Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

2017 Joint Committee on Finance Paper #161

State Employee Group Health Program (Budget Management and Compensation Reserves)

[LFB 2017-19 Budget Summary: Page 83, #2; Page 347, #2; Page 364, #24; and Page 460, #3]

CURRENT LAW

Compensation Reserves. Generally, compensation reserves represent reserves in the budget to provide funding for any increases in state employee salary and fringe benefit costs that may be required in the biennium, but for which funding is not included in the individual agency budgets as a part of the biennial budget. The reserve funds are not allocated at the time of budget development to individual agencies because neither the amount of any salary or fringe benefit cost increases, nor the specific amount of funding needed by each individual agency, is known at the time of budget development. Typically, amounts within compensation reserves are funds to pay for: (a) the employer share of increased premium costs in the forthcoming fiscal biennium for state employee health insurance; (b) the costs of any general wage adjustments or negotiated pay increases; (c) increases in the employer share of contributions to the state retirement fund for employees' future state retirement benefits; and (d) pension obligation bond payments for the state's unfunded prior service liability for retirement benefits, the accumulated sick leave conversion credit program, and income continuation benefits.

Self-Insuring for State Employee Group Health Plans. Under 2015 Act 119, the Group Insurance Board (GIB) must notify the Joint Committee on Finance if it intends to execute a contract to provide self-insured group health plans on a regional or statewide basis to state employees. Under the act, the Committee is provided 21 working days to review the proposed contract. If the Co-chairs of the Committee notify the GIB within the period of review that the Committee has scheduled a meeting for consideration of the contract, the GIB may not execute the contract without the approval of the Committee. If a meeting is not scheduled, the GIB may execute the contract.

University of Wisconsin System. Under 2015 Act 55, $7,928,000 GPR in 2015-16 and $13,385,500 GPR in 2016-17 was provided to fund projected increases in fringe benefit costs for University of Wisconsin (UW) System employees during the biennium. The Act also specified that the Board of Regents could not request any funds from the state's compensation reserve during the 2015-17 biennium to fund compensation and fringe benefit costs.

GOVERNOR

Compensation Reserves. Provide to compensation reserves $7,462,600 GPR in 2017-18 and $19,862,600 GPR in 2018-19 for state employees other than employees of the UW System to fund the following: (a) expected inflation in health insurance costs in each year of the biennium; and (b) estimated federal Affordable Care Act health insurer fee savings. Funding amounts would be provided as shown in Table 1.

Self-Insurance Lapse. Specify that, if the GIB executes a contract to provide self-insured group health plans on a regional or statewide basis to state employees for calendar years 2018 and 2019 (other than the current self-insured plan known as the "standard plan"), the Secretary of the Department of Administration (DOA) must calculate the GPR savings in 2017-18 and 2018-19 for state agencies other than the UW System, reduce the estimated GPR expenditures for compensation reserves in 2017-18 and 2018-19 by an amount equal to the state agency savings, and lapse the estimated savings to the general fund. Estimate a lapse in the general fund condition statement of $10,147,000 GPR in 2017-18 and $20,294,100 GPR in 2018-19 associated with estimated savings from self-insuring for state employee group health plans.

Per Pupil Aid. Specify that a school district would be eligible for an increase of $12 per pupil in 2017-18 and $24 per pupil in 2018-19 if the Secretary of DOA lapses funding from state compensation reserves related to the state contracting to provide self-insured group health plans for state employees. Funding would be subject to two certifications relating to: (a) the distribution of aid by number of pupils enrolled in each school; and (b) a requirement that employees of the school district pay at least 12 percent of all costs and payments associated with health care coverage plans. Specify that if the Secretary of DOA does not lapse funding from state compensation reserves related to the state contracting to provide self-insured group health plans for state employees, DPI must subtract the associated change in the per pupil aid payment (a $12 per pupil change to the prior year payment in each year) from the indexing calculation each year for payments for the choice, charter, and open enrollment programs.

University of Wisconsin System. Provide net reductions of -$3,894,300 GPR in 2017-18 and -$3,851,900 GPR in 2018-19 to fund the following: (a) the GPR portion of expected inflation in health insurance costs in each year of the biennium; (b) the GPR portion of estimated federal Affordable Care Act health insurer fee savings; and (c) the GPR portion of estimated savings from self-insuring for state employee group health plans. Specify that the Board of Regents could not request any funds from the state's compensation reserve during the 2017-19 biennium to fund compensation and fringe benefit costs. Funding modifications would be made as shown in Table 1.

TABLE 1

Governor's Recommended Funding for State Employee Health Program, Changes to Base Funding for Compensation Reserves and UW System

	State Compensation Reserves			UW System		
	2017-18	2018-19	Biennium	2017-18	2018-19	Biennium
Health Insurance						
Prior Period and Inflation	$11,545,300	$28,027,900	$39,573,200	$9,205,700	$22,348,100	$31,553,800
Affordable Care Act Fee	-4,082,700	-8,165,300	-12,248,000	-3,247,000	-6,494,100	-9,741,100
Self-Insurance Reduction	0	0	0	-9,853,000	-19,705,900	-29,558,900
Total Appropriation	$7,462,600	$19,862,600	$27,325,200	-$3,894,300	-$3,851,900	-$7,746,200
Self-Insurance Lapse	10,147,000	20,294,100	30,441,100	0	0	0
Net Bill Funding	-$2,684,400	-$431,500	-$3,115,900	-$3,894,300	-$3,851,900	-$7,746,200

DISCUSSION POINTS

1. This paper addresses budgeted amounts in the bill for state employee health insurance inflation, savings associated with the potential repeal or suspension of a health insurance provider fee levied under the federal Affordable Care Act (ACA) and savings estimates associated with self-insuring for group health plans. First, an overview and alternatives are provided relating to the following state employee health insurance provisions in the bill for the Committee to consider if it chooses to approve the self-insurance proposal: (a) budgeting for state employee health expenses in general; (b) a reestimate of bill provisions to correct a calculation error; (c) self-insurance savings assumptions; (d) health insurance inflation; and (e) stop-loss coverage.

