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EXECUTIVE SUMMARY

Employees' Group Health Insurance

Purpose

The Management Audit Committee directed program evaluation staff to undertake an evaluation of the state's health insurance plan. The Committee asked for a review of the plan to determine how employee costs compare to those of similar plans, and to determine whether the plan's placement affects the state's ability to offer a competitive plan.

Background

In 1967, the Legislature created the State Employees' and Officials' Group Insurance Board of Administration (EGI) and gave it autonomous authority to administer and manage a group insurance program. Currently, the health plan insures approximately 24,000 individuals, including active employees and their dependents from the executive, judicial, and legislative branches of state government (52 percent); the University of Wyoming (19 percent); the state's seven community colleges (10 percent); and retirees and their dependents from all of those entities (18 percent). COBRA participants and Wyoming Community Development Authority employees and dependents complete the pool.

The EGI plan is self-funded, meaning the plan bears the financial risk of participant health care costs. Plan funding comes from a combination of state and employee premium contributions that cover both the costs of claims and administrative costs. The state makes a monthly contribution of $225 on behalf of each active employee. Employees who insure their dependents pay an additional amount for family coverage, while retirees pay the full premium for the coverage they select. In FY00, the state paid about $26 million in premium contributions; employees paid about $23 million toward premiums and an additional $14 million in deductibles and co-insurance.

The seven-member EGI board includes two gubernatorial appointees, the State Treasurer, the state's human resources administrator, and three members elected by employees covered by the plan. The board is responsible for all plan decisions, including premium levels, plan benefits, participant eligibility, and grievance resolution. It employs a director and administrative personnel to manage the plan, and contracts with a private company to administer claims and with a benefits consultant for expert advice. Total administrative expenses for the health insurance plan in 1999 were less than six percent of plan costs.

The EGI plan is considered a comprehensive major-medical plan with most expenses subject to a deductible, a co-insurance percentage, and an annual out-of-pocket maximum. All prescription drugs require participant co-pays, which do not count toward the deductible or the annual out-of-pocket maximum. Participants are free to choose their medical providers under the fee-for-

service plan, but receive a higher level of reimbursement if they use network providers under the plan's preferred-provider option.

Results in Brief

We found that EGI participants, particularly those with families, pay higher out-of-pocket costs than they would in comparator plans. Facing these higher costs, employees may insure dependents (who are often younger and healthier) at lower cost elsewhere. This means EGI does not receive premium income from those individuals least likely to incur significant medical claims, which in turn compounds the problem of higher costs for those who remain in the plan.

We identified fundamental limitations in the EGI administrative structure, including a lack of policy direction, limited administrative resources, variable expertise, and administrative isolation. These factors limit the board's ability to undertake the analysis and strategic planning necessary to develop a plan design and funding approach that will address the problem of higher costs.

Principal Findings

EGI participants pay higher out-of-pocket costs than in-state and out-of-state comparator plans we reviewed, especially for dependent coverage. For those who elect dependent coverage, annual out-of-pocket expenses can be as much as $6,400; an amount that is double what is paid in most of the comparator plans. We identified several reasons why EGI participants pay more for health insurance, including a lower employer contribution, an older pool, and inherent limitations in the plan's ability to manage costs.

Since plan costs are comparatively high, employees may be able to obtain dependent health insurance at lower cost on the private market or, if they are married, through a spouse's plan. We believe this is the primary reason the EGI pool is older and has fewer dependents than our comparator plans. An older pool has a compounding effect: it raises costs to the plan and increases average premiums, so eligible persons who are younger and healthier can obtain cheaper coverage on the private market. When they leave the plan, the pool becomes less healthy, claims costs increase, and the cycle continues.

We believe aspects of the plan's design create disincentives for younger and healthier individuals to participate in EGI. However, the EGI administrative structure is not positioned to address plan design issues and is unable to strategically manage the plan, as would be necessary to address the complex problems summarized above. Statute assigns the board transactional duties, designed to keep the health plan solvent. The EGI board performs these duties, but lacks the staff and information resources, policy direction, and expertise to identify and implement long-range strategies to improve employee benefits at stable costs. Further, the plan's organizational autonomy impedes the state's ability to enact total compensation planning, which the Legislature identified as a goal in the 2000 legislative session.

Recommendation

We recommend the Legislature establish a strategic framework to administer group insurance. The problems identified in our evaluation require a proactive solution, but limited policy direction, isolation, and insufficient resources and expertise diminish management's capacity to address these issues. To most efficiently address these structural weaknesses, we suggest disbanding the current autonomous policymaking board and creating a professional plan function within the Department of Administration and Information to manage the plan. This structure would integrate the program with overall compensation planning and would facilitate policy direction from the Governor. However, for the plan to operate strategically, plan managers, wherever they are organizationally situated, will also need to enhance administrative capacity and expertise.

Agency Comments

The majority of the EGI board members have no objection to the report's recommendation. They recognize that the employer must make decisions on the plan's organizational structure. Restructuring the plan has often been considered in the past, and the board believes it is appropriate to resolve the issue.

INTRODUCTION

Scope and Methodology

Scope

W.S. 28-8-107(b) authorizes the Legislative Service Office to conduct program evaluations, performance audits, and analyses of policy alternatives. Generally, the purpose of such research is to provide a base of knowledge from which policymakers can make informed decisions.

In May 2000 the Management Audit Committee directed staff to undertake a review of Employees' Group Insurance (EGI). The Wyoming State Employees' and Officials' Group Insurance Board of Administration provides health, life, and dental insurance to about 24,000 public employees, retirees, and dependents in Wyoming, and was the subject of a 1994 program evaluation. The Committee requested an updated analysis focusing on three aspects of the health insurance plan: cost, membership, and placement. We developed three objectives to examine these issues:

1. Is the EGI plan cost-effective, and are participant costs comparable to those in similar plans? Would increasing membership decrease costs?
2. Are participants continuing to insure their dependents outside of the EGI plan? If so, what is the impact on the EGI plan?
3. How does the plan's structure (placement, policy direction, staffing, and use of management information) affect the board's ability to make strategic decisions?

Methodology

This evaluation was conducted according to statutory requirements and professional standards and methods for governmental audits. The research was conducted from June through October 2000.

In order to compile basic information about the EGI plan, we reviewed relevant statutes, statutory and placement history, annual reports, budget documents, strategic plans, rules, statistical reports, and other internal documents. We reviewed a considerable body of professional literature about the insurance industry and public sector health insurance plans.

We attended two EGI board meetings and reviewed board meeting minutes from prior years. We interviewed current and former board members and conducted extensive interviews with EGI staff and the board's consultant. We also consulted with several experts in the field of health plan administration.

Finally, we identified four in-state and four out-of-state comparators in the public sector, offering a variety of plans with provider arrangements similar

to EGI. We chose out-of-state comparators based on their similar economic and demographic characteristics; in-state, we chose larger public employers. The comparator plans offer generally similar benefits and have slightly different cost-sharing arrangements. We compared the plans to the EGI plan using numerous variables.

Acknowledgments

The Legislative Service Office expresses appreciation to those who assisted in this research, especially the EGI board and staff, former board members, and the Departments of Insurance and Administration and Information. We also thank the many other government, nonprofit, and private-sector individuals who contributed their expertise. We would specifically like to thank the health insurance administrators from other states who provided information on their plans, and Centennial Consulting for information they provided on public-sector comparators.

CHAPTER 1

Background

Health Insurance is Primarily Provided by Employers

Health insurance has become an expected benefit in employee compensation packages.

The original intent of health insurance was to spread risk broadly and to protect against catastrophic losses. Corporations began offering health insurance as a tool to recruit and retain workers during a World War II wage freeze. Over time, this benefit has become an expected benefit in employee compensation packages. According to the U.S. General Accounting Office, more than 90 percent of people with private health insurance coverage have access to insurance through their employer. Large employers are more likely to offer coverage than smaller employers, and public employers are more likely than private employers to offer health insurance. Individuals who do not have access to employer-provided group plans can purchase individual coverage on the private market.

Employees' and Officials' Group Insurance

Statutes assign health insurance program administration to an autonomous board.

W.S. 9-3-204 through W.S. 9-3-213 established the state group insurance plan in 1967 by creating the State Employees' and Officials' Group Health Insurance Board of Administration (EGI) and giving it authority to administer and manage a group insurance program. The state program now includes life insurance, dental insurance anda flexible-benefits plan, as well as health insurance. This report focuses solely on the health insurance benefit and how its costs affect active employees.

EGI refers to itself as a comprehensive major-medical plan[1], covering most medical expenses and providing wellness benefits. Under these kinds of plans,all expenses are subject to a deductible, then a co-insurance percentage, and finally, an out-of-pocket maximum. Few benefits are payable at 100 percent.

About 24,000 individuals are insured in the plan.

EGI health benefits are available to active employees and their dependents from the executive, judicial, and legislative branches of Wyoming state government, from the University of Wyoming (UW) and the state's seven community colleges, from the Wyoming Community Development Authority (WCDA), and to COBRA (Consolidated Omnibus Budget Reconciliation Act[2]) participants. Retirees from these entities and their dependents are also eligible for plan coverage. Currently, an estimated23,700 employees, retirees, and dependents are insured in the plan. A breakdown of participants by entity, plan option, and subgroup follows on page 8.

State and participant contributions fund the health insurance plan.

EGI insurance benefits are funded with a combination of state and plan participant contributions. Currently, the state contributes $225 for each active employee; this amount is sufficient to cover that employee's premiums for health, preventive dental and, depending on age, life insurance benefits. Employees contribute additional amounts to insure their dependents, while retirees pay the full premium established by the board for any coverage they elect for themselves and their dependents.

Insuring the Plan

The EGI plan is self-funded, meaning the plan essentially acts as its own insurance company and bears the financial risk of participant health care costs. Employer and employee contributions go into a trust fund from which claims and plan administrative costs are paid.

It is common for large employers to self-insure their plans.

