TO: Brad Wirtz
Human Resources Director

FROM: Mike Lipski ML
Compensation and Benefits Manager

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SUBJECT: Health Insurance

As you are aware, the City has a significant budget challenge ahead for 2012 and possibly the next few years after that. One idea that has been floated around to save money is to have the City cease participation in the Wisconsin Public Employers' Group Health Insurance Program (referred to herein as "the State plan") administered through the State Department of Employee Trust Funds (ETF). The City has participated in this program since 1992. I have talked with a number of people regarding this idea, including Greg Leifer-Labor Relations Manager, Dorothy Engsberg-Human Resources Analyst 1, and Randy Whitehead-Accountant 4/Purchasing. Greg was able to provide information regarding the impact on such a change on collective bargaining agreements. Dorothy worked in HR when the City administered its own health plans prior to 1992 and during the change to the State plan. She has worked with the plan on behalf of the City for over 20 years. Randy provided perspective from a purchasing standpoint regarding the process of going out for bid on the health plan. I want to discuss the history of the City's health insurance plan, the significant challenges to bid the plan to be effective 1/1/12, and overall pros and cons/hurdles to overcome if we were to bid out the plan to be effective 1/1/13 or some date thereafter.

History

Prior to 1992, the City of Madison administered its own health insurance plan. At that time, the City annually established its own uniform schedule of benefits and invited the various HMOs in the City to bid on the rates. The City was responsible for monitoring all changes to health insurance law to ensure the uniform schedule of benefits properly covered various required medical treatments and was non-discriminatory. The City offered 4 HMOs to employees, as well as a point of service plan administered by WPS. Human Resources annually published a booklet for all employees explaining the health insurance options and the uniform schedule of benefits. Human Resources handled the enrollment for employees, taking in the applications and forwarding them to the proper carrier. In addition, Human Resources was involved if employees had concerns with how a claim was being paid. Although the carriers had complaint resolution processes, it was not uncommon for Human Resources to contact a carrier if an employee was having a problem. Finally, Human Resources handled all insurance enrollment for retirees and individuals with COBRA coverage as well as employees.

In 1992, the City enrolled in the State plan. At that time, ETF took over administration of the plan, including developing and bidding out the uniform schedule of benefits, and monitoring changes in health insurance law to ensure the uniform schedule of benefits remained in legal compliance. The State plan still offered the same HMOs and point of service plan the City had

previously offered, as well as additional options for employees who live outside of Dane County. While the City still handled enrollment of employees, the process was simplified. Employees filled out a health insurance application, Human Resources staff coded appropriate information at the bottom, and the application was forwarded to ETF who took care of enrollment with the individual carriers. ETF also developed and printed the annual enrollment books that were distributed to employees. The City pays a nominal fee for the books, built into the plan rates. The City is no longer involved if employees are having problems with a claim; rather the employee is directed to contact either the carrier or ETF for assistance. ETF also handles insurance changes for retirees and for individuals on COBRA. In fact, for retirees, in most cases the insurance premium is taken right out of their Wisconsin Retirement System (WRS) pension check so that they do not need to send in a separate payment for health insurance.

When the City enrolled in the State plan, ETF had to make changes to State law to accommodate existing City practices. For instance, the City allowed seasonal/hourly employees to enroll in health insurance upon being promoted to permanent employment. At the time the City joined the State plan, this was not considered a qualifying event for new enrollment. The state law was changed to accommodate this practice. In addition, with ETF taking over administration of the plan, ETF has been responsible for implementing various other legal changes to the plan, including the recent addition of domestic partners and children to age 27 to the plan, imputed income as a result of those changes, and changes resulting from the implementation of the Patient Protection and Affordable Care Act.

In 2010, ETF established an on-line enrollment option for employees to enroll or make changes to the health insurance, which has simplified processing at the City level. During the It's Your Choice annual enrollment period, Human Resources receives between 50-100 applications for changes. Human Resources, after coding the information, passes the applications on to ETF, as described above. With the new on-line system, the number of paper applications turned in to Human Resources was reduced by 50%. For those who enrolled or made changes on-line, Human Resources merely had to log on the system and press a button accepting the enrollment changes.