2. Following the discussion of self-insurance, information is provided relating to several other alternatives: (a) the status of the ACA health insurer fee; (b) per pupil aid increases tied to the approval of self-insurance contracts; (c) health insurance plan negotiations; (d) state health program reserves; (e) UW System tuition-funded fringe benefits; (f) regionalization and health plan tiers; and (g) legislative input.

3. On May 8, 2017, pursuant to s. 40.03(6)(L) of the statutes, the GIB submitted to the Committee one statewide and six regional contracts to self-insure for group health plans. On June 2, 2017, the Committee notified the GIB that a meeting was scheduled for the purpose of reviewing the contracts. A separate memorandum addresses self-insurance issues in more detail for the Committee's consideration under s. 13.10 of the statutes, including the Committee's decision to approve or reject the contracts.

Budgeting for State Employee Health Expenses

4. Table 2 below shows the share of pre-Medicare premium contributions paid in calendar year 2016 relative to the program as a whole by state employers, state employees, state retirees, and local participants (local employers, employees, and retirees). State employer contributions constitute approximately 81.8% of total program costs and approximately 83.2% of

state program costs.

TABLE 2

Share of Premium Contributions by Program Group for Pre-Medicare Participants, Calendar Year 2016

	Premiums Paid ($ in Millions)	Contribution Percentage	Share of State Program Only
State Employer	$956.9	81.8%	83.2%
State Employee	126.0	10.8	11.0
State Retiree	67.4	5.8	5.9
Local Programs	19.3	1.6	
Total	$1,169.5	100.0%	100.0%

5. Table 3 below shows the proportions budgeted in the bill to compensation reserves and the UW System for state employee health insurance that are funded from GPR and from other fund sources (FED, PR, and SEG). As shown in the table, approximately 50.7% of health insurance expenses are allocated to compensation reserves, while 49.3% of such expenses are allocated to the UW System. In addition, 49.5% of health insurance expenses are allocated to GPR under compensation reserves, while 40.6% of such expenses are allocated to GPR for the UW System. Overall, 45.1% of funding for state employer health insurance expenses is allocated to GPR funding.

TABLE 3

2017-19 DOA Budget Allocation of State Employer Compensation Expenses by Fund Source

State Employer Type	Budget Allocation	Share of State Costs
Compensation Reserves (Non-UW)		
GPR	49.5%	
Other Funds	50.5	
All Funds	100.0%	50.7%
UW System		
GPR	40.6%	
Other Funds	59.4	
All Funds	100.0%	49.3%
Total State Employer Costs		
GPR	45.1%	
Other Funds	54.9	
All Funds	100.0%	100.0%

Reestimate of Bill Provisions

6. Subsequent to introduction of the Governor's recommended budget, several calculation discrepancies were identified relating to: (a) estimated savings relating to the repeal or suspension of the ACA health insurer fee; and (b) estimated savings associated with contracts to self-insure for state employee group health plans. Specifically, errors resulted when estimated ACA and self-insurance savings for all expenses of group health plans administered by the Department of Employee Trust Funds (ETF), including local plans and contributions from retirees and employees, were converted into the amounts of GPR savings that would be realized by state employers. In total, savings were overestimated by approximately $16.8 million GPR over the biennium (difference of $0.1 million shown in Table 4 is due to rounding). Table 4 shows the overall GPR funding that was reduced under the bill and a reestimate of the amounts based on a corrected application of budget allocations: 36.9% is equal to the state employer share of total program costs noted previously (81.8%) multiplied by the percentage used by the administration to budget for state employer GPR expenses for health insurance (45.1%). As shown in Table 4, the bill estimates were based on Segal's midpoint projections of savings. [Segal Consulting is the GIB's consulting actuary for health benefit programs.]

TABLE 4

Reestimated 2017-19 Self-Insurance and ACA Savings Using Segal Estimates and DOA Budgeting Practices ($ in Millions)

		State Employer GPR							
	Total		Bill Estimate				Reestimate		
Type of Expense	Program per Calendar Year	Percentage Applied	2017-18 (Six Mos.)	2018-19 (12 Mos.)	Biennium (18 Mos.)	Percentage Applied	2017-18 (Six Mos.)	2018-19 (12 Mos.)	Biennium (18 Mos.)
Claims and Administration									
High	$116.1		N/A	N/A	N/A	36.9%	$21.4	$42.8	$64.2
Midpoint*	85.2	50.0%*	$20.0	$40.0	$60.0	36.9%	15.7	31.4	47.1
Low	53.7		N/A	N/A	N/A	36.9%	9.9	19.8	29.7
Affordable Care Act Fee	$32.5	45.1%	$7.3	$14.7	$22.0	36.9%	$6.0	$12.0	$18.0
Change to Savings Estimates									
Self-Insurance (Midpoint)							-$4.3	-$8.6	-$12.9
ACA Health Insurer Fee							-1.3	-2.7	-4.0
Total							-$5.6	-$11.3	-$16.9

*Under AB 64/SB 30, 50% of $85.2 million ($42.6 million) was rounded down to $40 million per calendar year, or $60 million for the 2017-19 biennium.