Self-funding of health insurance plans is commonplace for employers of more than 1,000 employees. W.S. 9-3-201(d) gives the state and any political subdivision authority to self-insure, providing proper funding is adopted and the cost of the plan is included in the annual budget. Public sector self-insured plans within Wyoming are generally within the jurisdiction of the state insurance commissioner, and include any coverage mandated by the Wyoming insurance law.

As a completely self-funded program, EGI does not purchase stop-loss insurance for protection against extremely large claims or annual losses in excess of a specified maximum amount of dollars. Although the plan

carried this insurance in years past, the EGI board now maintains a claims fluctuation reserve to cover claims in excess of premium income.

Plan Administration

The EGI plan has four different administrative aspects: a policy board, administrative staff, a third party claims processor, and the services of a consultant.

Policy Board

The autonomous board consists of designated, appointed, and elected members.

EGI is a seven-member autonomous board charged with administering the group health plan. The Governor appoints two members, one to represent retirees and the other to represent the insurance industry. Statute requires that the State Treasurer and the administrator of the Department Administration and Information (A&I) Human Resources Division serve on the board. Every other year, state employees covered by the plan elect the final three members to represent their interests. Board terms are two years, and appointed members may be reappointed.

Over time, changes have been made to board membership and organizational location.

Over the years, the Legislature has made changes in board membership as well as in plan organizational status. Since 1990, the Legislature has increased voting members from five to seven, and changed the board composition. Prior to its creation as a separate and independent agency in 1987, the plan had been housed in the state personnel division and then in the Insurance Department.

As part of state government reorganization in 1991, a recommendation was made to consolidate the plan back into A&I's personnel division. However, this was not accomplished and the plan remained autonomous. Instead, statute "assigned" the plan to A&I. By statute (W. S. 9-2-2008), A&I is to provide administrative assistance and oversight, guidance on budget matters, and function as a liaison between the board and other agencies. A&I can review EGI practices and make recommendations, but is not empowered to affect the board's authority.

EGI Administrative Staff

Since 1987, the EGI board has had statutory authority to employ a director and other personnel. Currently, EGI has a staff of seven full-time positions: an executive director, a deputy director, a data base manager, and specialists in the areas of the flexible-benefits plan, direct billing, and fiscal operations. Administering the flexible-benefits program requires half of the EGI staff time. In addition, benefit specialists in all the agencies and entities participating in group insurance handle employee enrollment in the plan, and also field some participant questions. EGI's share of administrative expenses totaled about $250,000 in 1999, including board expenses.

Third-Party Claims Processor

EGI contracts out claims processing, which accounts for most of the plan's administrative expenses.

EGI has traditionally hired a third-party administrator (TPA) to process its claims, and since 1990, has contracted with Great West Life and Annuity Insurance Company (Great West) for claims processing services. In addition, the board contracts with Great West to manage a prescription drug plan, provide medical services utilization review, and operate a disease management program. Further, as part of its contract, Great West provides EGI plan participants access to in-state and out-of-state provider networks with which the company has negotiated reduced fees. The board could unbundle some of these contracted services, but in recent years has voted to combine them under Great West.

EGI pays approximately $2 million per year for Great West services, which adds approximately 5 percent to the plan's overall claims expense. EGI payments to Great West are based upon a per-employee (defined as active employee or retiree) basis, with set fees for claims administration, utilization review, network access, and disease management services.

Consultant Services

In addition to claims processing assistance, the board also contracts with a benefits consultant for technical assistance. EGI has contracted with The Segal Company since 1990 to advise the board at meetings about common practices and latest developments in the industry, and to assist the board in obtaining and evaluating contractor bid proposals and in negotiating with providers. The consultant also provides an annual evaluation of the plans offered by EGI. Annual consultant expenses were $84,538 in 1999.

The plan also contracts with a benefit consultant to provide technical assistance.

Plan Funding

Health benefits have grown into a major component of labor costs, and now, providing a health insurance program to employees represents a substantial investment on the part of an employer. Employees also share in the medical expenses they incur by paying deductibles, co-insurance, and co-payments on prescriptions. Additionally, employees who insure their dependents through the plan pay a family premium.

For the FY01-02 biennium, the Legislature authorized approximately $98 million for the health insurance portion of EGI's budget. This includes anticipated payroll deductions for both the employer's contribution of $225 per employee per month ($54 million) and the estimated payroll deductions from employees who purchase family coverage through the plan ($40 million), authorization to spend investment income ($3.5 million), and an appropriation from plan revenue for administrative services ($860,000).

In FY00, the state paid about $26 million in premium contributions and employees paid about $23 million toward premiums. In addition to the monthly family premiums, the plan requires all employees to share in the costs of medical expenses they incur through cost-sharing features, such as deductibles and co-insurance. In 1999, employees paid almost $14 million in deductibles and co-insurance.

The state and its employees paid about $63 million in health insurance costs in FY00.

The plan held about $18 million in reserves at the end of 1999. EGI holds reserves for three main purposes. Reserves are held for incurred claims that have not been submitted, or for those that have been submitted but not paid. Reserves are also maintained for contingencies, because the plan does not purchase stop-loss insurance to protect against unexpected claims fluctuations. Finally, some reserves are discretionary and can be used by the board to fund its priorities, such as temporarily offsetting premium increases.

Claims totaled 94 percent of the plan costs, while about 6 percent were administrative costs.

Claims totaled about $38 million in 1999 and have remained relatively constant since 1997. Administrative expenses represent less than six percent of the claims cost, or about $2.3 million. Of this amount, about $1.9 million was paid to Great West, for its TPA services. The remaining $350,000 in administrative expenses covered the costs of consultant services, temporary staff services, and all in-house office expenses, including EGI staff salaries and board expenses.

Plan Participation

About 40 percent of the individuals in the plan are dependents.

At the end of 1999, the EGI plan had an estimated 23,700 insured participants; of them, about 60 percent were active employees and retirees, while approximately 40 percent were their dependents. Since the actual number of dependents was not available from EGI, the remainder of our demographic discussion is based only on employees and retirees, the primary insureds, in the EGI plan. We divided them according to whether they elect individual coverage (only for themselves), or purchase a family contract (includes themselves plus a dependent spouse and/or child(ren)). Between 1999 and 2000, the number of primary insureds decreased from 14,012 to approximately 13,626.[3]

The majority of primary insureds in the plan work for state government branches.

Participating Entities

Seven entities participate in the EGI plan (see Figure 1 below): community colleges; WCDA; Auditor's Office (referring to all state employees paid through the State Auditor's Office); UW; Pre-65 Retirees; Medicare Retirees, and COBRA participants. The majority of primary insureds, 52 percent, are in the Auditor's Office group.

Figure 1: EGI Entities

	# of Participants	% of EGI Total
Community Colleges	1,333	10%
WCDA	19	0%
Auditor's Office	7,067	52%
UW	2,530	19%
Pre-65 Retirees	1,099	8%
Medicare Retirees	1,424	10%

COBRA	152	1%
Total	**13,624**	**100%**

Source: LSO analysis of EGI-reported data.

Plan Options

Most participants are enrolled in the low-deductible plan.

EGI has two plan options: a low-deductible plan ($350 for individuals; $700 for families), and a high-deductible plan ($750 for individuals; $1,500 for families). The overwhelming majority of primary insureds, 82 percent, participate in the low-deductible plan; of them, 77 percent have individual coverage, while 23 percent have family contracts. The high-deductible plan has a more even spread: 54 percent are individual contracts, and 46 percent are family (see Figure 2).

Figure 2: EGI Plan Options

	Individual	Family	Total	**% of Total**
Low-deductible	8,530	2,585	11,115	82%
High-deductible	1,349	1,163	2,512	18%
Total	**9,879**	**3,748**	**13,627**	**100%**

Source: LSO analysis of EGI-reported data, March 2000.

EGI Sub-Groups

Both active and retired employees participate in the plan.

EGI has four sub-groups: active employees; pre-65 retirees; Medicare retirees; and COBRA participants. Figure 3 shows the percentage of primary insureds by sub-group for a representative month in 2000, the percentage of the totalpremium income each sub-group brings into the plan, and what percentage of claims each is responsible for.

This data indicates that active employees cost the plan proportionately less than other sub-groups. They accounted for 80 percent of the premium income, but incurred only 78 percent of total claims costs. Medicare retirees generated slightly more premium income than their claims costs during the reported month; both were about 9 percent of the totals. For the 2000 plan year, the board increased Medicare retirees' premiums to more accurately reflect their claims. However, early retirees' premium income

(10 percent) does not cover their claims cost (12 percent). Thus, actives are subsidizing early retirees in the plan.

Figure 3: Subsidization in Sub-Groups For a Representative Month in the EGI Plan

The majority of the premium income is paid by active employees.

	Number	Premium Income	% of Prem. Income	Claims Paid	% of Claims Paid
Actives	10,952	$2,832,505	80%	$2,584,345	78%
Pre-65 Ret.	1,099	$364,706	10%	$390,437	12%
Medicare	1,424	$308,329	9%	$294,281	9%
COBRA	152	$37,079	1%	$54,749	2%
Total	**13,627**	**$3,542,618**	**100%**	**$3,323,813**	**101%**[4]

Source: LSO analysis of EGI-reported data, March 2000.

EGI Offers a Conventional Fee-For-Service Plan With an Integrated PPO Network

Under a fee-for-service plan, participants are free to choose any provider.

Insurance is traditionally provided under a "fee-for-service" model, meaning participants are free to choose any provider to provide medical services. Participants either pay providers directly and are reimbursed by their health plan, or the provider submits a claim to the patient's insurance company for reimbursement.

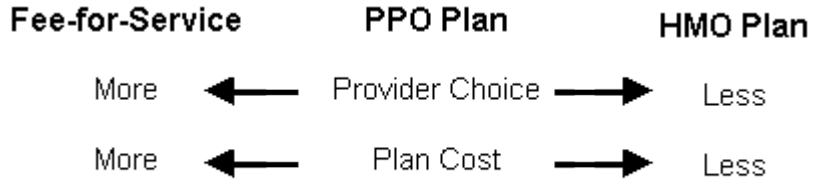
As plans faced increasing health care costs, many employers implemented "managed care" plans. Managed care plans offer financial incentives for participants to use the providers who belong to the plan. There are two common types of managed care plans: preferred-provider organizations (PPOs), which offer discounted rates with a group of providers; and health-maintenance organizations (HMOs), which contract for a set fee paid to providers to deliver medical services to members.

