
**GESC/Health Insurance
Board of Trustees**
*Presentation
Before the*

Committee of the Whole
September 21, 2016



Beverly A. Joseph,
Chairperson
GESC/Health Insurance Board of Trustees

Good morning members of the 31st Legislature of the Virgin Islands, members of the Committee of the Whole. I am Beverly Joseph, Chairperson of the GESC Health Insurance Board of Trustees and the elected representative on behalf of active employees in St Croix. Today, on behalf of the Board, I would like to present our recommendations for renewal of the Medical, Prescription Drug, Dental, Vision and Life Insurance plans for Fiscal Year 2017.

I would like to thank the members of the Legislature for the opportunity to appear before you, the Honorable Governor Kenneth E. Mapp, and my fellow Board members, Clemmie Moses Vice-Chair, appointed; Lori Anderson, Secretary, Elected Retiree Representative for St Thomas & St John; Dr. Gilbert Comissiong, Elected Active Representative for St Thomas & St John; and Adelbert Bryan Elected Retiree Representative for St Croix.

I would also like to thank our Advisory Members, the Division of Personnel including the Director, the Chief and Staff of Group Health Insurance, the Counsel to the Board, our Consultant, and all the Insurers for their assistance in developing these recommendations.

Essentially, we are looking at a “rate pass” for Active Employees and for pre-Medicare Retirees (who are insured by Cigna) for FY2017 in all benefit

areas, which means no increase to members or the Government. For Medicare Retirees (those over age 65), who are covered by United HealthCare, we are looking at small rate increases of approximately 2½% for the Medicare Supplement portion only and not effective until April 1, 2017.

I would like to begin with some background information about how we arrived at our recommendations.

Please note that “total cost” and “enrollment” figures that will be mentioned in my presentation generally exclude the active employees of non-General Fund entities that participate in the Government Employees’ Plan – such as UVI, VIPA, STEEMC, VIHA and FHC.

Normally, the GESC Board receives preliminary annual renewal proposals from its insurance carriers in mid-April, based on claims experience through March 31st of the current year. Negotiations and meetings with the carriers continue through mid-June. These culminate in release of a formal report to the Governor from the Board before June 30th. This report outlines final recommendations for premium rate and plan design changes. The V.I. Code requires that legislation reflecting the finalized renewal changes be submitted to the Legislature by August 1st.

At least once every five years, the Board is required to solicit competitive bids for the insurance program. Previously, bids were solicited for all benefits in 2006 and again in 2011. However, in 2013, in an effort to scrutinize outside assertions regarding opportunities, the Board solicited bids for the medical (including prescription drugs) plan only. Despite the added effort, the outcome was not significantly altered as it relates to the coverage of our Active Employees. Theoretically, the other benefit plans (i.e., Dental, Vision and Life Insurance), are eligible for re-bidding this year. The medical plan does not need to be re-bid until 2018. The Board believes that all benefit plans should be transitioned back to a uniform schedule for bidding, as this is the most efficient approach. Too frequent bidding of the medical insurance plan is disruptive to plan members and alarming to insurance companies. Therefore, the Board's recommended approach is to delay re-bidding of all of the benefit plans until 2018, assuming no unforeseen changes.

On January 15, 2016, we were approached by Cigna with a mutually beneficial proposal for our FY 2017 renewal with the understanding that the Government would not bid the medical plan in 2016. Cigna promised to put on the table an aggressive renewal proposal that would not be duplicated if the plan

was put out to bid. Details of the offer were confirmed on January 29th and further clarified on February 9, 2016.

The actual claims experience under the medical plan through December 31, 2015, indicated that a 13.6% renewal rate increase would be required on October 1, 2016, assuming no changes to the current plan design. However, Cigna offered to hold the current rates unchanged for another year. This would be an unprecedented occurrence in the history of the Government Employees' plan and represents a potential cost savings of \$18.6 million in FY17 for the Government and plan members. The only condition on this offer is that the Government leave on deposit with Cigna any funds currently in the premium stabilization reserve with the exception of the amount of \$2.5 million which would be used to ensure a true medical and dental rate pass for employees, given that the Senate had provided one-time additional funding last year to maintain the member contributions at the then current levels. For FY16, the Legislature voted to fund all increases in employee and retiree contributions, equivalent to approximately \$1.9 million. As a result this subsidy would end on September 30, 2016, and members would face a substantial increase in their contributions even though the Cigna premium rates are not changing on October 1, 2016. The

Board has reached agreement with Cigna to utilize \$1.9 million from the PSR to continue this subsidy during FY17, plus an additional \$600,000 to fund the required October 1, 2016, dental rate increase of +10%. Therefore, the only increase in member contributions for FY17 will be related to UHC coverage for post-65 retirees.