7. Additionally, the allocation of GPR self-insurance savings between compensation reserves and the UW System resulted in more funding being reduced from the UW System and less funding being reduced from compensation reserves than should have been reduced based on the administration's allocation method for other fringe benefit estimates shown in Table 3 above.

8. Corrected figures for the Governor's recommended budget provisions, which are based on Segal's calculation of the ACA health insurer fee and self-insurance savings as well as DOA's budget allocations of GPR funding for state employers, are provided in Table 5 below. Amounts are separately indicated for compensation reserves and the UW System. It should be noted that the figures in Tables 4 and 5 only represent a correction to the bill's calculations based on assumptions of the state's actuary and the administration. The figures do not represent projections or assumptions made by this office. If the Committee approves the Governor's recommendation to self-insure and adopts the administration's estimates, an additional $16,832,400 GPR over the biennium would be needed. [Alternative A1]

TABLE 5

Corrected ACA Health Insurer Fee and Self-Insurance Savings
Based on Consultant and Administration Estimates

	State Compensation Reserves			UW System		
	2017-18	2018-19	Biennium	2017-18	2018-19	Biennium
Health Insurance						
Prior Period and Inflation	$11,545,300	$28,027,900	$39,573,200	$9,205,700	$22,348,100	$31,553,800
Affordable Care Act Fee	-3,340,400	-6,680,900	-10,021,300	-2,656,700	-5,313,400	-7,970,100
Self-Insurance Reduction	0	0	0	-6,964,700	-13,929,400	-20,894,100
Total Appropriation	$8,204,900	$21,347,000	$29,551,900	-$415,700	$3,105,300	$2,689,600
Self-Insurance Lapse	8,757,100	17,514,100	26,271,200	0	0	0
Net Funding	-$552,200	$3,832,900	$3,280,700	-$415,700	$3,105,300	$2,689,600
Total Change to Base						
GPR	$32,241,500					
GPR-Lapse	26,271,200					
Net GPR	$5,970,300					
Change to Bill						
GPR	$742,300	$1,484,400	$2,226,700	$3,478,600	$6,957,200	$10,435,800
GPR-Lapse	-1,389,900	-2,780,000	-4,169,900	0	0	0
Net GPR	$2,132,200	$4,264,400	$6,396,600	$3,478,600	$6,957,200	$10,435,800
Total Change to Bill						
GPR	$12,662,500					
GPR-Lapse	-4,169,200					
Net GPR	$16,832,400					

Self-Insurance Savings Assumptions

9. Segal estimated self-insurance savings shown in Table 4 based on a range of assumptions relating to: (a) annual medical trend; (b) medical loss ratio indicating administrative expenses including profit; and (c) medical CPI (consumer price index, a measure of inflation in costs). As indicated in a presentation to the GIB on May 24, 2017, the numbers upon which the biennial budget were based "were focused on the midpoint scenario and deemed 'most likely.'" The

actual medical trend, medical loss ratio, and medical CPI cannot be predicted with certainty and are, therefore, still not known at this time.

10. Further, given that the assumptions upon which the consultant based its estimates could differ from actual market prices, administrative expenses, and use of medical care by covered members, the reestimated savings figures shown in Table 4 for Segal's "low" savings assumptions are not an absolute minimum. If the state were to self-insure, it would transfer the risk associated with medical claims from insurance companies to the state. Therefore, if medical claims should exceed estimated expenses, self-insurance could increase costs for the state.

11. Exhibit B of each self-insurance contract, which relates to discount guarantees, sets a 2018 "discount target" that is calculated by vendors based upon enrollment and regional assumptions. The contracts indicate that "Upon open enrollment, these will be re-based accordingly." The contracts also indicate that actual performance relative to discount targets would be calculated six months after the end of the calendar year. The consequence to a vendor of not meeting its discount target would be to reduce up to 10% of the vendor's total administrative fees. Discount targets and administrative fees for each vendor are not known at this time, as they were redacted from the contracts that have been submitted for review by the Joint Committee on Finance. However, based on figures provided by Segal, administrative fees that would be paid to vendors were estimated to total between $52 million and $55 million per calendar year. At most, fees at risk would total $5.5 million based on these estimates. In comparison, Segal estimated that medical claims under the proposal would total $1.15 billion to $1.17 billion. The actuary's calculations for administrative fees and medical claims expenses under the self-insured scenarios contained elements of proprietary and confidential information and were, therefore, not made available to review (unless through an agreement not to share the information). As such, the methodology cannot be evaluated. However, if medical claims expenses in a given year exceeded the actuary's estimates by 5% (under low savings assumptions) to 10% or more (under high savings assumptions), the proposal could ultimately increase rather than decrease program costs. A more detailed discussion of Segal's savings estimates is provided in the s. 13.10 paper.

Health Insurance Inflation

12. As indicated by the administration in a May 26, 2017, press conference, the bill assumes 7% growth in health insurance costs per calendar year. It should be noted, however, that the budgeted increases serve as the base estimate for program expenses before reductions are applied from ACA health insurer fee savings and self-insurance savings.

13. Table 6 below provides the following information for calendar years 2009 through 2017: (a) preliminary bids for premium increases submitted to ETF by participating health plans for the program year; (b) annual medical cost trend figures reported by PricewaterhouseCoopers (PwC) as a point of comparison; (c) state health program reserves used to reduce program expenses; (d) savings estimated by ETF associated with negotiating with health plans to reduce preliminary bids (savings attributable to all contributions under the state program only); and (e) final premium increases. It should be noted that final premium increases are not directly comparable to preliminary bids for two reasons. First, while preliminary bids are submitted by participating health insurers, final premium increases depend not only on final amounts paid to participating health plans, but

also include dental and pharmacy components which have in recent years been influenced to a great degree by the use of pharmacy reserves to reduce employer and employee expenses overall. Second, final premium increases may also be affected by transferring costs from state employers to employees through increases in deductibles, copays, and out-of-pocket maximums.

