

**PimaCountyCommunityCollegeDistrict**  
**Board of Governors**  
4905C East Broadway/Tucson, Arizona 85709-1010

**ACTION ITEM**

**Date:** 3/26/14

**Item Number:**

<b>Item Title</b>	<b>Contact Person</b>
Contract: Employee Medical Benefits and Pharmaceutical Benefits for Fiscal Year 2014-2015	Dr. David Bea Executive Vice Chancellor for Finance and Administration (206-4519)

**Recommendation:**

The Chancellor recommends that the Board of Governors approve employee medical and pharmacy benefits agreements and plan structures for Fiscal Year 2014-15.

**Justification:**

The District currently provides employees with group health insurance benefits through contracts with Cigna, for fully-insured medical benefits, and through Express Scripts, Inc. (ESI) for self-funded pharmacy benefits management (PBM). Within the health insurance contract, the District currently offers two health insurance plans: the Open Access Plus plan (OAP), which is a modified Preferred Provider Organization (PPO) plan; and the Open Access Plus – In Network plan (OAPIN), which is similar in design to a Health Maintenance Organization (HMO) plan. The OAP plan is the base plan for the District with the OAPIN available as a buy-up option for employees. The base plan is provided at no additional cost to employees for employee-only coverage. In both plans, all preventative care for enrolled District employees and their dependents is provided at no cost.

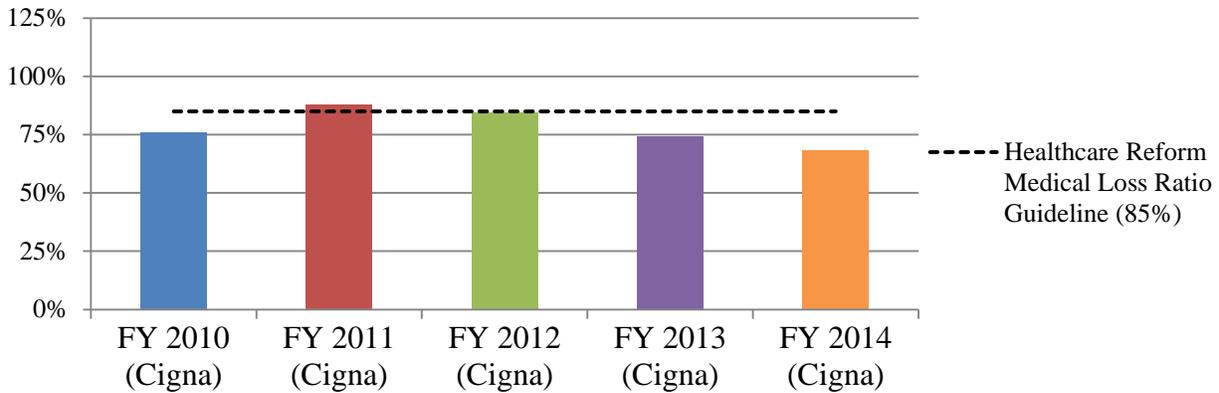
The Cigna contract expires at the conclusion of this fiscal year so the District issued a Request for Proposals (RFP) for a medical benefits provider. Concurrently, the District issued an RFP for a Pharmacy Benefit Manager (PBM) to bring the medical and pharmacy benefits provider contract schedule into alignment. The District used the RFP process to explore the continuation of our current fully insured medical benefits model and also whether moving to self-funding with an administrative service provider and Stop-Loss coverage for medical benefits would be beneficial to the District.

Medical Plan

The District has experienced favorable medical claims loss ratios (MLR) (claims divided by premiums) in the last five years (see chart below). Specifically, the District experienced an MLR of 76 percent in FY 2013 and the MLR is currently at 71 percent so far in FY 2014. This review of MLR ratios has led to an expectation that the medical RFP process would result in lower cost than the District is currently experiencing.

