

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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Date: April 28, 2017  
To:  USD 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 USD 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.

<b>GROUP# 167073</b>		<b>UNITED INDEPENDENT SCHOOL DISTRICT</b>			
<b>**NOTE OUT OF POCKET MAXIMUMS**</b>		<b>2017-2018 Health Insurance Program Group Number: 167073</b>			
<b>***STATE / CORE+ PLAN CHANGES</b>		<b>Effective 9/1/2017</b>			
		<b>Blue Cross Blue Shield Core Plan</b>		<b>Blue Cross Blue Shield ***State / Core Plus+ Plan</b>	
<b>Provider Network</b>					
Doctor's Hospital		Yes		Yes	
Laredo Medical Center		Yes		Yes	
<b>Benefits</b>					
<b>Deductible-Annual</b>					
X-Ray/CT/MRI/Sonograms		\$-0- Deductible		\$-0- Deductible	
<b>All Other Deductible-Annual</b>					
<b>In-Network</b>		\$1,800 Indiv/\$3,600 Family		<b>\$1,000 Indiv/\$2,000 Family</b>	
<b>Out-of-Network</b>		\$4,000 Indiv/\$8,000 Family		<b>\$3,000 Indiv/\$6,000 Family</b>	
<b>Physician Copay</b>		\$35 Then 100%		<b>\$35 Then 100%</b>	
<b>Specialist Copay</b>		\$60 Then 100%		<b>\$45 Then 100%</b>	
<b>After Hours Med Clinics</b>		<b>List of in-network Med Clinics can be found on RM website</b>			
<b>(Non-Emergency Rooms/Centers)</b>		<b>\$35 Then 100%</b>		<b>\$35 Then 100%</b>	
<b>Emergency Room (Hospitals &amp; ER Centers)</b>					
In-Network		\$500 & Then 80%		\$500 & Then 80%	
Out-of-Network		\$500 & Then 80%		\$500 & Then 80%	
<b>Deductible-Hospital</b>					
In-Network		\$-0- Per Admission		\$-0- Per Admission	
Out-of-Network		\$500 Per Admission		\$500 Per Admission	
<b>Co-Insurance Percent</b>					
In-Network		20% / 80%		20% / 80%	
Out-of-Network		40% / 60%		40% / 60%	
<b>Out of Pocket Maximum</b>					
<b>In-Network</b>		<b>\$7,150 Indiv/\$14,300 Family</b>		<b>\$7,150 Indiv/\$14,300 Family</b>	
<b>Out-of-Network</b>		\$16,000 Indiv/\$32,000 Family		<b>\$16,000 Indiv/\$32,000 Family</b>	
<b>Out of Pocket Maximums Include Calendar Year Deductible</b>					
<b>Prescription Drugs</b>					
Retail-Supply Limit		30 Days		30 Days	
<b>Generic</b>		\$10 & Then 100%		\$10 & Then 100%	
<b>Brand-Preferred</b>		\$60 & Then 100%		<b>\$50 &amp; Then 100%</b>	
<b>Brand-Non Preferred</b>		\$105 & Then 100%		<b>\$80 &amp; Then 100%</b>	
		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	
<b>Generic</b>		\$20 & Then 100%		\$20 & Then 100%	
<b>Brand-Preferred</b>		\$120 & Then 100%		<b>\$100 &amp; Then 100%</b>	
<b>Brand-Non Preferred</b>		\$210 & Then 100%		<b>\$160 &amp; Then 100%</b>	
		Plus cost difference between generic & brand if generic equivalent is available.		Plus cost difference between generic & brand if generic equivalent is available.	
<b>District Contribution</b>		<b>\$ 355.31</b>		<b>\$ 355.31</b>	
		<b>Emp Cont.</b>		<b>Emp Cont.</b>	
		<b>Policy Cost</b>		<b>Policy Cost</b>	
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