PPOs contract with a group of providers who offer discounted rates to the plan.

Figure 4 shows the differences between these three basic types of plans. According to insurance literature, fee-for-service plans allow more provider choice, but at higher costs to the plan. The EGI plan could be considered a conventional fee-for-service plan with an integrated PPO network. This approach allows participants the option of using managed care providers within the traditional fee-for-service plan. Participants can move fluidly between network and non-network providers, and receive

more or less reimbursement from the plan, depending on whether or not they use the network.

Figure 4: Level of Choice and Cost Along the Continuum of Provider Types



Source: LSO analysis of insurance industry literature.

Changes in Plan Costs

Cost-sharing features reduce plan costs and encourage cost consciousness.

According to health insurance literature, employers design plans with "cost sharing" features such as premium contributions, deductibles, and co-insurance to reduce plan costs and to encourage employee cost consciousness. Since 1996, EGI plan costs have increased for both the state and for employees. See Appendix C for more information on changes to participant costs over the past five years.

Health Insurance Premiums

In group plans, premiums are generally based on the average risk of the entire insured group. In other words, since individuals do not pay according to their specific risk, a degree of subsidization is built into traditional group plans. The extent of subsidization can vary from one group plan to another.

Employers who provide health insurance to employees determine how much of the premium cost the employer will absorb. In a noncontributory

Premiums for active employees have increased by 36 percent since 1996.

plan,the employer pays for the entire cost of the plan, while in a contributory plan,the employee shares in the cost of the plan. The state currently offers a noncontributory plan to individual employees and a contributory plan for employees who elect dependent coverage.

For the year 2000, the individual premium under the low-deductible option is $195 per month and $170 under the high-deductible plan.[5] Premiums for family coverage under the low-deductible plan are $451 per month and $391 under the high-deductible plan. Premiums for active employees have increased by 36 percent since 1996 for both individual and family coverage. Retirees pay higher monthly premiums, reflecting their increased risk to the plan. (See Appendix C for details.)

The Legislature has increased the state contribution by 29 percent since 1996.

The Legislature currently contributes $225 per month for each active employee, but does not contribute toward retiree premiums. Since 1996, the Legislature has increased the employer contribution to active employee premiums by 29 percent. Some community colleges contribute additional amounts to the family premium above the $225 contributed by the Legislature.

Since 1996, the employee share of the dependent premium has gone up 44 percent.

Employees who purchase dependent coverage through EGI can apply the employer's contribution toward the cost of the family premium. If they elect family coverage, employees pay $226 per month for their share of the family premium under the low-deductible plan; under the high-deductible plan, they pay $165 per month. Since 1996, the employee's share of the premium for dependent coverage has increased by 44 percent in the low-deductible plan and by 47 percent in the high-deductible plan.

Deductibles

Individuals who select the low-deductible option pay a $350 deductible, before the plan begins reimbursing expenses[6]; they pay $750 under the high-deductible plan. Families pay a $700 deductible under the low-deductible plan and $1,500 under the high-deductible plan. In 1999, deductibles under the low-deductible plan increased from $250 to $350 for individuals, and from $500 to $700 for families. The deductibles in the high-deductible plan haveremained constant since 1996.

Co-Insurance Rates

Co-insurance varies depending on the provider.

Co-insurance is the portion of medical expenses that the participant pays, after which the plan pays the remaining portion of the expenses. The plan pays 85 percent of the costs of services if participants use in-state network providers, or pays 80 percent on services if they use in-state non-network providers. The plan also pays 80 percent for out-of-state network providers. The plan pays only 60 percent of the services if a participant uses an out-of-state non-network provider in a network area. Co-insurance rates paid by the state decreased from 70 to 60 percent in 1997 for out-of-state non-network providers. In 1999, the board added an incentive to use in-state network providers by increasing the co-insurance paid for network providers from 80 to 85 percent.

Co-Insurance Maximums

The plan has a co-insurance out-of-pocket limit, above which the plan pays 100 percent of covered expenses. Individuals must pay co-insurance on the first$10,000 of covered services, or up to $15,000 of services if using out-of-state non-network providers. This means participants using in-state network providers have a maximum obligation of $1,500 annually in co-insurance. For family coverage, the service limit is $20,000 and $30,000 for out-of-state non-network providers. Therefore, using in-state network providers, families are liable for $3,000 in co-insurance annually. The total annual co-insurance obligation for individuals and families doubled in 1997.

Prescription Co-Payments

The prescription drug program has changed three times during the past five years. From 1996 to 1998, participants paid 80 percent co-insurance on prescription drugs, with these costs contributing toward the annual out-of-pocket maximum. In 1999, the board moved to a separate $250 deductible for prescription drugs with prescription costs still contributing toward the out-of-pocket maximum.

The prescription benefit has been "carved out" of the medical plan.

In 2000, the board "carved out" the prescription program from the medical plan, requiring participants to make co-payments on each prescription purchased. Participants pay $10 for generic prescriptions, $20 for preferred prescriptions, or $40 for non-preferred prescriptions. The plan covers 100 percent of the costs of the prescription beyond the co-payment. Currently,prescription drug expenses do not apply to either the deductible or the annual out-of-pocket maximums. Additionally, EGI sets no maximum out-of-pocket limits for prescription costs.

Health Care Costs Predicted to Continue to Increase Nationally

Rising health costs are not unique to the EGI plan or to Wyoming.

Rising health care costs are not an isolated phenomenon in either the EGI plan or in Wyoming. Nationally, health costs are a concern to employers and employees alike, as costs are expected to continue to increase.

After remaining relatively stable and low since 1994, health care costs started rising again in 1998. Further, they are predicted to rise more dramatically in the future: the U.S. Health Care Financing Admin-istration predicts that health care costs will grow at an average rate of 6.5 percent through 2008. Other sources indicate that insurance premiums will increase at an even greater rate. Experts have identified several factors that sparked increases in 1998 and will continue to increase costs in the coming decade:

- **Dwindling managed care savings:** Savings from managed care programs appear to be dwindling, as insurance plans become less restrictive in response to a managed care backlash. In a tight labor market, employers are willing to pay more for employee satisfaction.
- **Prescription drug costs:** Increases in prescription costs in insurance plans have been in the double digits since 1995, with pharma-ceutical cost increases reaching 17 percent in recent years. Experts attribute part of these increases to pharmaceutical manufacturers' increased use of direct-to-consumer advertising.
- **Aging population:** Health care costs increase as the population ages because the elderly generally require more health care.
- **Regulations and Technology:** State and federal mandates, high-cost medical technologies, and increased use of diagnostic testing are other factors that have increased costs.

The Current Plan Structure is Not Equipped to Address Rising Health Insurance Costs

Many factors that increase health costs are beyond the control of any one employer.

The EGI health insurance program represents a substantial cost to both the state and participants. The cost of insurance continues to increase for all employers, not just the state of Wyoming, and analysts predict these costs will continue to rise dramatically in the future.

It is critical to recognize that many factors that increase health costs are beyond the control of any one individual employer. Thus, employers need to anticipate that health insurance costs will likely represent an ever-increasing

share of labor costs. To some degree, a plan can impact health costs through cost-containment programs, and EGI has taken such steps.

However, the plan's ability to effectively manage costs in this complicated arena has been reduced by inherent limitations in its decision making structure. The individuals who administer the plan appear to be hard-working and dedicated to providing the best benefit to employees. Nevertheless, the staff and board have been given a very difficult task, due to the structural limitations we identify in the report. Plan observers noted that the EGI plan could be considered one of the largest insurance companies in the state, and yet we found little policy direction, few resources, and a lack of expertise dedicated to this major endeavor. This set of circumstances has constrained the ability of those administering the plan in their attempts to control costs.

However, limitations in the current plan structure make it difficult to effectively manage costs.

Two major studies have been conducted of the EGI plan in the past decade. The themes we identify in this report are consistent with problems identified in a 1991 report prepared by the State Auditor's Office, and a 1994 LSO program evaluation. Both studies noted that EGI participants paid more for health insurance than participants in other plans. We identified the same circumstances today, leading us to conclude that the current plan structure is not adequately designed to address the factors that increase costs to participants.

High participant costs identified a decade ago, continue today.

This report contains three findings about the cost-effectiveness of the plan and primarily focuses on the costs to employees who purchase dependent coverage through the EGI plan. In our first finding, we note that costs for EGI participants are higher than for participants in other plans. In our second finding, we note that the EGI pool is older and has fewer dependents than other plans. Our third finding discusses that EGI does not have sufficient policy direction or resources to proactively manage the plan.

EGI does not have sufficient policy direction and resources to manage the plan.

These three chapters have causal relationships: when insurance costs are high, the effect is that younger participants will opt out and purchase lower-cost coverage elsewhere. We believe EGI has not been able to more effectively control costs because of limitations within its current structure.

[1] See Appendix B for a listing of EGI's plan features.
[2] Consolidated Omnibus Budget Reconciliation Act of 1985 requires employers (state and local government employers of 20 or more, not federal) to continue offering group health insurance coverage under certain "qualifying events" (e.g., termination, less hours, divorce, death, etc.) for 18-36 months.
[3] The Wyoming Business Council withdrew from the EGI Plan, and, because of the conversion to a different payroll system at the Auditor's Office, EGI reported that it did not have accurate participation counts for many months. Since the data sources had slightly different numbers for primary insured participants, 13,624 and 13,627, as shown in the following figures, the average of 13,626 is cited.
[4] Due to rounding of percentages, those of premium income and claims paid do not total exactly 100 percent.
[5] This premium does not include the preventive dental premium of $8.02 for individuals and $8.86 for dependent coverage. If employees elect health insurance, they are required to select the preventive dental plan. Additionally, employees can elect to participate in the optional life insurance program, and the monthly premium depends on the age of the employee.
[6] Plan participants do not need to pay the deductible before receiving reimbursement for wellness care.