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**Employee Medical Benefits:  
Annual Average Medical Loss Ratio**  
(Total Claims/Total Premium Paid)(FY 2014 data is through February 2014)



Self-insurance utilizes a third party administrator for a medical services network, billing, and processing services, but claims costs are paid directly by the plan sponsor. In addition, the District explored a variation of a fully-insured plan, known as minimum premium, in which the District would pay a lower, fixed monthly premium while paying for medical claims as they occur. If claims experience is lower than expected, the District would share in the savings. However, because the plan is technically fully insured, higher than expected claims would be paid by the vendor.

Approximately 60 percent of covered workers in the U.S. are in some type of self-funded plan. The larger the company, the more likely it is to self-fund benefit plans. About 78 percent of employers with 1,000 to 4,999 workers are self-funded. Locally, TUSD and Pima County are self-funded and all of the other community colleges in AZ are self-funded either individually or as part of a cooperative trust.

Key elements of self-funded insurance include:

- The Administrative Service Organization (ASO) provides a medical services network with negotiated billing discounts, claims processing services, and disease management services.
- Stop-Loss Insurance is protection against extraordinary losses for self-funded plan sponsors. There are two relevant types of Stop-Loss insurance:
  - Specific Stop-Loss limits the plan sponsor’s liability on each individual covered under the medical plan to a predetermined amount, e.g. \$150,000. It is intended to protect the plan sponsor against the financial impact of catastrophic claims, such as organ transplants, premature infants, and other one-time high cost events.
  - Aggregate Stop-Loss insurance limits the overall annual claims liability by reimbursing the plan sponsor when the claims, as a whole, exceed a certain preset level, typically 125 percent of expected costs.
- A reserve to pay fluctuating monthly claims and aggregate claims above premiums to the level that triggers Stop-Loss coverage. It is unusual for claims to exceed premiums but the reserve will protect the District from the unlikely event that it would experience a series of catastrophic claims or higher utilization in one year. In the last five years, the District has only had 6 months in which utilization was above the premiums.

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Following is a chart that summarizes advantages and disadvantages of each of the funding approaches.

<b>Fully Insured Minimum Premium Advantages:</b>	<b>Self-Funded with Stop-Loss</b>
<ul style="list-style-type: none"> <li>• No employer risk for extraordinary claims activity</li> <li>• Monthly costs are capped</li> <li>• District retains the claims-based costs until they are actually incurred (traditional fully insured plans are essentially prefunded for claims)</li> <li>• District experiences direct savings when claims are lower than expected</li> </ul>	<ul style="list-style-type: none"> <li>• The risk of extraordinary claims is limited with Stop-Loss coverage. As such, the potential maximum risk is known. Actual monthly costs will depend on claims</li> <li>• District will earn interest on reserve account balances</li> <li>• District experiences direct savings when claims are lower than expected</li> <li>• Administrative costs are reduced</li> <li>• Actual claims costs are not subject to State premium taxes</li> <li>• Avoids ACA health insurer fee of 2.4%</li> <li>• Reduces insurance company profit and margins at District expense</li> <li>• Year to year benefits costs will be more predictable in future years</li> </ul>
<p><b>Disadvantages:</b></p> <ul style="list-style-type: none"> <li>• Possibility that high cost years will translate to higher costs in future years</li> <li>• Subject to a 2% State Premium Tax</li> <li>• Subject to ACA health insurer fee of 2.4%</li> <li>• Smaller cash flow advantage</li> <li>• Must be compliant with all ACA mandates, such as community-based rate setting (2018)</li> </ul>	<ul style="list-style-type: none"> <li>• Requires long-term commitment</li> <li>• Increased risks for extraordinary claims up to 25% aggregate Stop-Loss coverage</li> <li>• Cash flow will fluctuate</li> <li>• Requires reserves</li> </ul>

Pharmacy Benefits Manager (PBM)

Simultaneous with the health insurance RFP process, the District considered moving its self-funded pharmacy program from a traditional pricing model to a transparent one by eliminating the dispensing fee spread that exists for retail claims and providing the District with 100 percent of the pharmaceutical manufacturer rebates earned by the plan.

