Welcome to the Group Insurance Board

February 26, 2025

Meeting will begin at: 8:30 a.m.

WIFI

WI-GUEST

No Password is needed

Please Sign In

- Who? All meeting attendees
- Sheet available at the door

Meeting Materials

- Scan the QR Code
- Available at etf.wi.gov

Please Silence your Cell Phone and Mute your Microphone

Announcements

Item 1 – No Memo

Renee Walk, Director

Office of Strategic Health Policy

Consideration of:
Open and Closed Minutes of January 15, 2025, Meeting

Items 2A – 2C – Memos Only

Action Needed

- Motion needed to accept the Open and Closed Minutes of the January 15, 2025, Meeting as presented by the Board Liaison.

Contract Compliance Audit Results of the Wisconsin Public Employers Group Life Insurance Program for Plan Years 2022-2023

Item 3A – Group Insurance Board

Tom Rasmussen, Life and Dental Insurance Program Manager

Office of Strategic Health Policy

Informational Item

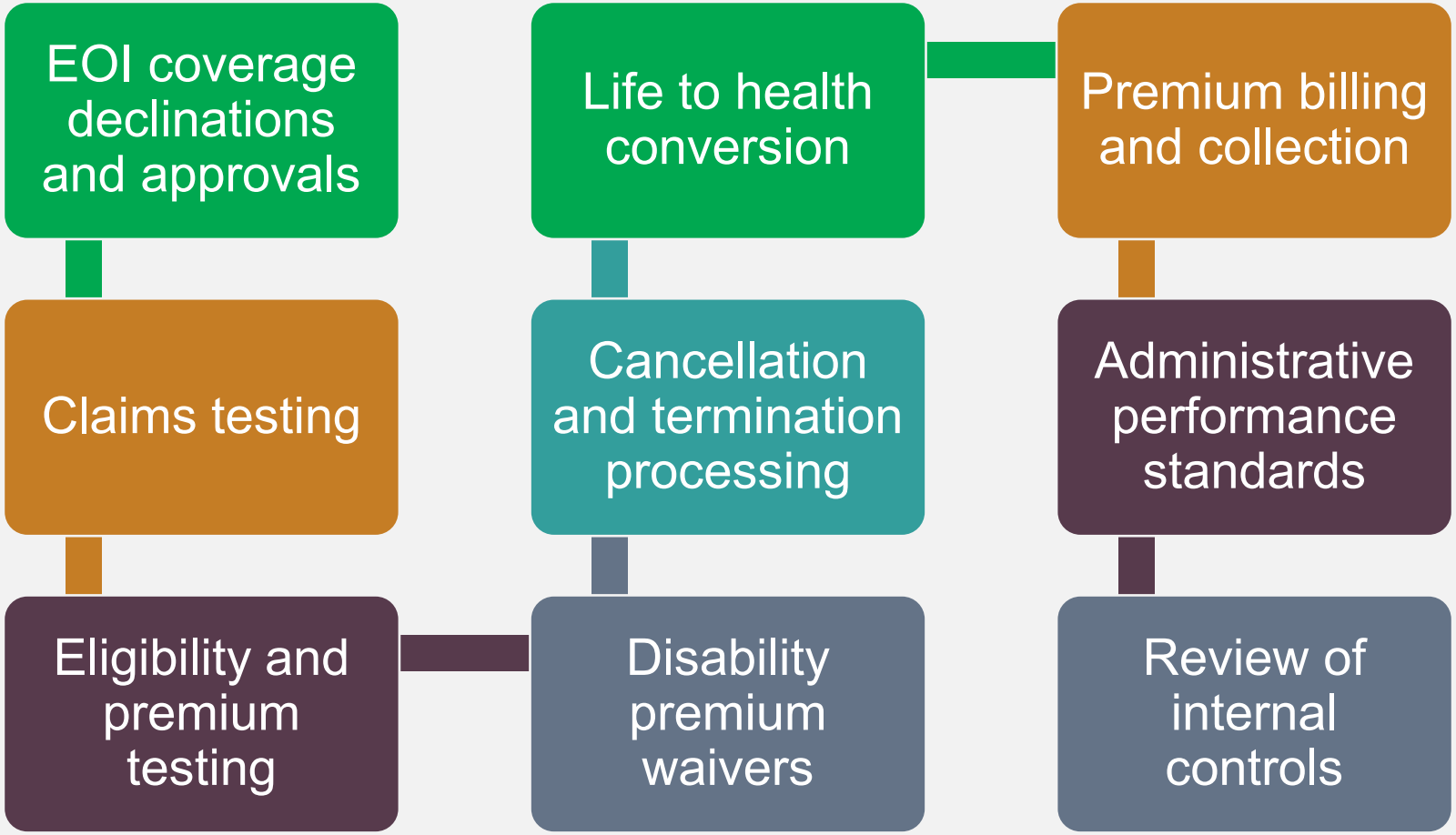
No Board action is required.

Background

- ETF retained Wipfli to conduct a biennial compliance audit of the Life Insurance Program administration
- Plan years 2022 and 2023
- Report on applying agreed upon procedures
- Report on selected internal controls, policies, and procedures

(Ref. GIB I 02.26.25 I 3A, Page 1)

Areas of Examination



(Ref. GIB I 02.26.25 I 3A, pages 2-6)

Findings

No significant exceptions were identified

No recommendations were made by Wipfli

ETF is satisfied with Securian's responses and corrective actions

(Ref. GIB I 02.26.25 I 3A, page 7)

Questions?

Thank you

etf

wi_etf

etf.wi.gov

ETF E-mail Updates

608-266-3285
1-877-533-5020

Life Insurance Actuarial Audit

Item 3B – Group Insurance Board

Tom Rasmussen; Life and Dental Insurance Program Manager

Office of Strategic Health Policy

Dan Skwire; FSA, MAAA

Milliman

Paul Correia; FSA, MAAA

Milliman

Action Item

ETF recommends the Board accepts the State of Wisconsin Department of Employee Trust Funds Group Life Insurance Program 2024 Group Life Insurance Actuarial Audit and Securian's responses.

Background

ETF retained Milliman to perform an actuarial audit of the Life Insurance Program to:

- Review the financial results presented to the Board in the 2024 Financial Experience Report
- Review the Program's reserves, funding and investments strategies
- Review rate methodology for compliance with the federal Older Workers Benefit Protection Act

(Ref. GIB I 02.26.25 I 3B, page 1)

Findings

Conclusions

Recommendations

- Additional discussions between ETF, Securian, and Milliman to address the recommendations

(Ref. GIB I 02.26.25 I 3B, page 1-2)

Actuarial Audit of Wisconsin Group Life Insurance Program

Daniel D. Skwire, FSA, MAAA
Paul Correia, FSA, MAAA

FEBRUARY 26, 2025

Milliman
Solutions for a world at risk™

Wisconsin Group Life Insurance Program

Benefits

- Includes coverage for active employees and retirees.
- Coverage is voluntary and includes basic life, supplemental life, additional life, and accidental death and dismemberment (AD&D) insurance. Employees may also elect spouse and/or dependent life insurance.

  - Basic life benefit amount: 100% of annual salary
  - Supplemental life benefit amount: 100% of basic benefit amount
  - Additional life benefit amount: Up to 300% of basic benefit amount
  - Spouse life benefit amount: $10,000 or $20,000
  - Dependent life benefit amount: $5,000 or $10,000
  - AD&D benefit amount: Up to 100% of the total life insurance amount

- Employees must have basic life insurance to be eligible for coverage in the other plans.
- Coverage features benefit reduction schedules that begin at age 65. These reductions are delayed until the earlier of retirement or age 70 for active employees above age 65. Supplemental and additional insurance terminate at the later of age 65 or retirement, but not later than age 70.
- State and Local benefits are mostly equivalent, except that the Local plan features an additional benefit reduction schedule option.

Wisconsin Group Life Insurance Program

Premiums

- Premium contributions are made by active employees, the State, and participating local employers.

  - Employee contributions: Premium rates vary by attained age.