The claims to premium loss ratio through December 31st was running at 83%. Once expenses and projected trend were factored in the required rate increase for 10/1/16 became +13.6%. When we again checked, the claims to premium loss ratio was running at 87% through March 31st.

For the post-65 Retirees, United HealthCare (UHC), CY2017 prescription drug renewal rates will not be increasing and will be at the current benefit level. Medicare Supplement rates will change on April 1, 2017, by an estimated 2½% for residents of the Territory (but actual rates will not be known until early 2017). UHC has proposed to replace the AARP Medicare Supplement and PDP plan for the approximately 800 stateside retirees in 2017 with a Medicare Advantage PPO plus Rx plan. This plan is anticipated to be less costly for most retirees and will offer uniform rates for all stateside residents. Depending on which state they live in, 88% of stateside residents will

see a reduction in their premium. On average, the reduction will be 6% compared to 2016 rates. For the Government, which will continue to subsidize 65% of the cost of the “base” plan, this change alone will save an estimated \$136,000 per year.

For the Actives and Retirees Cigna is the insurer for the **Dental Benefits**. Based on the most recent claims experience through January 31, 2016, Cigna projects that the dental plan will require a 15% rate increase on October 1, 2016, when the rate guarantees expire. As a special concession, if the medical and dental plans are not bid this year, Cigna is willing to extend the current 10% rate increase caps for two additional years through September 30, 2018. This could represent an annual premium saving of \$285,000. Furthermore, Cigna is agreeable to funding the entire FY17 dental rate increase of approximately \$600,000 using existing surplus in the PSR. This means that there will be no dental premium cost increase on October 1, 2016, including on behalf of active employees of non-General Fund entities that participate in the Government Employees’ Plan – such as UVI, VIPA, STEEMC, VIHA and FHC.

When we last checked, the claims to premium loss ratio through March 31st was running at just over 100%. This is little changed from January 31st and is before expenses and projected trend are factored in.

All of the identified considerations are summarized in the attached Exhibit A.

For all health insurance coverages combined (including dental), plan outlays will be increasing slightly from \$157.5 million in FY16 to \$157.6 million in FY17. This is an increase of \$0.1 million (+0.05%), of which the employer's share is 65%. The entire increase is attributable to the United HealthCare Medicare Supplement portion. This increase is compliant with the directive received on January 27th from the Office of Management and Budget in which the Director advised that the Government's contribution to the Fiscal Year 2017 program was not to exceed \$105.0 million.

FY17 costs may still come in lower than this projection due to several factors that the Board is not yet able to quantify, including elimination of ineligible members and dependents.

The Board is not recommending any plan design changes for FY17. However, we are working on several initiatives to control and reduce health care costs. You may recall that for FY16, we implemented more stringent pre-certification requirements for some outpatient services under the Cigna plan through a program called "PHS+". This program continues to produce

additional savings. Also, for FY16, we increased the out-of-pocket maximums under the Cigna plan by a significant amount and we increased the retail Tier 2 drug copayment under the UHC plan from \$20 to \$40. We also enhanced the previous medical conversion provision with COBRA coverage.

More recently, a significant development that has occurred is the outsourcing of the eligibility administration to a third party vendor called “BenTek”. This process began in January with a full scale implementation date of October 1, 2016. An ongoing source of frustration for the Board has been the inaccuracy of the eligibility data resulting in the payment of substantial premiums on behalf of ineligible participants. We are optimistic that this new approach to administration will correct these deficiencies once and for all. There was no additional cost for the outsourcing because Cigna agreed to provide the funding as clearly the reporting of accurate eligibility data impacts their system as well. The Board is also in ongoing negotiations with Cigna and V.I. Equicare to renegotiate professional fees in the Territory to more manageable levels, with a focus on eliminating abuse by certain specialty practitioners.

The Government’s Wellness Program has continued to gain traction, thanks in large part to funding from CIGNA in the amount of \$400,000 per year

and from UHC in the amount of \$100,000 per year as well as the focus given to Wellness by the Division of Personnel and the penalty for not completing the Health Risk Assessment. The Board has also begun to implement a communications blitz about the health insurance plan in general and the wellness strategy initiative in particular, via the internet and public service announcements.

The Board is implementing new Wellness strategies to leverage the Government's claims utilization data to control the rising cost of chronic conditions and high amount claimants. We have already identified such problem areas as

1. Too many C-sections
2. Not enough mammograms
3. Low colon screenings
4. Overuse of ER
5. Low utilization of EAP
6. Low utilization of Cigna nurse-line
7. Most members haven't selected a PCP – which makes outreach very difficult

The objective is to partner with Cigna to make more effective use of the Consultative Analytics Program Report (CAP) statistics (and other information

sources) in pinpointing cost drivers. We also want to get better traction from Cigna's in-force disease management programs. Changing where and when people get care can result in some immediate savings.

