2018 Health Plan Renewals

August 30, 2017

Board	Mtg Date	Item #
GIB	8.30.17	7H

Overall Renewal Process

- Renewal process primarily unchanged for 2017
  - Savings targets pushed renewals goal to 3% overall State increase
- There was no consideration given to additional ACA fees currently projected for 2018
- The negotiation process involved the following:
  - May – Segal prepared addendum requirements and requested from Plans
  - May 15th – Addendum data submitted to Segal
  - June – Segal compiled data and calculated tier breakpoints
  - June 30th – Preliminary Rate Quotes submitted to Segal
  - July – Segal compiled rates and placed Plans into premium tiers
  - July 19th – Plans notified of their tier placement and offered renewal meeting to discuss
  - July 25th – 28th – Renewal meetings held with Plans
  - August 4th – Best and Final Offers received from Plans

Collect Addendum Reports & Data

- Plans are required to provide addendum reports for each group separately: State (Non-Medicare, Medicare, Grads), Local (Non-Medicare, Medicare), HDHP, Total Organization (Non-Medicare, Medicare)
- The reports include:
  - Enrollment and membership demographics
  - FFS claims and capitation encounter experience
  - Medical trend assumptions
  - Administrative expenses
  - Rate development
  - Medical Loss Ratio Report
  - Large claimant information
  - Actuarial Certification
- FFS claims and capitation encounter data is required with claim line detail
  - Validated to match reported claims
  - Segal developed utilization and aggregated statistics, nothing member specific
- Plans also submitted reports on network adequacy to determine which plans were qualified in each county

Tier Breakpoint Development – Based on Addendum

- Incurred claims and capitation experience are compiled for each plan for the State Non-Medicare group
- Catastrophic claims are removed and a pooling charge is added
- Total Incurred PMPM amounts are trended forward with projected trends “capped” at acceptable levels
- Administrative costs are “capped” at a target level above last year’s cap
- Total PMPM is then risk adjusted, combining a DxCG Rx model risk score (30%) with an age/sex score (20%) and region factor (50%). The result is a risk-adjusted normalized PMPM from which to reasonably compare Plan performance.
- Breakpoint levels were modified slightly from prior years due to budget limitation. Below is a summary of the results:

	Number of Plans		Non-Medicare Members	
Tier	**Dane**	**Non-Dane**	**Dane**	**Non-Dane**
1	1	8	8,748	9,235
2	2	7	38,389	56,110
3	1	7	35,123	11,013
	4	**22**	**82,260**	**76,358**

Compile Tier Placement From Preliminary Bid

- Plans submit their Preliminary Bids knowing there is an opportunity for negotiations and movement to Tier 1. They are also aware of the JFC decisions.
- Tier placement is performed using the State Non-Medicare group only. Negotiations of other groups will follow by design.
- Bids are converted to a PMPM and risk adjusted using an overall risk score comprised of prospective DxCG risk score (30%), age/sex (20%) and region (50%) - similar to experience adjustment except risk is prospective vs. retrospective.
- Credits/penalties are then applied to reflect quality scores and Medicare rates.
- The final adjusted rates are compared to the tier breakpoints developed from the Addendum experience rate projections.
- Plans are notified of their tier placement and given the opportunity to meet and discuss results. Meetings were held with all but two plans.

Tier Placement From Preliminary Bid
Non-Dane

- Anthem and Arise did not submit a preliminary bid offer.
- During negotiations, Health Tradition, Humana and UHC could not meet ETF proposed rates for Tier 1 and decided to no longer participate in the program.
- About half of the disruption is from physician services.
- There was approximately $5 million savings from the removal of the high cost/high premium plans during negotiations.

WPE Negotiations

- Traditionally, the local plan submissions were reviewed and negotiated based on their loss ratios and relationship to the State rates.
- This year a tier process similar to that utilized for the State bids was implemented for the Dane Region. The variability in the Non-Dane Region did not provide a reliable model given the small size of many plans.
- Consistent with last year, all plans were limited to a 5% increase, adjusted for quality credits. This limitation impacted the renewals of 12 plans.
- Two plans were placed in Tier 3 based on their rates being greater than a percentage of their State rates:
  - Security (2 service areas)
  - WEA Trust Northwest (2 networks)

2017 Inforce Rates

- State renewal process resulted in a $48.2 million savings, a 4.5% reduction from 2018 Preliminary Bids. The reduction was even larger for locals (11.8%) due to the additional 5% rate cap limitation.