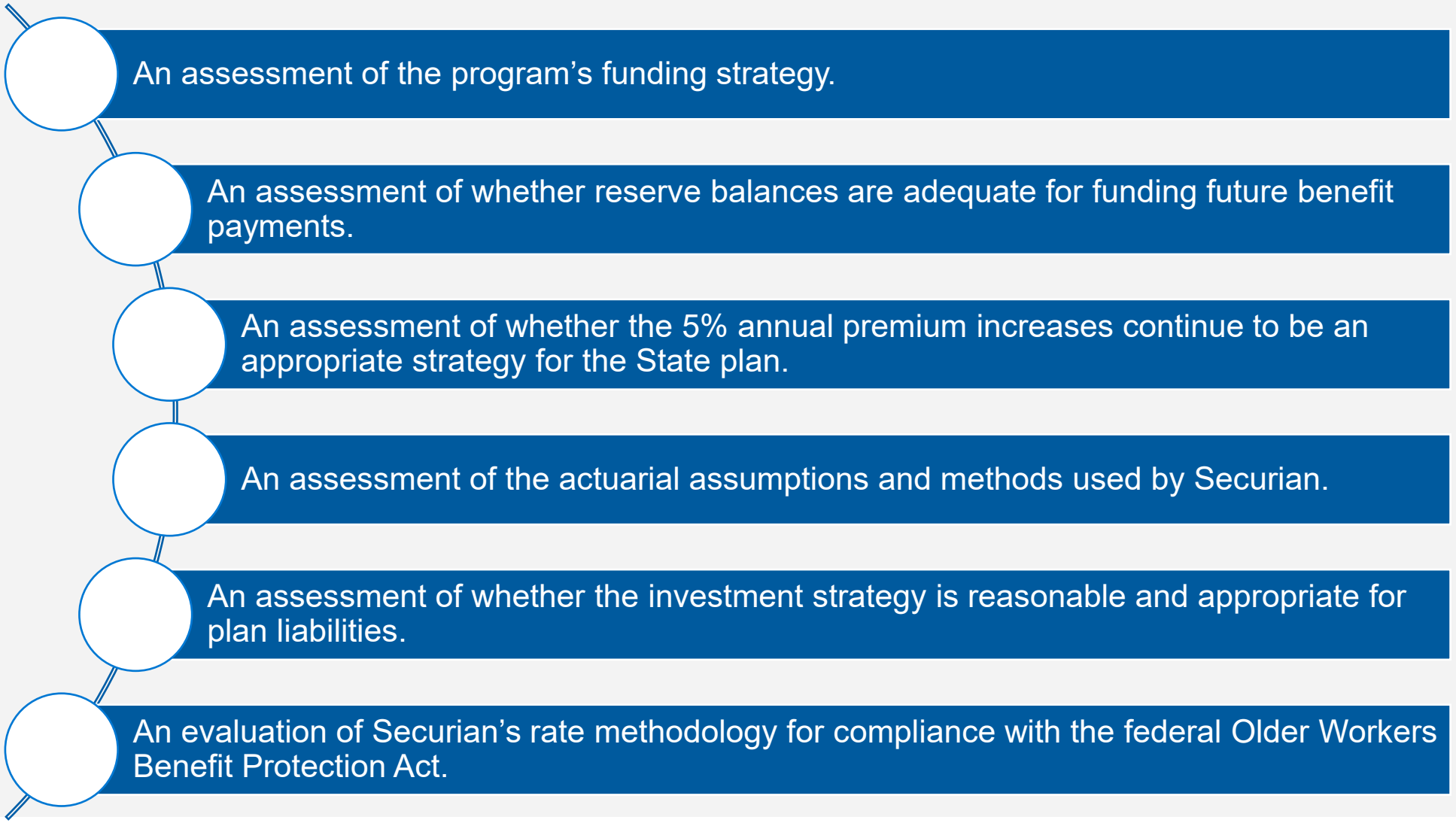
  - State contributions: 65.25% of employee contributions for basic insurance and 37.25% of employee contributions for supplemental insurance. State contributions cover costs for active employees and retirees.

  - Local employer contributions: 20% to 40% of employee contributions depending on the benefit reduction schedule elected by the employer.

- Retiree benefits are funded in advance by premium contributions from employers and pre-age-65 retirees, and from experience credits (if any) from pre-age-65 retiree experience. These amounts are deposited into a Premium Deposit Fund (PDF) for the purpose of paying future retiree claims and expenses.

- Favorable experience on the pre-retirement plan (including AD&D and other related benefits) is credited to a premium stabilization reserve (PSR), which is also available for funding future retiree benefits if the PDF proves inadequate.

Purpose and Scope



Conclusions

1. The funding strategy for the group life plan is reasonable. Both the State and Local funding ratios (i.e., assets divided by liabilities) were within the tolerable range of 85% - 115% as of December 31, 2023.

2. Although the funding ratio for the State plan was below the target of 100% as of December 31, 2023, it has been within tolerable levels since 2019 when the 5% annual premium rate increases began. For this reason, we believe the annual rate increases continue to be an appropriate strategy for the State plan in order to achieve the target funding level in future years.

3. The funding ratio for the Local plan was 110.6% as of December 31, 2023, meaning reserves were considered adequate for covering future benefit payments as of the valuation date.

4. The assumptions and methods used by Securian are generally reasonable and appropriate for the group life insurance program. They are also consistent with the program's funding objectives and with generally accepted actuarial standards and practices. However, Securian's pooling charges appear higher than necessary based on historical experience.

5. Securian's investment strategy seems reasonable and appropriate for the program's liabilities.

6. There may be compliance issues with the Older Workers Benefit Protection Act under the current benefit reduction schedules.

Recommendations

1. We recommend that ETF ask Securian to recalibrate its pooling charges to better align these charges with pooled claim levels. ETF may also wish to consider the possibility of eliminating pooling from the experience rating formula.

2. We recommend that ETF ask Securian about the administrative expenses included in the 2023 Financial Report. We compared expenses in the Financial Report to the expenses in the insurance agreement, and we noticed that the expenses in the Financial Report were higher than the expenses from the agreement for the Local plan.

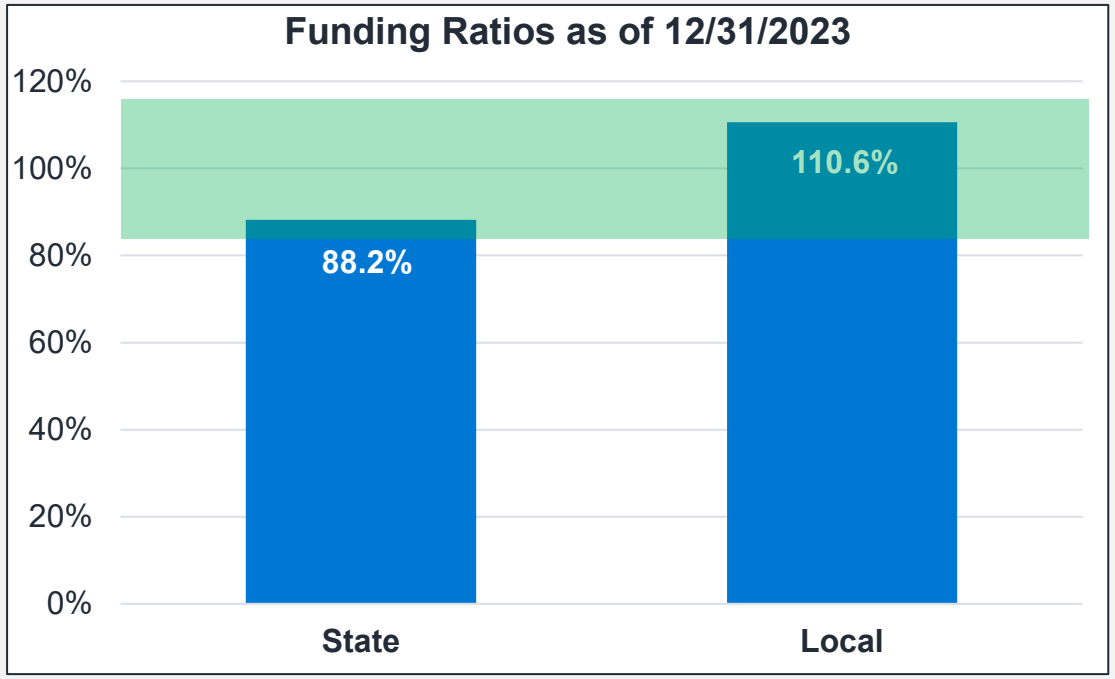
3. We recommend that ETF perform an equal cost test to assess compliance with the federal Older Workers Benefit Protection Act.

4. We recommend that Securian update its documentation to include all the factors used to compute disability reserves. We also recommend that Securian consider using the 2023 Group Life Waiver of Premium Valuation Table for calculating disability reserves.

