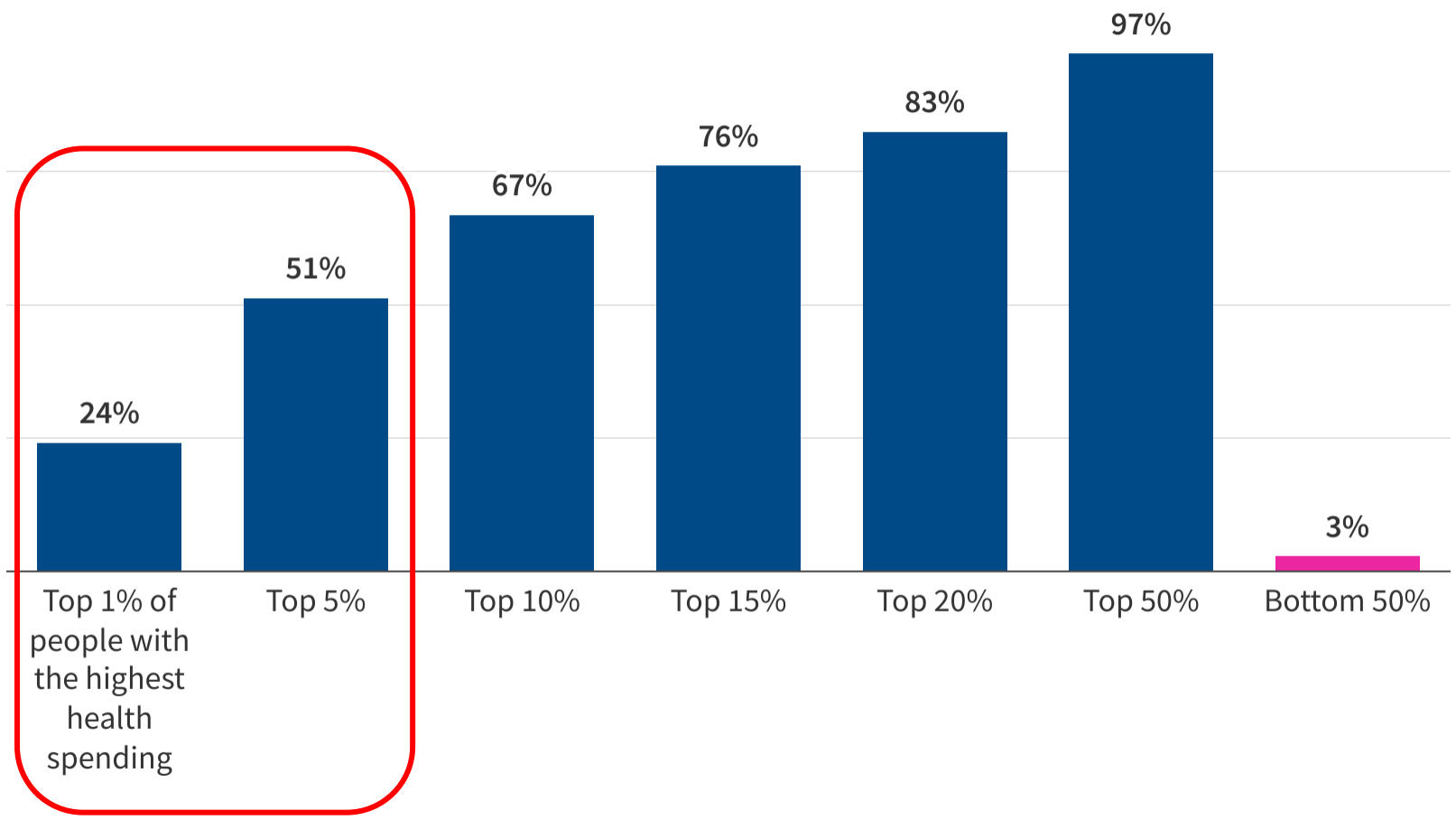
The Alera Group Clinical Team focuses on:

- High-cost claimant analysis and forecasting
- Real-time risk management of high-cost claims
- Assistance with Stop-Loss negotiations

Why Focus on High-Cost Claimants?