CHAPTER 2

Health Insurance Costs

Health Insurance is More Costly For EGI Participants

EGI participants pay more out-of-pocket costs than comparator plans we reviewed, especially for dependent coverage. As a result, participantscan obtain dependent health insurance at lower cost on the private market or, if they are married, through a spouse's plan. This reduces premium income to the EGI plan from individuals least likely to incur costs, leaving those employees who are likely to incur higher claim costs. We identified several reasons why EGI participants pay more for health insurance, including a low employer contribution, pool demographics, and inherent limitations in the plan's decision-making structure.

Out-of-Pocket Costs to EGI Participants are Higher Than Comparators

With relatively few exceptions, we found EGI participants pay a greater share of costs than participants in thecomparator plans we reviewed. We compared EGI participant premiums, deductibles, and annual co-insurance limits to those paid by participants in our eight comparators, some of which had more than one plan. The four states (Alaska, Montana, North Dakota and South Dakota) offered a total of seven different plans,6 while the four public-sector plans in Wyoming (Laramie County, Laramie County School District #1, City of Casper, and City of Cheyenne) offered one plan each.

We compared EGI participant costs to in-state and out-of-state plans.

All of the comparator plans are considered comprehensive major-medical plans and, based on our review, offer levels of coverage similar to EGI. General differences in plan costs are discussed below and in Figure 5, but for specific details about costs in each of these plans, refer to Appendix D.

We calculated the maximum obligation a participant would be expected to contribute annually for health insurance before the plan would pay 100 percent of covered services. We found that EGI participants with family coverage would incur significantly higher costs than comparators before the plan pays at 100 percent. An EGI participant would be liable for about $6,415 annually in out-of-pocket expenses, including premiums, deductibles, and co-insurance on services under the low-deductible plan. This is substantially more than the totals paid by participants in all of our

EGI participants are liable for about $6,400 annually before the plan

pays 100 percent.

comparators. The last column of Figure 5 shows the maximum out-of-pocket expenses for family coverage in each of the plans we reviewed.

Figure 5: Out-of-Pocket Expenses for Family Coverage in EGI and Comparator Plans

Plan	Employee Share Annual Premium	Annual Deductible	Co-Insurance Limit	*Annual Maximum*
EGI (low-deductible)	$2,715	$700	$3,000	$6,415
EGI (high-deductible)	$1,988	$1,500	$3,000	$6,488
Alaska	$984	$500	$1,000	$2,484
Montana (low-deductible)	$768	$600	$2,100	$3,468
Montana (high-deductible)	$348	$1,500	$4,000	$5,848
North Dakota (Basic)	$0	$600	$2,500	$3,100
North Dakota (PPO)	$0	$600	$1,500	$2,100
South Dakota (low-deductible)	$0	$1,250	$1,500	$2,750
South Dakota (high-deductible)	$0	$2,500	$1,500	$4,000
City of Casper	$1,230	$900	$2,000	$4,130
City of Cheyenne	$792	$300	$2,000	$3,092
Laramie County	$786	$500	$2,000	$3,286
Laramie County Schools	$477	$400	$2,000	$2,877

Source: LSO analysis of EGI and comparator-plan data.

The annual liability for EGI participants is double that of most of the comparator plans.

EGI Participants Pay a Higher Share of the Premium for Dependent Coverage

The employee's share of the family premium is significantly higher in the EGI plan.

EGI participants pay the highest dollar amount for family premiums of all the plans we evaluated. An EGI participant pays $226 per month for family coverage in the low-deductible plan; this is $123 or 119 percent more per month more than a participant pays for coverage in the next highest comparator plan, the City of Casper. An EGI participant pays $144 or 176 percent more per month than a participant in the next highest out-of-state comparator, Alaska.

EGI Participants Pay Higher Deductibles

Since most EGI participants are enrolled in the low-deductible plan, we compared deductibles paid in this plan with the four low-deductible options

available in the out-of-state plans. EGI participants pay higher individual and family deductibles than three of the four out-of-state, low-deductible plans. Participants in the EGI plan pay at least $100 more for both the individual and family deductibles than participants in these plans. The in-state comparators only offer one plan, and participants inall of these plans paid at least $50 less in individual deductibles than EGI; participants in three of the four also paid at least $200 less for the family deductibles than EGI participants.

EGI Participants Pay More Co-Insurance

At $1,500,EGI participants pay at least $250 more in individual co-insurance before reaching the annual maximum than participants in four of the seven out-of-state plans, and the same amount as participants in two of the plans. They pay at least $500 more family co-insurance than participants in three of the seven out-of-state plans. Depending on family size, EGI participants may pay more than participants in three other out-of-state plans. EGI participants also pay $500 more individual and $1,000 more family co-insurance than do participants in all of the in-state plans.

EGI participants pay $1,000 more in family co-insurance than in-state comparators.

EGI Participants Have Higher Prescription Costs

EGI participants pay more for prescription drugs than participants in two of the four states we reviewed. Additionally, EGI participants pay more for prescriptions than participants who use a mail-order program for maintenance drugs in two of the in-state comparators.

It is more difficult to compare prescription costs in the other plans we evaluated because, in addition to a flat co-payment for prescriptions, these plans require the participant to pay co-insurance. The out-of-pocket cost to the participant depends on the price of the prescription and may be more or less expensive than the co-pays required of EGI participants. Nevertheless, the co-pays are lower in every comparator plan. Furthermore, all of the comparator plans, except North Dakota, include a mail-order option for maintenance drugs with even lower co-payments. Montana and South Dakota also have an out-of-pocket maximum on prescription co-pays.

All but one of the comparator plans offer a mail-order drug program.

Higher Costs Lead Employees to Obtain Dependent Coverage Elsewhere

The effect of higher out-of-pocket costs on participants is that some then have a financial incentive to purchase dependent coverage on the private

market or to obtain dependent insurance through a spouse's plan. When employees can purchase dependent coverage less expensively elsewhere, in theory, a vicious cycle results: higher claim costs lead to higher premiums for the employees who remain, and more employees then purchase dependent coverage on the private market. This issue will be discussed extensively in Chapter 3.

EGI Has Implemented Cost-Containment Efforts to Mitigate Rate Increases

Many factors that increase costs are beyond an employer's control.

According to insurance experts, while many factors that affect health care costs are beyond an employer's control, there are specific actions employers can take to minimize the impact of rising health care costs. For example, they can work towards controlling or shifting the price of services, deterring unnecessary care, and reducing long-term costs by detecting and preventing illness. EGI has used all three of these strategies to manage costs, and it is likely that these cost-control efforts have moderated plan and participant expenses.

Nevertheless, there are actions that can minimize the impact of rising costs.

Negotiating with health care providers for discounts is one of the primary ways to control the price of services. However, according to insurance experts and literature we consulted during our evaluation, Wyoming providers currently face very little competition and the state has an almost non-existent HMO market. This makes it difficult to negotiate with providers for lower prices. Nevertheless, EGI has attempted to influence provider costs by offering participants the option of using Great West's PPO network. Great West reported savings to the plan from the network of $2.4 million for the 1999 plan year. Additionally, participants receive an incentive to use the network, in that they pay five percent less in co-insurance when using in-state network providers.

The plan has shifted more costs for services to participants.

EGI has also shifted more costs for services to participants by requiring them to pay a larger portion of health care costs out of pocket. According to experts, controlling the demand for services by passing costs on to participants provides a financial incentive to use services prudently. In the past three years, EGI has raised the deductible under the low-deductible option, decreased the co-insurance paid for out-of-state, non-network providers, doubled the out-of-pocket maximum for individuals and families, required co-payments on prescription drugs, and established retiree premium rates that more closely reflect the risks they represent to the plan. While cost sharing is a tool for the plan administrators to contain plan costs, this action may also help explain why EGI participants pay more for health care than do comparator plans we reviewed.

EGI has contracted for utilization review services through Great West to help deter unnecessary use of care. Services provided by Great West include pre-certification for hospitalization and surgery, case management for participants with chronic illness who need significant long-term medical supervision, and discharge planning to ensure hospital stays are only as long as medically necessary and to identify alternatives to extended hospital stays. In 1999, Great West estimated savings of $3.7 million, after fees, from its utilization review services.

This may help explain why EGI participants pay more for health care than comparators.

Finally, EGI has implemented programs to detect and prevent illness; many experts believe such programs are the key to long-term cost containment. EGI provides discounted diagnostic testing and free health screening, two approaches to early detection, and has also implemented a voluntary disease management program. It provides educational information to individuals with high-risk medical conditions, to help them manage their disease and control plan costs.

Additional Efforts May Help Minimize Cost Increases

In addition to the actions already undertaken by EGI to control claim costs, several other actions could further control plan costs:

- Pre-funding retiree benefits
- Contracting with a mail-order prescription program
- Conducting claims audits
- Implementing a member-audit program
- Targeting wellness efforts
- Implementing an employee education program

Additional measures may help to control claim costs.

However, as will be discussed in a later section and in Chapter 4, the plan may not have an optimal structure to implement further cost-containment programs.

Pre-Funding Retiree Benefits

Since 1995, EGI has increased retiree premiums to more accurately represent their actual costs and risks to the plan. As a result, retirees have seen their premiums increase dramatically over the past five years. The plan should consider alternatives to address retiree health care costs, especially since a large number of state employees are projected to retire in the next decade. The plan consultant has recommended the board and the Wyoming Retirement System study the feasibility of establishing a pre-funded retiree health insuranceprogram.

However, the current structure

is not equipped to address these issues.

Mail-Order Prescription Plans

Of all the in- and out-of-state comparators we reviewed, North Dakota is the only other plan besides Wyoming that does not offer a mail-order service for maintenance prescriptions. EGI officials stated the board is hesitant to implement such a plan because of the impact on local pharmacies. Although the board may have been keeping in mind the greater interests of the state, this is a decision that may mean higher prescription costs than could be obtained through a mail-order program.