5. We recommend that Securian include additional disclosures and documentation in its reports, which may be required under various Actuarial Standards of Practice (ASOPs).

Assessment of the Group Life Insurance Program's Funding Strategy

- The funding strategy for the State and Local plans includes a target funding level of 100% with a tolerable range of +/- 15%.
- The funding ratios for the State and Local plans were within the tolerable range as of December 31, 2023:



Assessment of the 5% Annual Premium Increases for the State Plan

	2018	2019	2020	2021	2022	2023
Assets ($ millions)						
Retiree Premium Deposit Fund	$356.7	$348.3	$334.1	$319.9	$303.6	$288.1
Active Stabilization Reserve	$46.5	$51.6	$57.0	$61.5	$67.7	$79.6
Total	$403.3	$399.9	$391.1	$381.4	$371.3	$367.7
Liabilities ($ millions)						
Post-Age 65 Retirees	$376.2	$411.8	$448.3	$473.8	$460.6	$458.2
Pre-Age 65 Retirees	$61.1	$58.4	$57.7	$57.7	$52.6	$47.7
Active Employees	$105.4	($66.7)	($100.9)	($84.8)	($93.4)	($88.9)
Total	$542.7	$403.5	$405.2	$446.6	$419.7	$417.0
Unfunded Accrued Liability ($ millions)	**$139.4**	**$3.6**	**$14.1**	**$65.2**	**$48.5**	**$49.3**
Funding Ratio	**74.3%**	**99.1%**	**96.5%**	**85.4%**	**88.5%**	**88.2%**

- The 5% annual premium rate increases continue to be an appropriate funding strategy for the state plan.
- The funding ratio has been within the tolerable range of 85% - 115% since 2019, when the benefit increases began.

Assessment of the Actuarial Assumptions and Methods Used by Securian

Pooling Methods

- The pooling level is $500,000 – i.e., claims are capped at $500,000 in Securian's experience rating formula.
- The pooled claims (i.e., amounts above $500,000 per claim) are replaced by Securian's estimate of the cost for claims above the pooling limit.
- Pooled claims and pooling charges from 2008 through 2023:

Financial Component in the Experience Analysis	Active Employees			Retirees		
	State	Local	Total	State	Local	Total
A. Pooled Claims	$6,606,146	$917,381	$7,523,527	$65,054	$170,107	$235,161
B. Pooling Charges	$24,390,155	$2,848,283	$27,238,438	$1,923,025	$428,413	$2,351,438
C. Difference (B – A)	**$17,784,009**	**$1,930,902**	**$19,714,911**	**$1,857,971**	**$258,306**	**$2,116,277**

- Pooling charges were approximately $20 million higher than pooled claims for active employees and approximately $2 million higher for retirees.
- Pooling charges were approximately $20 million higher than pooled claims for the State plan and approximately $2 million higher for the Local plan.
- For the State plan, pooling charges exceeded pooled claims in every year between 2008 and 2023, for both active employees and retirees. For the Local plan, pooling charges exceeded pooled claims in every year except 2021 for active employees and 2022 for retirees.

Assessment of the Actuarial Assumptions and Methods (Continued)

Expenses

- There are differences between the administrative expense charges in the insurance agreement and Securian's 2023 Financial Report:

Administrative Expenses as a Percentage of Annual Premium				
Coverage Type	State Plan		Local Plan	
	Agreement	Financial Report	Agreement	Financial Report
Pre-retirement	3.61%	3.54%	8.05%	8.65%
Spouse/Dependent	2.05%	2.05%	5.80%	6.34%

Disability Reserves

- Documentation of the claim termination rate basis seems incomplete, based on our reserve replication analysis.
- Disability reserves are calculated by Securian using older valuation tables with adjustments to estimate recent experience and trends. There is a new industry table that may be more appropriate (i.e., 2023 Group Life Waiver of Premium Valuation Table) as the basis for these calculations.

ASOP's

- Securian's reports should include additional disclosures and documentation that are required under various Actuarial Standards of Practice (ASOPs).

Assessment of Investment Strategies

Asset Class	Actual Allocation as of 12/31/2023	Target Allocation
Government	0%	0%
ABS	2%	3%
CMBS	24%	22%
Agency MBS	10%	10%
Commercial Whole Loans	26%	25%
Municipals	0%	0%
Investment Grade Corporate Bonds (incl. Long)	37%	40%
High Yield Corporate Bonds	0%	0%
Equity	0%	0%

- Actual allocations were very close to the target allocations as of December 31, 2023.
- Target allocations are consistent with industry standards which exclude riskier assets (e.g., equity) and include less risky assets (e.g., investment grade corporate bonds).

Compliance with the Older Workers Benefit Protection Act

- There are no compliance issues for employee benefit plans that provide equal benefits at all ages.
- The State and Local group life plans include benefit reduction schedules for older employees, however.
- Plans that provide lower benefits to older employees can comply with OWBPA if the cost of these benefits is no less than the cost of benefits provided to younger workers.
- ETF should perform an equal cost test to determine if the group life plan is compliant with OWBPA.

Considerations for an Equal Cost Test:

- Must show claim costs are at least as great for older workers as they are for younger workers.
- The protected class of employees is over age 40.
- The analysis can be performed in 5-year age bands with flexibility on the exact bands chosen.
- Employers may consider results across a package of employee benefits including more than just group life insurance.

Limitations

Milliman relied on information provided by the Wisconsin Department of Employee Trust Funds (ETF) and Securian. If this information is inaccurate or incomplete, our results may be affected.

The estimated liabilities and projections included in this presentation were developed by Securian. We have reviewed the projections for reasonableness and appropriateness to the intended purpose and compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs). An in-depth analysis of Securian's models and valuation assumptions was beyond the scope of work for this audit.

Milliman's work product was prepared exclusively for ETF and is not for the use or benefit of any third party for any purpose.

We, Daniel Skwire and Paul Correia, are consulting actuaries with Milliman. We are members of the American Academy of Actuaries and meet its qualification standards to render the actuarial opinions contained herein.

Milliman

Thank you

Action Item

ETF recommends the Board accepts the Life Insurance Program 2024 Group Life Insurance Actuarial Audit and Securian's responses.


Questions?

Wisconsin Department of Employee Trust Funds

Audit of the Actuarial Valuation of the Income Continuation Insurance Plans

Actuarial Audit of the December 31, 2023 Valuation for the State and Local Plans

February 26, 2025/ Robert Burrell/ Ben Kirkland

Segal

Agenda

About This Audit

About this Plan and Valuation Results

Plan Benefits

Segal's Methodology

Valuation Methodology

Liability Matching Results

Overall Audit Results

Assumption Review

Key Recommendations

Caveats

About This Audit

Points to note about this audit:

- Milliman performed the annual Income Continuation Insurance (ICI) Plans' actuarial valuations as of December 31, 2023
- Milliman also performed experience studies covering key assumptions used in the valuations
- There is both a State ICI Plan and Local ICI Plan. Both plans were audited, and this presentation summarizes the combined audit results.
- Data was initially provided by the State's Department of Employee Trust Funds (ETF) and supplemented by Milliman
- Segal was tasked to:
  - Replicate the liabilities using the data and assumptions used by Milliman
  - Opine on the assumptions
  - Provide an overall assessment of the report
- Segal's liability results were very close to Milliman's results

About this Plan and Valuation

Under both the State and Local ICI Plans:

- Both short- and long-term disability benefits are offered.
- During the first 12 months of disability, the participant is disabled if they are unable to perform their own job and are under the care of a physician.
- After the first 12 months of disability, the participant is disabled if unable to engage in any substantial gainful activity for which they are reasonably qualified.
- Benefit amounts do not increase and are subject to offsets if participants receive benefits from other plans (Social Security, WRS).