Figure 9

Share of Total and Out-of-Pocket Health Spending, by Percentile, 2021



Source: KFF analysis of 2021 Medical Expenditure Panel Survey data

Peterson-KFF Health System Tracker

Springbuk Medical Intelligence Platform

Health Analytics

Springbuk's analytics solutions help HR leaders, benefits teams, and analysts identify trends and predict their future impact. It delivers automated strategies and advanced trend exploration to help identify unexpected cost sources and forecast their impact on the business.

- Direct individual claims feed from Carriers/TPA's and PBM's
- Proprietary clinical triggers have been developed to identify emerging High-Cost Claimants
- This allows for real time (monthly) risk management

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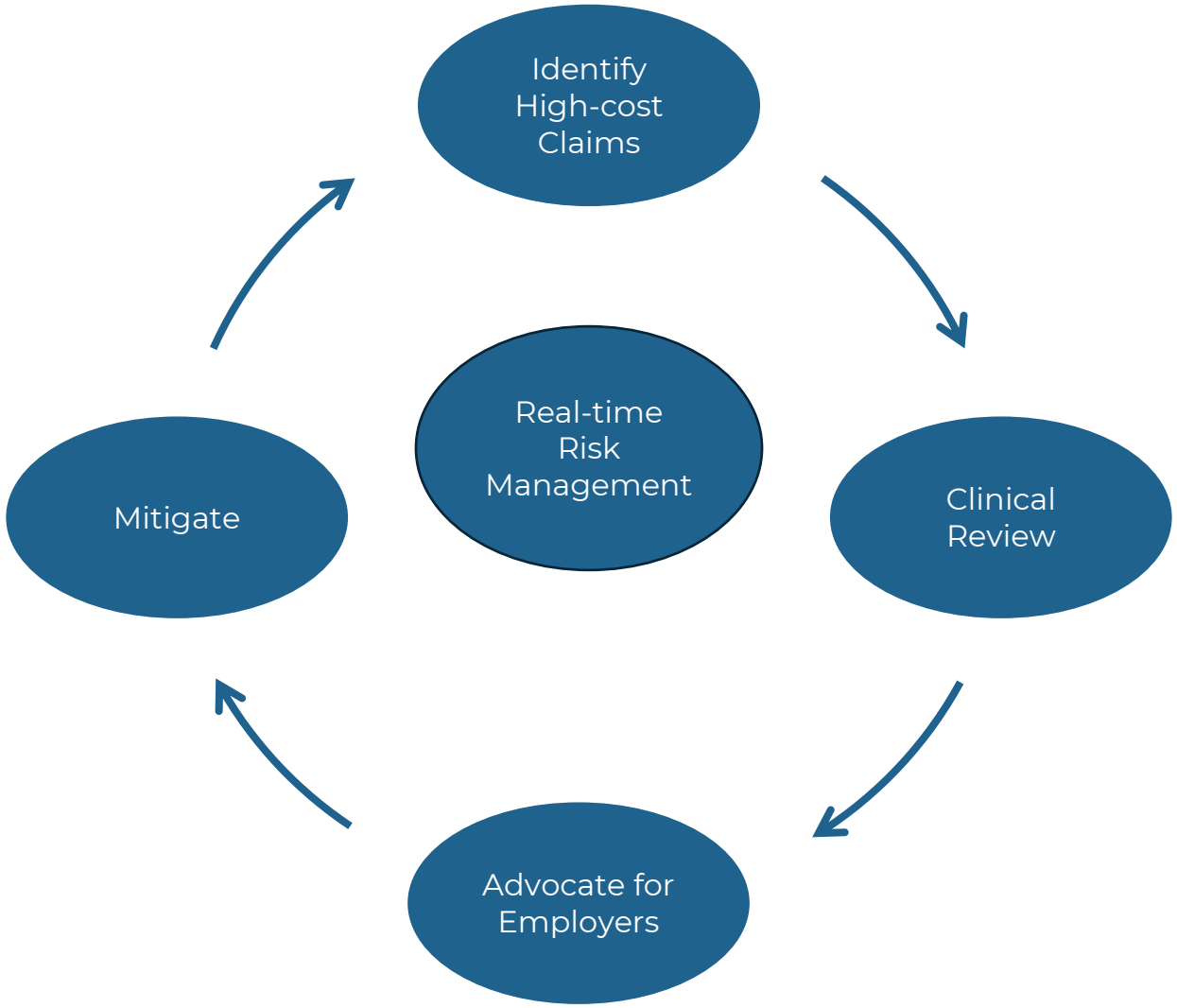
High-Cost Claimant Analysis and Forecasting