	2017 Inforce Rates	2018 Prelim Bids	2018 BAFO Rates	Change From Inforce	%	Negotiation Savings	%
State							
Non-Medicare	$ 847.7	$ 916.8	$ 872.6	$ 24.9	2.9%	$ (44.2)	-4.8%
Medicare	$ 70.4	$ 73.3	$ 72.9	$ 2.5	3.6%	$ (0.4)	-0.5%
Grads	$ 44.6	$ 47.8	$ 46.3	$ 1.7	3.8%	$ (1.5)	-3.1%
HDHP	$ 40.4	$ 43.6	$ 41.5	$ 1.1	2.7%	$ (2.1)	-4.8%
Total State	**$ 1,003.1**	**$ 1,081.5**	**$ 1,033.3**	**$ 30.2**	**3.0%**	**$ (48.2)**	**-4.5%**
Local							
Non-Medicare	$ 170.1	$ 200.7	$ 177.6	$ 7.5	4.4%	$ (23.1)	-11.5%
Medicare	$ 4.9	$ 5.6	$ 4.9	$ -	0.0%	$ (0.7)	-12.5%
HDHP	$ 1.1	$ 1.4	$ 1.1	$ -	0.0%	$ (0.3)	-21.4%
Total Local	**$ 176.1**	**$ 207.7**	**$ 183.6**	**$ 7.5**	**4.3%**	**$ (24.1)**	**-11.6%**
Grand Total	**$ 1,179.2**	**$ 1,289.2**	**$ 1,216.9**	**$ 37.7**	**3.2%**	**$ (72.3)**	**-5.6%**

- Preliminary Bids requested an increase of 7.8%. Negotiations limited the increase to 3.0%.

2018 Recommendations – With No Reserve Draw
Total Premium for State Non-Medicare

- With pharmacy, dental and admin included, total State Non-Medicare premiums are expected to increase 2.1%.

	2017 In-Force	2018 Premium	$ Change	% Change
State Non-Medicare, Non-Grad				
Medical	$ 847.7	$ 872.6	$ 24.9	2.9%
Pharmacy	$ 166.8	$ 160.4	$ (6.4)	-3.8%
Dental	$ 40.0	$ 41.7	$ 1.7	4.3%
Admin	$ 12.1	$ 14.2	$ 2.1	17.4%
Total	**$ 1,066.6**	**$ 1,088.9**	**$ 22.3**	**2.1%**

- Note that the $847.7 million 2017 In-Force amount does not have ACA Health Insurer Fees and that 2018 rates currently include the fees. Along with poor experience, the lack of passing through ACA fees likely impacted national plans to exit the program.

2018 Recommendations – With No Reserve Draw
Total Program Premiums – State and Locals, All Plans

- With pharmacy, dental and admin included, total program premiums are expected to increase 2.3%. Note that Medicare will have the largest decrease due to more aggressive negotiations and good pharmacy experience.

	2017 In-Force	2018 Premium	$ Change	% Change
State				
Non-Medicare	$ 1,087.9	$ 1,114.9	$ 27.0	2.5%
Medicare	$ 175.7	$ 172.8	$ (2.9)	-1.7%
Grads	$ 56.5	$ 58.8	$ 2.3	4.1%
HDHP	$ 52.0	$ 54.4	$ 2.4	4.6%
Total State	**$ 1,372.1**	**$ 1,400.9**	**$ 28.8**	**2.1%**
Local				
Non-Medicare	$ 206.5	$ 214.0	$ 7.5	3.6%
Medicare	$ 9.6	$ 9.3	$ (0.3)	-3.1%
HDHP	$ 1.3	$ 1.3	$ -	0.0%
Total Local	**$ 217.4**	**$ 224.6**	**$ 7.2**	**3.3%**
Grand Total	**$ 1,589.5**	**$ 1,625.5**	**$ 36.0**	**2.3%**

- Note that the above includes increases on the Standard & SMP movement to fully-insured with WEA Trust

Board Reserve Policy

Medical Plan – Fully-Insured HMO Rates

- Currently hold 3% (min) to 5% (max) of premiums. Used primarily as a premium fluctuation reserve, designed to mitigate a high trend year.

Pharmacy & Dental Plans – Self-Insured Claims

- Currently hold 15% (min) to 25% (max) of annual claims. Used to fund the reserve for claims incurred but not reported (IBNR). Also incorporates a similar 3% to 5% premium fluctuation reserve since a typical IBNR will be less than these percentages.