State Plan Valuation Results

Under the State plan, there were 988 open claims as of the December 31, 2023 measurement date, with the following liability profile, as reported by Milliman:

Income Continuation Insurance Plan Valuation (State)
Summary Results as of December 31, 2023

Description	Value (Millions)
1. Actuarial Liability	$85.1
2. Assets	172.5
3. Surplus (2 - 1)	$87.4
4. Funded ratio	202.7%

Local Plan Valuation Results

Under the Local plan, there were 97 open claims as of the December 31, 2023 measurement date, with the following liability profile, as reported by Milliman:

Income Continuation Insurance Plan Valuation (Local)
Summary Results as of December 31, 2023

Description	Value (Millions)
1. Actuarial Liability	$7.52
2. Assets	43.92
3. Surplus (2 - 1)	$36.40
4. Funded ratio	584.2%

Plan Benefits

Member benefits include the following:

- A gross benefit of 75% of salary up to $120,000 of covered salary
  - Less actual and assumed benefit offsets, including Social Security payments and retirement benefits, among others.
- Payable until earlier of recovery, death, or age 65 unless disability occurs after age 60, then max of 5 years
  - Recovery and death rates vary primarily by age at disability, disability duration, and cause of disability
- Benefit offsets can potentially come from multiple sources, making developing the projected benefit payment stream complicated.
- Most participants are expected to recover before reaching the maximum benefit duration.

Segal's Methodology

For each plan:

- Collect source data from ETF for claims and asset information.
- Match the participant count reported by Milliman.
- Match the benefits information reported by Milliman.
- Incorporate the valuation assumptions in our calculation model.
- Review the reasonableness of those assumptions.
- Match the assets displayed in the Milliman Valuation to the information received from ETF.
- Match the benefit liabilities (within tolerances) displayed in the valuation report.
- Comment on the overall assumptions, methods, plan provision summaries, and report accuracy.

Valuation Methodology

Liabilities for each plan were developed using the following framework:

- Determine covered participants as of the valuation date
- Estimate the benefit paid at each subsequent month
- Multiply by the probability of payment at each subsequent month through benefit expiration
- Discount the monthly values with interest and sum to determine the liabilities for each participant
  - The discount rate of 6.80% is prescribed by the ETF and was not reviewed as part of the audit

$$\sum_{\text{all valued}} \sum_{t=0 \text{ to exp}} {}_tp_x \, v^t \, (\text{Gross Benefit}_t - \text{Estimated Offsets}_t)$$

Liability Matching Results

Actuarial Liabilities for the State ICI Plan as of December 31, 2023

Liability Component ($M)	Milliman Valuation Results	Segal Replication	Ratio of Segal Replication to Milliman Valuation Results
Open Claims	$78.07	$78.18	100.1%
IBNR Claims	2.77	2.77	100.0%
Loss Adjustment Expense	4.25	4.27	100.5%
Total	**$85.09**	**$85.22**	**100.2%**

These tolerances are within our actuarial professional standards.

Liability Matching Results

Actuarial Liabilities for the Local ICI Plan as of December 31, 2023

Liability Component ($M)	Milliman Valuation Results	Segal Replication	Ratio of Segal Replication to Milliman Valuation Results
Open Claims	$6.55	$6.68	101.9%
IBNR Claims	0.50	0.50	100.0%
Loss Adjustment Expense	0.47	0.47	100.8%
Total	**$7.52**	**7.65**	**101.6%**

These tolerances are within our actuarial professional standards.

Overall Audit Results

- Overall, we believe that the Milliman Valuation reports accurately reflect the accounting results for the State of Wisconsin's Income Continuation Insurance Plans (State and Local) for the fiscal year ending December 31, 2023.
- Current assumptions result in a close match to recent claims experience. There is more volatility in short-duration claims, which is expected.

Table 2.3 from Milliman's 2023 Valuation: Runoff Study for ICI Plans (2018-2022): Annual Margin as a % of Initial Liability

Claim Duration	Average Annual Margin
1-12 months	6.1%
13-24 months	1.7%
25-36 months	0.8%
37-48 months	-1.9%
49-60 months	2.1%
61+ months	1.3%
Total	**1.0%**

Assumption Review
Loss Adjustment Expenses (State Plan)

- The liability for loss adjustment expenses is based on the present value of expected future administrative fees for current participants related to the ongoing management of open and IBNR claims.
- The liability as of the December 31, 2023 measurement date is $4.25 million.
- Based on the expected fees that were provided, together with the current open and IBNR claims, Segal estimated the liability as of December 31, 2023 to be $4.27 million.
- Milliman appears to be estimating this reserve appropriately, based on GASB 10 guidance.

Assumption Review
Loss Adjustment Expenses (Local Plan)

- The liability for loss adjustment expenses is based on the present value of expected future administrative fees for current participants related to the ongoing management of open and IBNR claims.
- The liability as of the December 31, 2023 measurement date is $466,000.
- Based on the expected fees that were provided, together with the current open and IBNR claims, Segal estimated the liability as of December 31, 2023 to be $470,000.
- Milliman appears to be estimating this reserve appropriately, based on GASB 10 guidance.

Assumption Review
Claim Termination Rates

- The claim termination (death and recovery) rates are based on the industry-standard 2012 Group Long-Term Disability Table (GLTD), with adjustments to the rates at various durations based on recent claim experience for the State and Local ICI plans combined (see table below).
- The 2012 GLTD contains death and recovery rates that vary based on age at disability occurrence, the duration of disability as of the measurement date, and the cause of disability (cancer, musculoskeletal, etc.)
- These primary death and recovery rates are further modified by factors related to benefit amount, elimination period length, and the changeover in definition of disability.
- Based on our review, Segal believes that these assumptions are reasonable.

Disability Duration	Adjustment Factor
1-12 months	1.20
13-24 months	1.60
25-36 months	0.85
37-48 months	0.40
49-60 months	0.25
61-120 months	0.85
121+ months	1.30

Assumption Review
Benefit Offsets

- The most significant benefit assumptions are for the benefit offsets that have not yet been awarded.
- Milliman performed significant analysis in their recent Income Continuation Insurance Experience Study to develop assumptions for future offset applicability and average offset amount.
- This analysis appeared to be robust and thoughtful, and we have no reason to doubt the results.
- This includes developing new offset applicability assumptions that increase from the current valuation date through an ultimate disability duration at a future date.

Cumulative Social Security Disability Approval Probabilities

Projected / Current Duration	1	2	3	4	5	6	7	8
1	0%							
2	11%	0%						
3	29%	10%	0%					
4	43%	26%	9%	0%				
5	55%	43%	29%	13%	0%			
6	65%	55%	45%	32%	7%	0%		
7	69%	61%	52%	41%	19%	5%	0%	
8+	71%	63%	54%	44%	24%	11%	0%	0%

Key Recommendations

As a result of our audit. we have the following recommendations:

- Milliman should disclose whether any of the assumptions have a significant bias to underestimation or overestimation, particularly regarding the claim termination/mortality assumption and related adjustment factors.
- Milliman should disclose whether the estimated liability is intended to be a conservative measure, a best estimate, or other measure of results.
- Future reports should consider including projection scenarios that provide sensitivity to demographic assumptions.

Additional discussion is included in our audit reports dated January 31, 2025.

Caveats

- This presentation is intended for the use of the Wisconsin Department of Employee Trust Funds.
- This discussion is a supplement to Segal's full audit reports dated January 31, 2025.
- Please refer to the full report for a description of assumptions and plan provisions reflected in the results shown in this presentation.
- Certain assumptions were not audited by Segal but play a significant role in the determination of the liabilities. It is suggested that the valuation actuary, Milliman, should provide regular detail with regard to the development and accuracy of these assumptions.
- The calculations included in this presentation were completed under the supervision of Robert Burrell, ASA, FCA, MAAA, EA.

Disclaimer

Disclaimer
This document has been prepared for the exclusive use and benefit of the client, based upon information provided by you and your other service providers or otherwise made available to Segal at the time this document was created. Segal makes no representation or warranty as to the accuracy of any forward-looking statements and does not guarantee any particular outcome or result. Except as may be required by law, this document should not be shared, copied or quoted, in whole or in part, without the consent of Segal. This document does not constitute legal, tax or investment advice or create or imply a fiduciary relationship. You are encouraged to discuss any issues raised with your legal, tax and other advisors before taking, or refraining from taking, any action.

Health Insurance Actuarial Audit

Item 5A – Group Insurance Board

Renee Walk, Director

Office of Strategic Health Policy

Action Needed

The Department of Employee Trust Funds (ETF) requests that the Group Insurance Board (Board) accept the audit report of the 2024 health insurance rate setting and reserving process and the response of the consulting actuary, Segal.

Background

- Audit conducted by Milliman, Inc.
- Audit completed of 2024 process and assumptions used to develop:
  - Fully insured medical rates
  - Self-insured pharmacy rates
  - Self-insured dental rates
  - Reserve fund targets

Findings and Recommendations

- Processes to calculate premiums and reserves were consistent with general actuarial practice.
- Assumptions were reasonable.
- Reserve amounts were calculated to be reasonable.
  - Slightly lower range was recommended for dental reserve.
- Additional recommendations for future consideration were provided.