Changing Premium Structures to Reflect Risk/Increase Accountability

Changing premiums to reflect risk could serve two purposes: it may control costs by giving participants a financial incentive to take better care of themselves; and it may reduce the amount of subsidization that exists in group plans by accounting for costs based on risk. South Dakota's plan age-rates its premiums, and includes lifestyle penalties such as an increased premium for smokers.

Claims Audits

According to literature we reviewed, plan administrators should conduct periodic claims audits to assess the level and accuracy of the claims administration services provided by the TPA. These audits help a plan ensure the TPA is neither under-paying nor over-paying claims. The plan consultant has recommended that the board conduct a comprehensive claims audit, as this has not been done since 1991 when Great West was selected as the TPA.

Member Audits

Experts also recommend member-initiated hospital bill audits as a method to reduce health care costs. Essentially, this program provides cash awards to participants who find errors on provider bills. All the out-of-state comparator state plans have implemented these programs.

Targeted Wellness Programs

As noted earlier, the plan demonstrated foresight by establishing wellness programs to control long-term costs. However, other than the disease management program, the plan's efforts have not been targeted to the greatest users of services. An insurance industry axiom is that 20 percent of health plan members use 80 percent of the services, so targeted efforts such as a disease management program are actually more cost-effective than generic wellness programs. Nevertheless, the plan increased its general wellness benefits to participants for the 2001 plan year. EGI might obtain better results for its investment by targeting certain risks and behaviors that drive up

plan costs, perhaps implementing smoking cessation and employee assistance programs.

Claim and member audits ensure proper payment of claims.

Participant Education

Experts we consulted and literature we reviewed note that the insulation of consumers from the direct costs of medical services is one of the primary causes of rising medical costs, and that employers do not adequately communicate with employees about how to control costs. EGI's main form of communication with employees is through a quarterly newsletter and annual employee benefit meetings. These efforts alone appear to be insufficient tools to communicate with plan participants. Other plans we reviewed send out wellness newsletters, have online wellness information, nurse help lines, and other educational aides to continually reinforce the message that unhealthy lifestyles lead to increased plan costs.

Targeted wellness and education programs attempt to change behaviors to reduce costs.

Factors Contributing to Higher Participant Costs

When we began our research, many plan observers speculated about the factors contributing to perceived high participant costs. We tested these theories, and identified three primary reasons why EGI participants pay higher out-of-pocket costs than do participants in the comparator plans.

The State Contributes Less to Family Premiums Than Comparators

A lower contribution for

The state's contribution to the family premium is significantly lower than the comparators we reviewed. EGI participants pay a higher percentage and a higher dollar amount for their share of the family premium than do

family coverage is the primary reason participant costs are higher than comparators.

employees in any of the other plans we reviewed. The state's contribution of $225 for each employee covers 50 percent of family coverage under the low-deductible option and 58 percent under the high-deductible option. The next lowest employer contribution is 71 percent that the City of Casper pays toward its employees' dependent coverage. All of the other comparators pay more than 80 percent of the family premium.

Demographics of Plan Participants Affect Cost

The effect of higher costs is that employees may not insure dependents through EGI, creating an older pool, as discussed in Chapter 3 and shown in the graph on page 32. This older pool helps explain why EGI has higher costs than the comparators we reviewed, since older individuals tend to incur higher claim costs. Because of the state's relatively low contribution toward family coverage, employees may look for other options to insure their dependents. This issue will be explained in Chapter 3.

EGI has an older pool than comparators, which increases costs.

Need for Additional Direction and Resources to Actively Manage Plan

Although EGI has taken steps to control plan costs, limited policy direction, resources, and expertise have made it difficult for EGI board members and staff to aggressively manage the plan to control participant costs. Since costs are predicted to continue to escalate, actions taken by any individual employer are not likely to produce an actual reduction in costs. However, proactive measures taken by plan administrators may help control the magnitude of future increases. We explain the impact of this issue in Chapter 4.

The current structure limits the plan's ability to control costs.

Other Factors Do Not Play a Significant Role in Higher Costs to EGI Participants

We considered other theories that participants and observers of the plan believed might be contributing to higher costs in the EGI plan. Our research revealed that taking the following actions would likely not produce significant cost savings to the plan:

- Reducing administrative costs
- Increasing managed care in the plan
- Purchasing insurance rather than self insuring
- Expanding the membership to other public entities

- Reducing reserves

Reducing Administrative Costs

Additional administrative resources may be needed to better control claims.

We believe it is unlikely there are administrative efficiencies the plan could undertake to further reduce plan costs. Chapter 4 presents evidence that the plan may not currently have sufficient administrative resources available to it for effective management. In fact, EGI may actually need additional resources to help it better control claim costs.

Total administrative expenses for the health insurance portion of the plan in 1999 were under six percent. This amount includes all services provided by Great West (claims administration, access to the PPO networks, and utilization review), consultant services, temporary services, and all in-house costs. Experts we contacted stated that, by industry standards, this is extremely low. Claim costs represent the bulk of plan costs and that is where health care plans can truly hope to control costs, not by further reducing marginal administrative expenses.

Claims represent the bulk of the costs, not plan administration.

Increasing Managed Care

According to insurance experts we interviewed, Wyoming does not have a significant managed care market that would allow the plan to negotiate more aggressively with providers to reduce plan costs. The plan has implemented a PPO network, as a voluntary option within its fee-for-service plan. Although EGI could consider offering the PPO option as a separate plan for employees willing to give up some provider choice for lower costs, it does not appear there is significant room for reduced fees, given Wyoming's current provider network.

Purchasing Insurance Rather Than Self-Insuring

Several observers suggested that purchasing coverage through an insurance company, rather than self-insuring, would reduce plan costs. However, all of the literature and experts we consulted recommend self-funding as the preferred approach for large plans because it saves money and allows the greatest flexibility in plan design. Nevertheless, coupled with that flexibility, self-funding requires proactive plan management, as is discussed in Chapter 4.

Although self-funding saves money, it requires proactive plan management.

In a self-funded plan, the employer pays the employee health care claims directly, rather than paying a set premium to an insurance company to provide coverage to employees. Large employers can self-insure because they are considered "credible" by insurance industry standards. Credibility means the pool has enough members to adequately spread the risk and accurately project costs based on plan experience.

Experts we contacted stated that if EGI were to purchase insurance, its rates would still be determined by the experience of its pool; moreover, it would face additional costs charged by the insurance company. Insurers include a profit margin and retention and risk fees in the premiums they charge employers. Another consideration is that as a self-insured plan, EGI generates interest income from its claims reserve and, until benefits are paid out, from invested contributions. Over the past five fiscal years, interest income has averaged $1.6 million per year to the plan; this is a revenue stream that would not exist if the state were to purchase insurance.

Expanding Plan Membership to Other Public Entities

We reviewed whether increasing the size of the EGI pool to include other public employers in the state would create economies of scale and increase negotiating power with providers. Experts we interviewed believed that the administrative savings created from economies of scale would be immaterial, and in fact, more resources might be needed to administer a larger plan. Further, these experts indicated Wyoming is a high medical-cost state and providers have little incentive to negotiate rates with insurance plans. From a public policy perspective, there may be interest in allowing groups that need to improve their costs to join the EGI pool. However, this action is not likely to reduce EGI plan costs.

Increasing the pool would not reduce plan costs.

Since the EGI plan is considered credible, adding additional members to the pool would not change the claims experience for the plan. Claims, not administrative expenses, make up the bulk of plan costs. The way to improve the claims experience of the plan is by bringing in large numbers of very healthy people or by improving the health of current participants, not just by bringing in more people. As one insurance expert put it, "bigger is bigger, better is better."

The way to improve claims experience is to bring in healthy individuals or improve the health of the existing pool.

We found that other public entities in the state offer insurance to their employees through a variety of mechanisms. Some self-insure, others purchase insurance from an insurance company, and yet others join in a multi-employer trust plan. Several insurance experts stated that only those public employers who could get lower costs with the EGI plan would want to join; if the objective were to lower premium costs, these would not be the groups EGI would want to include.

Given that EGI participants pay higher costs than other in-state public comparators, increasing the number of employers in the EGI plan would likely only compound the problems already faced in the plan. This is because the new employers would include employees with families, and those families could also likely purchase dependent coverage cheaper on the private

market. By the same token, those who would have a financial incentive to participate in the EGI plan would probably be higher cost individuals.

To reduce EGI plan costs, the state needs to focus on ensuring that the healthiest potential members of the existing pool have incentives to participate in the state's plan. It is harmful to the plan when employees purchase dependent coverage on the private market or through a spouse's employer, thus foregoing premium income to the EGI plan.

Increasing the pool at this time would likely compound the problems currently facing the plan.

Although increasing the EGI pool is not advisable, there may be opportunities for EGI to work with other public plans in Wyoming to negotiate provider discounts for services for each plan. Experts and literature we consulted noted that when individual plans band together to form purchasing alliances, they can increase negotiating power with providers. However, it is difficult to determine whether a purchasing alliance in Wyoming could affect provider rates, given the lack of competition among the state's medical providers.

Reducing Reserves

Another issue that some speculate is increasing costs to EGI participants is the level of reserves held by EGI. A majority of the reserves are retained for incurred but unreported and unpaid claims and to protect against claim fluctuations. However, there may be opportunities to reduce a portion of the reserves that is discretionary.

The plan consultant recommends that the plan maintain 20 percent of medical claims for claims that have been submitted but not paid, and for incurred claims that have not been submitted. EGI maintains about 15percent of claims inreserves for this liability. Additionally, the consultant recommends a minimum reserve equal to 10 percent of the medical claims for contingencies such as claims fluctuations, negating the need for stop-loss insurance. However, the board maintains approximately 16 percent of claims for unexpected fluctuations.

There may be opportunities to reduce discretionary reserves.