As of October, 2010, the City had almost 4000 participants in the State plan, including 3100 employee participants and employer paid annuitants as well as 870 retirees and individuals on COBRA.[1] Overall, there were approximately 16,500 participants, not counting retirees or individuals on COBRA in the State Plan, which means City of Madison participants are slightly less than 20% of the total plan enrollees. Within Dane County, not counting retirees or COBRA participants, Madison enrollees make up 3101 of 4716 total participants, or 66% of the total enrollees in the Dane County area.

[1] Employer paid annuitants are those employees who have retired from the City but the City still pays for health insurance. This includes police and firefighters who retire prior to age 55 but the City pays the premium until the month in which they turn 55 as well as for Metro employees who provide 1 year notice of retirement and then are eligible to have the City pay for health insurance for up to 5 years or age 65, whichever happens first.

Bidding the Plan effective 1/1/12

It has been suggested that in order to help with the budget issues, the City should consider withdrawing from the State plan as of 1/1/12 and administer its own plan to take advantage of potential cost savings. I will discuss the issue of cost savings in the next section. However, it would be extremely difficult for the City to implement its own health plan for 2012 considering it is already mid-July for the following reasons. First, most of our Union contracts indicate that the City must provide benefits equivalent to those offered by the State plan unless changed by mutual agreement. This means that if the City does not participate in the State plan, we still need to offer equivalent benefits. However, the language is flexible in that if the State plan reduces the level of benefits, we are not violating the Union contracts by offering those same benefits. This is important because the Budget Repair Bill that was passed by the Legislature included the following provision:

> **Section 9115. Nonstatutory provisions; Employee Trust Funds**
>
> (4) REDUCTIONS IN HEALTH CARE PREMIUM COSTS FOR HEALTH CARE COVERAGE DURING 2012 CALENDAR YEAR. The group insurance board shall design health care coverage plans for the 2012 calendar year that, after adjusting for any inflationary increase in health benefit costs, as determined by the group insurance board, reduces the average premium cost of plans offered in the tier with the lowest employee premium cost...by at least 5 percent from the cost of such plans offered during the 2011 calendar year. The group insurance board shall include copayments in the health care coverage plans for the 2012 calendar year and may require health risk assessments for state employees and participation in wellness or disease management programs.

It doesn't appear that significant changes are going to occur in the State plan but we will not know for sure until late August or September what the final plan design is. Normally, the City is provided the rates for the following year plan on the last Tuesday in August. Around this time, we would be able to find out what the plan design for 2012 looks like. The City would not want to bid out the health insurance plan until we know what the new plan design is because otherwise we would not be taking advantage of changes in the plan that could reduce premiums. Assuming this is the case, the earliest we would be able to start the bid process is the end of August.

In talking with Randy Whitehead, he estimated that from start to finish, the process of bidding out the insurance would take approximately 3 months. If we start the bid process at the end of August, this means it would be the end of November before we are in the position of making a decision. The City may also want to consider using a consultant to help navigate the process, which would cost money. Then Human Resources would have to prepare enrollment materials for employees, develop an application, publicize the change in plans, and have all 2600+ employee participants and 800+ retirees and COBRA participants fill out enrollment applications which would have to be turned over to the various carriers. This would have to take place in the month of December, when a large number of employees are off work for vacation around the holidays, in order for enrollment to be effective January 1, 2012. Normally, the insurance premium for January is taken out in December as employees pay for insurance one month in advance but this would not happen in this scenario as we wouldn't know employee's enrollment choices at that time. Finally, ETF requires that we inform them by October 1 of our intent to be in the plan for the following year. So, in the middle of the bid process, without knowing the outcome, we would have to withdraw from the State plan and we would not know whether we

are going to achieve any cost savings at that time. Even assuming we start the bid process immediately using the current uniform schedule of benefits as a template, if the process is a three month process, we would not know the outcome of the process until the end of October, after the date we would have to pull out of the State plan. Overall it would be extremely risky to the City and employees to pull out of the State plan without knowing whether we would achieve any cost savings at all.