Actuarial Audit of 2024 Health Insurance Rate Setting and Reserving

Wisconsin Department of Employee Trust Funds
Group Health Insurance Plan

Ellen Harrington, ASA, MAAA

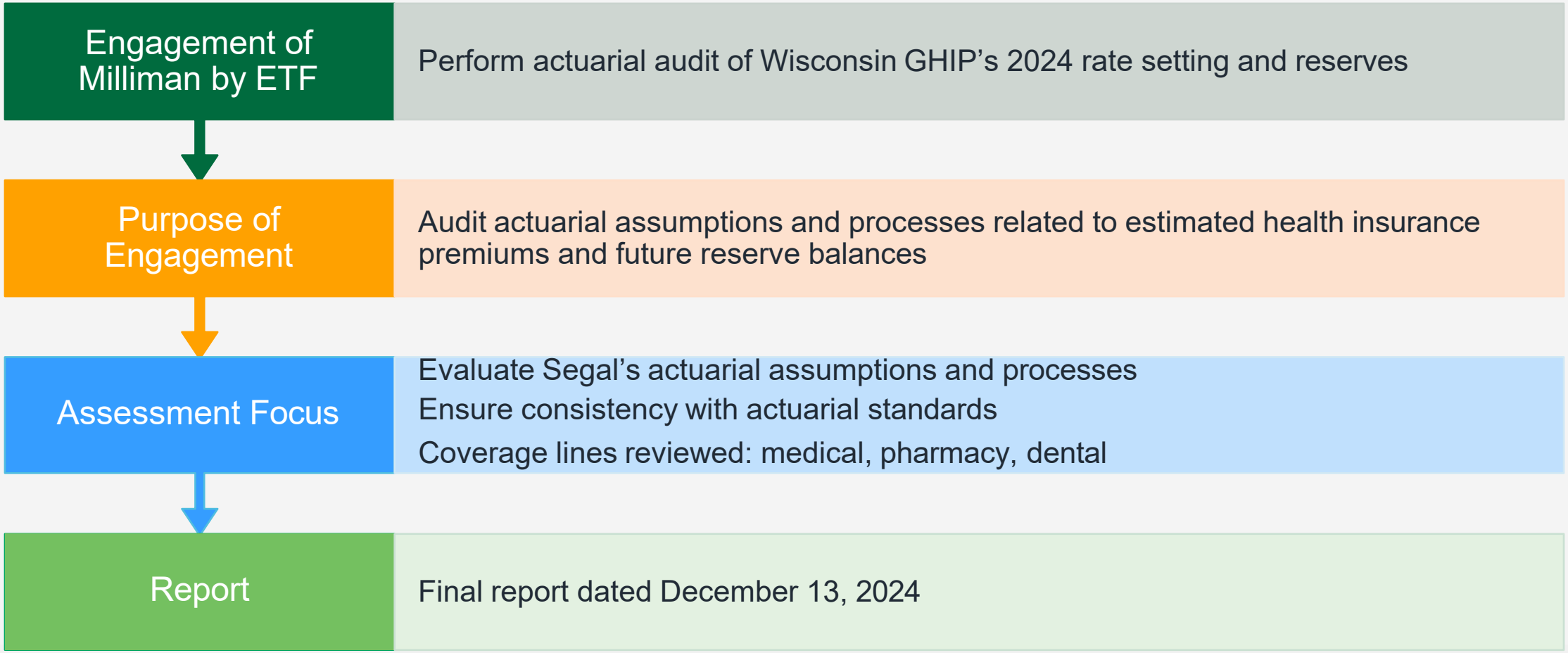
FEBRUARY 26, 2025

Milliman
Solutions for a world at risk™

Today’s Discussion

- Introduction and Background
- Summary of Findings
- Recommendations for:
  - Health Insurance Rate Setting
  - Projected Reserve Balances
- Actuarial Standards of Practice (ASOPs)
- Audit Limitations

Purpose and Scope of the Actuarial Audit



Overview

1

Overall process and assumptions are reasonable and consistent with those used in general actuarial practice

2

Specific recommendations have been provided for consideration in rate setting and future reserve balances

3

We suggest additional disclosure of assumptions and assumption development as described in ASOP 41

Audit Conclusions – Summary

Review of Procedures and Actuarial Assumptions	Segal's processes align with general actuarial practice. Overall process and assumptions deemed reasonable.
Opportunities for Improvement – Rate Setting	Periodic review of assumptions against recent experience to determine continued appropriateness.
Opportunities for Improvement – Projected Reserves	Actuarial analysis of target ranges to ensure adequate provision for future risk. Sensitivity modeling in projected reserves around potential adverse experience.
Communications	Additional disclosure of assumption development as described in ASOP 41.

Recommendations for Health Insurance Rate Setting

Review and Analyze Assumptions

- Evaluate HMO Tier 1 and Tier 2 limits against carrier loss ratios
- Compare aggregate rate tier ratios to GHIP's specific claims experience
- Validate risk adjustment assumptions for new groups based on emerging experience
- Adjust dental experience period to include most recent claims

Claims Analysis by Plan Type

- Monitor actual claims by plan (non-HDHP vs. HDHP)
- Ensure pricing differential remains appropriate
- Independently analyze historical pharmacy claims experience using regression analysis

Actuarial Communications

- Document assumptions in future working documents

Recommendations for Aggregate Rate Setting Assumptions

Review Tier Ratios Periodically

- GHIP's size makes it credible for periodic reviews
- Review tier ratios relative to specific claim experience
- Changes could result in winners and losers

Reflect Actuarial Cost Differences

Consider expanding tiers

- Consider providing three or four tier rates
- Align actuarial expectations with actual costs

Recommendations for Aggregate Rate Setting Assumptions

Review tier ratios periodically

- GHIP's size makes it credible for periodic reviews
- Review tier ratios relative to specific claim experience
- Changes could result in winners and losers

Reflect actuarial cost differences

- Spouses are more expensive than members
- Children are less expensive than members or spouses

Consider expanding tiers

- Consider providing three or four tier rates
- Align actuarial expectations with actual costs

Recommendations for Projected Reserve Balances

- Conduct formal actuarial review of reserve target ranges
- Consider an explicit premium deficiency reserve when rates are reduced under a “Buy-Down” strategy
- Consider performing additional sensitivity testing around fund balance projections
- Continue to review reserve policy to clarify recommended process when fund balance falls below target range
- Consider including additional disclosures in actuarial documents, as described in ASOP 41

Recommendations for Reserve Policy and Fund Projection

 Lower Target Range for Dental	Small impact on aggregate reserve balance due to small claims volume
 Periodic Actuarial Evaluation of Pharmacy Reserve Target	Target consistency with “Best Estimate” to “Moderately Adverse” claims scenario range, using Monte Carlo simulation or other actuarial modeling Prepare for adverse scenarios and inform rate action decisions Consider premium deficiency reserve under 'Buy Down' strategy
 Evaluate Multiple Projection Scenarios	Include sensitivity modeling for adverse claims, investment returns, and expenses Present analysis in an actuarial reserve report
 Clarify Process for Reserve Fund Below Target Range	Retain flexibility in reserve policy

Purpose of ASOPs

Actuarial Standards of Practice

Framework for Professionalism

Provide a basic framework accommodating additional considerations

Guidance for Actuaries

Techniques, applications, procedures, and methods reflecting appropriate actuarial practices in the U.S.