TABLE 6

State Group Health Program Preliminary Bids, Reserves Utilization, Negotiation Savings, and Premium Increases, 2009 to 2017 ($ in Millions)

Calendar Year	Preliminary Bid	Medical Cost Trend (PwC)	State Program Reserves Used	Negotiation "Savings"	Final Premium Increase
2009	10.0%	9.2%	$18.5	$13.5	8.1%
2010	10.0	9.0	6.1	18.8	7.7
2011	9.5	9.0	0.2	28.0	6.3
2012	2.1	8.5	30.0	30.1	-1.5
2013	8.7	7.5	32.8	33.1	5.1
2014	8.2	6.5	20.5	45.5	3.5
2015	6.9	6.8	20.0	19.3	5.0
2016	7.7	6.5	0.0	56.4	-2.5
2017	5.4	6.5	0.0	37.9	1.6
Average	7.6%	7.7%	$14.2	$31.4	3.7%

14. On May 24, 2017, Segal made a presentation to the GIB relating to addendum information submitted by the health plans that currently participate in the program. Segal indicated that the insurers are required to submit reports on "a wide array of information -- membership, claims, admin, trends, high dollar claimants, premiums, revenues, rate build-up, etc." Based on the information that was submitted on May 15, 2017, Segal made assumptions relating to medical cost increases and administrative expenses to produce estimated premium increases for 2018, with a projected premium increase bid of 14.0% and an overall target for the state to negotiate increases to 10.4%. In projecting an estimate, Segal indicated that: (a) actual medical claims decreased in 2016 relative to previous estimates; and (b) health plans participating in the program are currently operating at a very efficient level of only 4% administrative expenses including profit (96% medical loss ratio estimated in 2017 associated with medical expenses). Segal reasons that the 2016 decrease in medical expenses and efficient administration by insurers in 2017 (some of which currently report operating at a loss) will result in higher costs when the health plans submit preliminary bids. However, Segal's projections are well outside the range of preliminary and final bids for the past nine years, shown in Table 6 above.

15. Segal's projected premium increases based on May, 2017, addendum information submitted by health plans did not include actual preliminary bids, which are due later in June. However, the historical preliminary bid data shown in Table 6 could serve as a useful point of reference in setting expectations for bids. From 2009 to 2017, preliminary bids ranged from a 2.1% increase (2012) to a 10.0% increase (2009 and 2010). On average, preliminary bids were for a 7.6% increase.

16. Final premium increases for calendar years 2009 to 2017, which would include any cost shifts to employees or draw-downs of reserves, averaged 3.7%. The only years in this period in which significant draw-downs of reserves and cost shifts to employees did not occur were 2011 and 2017. The average preliminary bid increase for these years was 7.5%, and the average final premium increase was 4.0%. Additionally, based on information in Table 6, negotiations with participating health plans reduced estimated premium expenditures by $19 million to $56 million each year (approximately $31 million annually on average). State health program reserves were used in seven of nine years to reduce program costs. Due to the dynamic nature of negotiations, health program reserves, and other factors, it is difficult to predict the final percentage increase in health program expenses.

17. While the bill assumes 7% health inflation in each year of the biennium, this amount of assumed growth would include an ACA health insurer fee, if it were to be charged, because the bill separately reduces funding associated with the fee. Given that average preliminary bids in 2014 through 2016 were 7.6%, and that the ACA health insurer fee was assessed in those years, it could be argued this is a reasonable point of comparison and that the bill's assumption of 7% growth (not including any savings estimates) is also reasonable. Additionally, these initial percentage increases are similar to national medical cost trend data published by PwC.

Stop-Loss Coverage

18. As noted previously, issues relating to self-insurance, and the contracts to self-insure in particular, are discussed in more detail in a separate paper for the Committee's consideration under s. 13.10 of the statutes. However, it should be noted that a number of Committee members have expressed an interest in the cost to the state to purchase a stop-loss insurance policy if the state does self-insure for the purpose of limiting the risk of large, unexpected claims.

19. If the Committee chooses to approve the contracts to self-insure for group health plans, the Committee could consider providing funding to purchase a stop-loss insurance policy for large claims. In its May 8, 2017, letter to the Committee, the GIB indicated that Segal had estimated such coverage could cost as much as $4 million per calendar year (corresponding to a $1 million attachment point). As a proportion of total program costs, the GPR share of coverage is estimated at $738,200 GPR in 2017-18 ($411,200 for compensation reserves and $327,000 for the UW System) and $1,476,300 GPR in 2018-19 ($822,300 for compensation reserves and $654,000 for the UW System). [Alternative A2]

Affordable Care Act Fee

20. If the Committee does not approve the recommendation to self-insure for state employee group health plans and the ACA health insurer fee is assessed in calendar year 2018 or 2019, the degree to which additional funding could be needed associated with the fee would depend on the outcome of negotiations with health insurers.