	State			Local		
	15%	20%	25%	15%	20%	25%
Reserve Level	$ 88.1	$ 117.5	$ 146.8	$ 12.9	$ 17.2	$ 21.5
Projected 12/31/2017	$ 184.9	$ 184.9	$ 184.9	$ 17.0	$ 17.0	$ 17.0
Available Draw	$ 96.8	$ 67.4	$ 38.1	$ 4.1	$ (0.2)	$ (4.5)

- A reserve draw in any year impacts the following year's renewal and will require higher increase in the future.

2018 Recommendations – With Reserve Draw

0% Rate Change in 2018, 20% Reserve by 2019

	Budget	7%						
Calendar 2018	**2017 In-Force**	**2018 Budget**	**2018 Renewal**	**Reserve Draw**	**Net 2018 Premium**	**% Increase**	**Annual Savings**	**Biennial Budget**
Total Premiums (In $Millions)								
Medical	$ 1,041.1	$ 1,114.0	$ 1,078.9	$ 13.0	$ 1,065.9	2.4%	$ 48.1	$ 48.1
Pharmacy	$ 255.0	$ 272.9	$ 240.6	$ 16.0	$ 224.6	-11.9%	$ 48.3	$ 48.3
Dental	$ 55.6	$ 59.5	$ 59.8	$ -	$ 59.8	7.6%	$ (0.3)	$ (0.3)
Admin	$ 20.4	$ 21.8	$ 21.6	$ -	$ 21.6	5.9%	$ 0.2	$ 0.2
Total	**$ 1,372.1**	**$ 1,468.1**	**$ 1,400.9**	**$ 29.0**	**$ 1,371.9**	**0.0%**	**$ 96.2**	**$ 96.2**
Change from 2017			2.1%		0.0%			
	Budget	7%	5%					
Calendar 2019		**2019 Budget**	**2019 Renewal**	**Reserve Draw**	**Net 2019 Premium**	**% Increase**	**Annual Savings**	**Biennial Budget**
Total Premiums (In $Millions)								
Medical		$ 1,192.0	$ 1,132.8	$ 18.0	$ 1,114.8	4.6%	$ 77.1	$ 38.6
Pharmacy		$ 291.9	$ 252.6	$ 20.4	$ 232.2	3.4%	$ 59.7	$ 29.9
Dental		$ 63.7	$ 62.8	$ -	$ 62.8	5.0%	$ 0.9	$ 0.4
Admin		$ 23.4	$ 22.7	$ -	$ 22.7	5.0%	$ 0.7	$ 0.3
Total		**$ 1,570.9**	**$ 1,470.9**	**$ 38.4**	**$ 1,432.5**	**4.4%**	**$ 138.4**	**$ 69.2**
Change from 2018			5.0%		4.4%			
Total Biennial Savings								**$ 165.4**
					GPR		**36.9%**	**$ 61.0**

- This scenario results in less premium fluctuations between years.
- Reserve = 26.5% in 2018

Net Fund Balance (Proposed Policy)

- The proposed policy looked at a number of factors and is recommending reducing the reserve levels for the self-insured pharmacy and dental programs.
- The proposed policy recommends:
  - Medical – 3% to 5% of premium
  - Pharmacy – 8% to 10% of projected claims
  - Dental – 3% to 5% of projected claims
- Using a midpoint target we estimate the reserve level at $73.7 million, a reduction of $43.8 million from the midpoint of the current reserve target, $117.5 million.
- We also propose moving to the midpoint of the proposed policy over a 4-year period to minimize premium fluctuations.
- Given the biennial budget savings goal, we recommend using the reserve this year to keep overall costs flat, a 0% overall increase.

Multi-Year Reserve Draw Strategy

- The table below illustrates the recommended draw over the 4-year period:

State Reserve Multi-year Strategy						
	Balance*	Target**	% of Claims/FI Prem	Surplus***	Draw	Surplus after Draw
2018	$184.9	$117.5	8.1%	$67.4	$29.0	$38.4
2019	$155.9	$117.5	8.1%	$38.4	$38.4	$0.0
2020	$117.5	$73.7	5.1%	$43.8	$21.9	$21.9
2021	$95.6	$73.7	5.1%	$21.9	$21.9	$0.0

* Assumes there are no future gains or losses that would impact the fund balance.

** New Reserve Target Policy in 2020. No trend was applied.

*** The Surplus refers to the money in the fund that exceeds the Midpoint Target Reserve.

Questions & Discussion

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Thank you!