Bidding Health Insurance in the Future

It would certainly be possible to bid out the health insurance in future years. However, if this is something the City wants to consider, it is important to consider all factors besides a potential cost savings because doing so comes with a number of benefits, drawbacks, and other considerations which will be discussed in this section.

Benefits

- Control over Plan Design—By controlling the health insurance, the City would have control over the plan design. If the City wanted to incorporate copays and/or deductibles, we could make the choice and at what level.[2] In addition, the City could change the level of coverage such that instead of a single and family plan, we could offer an employee + 1 option, similar to the Delta Dental plan. Under the State plan, the State dictates the uniform schedule of benefits and the City offers what the State offers.
- Control over costs—Similar to plan design, the City would control what portion of the premium it wants to pay and what it wants to charge employees. The Budget Repair Bill established a requirement that participants in the State plan could not pay more than 88% of the premium of the lowest tier plans. By not participating in the State plan, the City would be freed from this requirement.
- More information regarding utilization—Because the City participates in the State plan, we are unable to get specific utilization statistics on our employees. Rather ETF maintains this data for the plan as a whole, but doesn't break it out by employer. Getting the utilization information would allow the City to do studies based on employee group and other factors to determine whether we need to make changes in job design to help keep claims down.
- Cost savings—By having a plan for only City employees, it is possible we may see a reduction in premiums. This is more likely if the City reduces the number of HMOs offered to employees. However, this is difficult to quantify without actually going through a bid process. This will be discussed further below.

Drawbacks

- Labor Relations issues—As mentioned earlier, current bargaining agreements indicate that the City must continue to offer the same level of benefits as the State plan unless the Unions agree to a change in plan design. This means that until contracts expire in 2014,

[2] This is true once current contracts expire. While the contracts are in effect, they state that we must offer equivalent benefits to the State plan.

the City cannot make changes to the plan design without agreement from the Unions. In addition, State law still requires the City to negotiate with the Teamsters regarding employees at Metro so any plan design changes will have to be agreed upon with that unit. The City could not bid out insurance on such a small group of employees in a cost-effective manner, especially considering the likely utilization statistics among that group. Another issue to consider is that if the City changes to its own policy prior to 2014, it is likely the greatest cost savings will be if the City reduces the number of carriers who offer insurance. As a carrier has a larger group of employees covered, the premium rates go down, so offering 1 or 2 carriers should result in lower rates than if the City offers all 4 HMOs as well as the standard plan. However, although AFSCME Local 60 and Laborer's Local 236 have verbally indicated that if the City were to reduce the number of carriers prior to 2014, they wouldn't consider this a change in the benefit level, the City would need to get this in writing from all Unions, ensuring that such a change would not result in a grievance and arbitration. It is likely members may perceive this as a change in benefit level if they are forced to change doctors due to the fact the City no longer offers their insurance as an option.

- Administration—This can be broken down into a number of issues:
    - *Processing paperwork*—In the first year of a change in insurance, the City would have to contact all current participants in the plan, including employees, employer-paid annuitants, retirees, and individuals on COBRA to advise them of the change. The City would need a new application from all these individuals, almost 4000 people, and Human Resources would have to process all these applications. This would require a significant amount of staff time during the enrollment period. Annually thereafter, it is likely changes would be fewer, but because the City would be administering the plan, the City would be responsible for changes by retirees, employer-paid annuitants, and individuals on COBRA, changes currently handled by ETF. The number of applications annually would likely be closer to 200 than the usual 50-100. It is possible, though, that in the RFP process, the City could explore having participants enroll directly with the insurance carriers, reducing this burden on Human Resources.
    - *Annual bidding of the insurance*—ETF currently bids the State plan every year, making adjustments to the uniform schedule of benefits and finding the best rates. They start the process in January and get the rates at the end of August. The City would be responsible for this annual bidding process, updating the Uniform Schedule of benefits, setting up the RFP, receiving the bids, and determining the provider(s). This would involve representatives from the Office of the City Attorney to ensure we are properly incorporating any legal changes to the plan design, Human Resources, and the Finance Department. An annual bid process will be extremely important if the City reduces the number of providers as we will want to ensure we are providing the lowest cost options every year.
    - *Annual enrollment materials*—The City would be responsible for annually creating enrollment materials and printing them for participants. Currently ETF provides the materials for the enrollment and each premium includes a monthly administrative fee of $2.60, which includes printing the books, among other items. In recent years, although the City has distributed booklets electronically where possible, we have still purchased 1,200 books for employees who do not

