



# MONTANA LEGISLATIVE BRANCH

## Legislative Fiscal Division

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**Director**  
AMY CARLSON

DATE: September 23, 2014  
TO: Legislative Finance Committee  
FROM: Kris Wilkinson  
RE: State Employee Group Benefits Plan (plan)

The state provides group health care benefits to employees, retirees, legislators, and their families through a self-funded insurance plan. The purpose of this memorandum is to provide the Legislative Finance Committee with an update on the financial status of the plan and outline changes proposed for contributions, deductibles, and out of pocket amounts in calendar year 2015.

The state health plan operates on a calendar year basis, releasing financial information at the end of each quarter. The last published data for the plan is from the first quarter (January through March). Legislative Fiscal Division (LFD) staff noted the following areas of concern in relation to the medical plan:

- o Revenues increased 1.8% when compared to the same period in plan year 2013, from \$36.5 million to \$37.0 million, an amount that does not provide for the costs of the claims during this period. The change is a combination of two factors:
  - o Revenues increased by state share contribution that was raised 10% from \$733 per state employee per month to \$806
  - o Revenues decreased for contribution reductions of \$20 per participant 18 years or older per month for participation in health screenings and tobacco cessation programs, up to a maximum of \$40 per month per family
- o Expenditures for medical expenses increased 50.3% when compared to the same period in plan year 2013, from \$31.5 million to \$47.4 million. Health Care and Benefits Division (HCBBD) staff have outlined a number of factors that contributed to the changes, which are outlined in the LFD report FY 2014 Fiscal Year End and 2015 Biennium Budget Update Report. In addition HCBBD staff believe that the first quarter of plan year 2013 costs were lower than anticipated for three reasons:
  - o Transition between third party administrators resulted in payment delays
  - o Implementation of new care policies directed by HCBBD staff are believed to have improved the medical review process for medical care and related costs but resulted in delayed payments
  - o Claim repricing for network discounts were delayed in implementation
- o Plan reserves were \$80.3 million at March 31, 2014 or 314% of the actuarially calculated potential loss to the plan. Plan reserves were \$98.5 million or \$33.97 million above actuarially recommended levels at March 31, 2013, a decrease in reserves of \$18.2 million. Actuarial estimates project surplus reserves to be \$4.6 million below recommended levels at the end of the plan year or a projected reserve level of 246%.

Second quarter data for the plan has yet to be made public. Data reported in the quarterly report includes costs by type of plan such as the medical plan discussed above, dental, and vision plans. LFD staff reviewed the financial data available on the state's accounting system. This information does not provide sufficient detail to be able to calculate the costs of the medical and dental plans separately. However it does allow for period to period comparisons. This review of the first six months of 2014 compared to the first six months of 2013 shows further areas of concern, including:

- o Revenues for both the medical and dental plans increased 2.0% for the first six months of the 2014 plan year when compared to the same period in plan year 2013, which is significantly below expenditures for the same period
- o Expenditures for the plan benefits were 33.9% higher when compared to the same period in plan year 2013. Total expenditures exceeded revenues by \$14.9 million in the first six months of the plan
- o Fund balance for the plan was \$52.9 million as of June 30, 2014. Fund balance for the health plan includes a portion of the reserves. When added to incurred but not reported (IBNR) estimates the amount determines the surplus reserve levels. See Appendix A for further information on reserve requirements.

To address higher costs for increased medical and dental claims the Governor has implemented increased contributions, deductibles, and copays for participants for plan year 2015. The figure below shows the planned changes to deductibles and copay amounts.

| Department of Administration                   |        |  |        |          |
|--|--------|--|--------|----------|
| Health Care and Benefits Division              |        |  |        |          |
| Changes to Deductibles and Out of Pocket Costs |        |  |        |          |
| Item   | 2014   |  | 2015   | % Change |
| Single Member In-Network Deductible            | \$500  |  | \$750  | 50.00%   |
| Family In-Network Deductible                   | 1,000  |  | 1,750  | 75.00%   |
| Single Member Out-of-Network Deductible        | 750    |  | 1,250  | 66.67%   |
| Family Out-of-Network Deductible               | 1,750  |  | 2,750  | 57.14%   |
| Single Maximum In-Network Out of Pocket        | 4,150  |  | 4,950  | 19.28%   |
| Family Maximum In-Network Out of Pocket        | 8,300  |  | 9,900  | 19.28%   |
| Single Maximum Out-of-Network Out of Pocket    | 5,900  |  | 6,600  | 11.86%   |
| Family Maximum Out-of-Network Out of Pocket    | 12,800 |  | 14,200 | 10.94%   |
| Office Visit                                   | 15     |  | 20     | 33.33%   |

