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Correspondence Memorandum

Date: June 21, 2022

To: Group Insurance Board

From: Eileen Mallow, Director
Office of Strategic Health Policy

Subject: Overview of Rate Setting Process and Available Tools

This is an informational item only. No Board action is required.

The Group Insurance Board (Board) can affect program costs both with benefits approved for coverage and through an annual rate setting process to establish appropriate, cost-based premiums. The Board has further ability to affect premiums through the application of program surpluses as described below.

Background

Under s. 40.03 (6)(c), Wis. Stat. the Board has the authority to modify or expand benefits for the Group Health Insurance Program (GHIP), subject to the limitation that "…the modification or expansion is required by law or would maintain or reduce premium costs for the state or its employees in the current or any future year." While the Board has not expected that any cost savings associated with a benefit change occur in the plan year in which the change was implemented, no change with expected savings to occur more than two years after the change has been approved. For example, the recent adoption of bariatric surgery benefits was approved with the expectation that program savings would occur in year two of the benefit. The annual review of benefit changes that is shared with the Board during the February and May meetings identifies estimated cost impacts for Board consideration. Benefit changes that are required by law or approved by the Board are factored into rate modeling for the upcoming benefit year.

In addition, ETF annually collects financial and enrollment information, proposed provider networks and preliminary bids from health insurers interested in participating in the GHIP. The Board retains Segal Consulting as its consulting actuary to maintain a model to assist with plan qualification, premium pricing and tier placement for each participating health plan, which only applies to the medical portion of the overall premium. Plans are offered individual opportunities to discuss their tier placement and

Reviewed and approved by Shirley Eckes, Deputy Secretary

Electronically Signed 06/24/2022

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premium proposals in early July. At the August Board meeting each year, ETF and Segal present rate recommendations, that has a combined medical, pharmacy, dental and ETF components. Segal also offers options for the Board to apply surplus reserve funds in establishing premiums for the upcoming plan year. A more detailed summary of the rate process was presented at the May 12, 2021 meeting (Ref GIB | 5.12.21 | 3).

Premium Negotiating Points

The rate model used by Segal to establish the medical portion of premiums has several points that can be used to affect final rate recommendations. Segal provides a summary to the Board during its August presentation (Ref GIB | 8.18.2021| 4d, slides 28 and 30) for the most recent example). While we are careful with the specific information, we share with plans regarding the model leverage points, generally the model can be adjusted for the items listed in detail below.

Assumed Trend

The model assumes a trend adjustment, based on aggregate information provided by health plans in the preliminary bids and Segal judgement about markets. The assumed trend can be adjusted to affect the total cost; however, tightening the trend assumption too low could reduce plan interest in participating in the GHIP.

Tier Breakpoints

The tier breakpoints can be used as a tool in modeling rates. As an example, for the 2021 plan year, the model assumed a negative trend in consideration of the reduced utilization that resulted during the COVID pandemic that was reflected by lowering the tier breakpoints by 3.2%.

Caps on Annual Increases

We have traditionally placed a limit on the total year over year percentage increase permitted. Normally the result of this cap is to place a plan in a higher tier than their bid might suggest.

Caps on Specific Premium Components

In an effort to assure that premium dollars are directed towards patient care, we have applied an overall cap on the portion of premium that can be directed towards administrative expenses. For the 2022 plan year, the administrative cap was allowed to increase by 3% to allow for administrative expenses related to SOC 2 compliance.

Health Care Quality Credits

Plans are required to submit their most current HEDIS and CAHPS scores to ETF. Staff stratify participating plan performance by select quality scores and allow for quality credits based on overall performance. The current quality credit is up to 1%, but this number has ranged from 0.5% to 1.5% in recent years.

Surplus Reserves

In any year, premiums collected may be different than actual program costs. Any collections that exceed expenditures are captured in a premium reserve that is managed by the Board. The Board has established policies on the appropriate amount of reserves; any excess over the established policy is considered “surplus” that can be applied to premiums in subsequent years. The final premium recommendations presented to the Board include medical, pharmacy, dental and ETF administrative expenses. Once the final premium is approved, the Board is offered options to apply surplus reserves to “buy-down” the premium increase in any year. Although application of surplus reserves may affect premium changes in any year, it does not affect underlying costs.

Staff will be available at the Board meeting to respond to questions.