21. There are two primary reasons to question whether the state would pay the full amount of the estimated fee. First, the fee is paid by insurance companies rather than being paid directly by consumers (that is, the state would not pay the fee directly). On one hand, it stands to reason that

some percentage of the fee would be passed on to purchasers of insurance. On the other hand, due to differences in the circumstances under which insurance is purchased, it is possible that some consumers pay more or less than their proportionate share of the fee. It is also possible that the fee would be paid by an insurer, in part, from the net revenue that the insurer would otherwise retain. While Segal estimates that the state's full proportionate share of the fee would be paid to each insurer, the state could end up paying less than its share if some or all insurers do not have sufficient bargaining power or if they value the state's business highly. An insurer could either absorb at least some of the cost or pass a portion of the cost on to other purchasers of insurance. Second, through the preliminary bidding and negotiation process, the degree to which insurers and ETF believe that the fee will be assessed in 2018 or 2019 could affect the final premium amounts the state agrees to pay. If an insurer believes that the fee is likely to be repealed, or that a moratorium on the fee is likely to continue, the insurer may be willing to accept a premium that would reflect a lower cost. Likewise, if ETF believes that the fee is likely to not be assessed, the agency may be unwilling to agree to pay a premium that would include the cost of the fee.

22. If the Committee wishes to provide funding to pay the full amount that Segal estimates for the ACA health insurer fee, $17,991,400 GPR would be needed over the biennium ($5,997,100 in 2017-18 and $11,994,300 in 2018-19). [Alternative B1] However, Congress has indicated that health insurance legislation and tax legislation continue to be high priorities. Therefore, the Committee could maintain the bill's assumption that the fee will not be assessed.

Per Pupil Aid Increases

23. If the Committee chooses not to approve the recommendation to self-insure, it could also delete the explicit links in the bill between self-insurance and: (a) per pupil aid increases of $12 and $24; and (b) the indexing calculation each year for payments for the choice, charter, and open enrollment programs. Funding levels and calculations for categorical aid are addressed in other budget papers. [Alternative B2]

Negotiations and Health Program Reserves

24. If the state does not self-insure for state employee group health programs, ETF would enter into negotiations with insurers regarding 2018 premium increases. Using an average for program years in which the ACA health insurer fee was assessed (2014 through 2016), negotiation savings from preliminary bids are estimated at $40.4 million per calendar year for the state program as a whole, not including local employers. Of this amount, approximately 37.5% (or 45.1% of 83.2%) would be GPR. In addition, if the Committee does not approve the Governor's recommendation to self-insure for group health plans, state health program reserves could be utilized to minimize program cost increases.

25. The Group Insurance Board approved a program reserves policy in August, 2011, recommended by the state's health program actuary at the time, Deloitte Consulting, to maintain a fund balance that equals 15% to 25% of the sum of: (a) 100% of annual self-funded medical claims; and (b) 20% of annual fully-insured medical claims. The policy has not been modified since its adoption in 2011. Table 7 provides the actual amounts of year-end reserves (2016 figures are unaudited) for the past five calendar years and the estimated amount of year-end reserves that would

correspond to the Board's reserve policy based on actual or estimated medical claims expenses for the same years. As shown in the table, as of the end of calendar year 2016, program reserves were $18.4 million greater than the maximum 25% medical claims benchmark and $68.8 million more than the minimum 15% medical claims benchmark.

TABLE 7

Health Program Reserves for State Employees and State Retirees, Calendar Years 2012 to 2016 ($ in Millions)

	Calendar Year				
	2012	2013	2014	2015	2016
Claims Benchmark*	$430.8	$449.0	$481.6	$502.2	$504.0
Year-End Reserves	140.8	129.8	100.1	81.5	144.4
Reserves as % of Claims	32.7%	28.9%	20.8%	16.2%	28.6%

	Amount	Difference
2016 Reserves	$144.4	N/A
25% of Claims	126.0	$18.4
15% of Claims	75.6	68.8

*Benchmark established in August, 2011, was 100% of actual self-insured claims and 20% of estimated fully insured claims.

26. As a share of available program reserves that could be utilized, 37.5% of program reserves for the state (45.1% of 83.2%) would correspond to budgeted GPR expenses for compensation reserves and the UW System. The amounts shown in Table 7 in excess of 25% and 15% would correspond to approximately $6.9 million GPR (25% policy) and $25.8 million GPR (15% policy). If used over a two-year period, reductions of $2.3 million GPR in 2017-18 and $4.6 million GPR in 2018-19 could be applied if reserves were drawn down to 25% [Alternative C1], while $8.6 million GPR in 2017-18 and $17.2 million GPR in 2018-19 could be applied if reserves were drawn down to 15% [Alternative C2]

27. The following tables provide a reestimate of certain health insurance expenses in the bill as follows: (a) growth in expenditures based on actual prior period inflation as well as estimated preliminary bids of 7% in 2018 and 2019 (no change to bill); (b) reestimated ACA health insurer fee savings (funding for which would be provided under Alternative B1 if selected); (c) negotiation savings of $15,157,500 GPR per calendar year, or $22,736,300 GPR over the biennium (37.5% of $40.4 million per calendar year, as allocated between compensation reserves and the UW System); and (d) savings from drawing down state program reserves to a level of 25% [Alternative C1], or 15% [Alternative C2]. As shown in the tables below, the increase in bill funding over the biennium would be $34.4 million GPR (shown in Table 8, if reserves are drawn down to 25%) or $15.4 million GPR (shown in Table 9, if reserves are drawn down to 15%). In comparison, the Governor's recommendation as reestimated would require an increase of $16.8 million GPR associated with overestimated savings (shown in Table 5).