Finally, EGI also maintains a discretionary operating reserve, totaling just over $4 million in FY99. These monies are available to the board to use at its discretion to decrease premiums or enhance benefits. The EGI director stated that this portion of the reserves does not affect the financial stability of the plan, so this may be an area where the plan could consider reductions.

The EGI board has consciously drawn down its operating reserves in the last few years: in FY96-97, this category averaged $9.3 million. Because the board's focus and primary responsibility is fiduciary, we believe members

have been conservative with these monies. Additionally, because of the autonomous position of the plan, the board may feel it is necessary to keep a higher level of reserves than would otherwise be necessary. Revisiting the structure of the plan, as discussed in Chapter 4, may lead policy makers to consider whether or not this level of reserves is needed.

Due to its autonomy and fiduciary charge, the board has been conservative with reserves.

Actions Needed to Actively Manage Overall Plan Costs

Costs to EGI participants are significantly higher than those paid by participants in other public-sector plans in Wyoming and in other state government plans we reviewed. Consequently, it is not surprising that EGI participants have expressed dissatisfaction with the current plan and may be electing to purchase dependent coverage on the private market or through a spouse's employer, or perhaps may be leaving their dependents uninsured. A lower employer contribution for dependent coverage largely accounts for higher participant costs. Nevertheless, before requesting an increase in the contribution from the Legislature, plan administrators should analyze the level at which the contribution needs to be set to attract employees who are currently not purchasing dependent coverage through EGI.

A lower employer contribution accounts for higher costs, but analysis is needed before increasing it.

More active plan management is necessary to rectify the problems identified in this and previous reports. However, as we explain in the remainder of this report, there are limitations in the current administrative structure that make it difficult to take such steps. It will be important to address the fundamental structural limitations in the plan before taking specific actions to manage long-term plan costs.

It is critical to address structural limitations in the plan before taking specific actions to manage costs.

In the next chapter, we examine the financial disincentives in the EGI plan that discourage employees from purchasing dependent coverage through EGI. The board has not addressed issues of plan design that create such disincentives. Consequently, in Chapter 4, we contend that a new decision making structure is needed to most effectively manage costs in this difficult arena.

In this chapter, however, we make no direct recommendation regarding how to reduce participant out-of-pocket costs. We believe the best way to ultimately affect these costs is to implement the recommendation in Chapter 4 that deals with structural issues that affect plan management.

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6 The seven plans included a fee-for-service plan in Alaska, two fee-for-service plans in Montana with different deductible and premium options, a fee-for-service and a PPO plan in North Dakota, and two different PPO plans in South Dakota that offered different deductibles and premiums. All of these states also offered additional plans that we did not compare to EGI, including three cafeteria-style plans offered to certain employees in Alaska, three HMO options in Montana, an EPO (exclusive-provider organization) option offered in North Dakota, and a PCP (primary-care provider) option offered in South Dakota.

CHAPTER 3

Adverse Selection

Plan Has Disincentives For Young, Healthy Individuals to Participate

The EGI pool is older and has fewer dependents than our comparator plans. According to insurance industry theory, having an older pool has a compounding effect: it raises costs to the plan and increases average premiums, so eligible persons who are younger, healthier, and can obtain cheaper coverage on the private market, leave the plan. This makes the pool less healthy so that claims costs increase, and the cycle continues.

The EGI pool is older because younger and healthier individuals can obtain coverage less expensively elsewhere.

We believe aspects of the design of the plan create disincentives for younger and healthier individuals to participate in the EGI plan. For example, the state makes a lower contribution for dependents of employees than our comparators, premiums are not risk-rated, and the plan's tiers lacked analysis.

EGI Has Older Participants and Fewer Dependents Than Comparators

Compared to other public plans we examined within and outside of Wyoming, the EGI pool is older and has the lowest percentage of employees who purchase dependent contracts. This is a concern because there is a proven relationship between people's ages and the amount of health care costs they incur. On the whole, those who are older tend to be less healthy and have higher health care costs, while younger individuals tend to be healthier and thus less costly to cover.

There is a correlation between age and health care costs, with older individuals tending to incur higher costs.

Group premiums are basically determined by dividing the pool's total claims by the number of primary insureds. Premiums will be lower if there are individuals in the plan who contribute premium income and spread risk, but incur minimal claims. Thus, it is important for group plans to have a greater percentage of younger and healthier participants; the right balance can lower the overall costs to the plan.

Adverse Selection Is Occurring

Based on a number of demographic indicators we examined, we believe the EGI plan is experiencing a phenomenon called "adverse selection," where the composition of a particular group causes it to have higher costs. These indicators include: a number of employees electing not to insure dependents through EGI; a decreasing number of dependent contracts; an older participant pool and fewer dependent contracts than comparators; and, as discussed in Chapter 2, higher costs than our comparator plans.

Adverse selection occurs when a plan attracts individuals with health problems, creating disincentives for healthy individuals to participate.

According to insurance industry literature, when a plan tends to attract older persons or those with health problems who are more expensive to insure, it has adverse selection. In other words, younger, healthier and less costly individuals elect not to be part of a plan. Insurance experts state that healthy individuals can typically obtain less expensive coverage in the private market.[7] The assumption is that people will act in their best financial interest. Older and less healthy people are not likely to get cheaper coverage on the private market, so they have an incentive to stay in the plan, which in turn makes the plan more costly.

We cannot state with certainty that EGI is experiencing adverse selection, because the plan does not track demographic information about the universe of potential participants. We considered whether, rather than experiencing adverse selection, the eligible participants are simply older with few dependents. In this case, there would not be opportunities to insure a significantly higher number of dependents through EGI.

However, the demographic data we reviewed leads us to conclude that there are many employees who are electing not to insure dependents through EGI. Anecdotal evidence from a number of sources, including EGI officials and insurance experts in Wyoming, indicates that it is not unusual for EGI participants to insure their dependents on the private market. Further, if public sector workers in Wyoming are older, one would expect the four other in-state public plans we examined to have demographics similar to EGI's, but this is not the case.

Demographic data indicates that many employees may be electing not to insure dependents in the plan.

Many Employees Elect Not to Enroll Their Families in the EGI Plan

A primary indicator that the plan is experiencing adverse selection is the number of employees who are not insuring their dependents through EGI. As part of the total compensation study efforts, A&I contracted for a survey of state employees to gain their perspectives about the state's benefit package.[8] This survey found that 71 percent of respondents are married, and 50 percent have children. However, only 40 percent of all respondents enroll their family members in the EGI plan.

A majority of respondents to a

EGI Premiums Increasing,

recent benefit survey said they do not insure their dependents under the EGI plan.

Dependent Contracts Decreasing

Another indicator of adverse selection is the reduction in the number of employees who purchase dependent contracts. Over the past five years, as EGI premiums have gone up, the number of dependent contracts has gone down. From 1996 to 2000, in the low deductible plan, family premiums of actives increased by 36 percent, while coverage of their dependents decreased by 20 percent (see Figure 6).

In the high deductible plan, family premiums also increased by 36 percent. However, dependent participation of actives rose as well by 31 percent, which may have been due to the lower premium available under this option.

The number of employees who purchase dependent coverage has decreased 20 percent since 1996.

Figure 6: Dependent Contracts of Active Employees[9]

	2000	1999	1998	1997	1996
Low-Deductible Plan	2,341	2,622	2,852	2,965	2,916
High-Deductible Plan	573	478	409	423	438

Source: LSO analysis of EGI-reported data.

EGI Pool Is Older

EGI has an older pool of participants than the six comparators[10] reporting demographic information, shown in Figure 7, including in-state, public comparators. In 1999, EGI had the highest percentage of participants over the age of 54. EGI also had more participants over the age of 44 than all four of the Wyoming plans we reviewed.

Figure 7: Breakdown Of Ages In Comparator Plans In 1999[11]

	Under 35		35-44		45-54		Over 54		Total Over 44	
EGI	8,454	36%	4,163	18%	5,338	23%	5,459	23%	10,797	46%
S. Dakota	8,785	39%	5,700	26%	4,671	21%	3,149	14%	7,820	35%

EGI has the lowest percentage of young participants in its plan.

N. Dakota	25,015	49%	8,974	17%	8,407	16%	9,181	18%	17,588	34%
Cheyenne	753	51%	299	20%	251	17%	166	11%	417	28%
Casper	733	55%	255	19%	204	15%	138	10%	342	25%
Lar.Co.	383	48%	167	21%	127	16%	121	15%	248	31%
Lar. Co. Schools	1,747	44%	638	16%	966	24%	646	16%	1,612	40%

Source: EGI and comparator-reported data.

EGI Has Lowest Percentage of Dependent Contracts

EGI has a much lower percentage of employees who insure their family members through the plan than the comparators.

The ratio of dependent contracts in comparator plans also indicates adverse selection in EGI. Compared to seven[12] other public plans we reviewed that provided demographic information, EGI has the lowest percentage of employees purchasing dependent coverage (as shown in Figure 8). The ratio of individual to dependent contracts in the EGI plan is about 67 percent to 33 percent. Insurance experts state that the reverse of this ratio is ideal: 30 percent individuals and 70 percent dependents. This is because dependents such as children are generally young and healthy, and because they also add premium income to a plan.

Figure 8: Comparator Ratios of Individual to Dependent Contracts

The percentage of family contracts is much higher in the comparators, indicating adverse selection in the EGI plan.

	Individual		Family	
EGI	9,359	67%	4,653	33%
South Dakota	7,178	60%	4,871	40%
North Dakota	6,754	33%	13,872	67%
Montana	NA	40%	NA	60%
Cheyenne	191	32%	398	68%
Casper	143	29%	351	71%
Laramie County	95	30%	226	70%
Laramie Co. Schools	770	44%	993	56%

Source: EGI and comparator-reported data.

We believe EGI is experiencing significant adverse selection when measured against comparators. EGI has roughly half as many dependent contracts as two comparable state plans, North Dakota and Montana. Within Wyoming, all four comparators had proportionately more dependent contracts thanEGI; three of the four had more than twice EGI's percentage, and the fourth had 23 percent more dependent contracts than EGI.