The new PBM contract will continue efforts to contain costs. More aggressive discounting and transparent rebates will result in projected costs below FY 2014. It is worth noting that specialty drugs will become an increasingly significant cost factor with new drugs coming on the market.

Request for Proposals (RFP)

The District asked vendors to bid on three medical funding models: self-insurance, traditional full insurance, and minimum premium full insurance. In addition, the District requested proposals for pharmacy benefit management (PBM) on a self-funded basis using the transparent

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pricing model. Companies were asked to bid based on the District's current medical plan design as described above. Vendors could bid on all medical models and/or offer a PBM.

Medical insurance and PBM competitive procurements are complex and require specialized medical, pharmacy, and insurance knowledge. The District utilized the Segal Company to provide expert analysis on this procurement. This consultant, which has consulted on all District benefits contracts during the last 10 years, included an underwriter and a pharmacist on their analysis team.

The District received bids from four medical insurance vendors, one for only self-insurance, and the others for both fully-insured and self-insurance medical plans. The District received proposals from seven prescription benefit managers (PBM), three of whom also bid on the medical insurance. The employee benefits work group, which included representatives from AFSCME, ACES, PCCEA, and Staff Council, reviewed all medical and pharmacy proposals based on the following evaluation criteria:

1. Responsiveness of the Proposal (scope of work, plan design and contractual requirements)
2. Network size and disruption
3. Ability to meet the needs of the District (services and expertise)
4. Qualifications and experiences of firm and staff
5. Cost (including network discounts)
6. Reporting
7. Performance guarantees

The PBM bids were evaluated against the following additional criteria:

- Financial Offer
- Non-Financials (contractual requirements)
- Customer Service, Administrative and Account Service Capabilities
- Organizational Experience and Stability
- Ability to Manage Drug Mix
- Strength of Pharmacy Network
- Formulary Offering
- Clinical Edits

The District's benefits consultant provided the work group with an analysis of the responses on February 12, 2014. This review resulted in inviting five finalists for on-site presentations. Each finalist addressed a series of follow-up questions in the final interviews on February 27, 2014 and March 2, 2014.

Following on-site presentations, the District requested best and final rate proposals and answers to questions posed in the interviews from the vendors. District staff and the consultant analyzed these final products and shared the results on March 19, 2014 with the work group. At the conclusion of the review, the working group recommended Cigna as the preferred fully insured vendor, and Blue Cross Blue Shield (BCBS) as the preferred self-insured vendor. The working group selected either Cigna or ESI for a PBM based on the selected medical plan. At the same time, District staff performed reference checks on the finalists.

**Financial Considerations:**

The District is expecting to save between \$1.2 and \$1.8 million on medical premiums depending on the whether a decision is made to remain fully insured or move to self-insurance. In addition, pharmacy benefits management savings in the range of \$260,000 to \$400,000 are expected. These savings allow the District to maintain its strong benefits program, maintain employee premium costs at the current level, and provide funding for a wellness program. Following is a summary of the options:

Medical and Pharmacy

**Option 1: Fully insured for medical with Cigna using a minimum premium structure with Cigna as the PBM.**

This option projects medical premium costs of \$8.2 million for an estimated savings of \$1.2 million against FY 2014 medical costs. The PBM cost is \$2.7 million for a savings of over \$400,000. Total annual savings with this option is estimated at \$1.6 million. The Cigna PBM is only available with Cigna medical.

Minimum premium funding offers many of the benefits of self-funding, including better cost management and reduced (but not eliminated) state premium and health insurer taxes. Minimum premium offers the protection of a fully insured contract in which the insurance company remains responsible for costs in excess of the premiums. It is a dividend-eligible product so any excess premiums paid are potentially returned to the District in a year-end reconciliation.