TABLE 8

Estimated State Employee Health Program Expenses under Current Structure -- Changes to Base Funding for Compensation Reserves and UW System (25% Reserve)

	State Compensation Reserves			UW System		
	2017-18	2018-19	Biennium	2017-18	2018-19	Biennium
Health Insurance						
Prior Period and Inflation	$11,545,300	$28,027,900	$39,573,200	$9,205,700	$22,348,100	$31,553,800
Affordable Care Act Fee	-3,340,400	-6,680,900	-10,021,300	-2,656,700	-5,313,400	-7,970,100
Negotiation Savings	-4,221,300	-8,442,500	-12,663,800	-3,357,500	-6,715,000	-10,072,500
Reserves Draw-Down to 25%	-1,281,700	-2,563,400	-3,845,100	-1,019,500	-2,038,900	-3,058,400
Net Funding	$2,701,900	$10,341,100	$13,043,000	$2,172,000	$8,280,800	$10,452,800
Total Change to Base						
GPR	$23,495,800					
GPR-Lapse	0					
Net GPR	$23,495,800					
Change to Bill						
GPR	-$4,760,700	-$9,521,500	-$14,282,200	$6,066,300	$12,132,700	$18,199,000
GPR-Lapse	-10,147,000	-20,294,100	-30,441,100	0	0	0
Net GPR	$5,386,300	$10,772,600	$16,158,900	$6,066,300	$12,132,700	$18,199,000
Total Change to Bill						
GPR	$3,916,800					
GPR-Lapse	-30,441,100					
Net GPR	$34,357,900					

TABLE 9

Estimated State Employee Health Program Expenses under Current Structure -- Changes to Base Funding for Compensation Reserves and UW System (15% Reserve)

	State Compensation Reserves			UW System		
	2017-18	2018-19	Biennium	2017-18	2018-19	Biennium
Health Insurance						
Prior Period and Inflation	$11,545,300	$28,027,900	$39,573,200	$9,205,700	$22,348,100	$31,553,800
Affordable Care Act Fee	-3,340,400	-6,680,900	-10,021,300	-2,656,700	-5,313,400	-7,970,100
Negotiation Savings	-4,221,300	-8,442,500	-12,663,800	-3,357,500	-6,715,000	-10,072,500
Reserves Draw-Down to 15%	-4,792,500	-9,584,900	-14,377,400	-3,811,900	-7,623,700	-11,435,600
Net Funding	-$808,900	$3,319,600	$2,510,700	-$620,400	$2,696,000	$2,075,600
Total Change to Base						
GPR	$4,586,300					
GPR-Lapse	0					
Net GPR	$4,586,300					
Change to Bill						
GPR	-$8,271,500	-$16,543,000	-$24,814,500	$3,273,900	$6,547,900	$9,821,800
GPR-Lapse	-10,147,000	-20,294,100	-30,441,100	0	0	0
Net GPR	$1,875,500	$3,751,100	$5,626,600	$3,273,900	$6,547,900	$9,821,800
Total Change to Bill						
GPR	-$14,992,700					
GPR-Lapse	-30,441,100					
Net GPR	$15,448,400					

Fully-Insured Reserve Policy

28. As noted above, GIB's actuary in 2011, Deloitte Consulting, recommended that reserves of 15% to 25% should be held for 20% of fully-insured medical claims as well as for 100% of self-insured medical claims. Two reasons were provided for the fully-insured reserve policy: first, that the policy is consistent with the risk-based capital method developed by the National Association of Insurance Commissioners for insurance firms; and second, that in any given program year, one or more fully-insured plans (particularly in rural areas) could discontinue participation, resulting in a need for the state to provide self-insured coverage to members who had previously been covered under the plans.

29. Questions have been raised about the appropriateness of this policy. Specifically, it could be argued that it may be unnecessary to maintain a reserve for fully-insured plans at all, or that the basis of 20% is more cautious than is warranted and a lower percentage basis could be sufficient. An alternative is not offered in this paper to direct the GIB to modify its policy. However, the Committee could choose to direct the GIB to review the fully-insured reserve policy with regard to its continued appropriateness. The Committee could further specify that the GIB review: (a) the history of changes in fully-insured plan participation in the group health insurance program; and (b) the dollar amount of claims or premiums and the number of members affected by discontinuation of such plans year to year. If the GIB determines that the 20% basis could be reduced to an amount such as 15% or 10%, it is possible that further employer and employee cost reductions could be realized by way of additional reserve draw-downs. [Alternative C3]

UW Fringe Benefits

30. The Governor's budget does not provide an appropriation increase or decrease associated with the tuition-funded portion of health insurance for UW System employees. During its executive session on May 25, 2017, the Joint Committee on Finance adopted a motion that would continue the freeze on resident undergraduate tuition in 2017-18 and 2018-19. As resident undergraduate tuition will be frozen, the UW System would not be able to generate the additional tuition revenue necessary to fund health insurance increases for positions funded with a combination of GPR and tuition revenues. As an alternative, the Committee could provide additional funding through the UW System's GPR block grant to fund the tuition portion of the estimated increases.

31. If the self-insurance contracts were approved, based on DOA's estimates and information provided by the UW System regarding GPR and tuition expenditures for health insurance premiums in 2016, it is estimated that the UW System would need an additional $1,206,600 GPR in 2017-18 and $367,500 GPR in 2018-19 to fund the tuition portion of fringe benefit costs based on the GPR increases shown in Table 5. (These amounts include reestimates of the tuition portion of health insurance and other fringe benefits.) [Alternative D1] If self-insurance contracts are not approved and the Committee directs ETF to draw state program reserves down to 25%, it is estimated that the UW System would need an additional $2,282,600 GPR in 2017-18 and $2,519,600 GPR in 2018-19 to fund the tuition portion of fringe benefit costs based on the GPR increases shown in Table 8. [Alternative D2] If the Committee directs ETF to draw reserves down to 15%, it is estimated that the UW System would need an additional $1,121,500 GPR in 2017-18 and $432,900 GPR in 2018-19 to fund the tuition portion of fringe benefit costs based on the GPR

increases shown in Table 9. [Alternative D3]