Mandatory Compliance

Members of actuarial organizations in the U.S. must satisfy applicable ASOPs when providing actuarial services

Additional Considerations

Legal and regulatory requirements

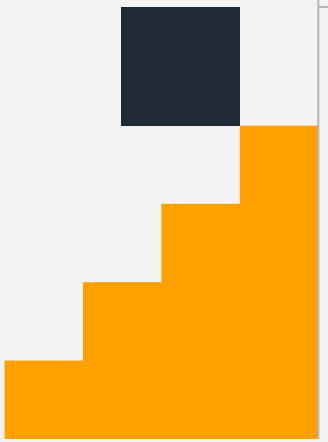
Professional requirements from employers or actuarial organizations

Evolving actuarial practice

Actuary's professional judgment informed by the nature of the engagement

Description of Potentially Relevant ASOPs

Several ASOPs are relevant to this work



ASOP 23

Data quality

Guidance on selecting, reviewing, using, and relying on data

Disclosures on data source, selection, review, and reliance

ASOP 28

Statements of opinion on assets & liabilities

Guidance on issuing statements of actuarial opinion on health insurance assets and liabilities

Identification of applicable balance sheet items

ASOP 41

Actuarial communications

Guidance on communication of actuarial findings

Disclosure of material assumptions, methods, and data

Documentation of work and communication of uncertainties

ASOP 42

Health and disability actuarial assets and liabilities

ASOP 56

Financial modeling

Audit Limitations

The scope of our actuarial review did not extend to the following:

- Source Data Validation
- Data Validation Methodology
- Replication of Health Insurance Rate and Reserve Calculations
- Review of HMO Renewal Information
- Financial Soundness of GHIP

Certification Statement of Audit Report

The statement below was included in our report dated December 13, 2024:

We have performed an actuarial audit review of the 2024 Health Plan Rate Setting and Reserving process and results presented to the State of Wisconsin Group Insurance Board (“GIB” or “Board”) in August 2023 by Segal, the actuary for GIB. This report presents the results of our review. An overview of our findings is included in Section 1 of the report. More detailed commentary on our review process and findings is included in the latter sections.

Milliman’s work product was based on the Department of Employee Trust Funds’ (”ETF”) and Segal’s process and assumptions for a specific and limited purpose. It is a complex, technical analysis that assumes a high level of knowledge concerning the operations of the State of Wisconsin Group Health Insurance Program (GHIP) and uses data described in Appendix A, which Milliman has not audited. ` No third-party recipient of Milliman’s work product should rely upon Milliman’s work product. Such recipients should engage qualified professionals for advice appropriate to their own specific needs. If this report is distributed to other parties, it must be copied in its entirety, including this certification section. Milliman consents to release of this report to Segal.

In preparing this report, we relied, without audit, on information (both oral and in writing) furnished by ETF and Segal. We would like to express our appreciation to the ETF staff and the Segal staff for their assistance in supplying the requested information and for providing prompt responses to our questions.

On the basis of the foregoing, we hereby certify that, to the best of our knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices which are consistent with the Actuarial Standards of Practice promulgated by the Actuarial Standards Board and the applicable Guides to Professional Conduct, amplifying Opinions, and supporting Recommendations of the American Academy of Actuaries. The consultants who worked on this assignment are health care actuaries. Milliman's advice is not intended to be a substitute for qualified legal or accounting counsel. The signing actuaries are independent of GIB and ETF. We are not aware of any relationship that would impact the objectivity of our work. We are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Milliman

Thank you

Ellen Harrington, ASA MAAA

Ellen.Harrington@milliman.com

Action Needed

The Department of Employee Trust Funds (ETF) requests that the Group Insurance Board (Board) accept the audit report of the 2024 health insurance rate setting and reserving process and the response of the consulting actuary, Segal.

Questions?

Rate Setting Actuarial Assumptions

February 26, 2025

Segal Consulting

1. **Overview**
2. Medical Rate Development
3. Prescription Drug Projections
4. Dental Projections

Rate Setting Overview

- Medical is fully insured
  - HMOs use Tier Rate/Model approach for Rate Setting
  - Access and SMP Rates are negotiated with Dean Health Plan
  - Medicare Advantage and Medicare Plus rates are negotiated with UHC
- Dental and Rx are self-insured and rates are calculated by Segal
  - Navitus is Pharmacy Benefits Manager
  - Delta Dental is Dental vendor
- ETF Admin fees are supplied by ETF and used to build in internal operational costs
- Reserve Projections can impact the final rates if the board elects to apply an additional buy-up or buy-down to help achieve a future fund balance target.
  - ETF plans to return with a further reserve discussion as we look at revising the approach at a coming meeting

1. Overview
2. **Medical Rate Development**
3. Prescription Drug Projections
4. Dental Projections

Medical Rate Development (HMO Group)

- The Tier Model is a group underwriting exercise for the Medical HMO's
  - Groupings are split by Dane, Non-Dane, and Local groups. Within each group:
    - Data is aggregated
    - Adjustments for plan specific cost and utilization experience
    - Baseline Claims Data PMPM (per member per month) is trended to renewal period using vendor assumptions up to Trend Limit
    - Vendor admin fee load assumption PMPM is applied up to the Admin Limit
    - Retrospective risk adjustments are applied
    - Total PMPM (Claims + Admin) is calculated for each plan
    - Weighted average PMPM is calculated based on plan's enrollment
    - A percentage is taken of the adjusted required premium per member per month (PMPM) to determine the Tier 1 and Tier 2 Breakpoint Limits
- The Tier Rate tool is used to determine the tiering of the preliminary bid for each plan
  - This rate is risk adjusted (age-sex, prospective Merative risk score, and regional score)
  - Adjusted for large catastrophic claims
  - Adjusted for the Quality Credit

Medical Rate Example

- Vendor A bids a preliminary bid of $800 (Single Rate)
- Bid is risk-adjusted, adjusted for catastrophic claims, and given a quality credit. After these adjustments, the new adjusted premium calculated by Segal is $750.
- Given a Tier 1 breakpoint of $700, a 6.7% reduction would be needed in the Best and Final Offer (BAFO) for the rate to be considered Tier 1.

Medical Rate Development Assumptions

- The following are in the medical rate development assumptions for the HMOs:
  - Tier Model
    - Experience Period for Claims and Enrollment
    - Fee for Service (FFS) Trend Limit
    - Capitation Trend Limit
    - Medical Admin Limit
    - Experience Adjustment
    - Tier Limits
  - Tier Rate
    - Conversion Factor
    - Catastrophic Claims Adjustment
    - Premium Caps (State & Local Caps)
    - Risk Scores
    - Quality Credits

Experience Period – Tier Model

- Enrollment and claims data are submitted to ETF and Segal by the health plans through the FUDS tool provided by Segal
  - Enrollment data
    - Segal uses 15 months of enrollment data. For the 2025 rate setting, the experience period was October 2022 through December 2023.
    - Contracts and member counts are collected by month split by single and family
  - Claims data
    - Segal uses 12 full months of claims data with 3 months of runout. For the 2025 rate setting, the experience period used was incurred claims from October 2022 to September 2023 and paid through December 2023.
- This experience period is selected to incorporate the most up-to-date data given the timing of deliverables

Claims Trend and Admin Fee Limits – Tier Model

- The experience period data needs to be trended to renewal period. We use a midpoint-to-midpoint approach, thus applying 27 months of trend.
- Trend limits are set in a joint effort by ETF and Segal based on market trends and budget constraints
- These limits are used to adjust for excessive trends reported by the plans, which helps prevent over-inflation of the breakpoint
  - Fee for Service Trend Limit
    - 6.5% used for Local, and 5.5% used for Dane and Non-Dane
  - Capitation Trend Limit
    - 5.5% used for Local, and 4.5% used for Dane and Non-Dane
- Medical Admin Fee limit adjusts admin fees reported by the vendors that exceed the threshold set by ETF and Segal, which also maintain a reasonable breakpoint
  - Medical Admin Fee Limit
    - $53.46 PMPM used for Local, $49.17 PMPM for Dane, and $51.90 PMPM for Non-Dane

Experience Adjustment – Tier Model

- Experience Adjustment is used to account for actual plan experience during the experience period and is dependent on the individual plan's reported cost and utilization
  - Data comes from ETF's Data Warehouse. This is a relatively new adjustment and was first implemented during COVID.
  - We recognized that some vendors had large costs per service increases. Paying providers significantly more than average to offset decreases in utilization.
  - In a capitation arrangement, the vendor is essentially paying themselves a higher amount
  - We analyze the Cost Per Service vs Utilization in the underlying experience and adjust for any unusual inflation to keep the breakpoint from artificially increasing

Tier Breakpoint Limits – Tier Model

- The percentages below are used to calculate each tier threshold by multiplying the percentage by the average of all plans Capped Required Premium (PMPM) for that group
- If the plan's risk adjusted premium falls below the tier limit, the plan is classified as that tier
- Plans are placed in either Tier 1, Tier 2, or Tier 3
- Tier Limits are set in a joint effort by ETF and Segal. They remain mostly consistent.
  - Tier 1 Limit
    - This is the maximum rate required for a plan to be classified as Tier 1
    - 91% used for Dane, 95% for Non-Dane, and 97.5% used for Local
  - Tier 2 Limit
    - This is the maximum rate required for a plan to be classified as Tier 2
    - 102% used for Dane and Non-Dane and 102.5% used for Local
  - Tier 3
    - Any rate outside of Tier 2 is considered Tier 3