have computer access at work and ETF continues to send hard copy books to retirees and individuals on COBRA. So the City would have to print upwards of 2,000 books annually as well as incur postage costs to annually send books and application materials to the retirees and individuals on COBRA.

- *Retirees*—Currently retirees can have their premium deducted from their regular WRS check. If the City administers the plan, the Finance Department would be responsible for billing and collecting premiums on retiree insurance. However, it is possible to write the billing of retirees into the RFP to require the carriers to perform this function. The City would still be required to assist with problems.
- *Legal Compliance*—Currently ETF is responsible for ensuring that changes in State and Federal law are incorporated into the plan design. This was especially important when the State of Wisconsin added dependent and domestic partner coverage to the plan for the 2010 plan year. Such individuals were not considered qualifying dependents for IRS tax purposes so their portion of the premium could not be taken with pre-tax dollars. This required ETF to determine tax impacts of such action and develop a schedule of imputed income for those individuals. If the City takes over administration of the plan, the City would take over responsibility for this function, which would include representatives from Human Resources and the Office of the City Attorney. In the example above, the City would have been required to hire an actuary to determine the imputed income amounts for the plan. Legal compliance will be especially important in coming years with implementation of the Patient Protection and Affordable Care Act and the health insurance exchanges.
- *COBRA and Claims administration*—Currently ETF handles enrollment and changes for individuals on COBRA. Also, if participants have issues with claims adjustment, ETF provides the support. These functions would be handled by the City. However, it may be possible to write such administration into the RFP so that the insurance companies provide this function.

- Prescription Drug Plan—Currently ETF contracts with Navitus to provide prescription drug coverage to supplement the health insurance plans. If the City takes over administration of the health insurance, the City would be responsible for finding a prescription drug carrier and would have to bid this coverage out on a regular basis.
- Impact on the State plan—As mentioned above, the City provides the most participants in the State plan. After the City's 3100+ employees and employer paid annuitants, the next largest participant has 800+ employees. Within the Dane County area, the City participants make up 2/3 of the total participants. In an off-the-record conversation, a representative from ETF indicated that if the City pulls out of the State plan, it would "destroy the plan."

Other considerations

- The direct impact of cost savings is unclear. Currently, because the City of Madison is the main participant in the Dane County area under the State plan, it is likely that the current premium rates are based mostly on City of Madison utilization such that the premium rates the State plan gets are going to be similar to what the City may get on its own. It is important to note, however, that the City has certain groups who likely have

high utilization of the insurance, like Metro, such that participation in the larger group may actually have a beneficial impact on our rates. Their utilization spread out over 4700 participants may be keeping rates down whereas putting their utilization in the City group of 3100 participants (not counting retirees, another high-use group) may cause the rates to increase.

- The duration of any cost savings may be limited. Health insurance rates continue to rise such that even if the City sees an initial reduction in premium rates, this reduction will probably only have an impact on the budget for a couple of years before annual increases in premiums put us right back to where we currently are. Also, being a smaller group gives the City less leverage in getting good rates unless we have the HMOs bid against each other and limit the offering. As indicated above, employees will likely be upset if they are forced to change doctors annually because the City offers a single carrier and then changes carriers based on the cheapest rates.
- If the City pulls out of the State plan, it will be extremely costly to get back into the plan. The City would have a 3 year waiting period and then ETF could have the ability to "...impose enrollment restrictions on the employer appropriate to preserve the integrity of the program..."[3] This means that ETF could impose a fine on the City or take other actions at the time of reenrollment.

[3] "How to Become a Participating Employer Under the Wisconsin Public Employers' Group Health Insurance Program," ET-1139, Department of Employee Trust Funds, published 8/2009.