Regionalization and Health Plan Tiers

32. The Group Insurance Board has not made a final determination regarding its course of action if the Committee does not approve the contracts to self-insure. Instead, the GIB directed ETF staff at its May 24, 2017, meeting to proceed with soliciting bids from health plans under the current program model as well as requesting bids to administer fully-insured health plans on a regional basis (as outlined in the proposal to self-insure). However, the GIB has indicated that it would seriously consider pursuing regionalization on a fully-insured basis and may consolidate health insurance purchases with fewer insurers, to realize cost efficiencies from lower premiums. Several members of the GIB have cited, as a reason for pursuing consolidation with fewer lower-cost health plans, the tendency of health plans to be placed in Tier 1 regardless of the premium paid by employers. Tier 1 is the lowest-cost tier of three tiers designated in statute for employees' share of health insurance premium contributions.

33. However, two main concerns have been raised regarding the pursuit of consolidation: (a) the policy could reduce member choices and potentially disrupt the continuity of health care services that employees and their families receive; and (b) consolidation of the state's programs with fewer insurers could reduce competition through increased market share for the remaining insurers. Some have observed that among the lowest-cost, high quality health plans that currently participate are smaller local insurers that would not be able to cover an entire region. Transition to a regionalized model with fewer and larger insurers could ultimately lead to further restructuring of the insurance market in the state and higher prices being eventually charged to: state employers, other public and private employers, and individuals. When market competition is reduced, prices can be increased independent of actual costs to the companies. Economists, business analysts, and the U.S. Department of Justice have observed that if consumers have fewer options available, producers can charge more for products and services. Other consequences could include reductions in service availability or quality.

34. The statutory requirement that health plans be placed into one of three tiers based on the employee's share of premium costs was first created under 2003 Act 33 based on a proposal developed by a study group of the GIB. Health plans are placed into each of the three tiers according to the cost-effectiveness of the plans, which can include consideration of factors other than cost alone, such as the risk profile of participants in the plan. The employer contribution share is highest for Tier 1 plans, which are deemed most cost-effective. Currently, the state employer share for Tier 1 plans is approximately 88%, while the employee share is approximately 12%. In comparison, the state employer contribution for Tier 3 plans (which are higher-cost) is approximately 81%, while the employee share is approximately 19%. The purpose of the tiering structure is, in part, to reduce employer expenses by encouraging health plans to become more cost-effective (through lower premiums) and by encouraging state employees to choose lower-cost plans.

35. In part because Tier 1 plans require a lower employee contribution amount, most employees select a Tier 1 plan. Plan administrators generally wish for their plans to be placed in Tier 1, and are to some extent willing to lower bids for premium increases if it would result in a Tier 1 designation. Because there are many more plans than tiers, premiums paid by the state can range

widely within a tier. Currently, the total premium paid for non-Medicare Tier 1 plans with dental coverage, including both employer and employee contributions, is between $652 and $880 for single coverage and between $1,606 and $2,175 for family coverage. As noted above, a number of GIB members have expressed concern that most health plans are designated as Tier 1 plans, which they believe is due in part to pressure from plan administrators. Board members have also recently indicated an interest in distributing plans more evenly to Tier 2 and Tier 3 to encourage more cost-effective premium negotiation results. Increased utilization of the tiering structure in this manner could also lead to reduced employee participation in less cost-effective plans and increased employee contributions for higher-cost plans. Both would have the potential to reduce state employer expenditures.

36. The Committee could consider expanding the number of tiers from three to a total of five to provide the GIB with additional means by which health plan premiums, state employer share of premium contributions, and state employee use of higher-cost plans could be reduced. If there are five tiers rather than three, the GIB could more easily distribute plans according to cost with a lower risk of crowding in one tier. This approach to reducing state employer expenses would maintain competition between insurers as well as health plan choices available to employees. [Alternative E1]

Legislative Input

37. Finally, given the statewide public interest of maintaining a competitive health insurance market, the value of health plan benefits in recruiting and retaining state employees, and the financial impact of providing cost-effective employee health plan benefits, the Committee may wish to provide for increased involvement in such matters by the Legislature. Following are several alternatives that could be considered to increase the input, oversight, and general participation of the Legislature in shaping policies relating to state employee health plan benefits.

38. The Committee could consider modifying the composition of the GIB to provide for legislative review and representation. Currently, the GIB is composed of 11 members, six of which are appointed by the Governor directly, and four of which serve as ex-officio members (or the specified individual's designee): the Secretary of DOA, the administrator of DOA's Division of Personnel Management, the Commissioner of Insurance, and the Governor. The eleventh member is the Attorney General or his or her designee. The Committee could specify that the six members appointed by the Governor be appointed with the advice and consent of the Senate [Alternative F1] and could additionally specify that the following four members be added to the GIB: (a) a member appointed by the Senate Majority Leader; (b) a member appointed by the Senate Minority Leader; (c) a member appointed by the Speaker of the Assembly; and (d) a member appointed by the Assembly Minority Leader [Alternative F2].

39. The Committee could further specify that: (a) the GIB, in consultation with DOA's Division of Personnel Management, must annually, by April 1, submit any proposed changes to the state group health insurance program to the Joint Committee on Finance under a 21 working day passive review; and (b) if the Committee notifies the GIB within 21 working days that a meeting has been scheduled for the purpose of reviewing the changes, the changes may not be implemented unless approved by the Committee. [Alternative F3]

ALTERNATIVES

A. Governor's Recommendation: Approve Self-Insurance

1. Approve the Governor's recommendations regarding the following provisions as reestimated based on corrected percentages for state employer expenses: (a) health insurance inflation for state employees including UW System employees; (b) anticipated moratorium or elimination of the Affordable Care Act health insurer fee; and (c) reductions associated with self-insuring for group health plans. Provide funding to compensation reserves and the UW System and reestimate lapses associated with self-insurance as shown in Table 5.

