No.________________

UNITED INDEPENDENT SCHOOL DISTRICT
AGENDA ACTION ITEM

TOPIC Approval of District Group Health Insurance Rates and District Contributions

SUBMITTED BY: Robert Chapa **OF:** Risk Management

APPROVED FOR TRANSMITTAL TO SCHOOL BOARD: ________________

DATE ASSIGNED FOR BOARD CONSIDERATION: May 17, 2017

RECOMMENDATION:

The Employee Benefits Committee (EBC) has concluded a review of the district self-insured health plan and is prepared to make employee and district premium rate recommendations for Board Approval.

RATIONALE:

In school year 2015-16 the UISD Board of Trustees approved the implementation of a self-insured health plan for employees. The health plan is completing its second year of service and requires establishment of employee premium rates for the coming school year.

BUDGETARY INFORMATION

BOARD POLICY REFERENCE AND COMPLIANCE:

UNITED INDEPENDENT SCHOOL DISTRICT

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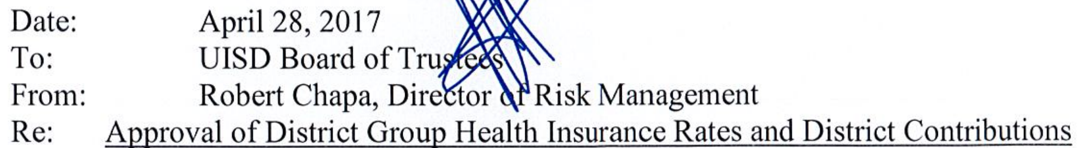
201 Lindenwood Drive
Laredo, Texas 78045
Phone: (956) 473-6219
Facsimile: (956) 728-8691



Date: April 28, 2017
To: UISD Board of Trustees
From: Robert Chapa, Director of Risk Management
Re: Approval of District Group Health Insurance Rates and District Contributions

In school year 2015-16 the UISD Board of Trustees approved the implementation of a self-insured health plan for employees. The health plan is completing its second year of service and requires establishment of employee and District premium rates for the coming school year.

Recommendations: The Employee Benefits Committee (EBC) has concluded a review of the district self-insured health plan and recommends the Board of Trustees approve the following plan adjustments:

1. That all employee premium rates remain unchanged for the 2017-18 school year. (See attached Schedule of Benefits)

2. That the District contribution remains the same at $355.31.

3. That minor changes be made to the Core plan coverages in order to keep the plan self-sufficient and solvent. (See attached Schedule of Benefits)

4. That changes be made to the Core Plus plan coverages in order to keep the plan self-sufficient and solvent. (See attached Schedule of Benefits)

Health Plan Observations and Analysis 2016-17

A review of the Claims/Premium Summary shows we are maintaining an 84.5% total plan loss ratio. This is a healthy ratio. Conservatively we target an 80% loss ratio which allows us to cover all claims during the plan year and claims that arrive after the plan year ends. Medical providers have up to 12 months after a bill is incurred to bill our insurance for payment. These late bills are called "Runoff" and can eat up as much as 20% of budgeted premiums. At 84.5% we would only have 15.5% of our premiums available to pay off runoff bills. Bottom line is that we would like to see 80% loss ratio but are confident we will finish the year on a breakeven basis even with the 84.5% loss ratio.

Observations

1. Membership averages 3,960 (72%) for the Core plan and 1,550 (28%) for the Core+ plan.
2. State/Core+ members make up 28% of the district health plan but are responsible for 47% of medical/Rx costs while contributing 32% of premiums and fees.
3. The State/Core+ plan is operating at 122.3% expenses above premiums. In the prior 2015-16 year the State /Core+ plan operated at a 134.2% loss ratio. Plan adjustments at the start of the year accounted for the reduction in loss ratio.

2017-18 Recommendations

Though the total health plan is operating at a breakeven level it is struggling.
For two years pressure on the plan has come in the form of losses from the State/Core+ plan. Claims for this plan have exceeded premiums by 34% and 22%. Though the loss is narrowing, it is still losing money. Changes to the SC+ plan last year resulted in a 12% decrease in claims. For the coming year we propose that we again reduce some of the benefits in the SC+ plan and that if in the following year the losses continue, that premiums for the State/Core+ plan be raised by the amount of the shortage. We also are recommending two minor changes to the Core plan. The proposed changes are as follows: (See attached schedule).