Adverse Selection Has

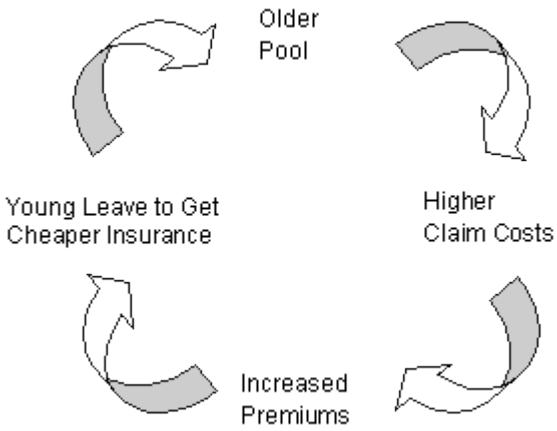
A Compounding Effect

Employees can obtain less expensive coverage for their families elsewhere.

In theory, adverse selection has a compounding effect (see diagram on the following page): having an older pool results in higher costs to the plan, and higher plan costs result in increased premiums. When young and healthy individuals can obtain coverage for less on the private market, they tend to do so. Remaining individuals who cannot get less expensive coverage elsewhere, stay in the plan. This again contributes to higher plan costs, and the cycle continues.

Figure 9: Cycle of Compounding Adverse Selection

Higher costs lead to increased premiums, creating financial disincentives to purchase dependent coverage through EGI.



Source: LSO analysis of industry literature.

The question of adverse selection revolves around participants who, because of the cost they incur, choose to buy coverage elsewhere for their young, healthy dependents. When participants' premiums are fully covered, as are singles in the EGI plan, they have no financial reason to opt out of the plan.

EGI Plan Design Creates Disincentives To Cover Young, Healthy Dependents

Aspects of the EGI plan structure are creating incentives for some employees to insure their dependents on the private market or through their spouse's plan. For example, EGI employees receive a lower employer contribution for dependent health insurance than the comparators because they do not receive a direct contribution from the state for dependent premiums.

It is important to design a plan that attracts as many young and healthy participants as possible.

According to expert literature, "Inherent in the principle of group insurance is the understanding that all employees can be covered." Since the intention of group plans is to spread risk among many participants, including high-cost individuals, it is important to design a plan to attract as many young, healthy participants as possible. This helps keep the average costs down. However, certainaspects of EGI's plan design provide disincentives for younger and healthier people to participate in the plan. In addition to the lack of contribution for dependents, other disincentives are: tiers that do not attract the young and healthy, premiums not rated according to risk, lack of choice, and open enrollment.

No Targeted Dependent Contribution

Employees who elect individual coverage in the EGI plan are fully covered by the state's contribution. Employees who elect dependent coverage can apply this contribution towards the family premium, but the state does not make a direct contribution targeted to covering the cost of dependent coverage. This is one of the factors contributing to adverse selection, since employees who can obtain coverage for healthy dependents elsewhere at lower cost, have incentives not to participate in the EGI plan.

Employers who pay a greater percentage of the premium can keep healthy participants in the plan.

A Wyoming consulting firm recently conducted an analysis of 12 Wyoming school districts that participate in the Educators' Benefit Trust. Their results show those plans that paid the majority of the family premium had lower premium costs for each primary insured. This suggests that when employers pay a high enough portion of the family premium, healthy employees or dependents will not leave the plan, and consequently, the plan will have lower costs.

EGI participants pay a higher percentage and higher dollar

amount for their share of the family premium than comparators.

As noted in the previous chapter, EGI participants pay a higher percentage and higher dollar amount for their share of the family premium than do the employees in all our comparators. We believe this factor contributes to EGI's low percentage of dependent contracts in the following way: when employers do not pay a substantial amount of the family premium, and healthy employees can purchase dependent coverage less expensively on the private market, they tend to do so. Losing those dependents leads to higher average claims costs and higher premiums for the remaining pool of employees who remain.

The degree to which the contribution affects adverse selection depends on what employees could pay elsewhere.

The degree to which the amount of employer contribution affects adverse selection depends on how much of the premium the contribution covers, compared to what the employee could pay elsewhere. According to experts, to avoid adverse selection, employers should ideally contribute 100 percent for employees and at least 50 percent for dependents. Even though the EGI employer contribution rates meet industry standards, if employees or dependents can get coverage cheaper elsewhere, adverse selection will continue. As will be discussed in Chapter 4, continual monitoring of a plan's design, benefits, and costs, in relation to what people can obtain elsewhere, is of critical importance.

Tiers Not Set to Attract the Young and Healthy

Another way to attract healthy people is by offering them a premium rate that reflects their lower degree of risk. Tiers are means of structuring different premium rates within a plan according to participant risk, thus providing for more equity in a plan. Without tiers, everyone in the plan pays the same premium regardless of their degree of risk or the amount of claims they incur.

Plans can attract healthy individuals by offering them a premium rate that reflects their lower risk.

EGI has traditionally offered two tiers: a single tier for an employee only; and a "family"tier that included an employee and dependent(s). Consequently, smaller families are subsidizing larger families since they pay the same amount for coverage regardless of family size. Effective January 1, 2001, EGI will add a third tier with a new premium rate for employees who insure themselves and a dependent spouse only, or themselves and a dependent child or children only.

More data is needed to ensure the tier is set at the optimal level to attract young dependents.

Although this change shows initiative on EGI's part, we believe that the board needs more data on the eligible participant population to ensure the tier is set at the optimal level to attract young dependents. For example, plan managers need to know the number of dependents not currently insured under the plan. Additionally, they need information about the level the premium should be set to create financial incentives for employees to insure their dependents through EGI.

It is critical that the board strategically set the new tier for it to have the desired effect. Unless the new tier attracts more premium revenue to offset its costs (which are being paid out of reserves in 2001), the board will need to increase family premiums. This premium increase may cause other dependents to leave the plan. Ironically, then, it is possible the net effect could be that more dependents leave the plan than come in with the new tier. We believe more ongoing data analysis is necessary to strategically manage the plan, as will be discussed in the next chapter.

EGI Premiums Are Not Based on Risk

There are a number of ways to risk-rate premiums, such as by age and personal habits like smoking. Setting premiums based on risk would serve as an incentive for the young and healthy to participate in a plan.

A proven correlation exists between age and the amount of health insurance used in general: the older the participant, the greater the claims. Because higher age is probably the single biggest determinant of cost, older persons pay higher premiums than the average young person, on the private market. However, since the EGI plan is not rated according to risk, older active employees pay the same premium as younger ones. Thus, the premiums of healthier participants are inflated, and those of sicker participants are lower than they would be in the private market.

In the EGI plan, the premiums of healthier participants are inflated compared to what they could pay on the private market.

The EGI board has taken some steps to rate retiree premiums to more closely reflect their risk. However, as discussed in Chapter 1, active employees are still subsidizing early retirees.

EGI Participants Lack True Choice

"Choice" in the health insurance context refers to a variety of arrangements, such as the ability to select among plans with different deductibles and premiums, among types of provider arrangements such as HMOs and fee-for-service, or among specific benefits within a plan such as vision and orthodontic. Other states we reviewed offer many more plan options in these three areas. Offering greater choice can better meet individual needs both in terms of benefits and costs. Theoretically, this could entice employees to insure their younger, healthier dependents in the EGI plan since they might perceive more personal benefit.

The out-of-state plans we reviewed offered more choice to participants than the EGI plan.

Currently, the EGI plan contains some choice regarding providers. Participants can elect to use PPO network providers and pay a

lower co-insurance rate. Participants are also free to choose their own out-of-network provider and pay a higher percentage of the cost.

The current plan provides a fixed package of benefits to all participants and does not allow participants to choose among different types of benefits to meet individual needs. Eighty percent of the respondents to the A&I benefit survey stated they would like the option of selecting which benefits are included in their benefit package.

Paying lower out-of-pocket costs appears to be a higher priority to EGI participants than having more benefit choice.

Nevertheless, based on interviews we conducted with employee representatives, paying lower out-of-pocket costs is a higher priority for EGI participants than having more benefit choice. However, the EGI plan lacks true choice when it comes to allowing participants to select between plans with different monthly costs. Although the plan has two deductible options, the premium for the high deductible plan is more than it should be, if it were based solely on claims experience. More accurately rating the premiums of the high and low deductible plans might make the high option more attractive to those participants interested in paying a lower premium and assuming greater risk.

Open Enrollment Contributes to Adverse Selection

With true open enrollment, a plan accepts eligible individuals not currently covered without restriction. Open enrollment has the potential to cause significant adverse selection, since it can draw in people who could not get coverage for less through the private market. EGI has open enrollment every two years, with some pre-existing condition limitations, which can help to mitigate adverse selection.

Even though open enrollment contributes to adverse selection, discontinuing it would conflict with the inherent principle of group plans, that everyone can be covered. Allowing open enrollment simply reinforces the importance of having a competitive plan in order to attract a healthy mix of participants and to mitigate adverse selection.

Actions Needed to Modify Plan Design

Plan design features create disincentives for employees to purchase dependent coverage through EGI.

The factors of plan design mentioned above appear to be disincentives for employees to purchase dependent coverage through the EGI plan. However, we do not make specific recommendations about what the plan should do to address adverse selection, because we believe the current administrative structure is ill-equipped to address these issues. Changing the administrative structure, as outlined in the

recommendation in the next chapter, is a necessary first step before plan administrators tackle plan design issues.

An employer's contribution for dependent coverage is an important factor in minimizing adverse selection.

For example, we found the primary disincentive to employees purchasing dependent coverage through EGI is the low employer contribution. Research shows that an employer's contribution for dependent coverage is an important factor in minimizing adverse selection. If the state were to make a targeted contribution for dependents of employees, our research strongly suggests that more dependents might be attracted into the plan. In this way, the state may experience less of an increase in long-term premium costs.

Analysis is needed to determine the contribution required to entice employees to purchase dependent coverage from EGI.