Relationship	Age Group	Status	Current Primary Diagnosis	Total Plan Paid	Medical Paid	Rx Paid	Clinical Notes
Spouse / Partner	50-64	Active	Hematology & Oncology	$560,420	$373,340	$187,080	Multiple Myeloma on Kyprolis infusions in office setting ($13k/2 weeks) and oral Revlimid ($17.5k/month). Cost of combined treatment $548k. Likely to remain ongoing.
Dependent	0-17	Active	Neonatology	$545,576	$534,858	$10,718	Infant born in March with prolonged NICU admission and surgical procedure for cardiac defect. Had 2 additional hospitalizations for cardiovascular and gastrointestinal issues. Most recent claims indicate attending well-child visits and receiving routine immunizations.
Spouse / Partner	50-64	Active	Gastrointestinal Surgery	$252,942	$173,924	$79,019	Crohn's Disease on Stelara injections ($25k/2 months, annualized cost $163k). Likely to remain ongoing. Also hospitalized in April for gastrointestinal complications - likely resolved.
Employee	36-49	Active	Gastrointestinal Medicine	$168,278	$167,111	$1,167	Crohn's Disease - started on Entyvio infusions in January at Hospital XYZ ($22k/8 weeks, annualized cost $143k). Likely to remain ongoing. Was previously on Remicade infusions every 8 weeks in office setting ($10k/infusion).
Spouse / Partner	65+	Active	Cardiovascular Surgery	$153,580	$143,762	$9,818	Hospitalized in September for cardiac procedure to treat arrhythmia and in July for thoracic aneurysm and atherosclerosis requiring cardiac surgery. Given history, at risk for future high costs.
Employee	36-49	Active	Breast Neoplasm	$138,962	$138,579	$382	Breast cancer, appears diagnosed in September. Began chemotherapy and Trastuzumab/Pertuzumab infusions in October in office setting. This treatment is given for HER2+ tumors and is likely to remain ongoing for 12 months ($7.8k/3 weeks, annualized cost $133k).
Employee	36-49	Active	Preventive Health	$134,753	$132,622	$2,131	Underwent surgery for benign brain neoplasm in June. Generally acute issue.

Key:
Red: >$100k over next 12 months
Yellow: $50k-$100k over next 12 months
Green: <$50k over next 12 months

Managing High-Cost Claims: Clinician Oversight and Advocacy



Alera Captive Clinician Team-Real Time Risk Management Results:

Payment Integrity

➢**Is this cost appropriate for this service?**
- Keytruda in outpatient hospital setting moved to lower cost facility: Plan saved $680k annually.

➢**Are there any duplicative claims?**
- Dialysis being billed twice each session: Plan refunded: $42k.

Clinical Appropriateness

- **Is this treatment appropriate for this diagnosis?**
  - Member receiving chemotherapy, but plan billed for multiple surgical procedures: Plan refunded $223k.
- **Are there any opportunities to optimize care?**
  - Member receiving $1M medication, worked with PBM to optimize dosing: Plan saved $768k annually.

Vendor Accountability

- **Is the plan being administered properly?**
  - Cell Therapy (CAR T) not processed appropriately through transplant contract: Plan refunded $738k.
- **Are vendors meeting expectations?**
  - Dialysis carveout vendor billed monthly case rate while member was hospitalized: Plan refunded $18k.