ALT A1	Change to Base	Change to Bill
GPR	$32,241,500	$12,662,500
GPR-Lapse	26,271,200	- 4,169,200
Net GPR	$5,970,300	$16,832,400

2. Provide $411,200 GPR in 2017-18 and $822,300 GPR in 2018-19 to compensation reserves; and $327,000 GPR in 2017-18 and $654,000 GPR in 2018-19 to the UW System associated with purchasing a stop-loss insurance policy.

ALT A2	Change to Base	Change to Bill
GPR	$2,214,500	$2,214,500

B. ACA and Per Pupil Aid (Self-Insurance Not Approved)

1. Restore funding associated with the estimated state cost of paying the federal Affordable Care Act health insurer fee. [Under this alternative, funding reductions shown for the ACA health insurer fee in Table 1 would be reversed. The Committee may choose to maintain the program structure without selecting this alternative.]

ALT B1	Change to Base	Change to Bill
GPR	$0	$21,989,100

2. Delete provisions in the bill that would: (a) specify that per pupil aid increases of $12 and $24 would depend on the decision to self-insure for group health plans; and (b) modify the indexing calculation each year for payments for the choice, charter, and open enrollment programs based on the decision to self-insure.

C. State Health Reserves (Self-Insurance Not Approved)

Specify the following changes to the bill and maintain the current program structure: (a)

delete the requirement that the Secretary of DOA calculate GPR savings associated with self-insurance, the requirement to lapse these amounts from compensation reserves to the general fund, and the lapse estimate in the bill; (b) estimate negotiation savings shown in Tables 8 and 9 totaling $7,578,800 GPR in 2017-18 and $15,157,500 in 2018-19; (c) reduce ACA health insurer fee savings by $5,997,100 GPR in 2017-18 and $11,994,300 GPR in 2018-19 based on a reestimate; and (d) direct ETF to utilize the following amount of state health program reserves over the 2017-19 biennium to minimize health insurance cost increases to state employee health programs and reduce GPR funding for compensation reserves and the UW System by the amounts indicated under Alternative C1 or Alternative C2 [if selected with Alternative B1, bill funding would be increased by $5,997,100 GPR in 2017-18 and $11,994,300 in 2018-19]:

1. $18.4 million (maintain a 25% reserve); reduce compensation reserves by $1,281,700 GPR in 2017-18 and $2,563,400 GPR in 2018-19; and reduce funding to the UW System by $1,019,500 GPR in 2017-18 and $2,038,900 GPR in 2018-19.

ALT C1	Change to Base	Change to Bill
GPR	$23,495,800	$3,916,800
GPR-Lapse	0	- 30,441,100
Net GPR	$23,495,800	$34,357,900

2. $68.8 million (maintain a 15% reserve); reduce compensation reserves by $4,792,500 GPR in 2017-18 and $9,584,900 GPR in 2018-19; and reduce funding to the UW System by $3,811,900 GPR in 2017-18 and $7,623,700 GPR in 2018-19.

ALT C2	Change to Base	Change to Bill
GPR	$4,586,300	- $14,992,700
GPR-Lapse	0	- 30,441,100
Net GPR	$4,586,300	$15,448,400

3. In addition, specify that the GIB review its policy relating to reserves for fully-insured health plans (15% to 25% of 20% of fully-insured medical claims), including: (a) the history of changes in fully-insured plan participation in the group health insurance program; and (b) the dollar amount of claims or premiums and the number of members affected by discontinuation of such plans year to year.

D. UW System Tuition-Funded Positions

Provide the following amounts to the UW System to fund the tuition portion of estimated fringe benefit cost increases [this alternative assumes that resident undergraduate tuition is frozen in 2017-18 and 2018-19]:

1. $1,206,600 GPR in 2017-18 and $367,500 GPR in 2018-19, if the state self-insures for group health plans.

ALT D1	Change to Base	Change to Bill
GPR	$1,574,100	$1,574,100

2. $2,282,600 GPR in 2017-18 and $2,519,600 GPR in 2018-19, if the state does not self-insure and state health program reserves are drawn down to 25%.

ALT D2	Change to Base	Change to Bill
GPR	$4,802,200	$4,802,200

3. $1,121,500 GPR in 2017-18 and $432,900 GPR in 2018-19, if the state does not self-insure and state health program reserves are drawn down to 15%.

ALT D3	Change to Base	Change to Bill
GPR	$1,554,400	$1,554,400

E. Health Plan Tiers

1. Specify that the number of health plan tiers in statute would be five (rather than three).

F. Legislative Input

1. Specify that the six members of the GIB appointed by the Governor be appointed with the advice and consent of the Senate.

2. Specify that the following four members be added to the GIB: (a) a member appointed by the Senate Majority Leader; (b) a member appointed by the Senate Minority Leader; (c) a member appointed by the Speaker of the Assembly; and (d) a member appointed by the Assembly Minority Leader.

3. Specify that: (a) the GIB, in consultation with DOA's Division of Personnel Management, must annually, by April 1, submit any proposed changes to the state group health insurance program to the Joint Committee on Finance under a 21 working day passive review; (b) if the Committee notifies the GIB within 21 working days that a meeting has been scheduled for the purpose of reviewing the changes, the changes may not be implemented unless approved by the Committee.

Prepared by: Rachel Janke