Also, UHC has proposed a pilot diabetes monitoring program for Medicare Retirees. UHC plans to focus on diabetes claims over \$10,000 and partner with AARP.

In terms of future plan design considerations for FY18 and beyond, the Board is looking at a dual (or multi) option plan design. Multi-option medical plans might include high deductible offerings – and possibly even a low cost option that restricts coverage to the Territory and Puerto Rico. With outsourcing of the eligibility it may finally be possible to administer more complex plan designs. The objectives will be to control costs while providing additional employee choice.

The Government Employees' **Life Insurance** benefits have been insured by Aetna since October 1, 2011. At that time, Aetna submitted a bid that was substantially below the incumbent (Cigna) and all of the other competitors. Aetna also agreed to guarantee their quoted rates for 4 years through September 30, 2015. Not surprisingly, Aetna's rates proved too low to fund the plan's

costs and Aetna requested a substantial rate restructuring for FY16. After long and difficult negotiations, the Board was able to achieve more attractive pricing from Aetna combined with a three-year rate guarantee. The agreed upon rate changes were disruptive for members but saved the Government over \$300,000 per year and required Aetna to agree to continue to accept less than break-even pricing. The Board sees no advantage in marketing the life insurance plan in 2016. Current rates are already below break-even levels. The underwriting marketplace is not as competitive as it was in 2011 and life insurers are less likely to write new business at unsustainable rates. This is particularly notable because many features of the government's plan, including the generous optional insurance amounts for retirees, lessen the attractiveness of the business to potential bidders. The life insurance and AD&D premiums (insured by Aetna) are shared between the Government and participating plan members. The Government's current annual expenditure is approximately \$700,000 for the Basic Life/AD&D insurance.

The Government makes no contribution to the **Vision Care** insurance. This is a member-pay-all voluntary plan available to active employees and retirees by the Standard Insurance Company. Implemented in 2011, the plan is currently running smoothly and the rates have not been increased in 5 years.

Standard is willing to guarantee the current rates through FY18. The Board would market the vision benefits at the same time as the medical benefits are next put out to bid to leverage the weight of a comprehensive benefits package and to avoid unnecessary administrative disruption.

The Government also sponsors an **Employee Assistance Program (EAP)** for Active Employees insured by CIGNA. The EAP is included in the CIGNA Medical rates.

In summary, the Board recommends accepting the rate renewals that we have negotiated. The recent announcement that Blue Cross will be withdrawing from the Territory adds urgency to our need to reach an attractive deal with our current Carriers. With less competition in the Territory, Insurers may not be so willing to negotiate aggressively. The Board also believes that all benefit plans should eventually be transitioned back to a uniform schedule for bidding, as this is the most efficient approach. Too frequent bidding of the medical insurance plan is disruptive to plan members and alarming to insurance companies. The Board's recommended approach is to delay re-bidding of all of the benefit plans until 2018, assuming no unforeseen changes.

Members of the 31st Legislature of the Virgin Islands, the GES/Health Insurance Board of Trustees is appreciative of your continued interest and involvement in the Group Insurance Program and we look forward to your assistance to ensure this year's recommendations are approved as presented. We also ask for your ongoing support and direction with respect to the issues I raised at the beginning of my presentation.

The staff, providers, members of the Board and I stand ready to answer any questions you may have in regard to our insurance programs.

Once again, I thank you.

EXHIBIT A

Financial Charts

Annualized premium projections
(central Government only)

All figures in \$millions

	Proposed Cigna Med/Rx renewal	CIGNA Med/Rx	Cigna Dental	UHC Med ¹ /Rx	TOTAL	% Change from prior yr
FY16	+3.30%	\$136.9	\$5.3	\$15.2	\$157.5	+3.4%
FY17	No change	\$136.9	\$5.3 ²	\$15.3	\$157.6	+0.05%

*Numbers may not add due to rounding

¹UHC amounts exclude Plan F buy-up costs of \$2.4 million.² FY17 dental premium increase of +10% is funded using PSR

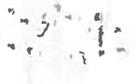
Medical/Rx/Dental Premiums

All figures in \$millions

	FY16	FY17	\$ change from FY16
Total Cost (100%)	\$157.5	\$157.6	\$0.1
Employer Share (65%)	\$102.4	\$102.4	\$0.05
Employee Share (35%)	\$55.1	\$55.2	\$0.05

*Numbers may not add due to rounding

¹UHC amounts exclude Plan F buy-up costs of \$2.4 million.



11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11