Assistance with Stop-Loss Negotiations

Diagnosis	Stop-Loss Vendor Notes	Alera Clinician Claims Review	Stop-Loss Vendor Annual Projection	Alera Clinician Annual Projection
Multiple Sclerosis	Member with diagnosis of Multiple Sclerosis. Began receiving Ocrevus infusions in July at cost of $19k/infusion. Had additional infusion in August. Projection based on monthly infusions at $19k/infusion.	Member started Ocrevus infusions in July at $19k/infusion. She received 2 loading doses - one in July and one in August ($19k/infusion). Going forward, she will only need one infusion every 6 months ($40k/infusion as it is double the loading dose).	$225k	$85k
Ulcerative Colitis	Member with diagnosis of Ulcerative Colitis receiving Entyvio infusions every 8 weeks at a cost of $19k/infusion and recently started Xeljanz tablets at a cost of $4.7k/month.	Member began taking Xeljanz tablets in August and was previously receiving Entyvio infusions every 8 weeks at a cost of $19k/infusion. There is no clinical need to take both of these drugs simultaneously, so it is likely that she will continue only on the Xeljanz tablets going forward.	$172k	$60k
Immunodeficiency	Member with immunodeficiency receiving intravenous immunoglobulin (IVIG) bi-weekly at a cost of $9k/infusion. Member also started Rituximab infusions in July at a cost of $7.5k/infusion.	Claims data show that member is actually receiving immunoglobulin infusions monthly (not bi-weekly) at a cost of ~$9k/infusion. Member did have 2 doses of Rituximab in July, however, has had no further treatment with Rituximab and has no medical diagnoses supporting need for ongoing treatment with this drug.	$265k	$115k
Psoriasis	Member with diagnosis of Plaque Psoriasis. Claims driven by 1 fill of Rx Cosentyx (~$23.5k) in December. Cosentyx $23.5k x 12 months = $282k.	Member filled a prescription for Cosentyx 300mg in December ($23.5k for 8 pens). The recommended dosage of Cosentyx for Plaque Psoriasis is 300mg weekly for 5 weeks followed by 300mg every 4 weeks. It is likely that the first fill in December was for the required starter doses. Going forward, the member will most likely only need 2 pens/month equaling a monthly cost of ~$6k.	Recommend contingency laser of $285k if member remains on Cosentyx.	$80k. Laser not warranted.
Skin Cancer	Member with diagnosis of metastatic skin cancer. Began receiving Opdivo and Yervoy infusions in June.	Member completed radiation treatment in March. Began receiving Opdivo and Yervoy infusions in June. Member will likely receive Yervoy x4 cycles and Opdivo will remain ongoing as maintenance therapy ($21k/month, annualized cost $252k). Previously on Mekinist/Tafinlar.	$600k	$300k
Multiple Myeloma with existing laser of $400k	Member with Multiple Myeloma, previously receiving high-cost Kyprolis infusions and oral Venclexta.	Member stopped taking Kyprolis and Venclexta and received CAR T cell therapy in February, which is a one-time treatment. Recent claims indicate member appears stable.	Recommend $400k laser remain.	Recommend removing laser.
Brain Neoplasm	Member with recent diagnosis of brain neoplasm, no treatment has begun.	Member with obstructive hydrocephalus requiring surgical procedure/shunt in August. Has claims with diagnosis code for malignant brain neoplasm, but no treatment claims to support this diagnosis. Suspect provider coding error when ordering brain imaging. Carrier case notes confirm diagnosis of hydrocephalus with no active treatment post shunt placement.	$800k	<$50k

Questions & Answers

MHFC Summary

Provides Control, Autonomy and Leverage

- **Control**: Member-driven governance that allows decisions about stop loss plan structure and risk management.
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- **Autonomy:** Members maintain autonomy with their existing plan design, eligibility, union negotiated terms, contributions, and risk tolerance
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- **Results in Long-term Savings:** Ability to outperform commercial stop loss trends

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Want to learn more?

Next Steps

- Set up meeting to discuss in more detail about program
- We are offering a free feasibility study to see if the MHFC is a good fit for you
- For those fully insured feasibility study will include analysis of moving to a self funded model using the MHFC

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