In terms of drawbacks, the insurer would determine premium rate changes each year and will likely add margin in the rates to protect themselves. Minimum premium also has higher expenses than self-funding as insurers include cushions for risk, state premium taxes, and health insurer taxes within the premium rates. It is worth noting that experience has shown that annual rate increases in the range of 10 percent have been common over the years, regardless of our actual MLR experience. Below is a chart that details the District’s experience with fully insured medical contract renewal.

	<u>FY</u> <u>2010</u>	<u>FY</u> <u>2011</u>	<u>FY</u> <u>2012</u>	<u>FY</u> <u>2013</u>	<u>FY</u> <u>2014</u>
Initial Renewal	42.0%	16.2%	17.0%	17.1%	16.0%
Negotiated Renewal	12.9%	13.0%	13.0%	11.5%	7.5%

Remaining with Cigna offers the benefit of no doctor or medical services disruption for employees. In addition, the network discount, which is the markdown against medical service claims, was the second lowest of the four medical vendors. This is an attractive discount compared to our current plan.

**Option 2: Self-funding medical with Blue Cross Blue Shield (BCBS) and remain with ESI for PBM.**

Anticipated premiums of \$7.6 million will cover medical claims, the administrative service charge (including claims administration, disease management and wellness programs), and Stop-

Loss coverage. This is an estimated savings of \$1.8 million to the District. Using ESI as the pharmacy benefits manager will cost the District \$2.8 million, and will provide a savings of \$260,000 versus the current PBM contract. This self-funding combination is anticipated to save the District a total of \$2.1 million next year compared to FY 2014.

Of the self-funded proposals, BCBS had the lowest fixed cost (administrative charges and Stop-Loss) and lowest expected claims cost due to better provider discounts. BCBS also offered a firm Stop-Loss insurance quote. ESI offered the lowest cost for a stand-alone PBM.

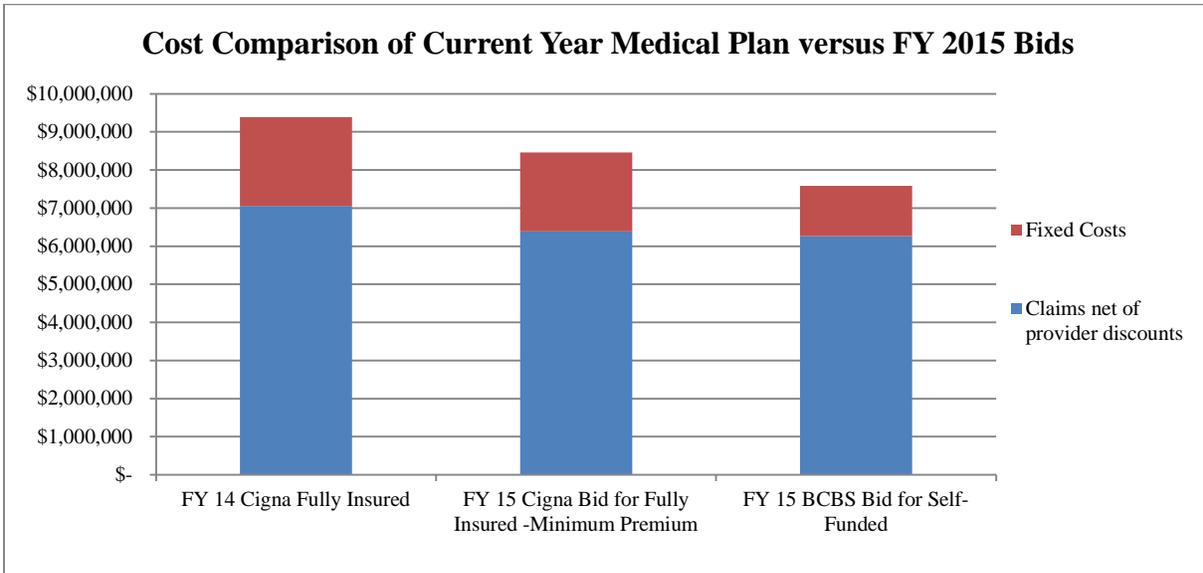
Because the District would essentially become the insurance company with this option, it will be at risk for all claims (net of any reinsurance through the Stop-Loss contract). There could be some doctor and services network disruption for employees, especially on the HMO side. BCBS has committed to a process of engagement with the District to add to the BCBS network. By volume, BCBS has more primary, specialists, and urgent care facilities in their network than Cigna. All major Tucson hospitals are covered as well as prominent facilities like the Mayo Clinic in Phoenix. The table below provides additional data that compares BCBS with Cigna in terms of health care providers.