Contributions for next year were based on the following assumptions:

- o Increased projections in costs of:
  - o Medical and dental costs are projected to increase 8%
  - o Pharmacy costs - 10%
  - o Vision costs - 3%
  - o Administrative costs - 2%
- o No contributions to plan reserves or to the dependent "subsidy" are contemplated

Proposed contribution increases for various groups are shown on the next page:

| Department of Administration      |           |       |           |       |          |
|-----------------------------------|-----------|-------|-----------|-------|----------|
| Health Care and Benefits Division |           |       |           |       |          |
| Premium Increases                 |           |       |           |       |          |
|                                   | Plan Year | State | Plan Year | State | % Change |
| Participants                      | 2014      | 2014  | 2015      | 2015  | Premiums |
| Single Employee                   | \$717     | \$806 | \$845     | \$887 | 17.85%   |
| Employee and Spouse               | 926       | 806   | 1,070     | 887   | 15.55%   |
| Employee and Children             | 809       | 806   | 935       | 887   | 15.57%   |
| Employee and Family               | 981       | 806   | 1,134     | 887   | 15.60%   |
| Non Medicare Retiree              | 734       | 0     | 931       | 0     | 26.84%   |
| Non Medicare Retiree and Spouse   | 1,037     | 0     | 1,314     | 0     | 26.71%   |

According to HCBD staff, the increases in the contributions, deductibles, and out of pocket amounts are projected to cover the estimated costs of the plan but will not increase the reserves. HCBD staff project at the end of plan year 2014 reserves will be \$4.6 million below the actuarially recommended levels or 246% of the calculated potential loss. This level of reserves would be maintained if projections for plan year 2015 are realized.

## APPENDIX A

Statute requires that the plan be maintained on an actuarially sound basis and reserves are sufficient to liquidate the unrevealed claims liability and other liabilities of the state employee group benefit plan. It does not specifically address how the reserve amounts should be determined.

There are several specific reserves set aside for the Montana plan. The state plan does not purchase reinsurance for large claims, so there is a reserve to cover these costs. The wellness and disease management program as well as a potential increase in COBRA enrollment have associated reserves. Medicaid Part D reimbursement for drug costs for Medicare eligible plan participants has varied from estimates so there is another reserve for these costs. Finally, there is a surplus reserve for 300% of potential plan losses.

During the 2009 biennium, the State Employee Group Benefit Advisory Council recommended a reserve level of between 200% and 300% of the potential loss to the plan. This results in a reserve that is above the estimated plan performance for the year.

The calculation is a benchmark to measure the State Employee Group Health Plan risk level. Total plan reserves are first reduced by the required reserves and the IBNR. The remaining balance is the surplus reserve. An actuarial calculation of underwriting risks is completed to determine the reserve amount required to cover the risk that underwriting factors for premiums and claims expenses don't meet projections. Basically, this is a "buffer" for potential losses to the plan. The goal is for surplus reserves to be at least 300% of the potential loss so that the plan remains in good financial condition.

In contrast private insurers in the health care market use a risk based capital (RBC) approach. The RBC formula establishes a minimum capital level needed by a health insurance plan based on its specific features and then compares the minimum level to the plan's actual capital level. This ratio provides a measure to compare to recommended levels of capitalization for insurance risk. Under the RBC approach, a target ratio or a measure known as the "authorized control level" of reserves indicates the financial stability of the insurance plan. Under the National Association of Insurance Commissioners guidelines adopted by Montana, the minimum recommended level of reserves required for a private health insurer is 200% of the authorized control level. As an insurer's risk based capital ratio falls below 200%, the company is subject to increasing degrees of regulatory oversight and control by the State Insurance Commissioner.