Conversion Factor – Tier Rate

- Factor that converts the preliminary single bid to a PMPM rate
  - Conversion factor calculated based off contract mix of single and family contracts provided in the FUDS tool submission for each plan
- Purpose of this factor is to convert the bids to a PMPM basis, which is the same basis as the Tier Model

Catastrophic Claims Adjustment – Tier Rate

- Catastrophic Claims Pooling Charge is a weighted average of the catastrophic claims PMPM by plan. These are defined as claims over $100,000.
  - $46.58 PMPM for Local, $72.56 PMPM for Dane, and $76.68 PMPM for Non-Dane
- The Catastrophic Claims Adjustment gives an adjustment to plans that have larger or more catastrophic claims than the Catastrophic Claims Pooling Charge
- This adjustment allows plans to get a higher rate to offset them paying a greater share of cataphoric claims than average
- Taking a weighted average lets the adjustment act as a credit for plans who have larger or more catastrophic claims
  - For example, if a Non-Dane plan has a catastrophic claims PMPM of $85, they could get an $8.32 credit due to the adjustment limit

Premium Caps – Tier Rate

- State
  - Cap imposed to limit the increase of the state premium year over year from the inforce rate for each plan
  - There was no premium cap used for 2025 rate setting
- Two types of Caps for Locals
  - Rate Increase Caps
    - Cap imposed to limit the increase of the Local premium year over year from the inforce rate for each plan
      - Tier 1 Cap – 10% Rate Increase Cap from In-Force Rate
      - Tier 2 Cap – 20% Rate Increase Cap from In-Force Rate
      - Tier 3 Cap – 30% Rate Increase Cap from In-Force Rate
  - % of State Rate Caps
    - Cap imposed to limit the increase of the Local Rate compared to the State Tier 1 Rate for that plan
      - Tier 1 – Cap is 120% of the State Tier 1 Rate
      - Tier 2 – Cap is 130% of the State Tier 1 Rate
      - Tier 3 – Cap is 140% of the State Tier 1 Rate

Risk Scores – Tier Rate

- Risk Scores are used to determine the risk for each individual plan and are comprised of an age-sex factor, prospective Merative risk score, and regional score
  - Age-Sex factor calculated through enrollment data submitted by the plans in the FUDS tool
  - Prospective claims risk score comes from the Merative Data Warehouse
  - Regional factors calculated based on Individual market medical data for the State of Wisconsin
- The scores are normalized and are combined into an overall risk factor to adjust premiums accordingly
  - Scores were weighted 20% for age-sex, 30% for risk, and 50% for regional

Quality Credits – Tier Rate

- Quality Credits are given to the top 5 plans based on a select group of Health Effectiveness Data and Information Set (HEDIS) measures
- ETF does the calculations and provides the results to Segal
  - First place is given to the plan with the best scoring and receives the largest premium credit, which is applied to the adjusted required PMPM for that plan
  - Segal applies premium credits of 1%, 0.875%, 0.75%, 0.625%, and 0.5%

Medical Rate Development (Access, SMP, & Medicare Groups)

- Different than HMO's Tier Model Process
- Access and SMP Rates are negotiated with Dean Health Plan
- Medicare Advantage and Medicare Plus rates are negotiated with UHC
- Vendors submit their renewals and provide data and assumptions used in the process
  - Segal reviews assumptions and renewal
  - Segal negotiates fair rate based on any assumptions that may be out of line

1. Overview
2. Medical Rate Development
3. **Prescription Drug Projections**
4. Dental Projections

Prescription Drug Projection Assumptions

- Prescription Drug assumptions are reviewed and discussed with Navitus
- Experience Period for plan year 2025
  - Baseline data utilized the most recent 12 months of paid claims, February 2023 through January 2024. This data is provided by Navitus to Segal.
- The following groups are pooled together during rate setting:
  - State Non-Medicare, Non-Grad
  - State Grads
  - State Medicare
  - Local Non-Medicare, Non-Grad
  - Local Medicare
- Trend
  - In past years, Segal used a mix of Segal's Rx trend survey and trend supplied by Navitus to determine Rx trend. In 2025, Segal used trend given by Navitus because it reflects their Humira biosimilar strategy.
  - Annual trend of 6.2% was used for Actives and 7.1% was used for Retirees

Prescription Drug Projection Assumptions (Cont.)

- Rebates were provided by Navitus
  - State
    - $103.5M for Non-Medicare and $45.6M for Medicare
  - Local
    - $20.9M for Non-Medicare and $3M for Medicare
- Medicare Subsidies were provided by Navitus for Direct Subsidies, Manufacturer Discount Program (MDP), Low Income Subsidy Cost Sharing (LICS), and Reinsurance
  - State
    - $22.8M for Direct Subsidies, $43.5M for MDP, $601K for LICS, and $25.6M for Reinsurance
  - Local
    - $1.3M for Direct Subsidies, $3.2M for MDP, $76K for LICS, and $1.5M for Reinsurance
- Admin Fees were provided by Navitus
  - $2.10 PMPM was used for Non-Medicare and $10.88 PMPM was used for Medicare
  - Same for State and Local
- Single rates are used for both single and family contracts when calculating the total revenue for the plan year
  - Family contracts are multiplied by a factor of 2.5 for the average family contract size for Non-Medicare groups and by a factor of 2.0 for Medicare groups

1. Overview
2. Medical Rate Development
3. Prescription Drug Projections
4. **Dental Projections**

Dental Projection Assumptions

- There is one combined risk pool for both State and Local
- Experience Period
  - Segal uses projected incurred claims from January 2023 through December 2023 with one month of paid runout (January 2024) for the 2025 Dental rate setting
  - This data is provided by Delta Dental in the Delta Dental Template Tool that is created by Segal
- Completion Factors are used to calculate the total projected incurred claims
  - Calculated based on historical claims lags
- Trend
  - Trend is determined by Segal trend survey and discussions with Delta Dental
  - Annual trend of 4% was used for all Actives and Retirees
- Plan design changes are provided by Delta Dental and validated by Segal; however, there were no plan changes for the 2025 plan year
- Admin Fee is provided by Delta Dental
  - $1.10 PEPM (per employee per month)
- Single rates are multiplied by a factor of 2.5 for the family rate

Questions & Discussion

Segal Consulting

Kenneth Vieira, FSA, FCA, MAAA
Senior Vice President
KVieira@segalco.com

Segal Consulting

Patrick Klein, FSA, MAAA
Vice President
Pklein@segalco.com

Segal Consulting

Zachary Vieira, ASA, MAAA
Associate Health Consultant
Zvieira@segalco.com

Consulting 94

BREAK

The Board is on a short break. Audio and visual feed will resume upon the Board's return.

Contract Compliance Audit of the Pre-Tax Programs for Plan Years 2022-2023

Item 6 – Group Insurance Board

Xiong Vang, HSA & ERA Accounts Program Manager

Office of Strategic Health Policy

Informational Item Only

No Board action is required.