Network Size and Disruption Analysis	Blue Cross Blue Shield		CIGNA	
	HMO	PPO	HMO	PPO
# of Primary Care Providers	1,454	1,463	1,018	1,018
# Accepting new patients	1,347	1,357	1,018	1,018
# of Specialists	4,820	5,118	2,340	2,340
# Accepting new patients	4,790	5,075	2,340	2,340
# of Facilities Match with Current	70	113	117	121
% Match	53%	85%	88%	91%
% Paid Claims Facilities	87%	93%	98%	98%
# of Providers Match with Current	453	596	569	626
% Match	69%	90%	86%	95%
% Paid Claims Providers	92%	97%	97%	99%

**Overall Recommendation: Self-funded medical using BCBS with ESI as the PBM.**

This option offers the best first year savings, and the District retains a greater degree of control over the five years of contract renewals. The District will be in a better position to manage future uncertainty because decisions can be made from a strategic, long-term view, and with the District’s best interest rather the insurance company’s. Actual claims data will be used to determine future benefit premium rates rather than MLR based calculations. The District will also avoid state premium taxes and ACA Health Insurer fees. The claim risks will be moderated by \$150,000 individual Stop-Loss coverage while overall costs will be limited by the 125 percent aggregate Stop-Loss coverage.

As the following chart illustrates, the BCBS proposal offers the lowest projected cost for FY 2015.



The fixed cost for administration, Stop-Loss, and ACA taxes is estimated to be \$1.3 million with BCBS’s self-funded proposal. The Cigna minimum premium proposal is expected to have fixed costs (retention, pooling, and ACA and state premium taxes) of \$1.8 million. Projected claims are slightly lower because of network discounts. Viewed another way, the cost of claims is borne directly through self-funding or indirectly through an insured contract. Insurance companies will use the District’s historical claims data to set future premium rates. So in any one year, the District may or may not benefit from an insurance contract. But over the long-term, an insurance contract will likely be more expensive than self-funding.

A necessary reserve of \$1.6 million will be set aside out of current fund balances to cover claims fluctuation and Stop-Loss insurance reimbursement and timing. An incurred but not recorded (IBNR) reserve of \$905,000 will be generated through premiums over time, as possible costs would only arise if the District selected a different vendor or returned to fully insured coverage.

With either PBM, there will be some formulary disruption. The District’s current custom formulary does not support the PBM’s rebate programs, and cost containment relies on the PBM’s established formulary. The formulary sets what drugs are preferred or not. In some cases, employees will benefit because a drug would move from non-preferred to preferred, in other cases the opposite may occur. Potentially affected employees will be notified of any changes and will be provided sufficient time to make a decision regarding a change to their prescriptions.

Wellness Program

A key component of a modern employer benefits package is wellness programming. The District has had a fledging wellness program, offering flu shots, biometric screenings, intranet wellness information, and a holiday weight management program. To turn this into a robust well-rounded program with an action plan, high employee engagement, and monitored impacts, adequate resources must be assigned. Utilizing a small portion of the savings achieved during this RFP process would allow the District to develop and implement a true wellness program that can contribute significantly to future cost containment.