Changes to Core plan

a. Decrease After hours med clinics from $40 to $35
d. Increase Maximum out of Pocket limit from $6,350/$12,700 to $7,150/$14,300 in network

Changes to State/Core+ plan

a. Increase in network annual deductible from $800/$1,600 to $1,000/$2,000 and out of network deductible from $2,000/$4,000.
b. Increase Specialist MD copay from $40 to $45.
c. Decrease After hours med clinics from $40 to $35
d. Increase Maximum out of Pocket limit from $6,350/$12,700 to $7,150/$14,300 in network and from $11,000/$33,000 to $16,000/$32,000
e. Increase brand-preferred Rx from $45 to $50; Mail Order $90 to $100
f. Increase brand-non-preferred from $70 to $80; Mail Order $140 to $160

The net result of the recommendation is that there will be **NO** change to the premiums of either plan for the 2017-18 school year. There will be some benefit changes to the State/Core+ plan and 2 minor benefit changes to the Core plan.

GROUP# 167073
NOTE OUT OF POCKET MAXIMUMS
***STATE / CORE+ PLAN CHANGES

UNITED INDEPENDENT SCHOOL DISTRICT

2017-2018 Health Insurance Program Group Number: 167073
Effective 9/1/2017

	Blue Cross Blue Shield Core Plan	Blue Cross Blue Shield ***State / Core Plus+ Plan
Provider Network		
Doctor's Hospital	Yes	Yes
Laredo Medical Center	Yes	Yes
Benefits		
Deductible-Annual		
X-Ray/CT/MRI/Sonograms	$-0- Deductible	$-0- Deductible
All Other Deductible-Annual		
In-Network	$1,800 Indiv/$3,600 Family	**$1,000 Indiv/$2,000 Family**
Out-of-Network	$4,000 Indiv/$8,000 Family	**$3,000 Indiv/$6,000 Family**
Physician Copay	$35 Then 100%	**$35 Then 100%**
Specialist Copay	$60 Then 100%	**$45 Then 100%**
After Hours Med Clinics	**List of in-network Med Clinics can be found on RM website**	
(Non-Emergency Rooms/Centers)	$35 Then 100%	$35 Then 100%
Emergency Room (Hospitals & ER Centers)		
In-Network	$500 & Then 80%	$500 & Then 80%
Out-of-Network	$500 & Then 80%	$500 & Then 80%
Deductible-Hospital		
In-Network	$-0- Per Admission	$-0- Per Admission
Out-of-Network	$500 Per Admission	$500 Per Admission
Co-Insurance Percent		
In-Network	20% / 80%	20% / 80%
Out-of-Network	40% / 60%	40% / 60%
Out of Pocket Maximum		
In-Network	**$7,150 Indiv/$14,300 Family**	**$7,150 Indiv/$14,300 Family**
Out-of-Network	$16,000 Indiv/$32,000 Family	**$16,000 Indiv/$32,000 Family**
	Out of Pocket Maximums Include Calendar Year Deductible	
Prescription Drugs		
Retail-Supply Limit	30 Days	30 Days
Generic	$10 & Then 100%	$10 & Then 100%
Brand-Preferred	$60 & Then 100%	**$50 & Then 100%**
Brand-Non Preferred	$105 & Then 100%	**$80 & Then 100%**
	Plus cost difference between generic & brand if generic equivalent is available.	Plus cost difference between generic & brand if generic equivalent is available.
Mail Order-Supply Limit	90 Days	90 Days
Generic	$20 & Then 100%	$20 & Then 100%
Brand-Preferred	$120 & Then 100%	**$100 & Then 100%**
Brand-Non Preferred	$210 & Then 100%	**$160 & Then 100%**
	Plus cost difference between generic & brand if generic equivalent is available.	Plus cost difference between generic & brand if generic equivalent is available.

	Core Plan Emp Cont.	Core Plan Policy Cost	State / Core Plus+ Emp Cont.	State / Core Plus+ Policy Cost
District Contribution	**$ 355.31**		**$ 355.31**	
Emp. Only	$ 46.12	$ 401.43	$ 123.62	$ 478.93
Emp./Children	$ 251.35	$ 606.66	$ 374.83	$ 730.14
Emp./Spouse	$ 378.04	$ 733.35	$ 535.95	$ 891.26
Emp./Family	$ 645.04	$ 1,000.35	$ 852.86	$ 1,208.17
Dual Family	$ 289.73	$ 1,000.35	$ 497.55	$ 1,208.17