Audit Background

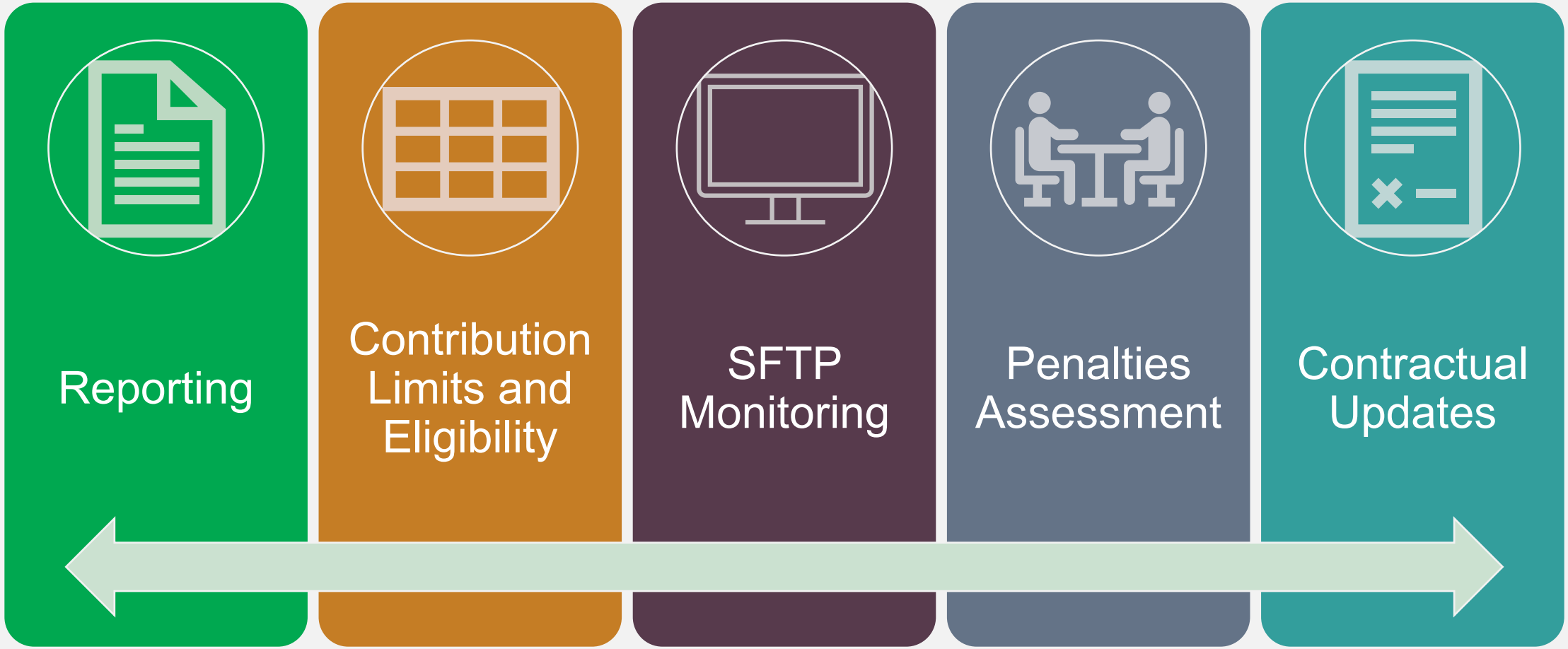
- ETF insourced audit of the pre-tax savings account program to ETF's Office of Internal Audit (OIA) (2nd audit done internally).
- The audit period included plan years 2022 and 2023 for the Pre-Tax Savings Account Programs.
- The audit was conducted in accordance with International Standards for the Professional Practice of Internal Auditing.

Audit Objectives

- Elections and Contribution Processing
- Compliance with Program Limits
- Claims Substantiation
- Billing for Claims and Administrative Fees
- Reporting Requirements
- Access to Program Data
- Performance Standards
- Prior Audit Recommendations

(Ref. GIB | 02.26.25 | 6, page 2)

Assessment of Prior Audit



(Ref. GIB | 02.26.25 | 6, page 2 & Attachment A)

Audit Findings

Found Exceptions

ERA and CB Claims Substantiation

Quarterly Performance Standards Reporting Deficiencies

Administrative Fee Invoicing

(Ref. GIB | 02.26.25 | 6, pages 2-3 & Attachment A)

ERA and CB Claims Substantiation

Finding

Claims substantiation process lacked sufficient controls

Internal procedures were not documented

Recommendations

Assess and document claims substantiation requirements that are clear

Improve controls over adjudicating claims

(Ref. GIB | 02.26.25 | 6, pages 2-3 & Attachment A)

Quarterly Performance Standards Deficiencies

Finding

Missing supporting documentation, duplicate values, inconsistent reporting, and multiple versions of reports

Recommendations

- Document procedures based on definitions
- Implement a review process and records to be maintain
- Request supporting documentations

(Ref. GIB | 02.26.25 | 6, page 3 & Attachment A)

Administrative Fee Invoicing

Finding

Duplicate billing and a fee overcharged

Recommendations

Improve its review of administrative fee invoices to ensure accuracy

(Ref. GIB | 02.26.25 | 6, page 3 & Attachment A)

Action Plan Status

ETF took proactive steps to address concerns.

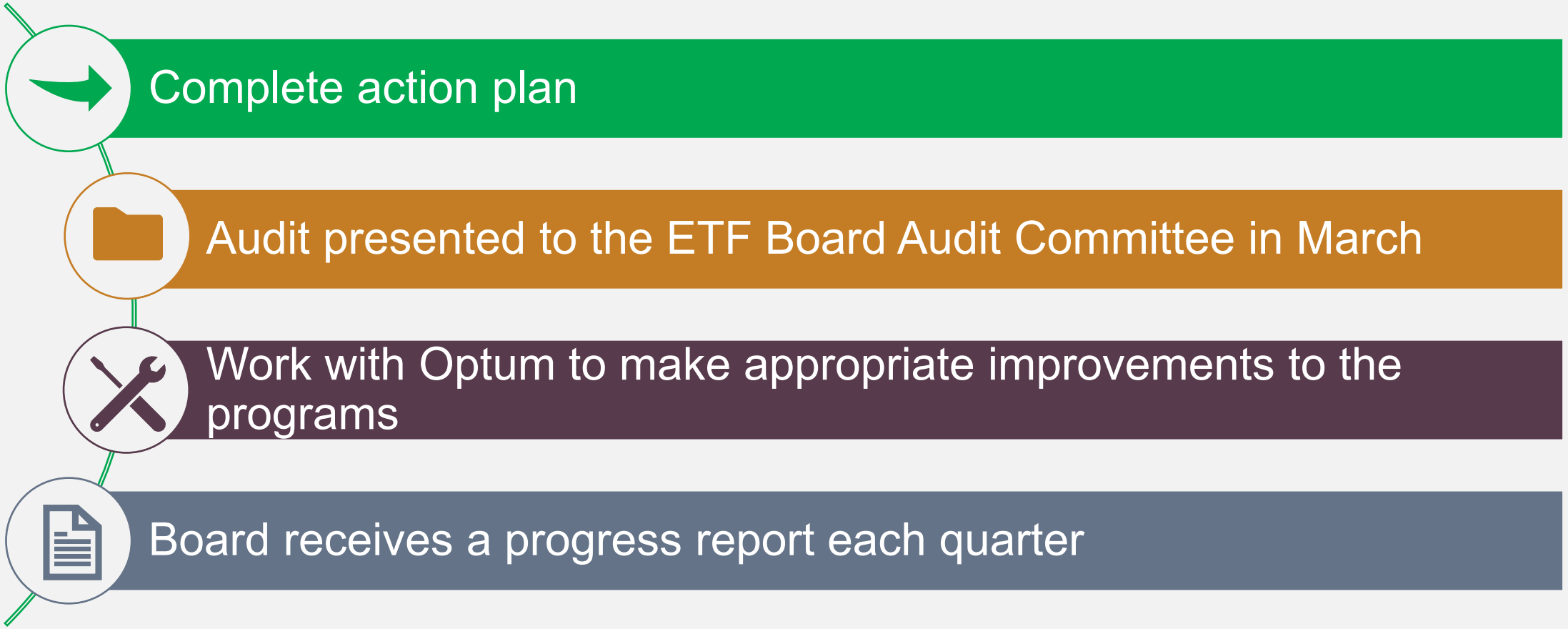
Optum has agreed with the additional efforts.

Administrative fees invoicing recommendations were resolved.

Optum and ETF meets regularly for progress status

(Ref. GIB | 02.26.25 | 6, pages 2-3, Attachment A & B)

Next Step



(Ref. GIB | 02.26.25 | 6, page 4)

Questions?

Thank you

etf

wi_etf

etf.wi.gov

ETF E-mail Updates

608-266-3285
1-877-533-5020

Operational Updates

Items 7A-7F – Memos Only

Move to Closed Session

Item 8 – No Memo

Action Needed

- Motion needed to move to closed session pursuant to the exemption contained in Wis. Stat. § 19.85 (1) (e) to deliberate or negotiate the investing of public funds or to conduct other specified public business, whenever competitive or bargaining reasons require a closed session. If a closed session is held, the Board may vote to reconvene into open session following the closed session.

The Board is meeting in closed session. Audio and visual feed will resume upon the Board's return.

Announcement on Business Deliberated During Closed Session Discussion

Item 12A – No Memo

Herschel Day, Chair

Group Insurance Board

Vote on Issuance of Letter of Intent to Award Contract(s) for Third Party Administration of HSAs, the Section 125 Cafeteria Plan, ERAs, and Commuter Fringe Benefit Accounts (RFPs ETD0052-53)

Item 12B – Group Insurance Board

Adjournment

Item 13 – No Memo