However, before requesting a direct contribution for dependent coverage, analysis is needed to determine the level of increased contribution needed to entice employees to purchase dependent coverage from EGI. Examination of these and other factors that are theoretically contributing to adverse selection in the EGI pool should be conducted before taking action on these issues. At the operational level, this information would benefit the plan by its potential to improve EGI's demographic composition and costs relative to other plans.

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[7] We were not able to obtain actual prices for family premiums on the private market, because insurance experts stated that pricing varies by family size and individual risk.

[8] 3,297 surveys were completed, representing 46 percent of the state's workforce.

[9] EGI does not track the total number of dependents in the pool, only the number of employees who purchase dependent contracts, which could cover anywhere from one participant's spouse or child, to a large family. EGI can only estimate the number of dependents covered under the plan.

[10] Age data was not available for Montana and Alaska.

[11] Comparator age-groupings are one to two years different from EGI in three categories: 36-45; 46-55; and Over 56.

[12] Data was not available for Alaska, and only percentages were provided by Montana.

CHAPTER 4

Plan Administrative Structure

Plan's Administrative Structure Limits Its Management Potential

Administrators must be able to strategically design and manage the plan.

By electing to become self-funded, the state health insurance board has, in a sense, formed its own insurance company. The potential benefits of self-funding are twofold: reducing costs and gaining flexibility in plan design to meet specific goals and needs. However, to optimally realize these benefits, the plan must be structured such that its administrators can adequately monitor costs and strategically design the plan.

Several factors, including a lack of overall direction from state policy makers, limited administrative resources, variable board expertise, and administrative isolation,limit the current plan's potential for realizing the benefits of being self-funded. Further, the plan's administrative structure has not allowed the EGI board to address the issues of high participant costs and adverse selection discussed in the previous two chapters. These complex problems require a long-term strategic approach that the current EGI administrative structure has not been able to provide.

Benefit Management Requires A Combination of Planning and Administrative Approaches

Plan administrators need the capacity to identify problems and research alternatives.

Managing a health insurance program is a complex undertaking that requires a myriad of day-to-day administrative responsibilities and processes. First and paramount, plan administrators must keep the plan financially solvent to meet the obligation to pay participant claims. Further, administrators must implement processes to address transactional responsibilities such as eligibility questions, complaints, enrollment details, and claims payments. Managing a plan that provides health insurance benefits also requires administrators to attend to an array of business responsibilities such as negotiating contracts and addressing legal requirements.

In addition, because of the rapid increase in health care costs and the changing workforce, administrators must strategically plan so that they can respond to current trends. They must be able to identify problems in organizational strategies and research alternatives that might address them. One expert summarizes that plan administrators need both the implementation skills of the practitioner and the ongoing inquiry associated with the consultant.

EGI Board Concentrates on Financial and Transactional Responsibilities

We found that the EGI board focuses on its financial responsibilities and administrative duties, but little on its planning role. Statute implicitly charges the autonomous board with full financial responsibility for maintaining the plan and assuring that it meets plan obligations. Members and observers of the EGI board see assuring that premium revenues cover medical claims as the board's primary responsibility.

Statute assigns a primarily transactional role to the EGI board.

Statute (W.S. 9-3-205) also assigns the board a list of transactional duties. These include establishing contract specifications, claims administration processes, participant eligibility rules, premium levels, and grievance procedures. The board itself makes decisions with regard to these matters rather than delegating them to its staff. It serves as the adjudicating body for all participant complaints relating to the allowance and payment of claims, eligibility for coverage, and other issues. Board decisions on these issues can result in plan benefit changes. The board also attends to such matters as approving all benefit booklet changes and all non-contractual administrative expenses.

The board has accomplished its overall responsibility of keeping the health plan solvent and meeting its benefit obligations.

Contracting responsibilities, a primary statutory assignment, occupy a good portion of the board's time. Statute gives the board authority to determine the intervals at which it will award contracts through competitive bidding, but requires annual review of contracts. In 1998, the board adopted a policy to re-bid its contracts at least every six years. Since then, the board has re-bid its major contracts twice, most recently in the summer of 2000.

Board Has Not Developed A Strategic Focus

Benefit experts agree that it is increasingly important to integrate benefits into overall compensation strategies. Yet, while EGI board members and officials are aware of this objective, it is not a guiding consideration in managing the plan. Although the head of the state's personnel division, who serves on the board by statute, brings this perspective, there does not appear to be a board-wide impetus to integrate the insurance benefit into the state's emerging compensation objectives.

There is not a board impetus to integrate insurance benefits into the state's emerging total compensation objectives.

Concentrating on eligibility issues, addressing complaints, and adjudicating claims are other ways in which organizations are reactive rather than strategic. Further, modifying benefits in response to complaints or problems, rather than to align them with an overall strategy, is another indication of a transactional approach. EGI meeting minutes indicate that the board is most often focused at this level.

While all of these are important processes, benefit organizations must also work at a higher level to identify and implement long-range objectives to improve employee benefits at stable costs. Plan observers and officials alike note that the EGI board tends to operate on a year-to-year basis, rather than planning strategically for the long-term. Its tactical focus is not surprising, given that the board and its staff interpret statute as giving the board sole authority for all decisions affecting plan management. One board member noted that the broad statutory authority leads to micro-management by the board, rather than a policy focus.

Benefit organizations must have the capacity to identify and implement long-range strategies.

Non-Strategic Approach Leaves Long-term Problems Unresolved

Although the board has accomplished its overall responsibility of keeping the health plan solvent and meeting its benefit obligations, it has not been able to address long-standing issues. These include the low ratio of dependent coverage discussed in Chapter 3, which leads to the high participant costs discussed in Chapter 2. In addition, the board's outside consultant has repeatedly recommended initiatives to improve the plan, but the board has not moved forward with them.

Board Has Not Addressed Low Dependent Ratios

Although board officials have been aware that many employees find it more cost-effective to insure dependents elsewhere, the board has been slow to address the problem. It has not directed an analysis of what plan design features may be contributing to this situation, and of what might reverse it by bringing younger, healthier participants into the

The board has not analyzed this situation.

plan. The board's general sense has been that the employer contribution needs to be increased. However, it has not determined at what level either to set the premium or to request a contribution increase to make it financially prudent for more employees to insure their dependents in the plan.

Other plan managers recognize that plans must be competitive to attract lower-cost participants.

The board relies on increases in the state contribution to offset premium increases for all plan sub-groups, rather than strategically targeting them to change plan demographics. This contrasts with other plan managers and experts we contacted who recognize that plans must be competitive to attract lower-cost individuals and thereby decrease costs for all participants. Further, as noted in Chapter 3, when establishing the third tier, the board did not strategically set the rate at a level it knew would prompt employees to insure their dependents.

Board Unable To Implement Consultant's Recommendations

Each year, the plan consultant provides an annual report in which it makes recommendations for the board's consideration that "may enhance the health benefit programs in the future." The recommendations have included:

These complex issues require a long-term planning process that the current board structure cannot support.

- Providing more employee choice
- Adding voluntary benefits such as long-term disability and long-term care
- Encouraging greater participation in the high deductible option by pricing it closer to its cost
- Implementing a voice enrollment system
- Establishing a way to allow employees to pre-fund retirement health insurance costs
- Developing a website
- Contracting for a comprehensive claims audit of claims administration

The board has not addressed these issues, even after repeated recommendation. According to the consultant, these are complex issues that would take a long-term planning process. As noted, the current EGI board structure does not supportthe strategic thinking that addressing these issues requires.

Board Does Not Continuously Study All Plan Aspects

Another effect of the board's transactional focus is that it limits its ability to study the plan. Statute directs the board to continuously study

the operation of the group plan, including such matters as costs, benefits, utilization of benefits, and claims administration. The board continuously monitors the plan aspects that directly relate to plan solvency. For example, members regularly receive information showing the plan's financial status, including its retained earnings; plan claim costs; participation by subgroup; and premium income to claim costs by subgroup. This is the information that the plan director sees as necessary to administer the plan.

The board regularly monitors only plan financial data.

However, the board inconsistently tracks other trend data that indirectly bear on the plan's financial status. It does not use demographic information to help design plan options to improve the demographic mix of participants. Nor does the board regularly track comprehensive health claims utilization information to determine the causes of plan health care cost increases. Analyzing this information would enable the board to determine how plan utilization has trended and how it compares with national benchmarks. It would also provide a basis to review plan design to see if changes could be made to control costs.

It does not consistently track other plan data that bear on the plan's financial status, such as health claims utilization.

As the board has changed or added benefits, it has not followed up with data analysis to determine whether those changes are producing the intended results. For example, the board substantially changed its prescription drug program in 1999 by carving it out and assigning co-pays to participants. There was some sense among board officials that this change might have contributed to the current favorable claims experience, but no data was assembled to determine its actual effect.

Further, during the course of our study, board members and officials attributed lower than expected claims to the plan wellness benefits implemented in years past. However, there had been no analysis of health care utilization information to determine if there were positive impacts that could be attributed to wellness interventions. Nonetheless, the board increased wellness benefits for the 2001 plan year.

Plan managers have not followed up with data analysis to determine the effects of benefit changes.

Variety of Causes Limit Board's Capacity to Act Strategically

We found that multiple factors combine to inhibit the board's ability to manage the health insurance plan in a strategic manner. These include a lack of policy direction, an organizational position independent of

state compensation planning, a lack of administrative resources and plan information, and variable board expertise.

Board Lacks Strategic Direction From State Policy Makers

Organizations should have clear direction on benefit strategies.

According to the professional literature, organizations should have clear and agreed upon direction with respect to their benefit strategies. Further, these strategies or philosophies should be revisited and updated periodically to ensure that they make sense in current conditions. Benefits experts write that many organizations are operating under benefit strategies developed years ago when completely different market conditions existed.

Plan statutes provide neither policy direction nor statement of purpose.

Statutes authorizing the state group insurance plan, dating from 1967, provide neither policy direction nor statements of purpose. Other than its decisions relating to the level of the state contribution, the Legislature does not communicate policy direction to the plan. The Governor is positioned to have a policy role, with two appointments and a high-level executive branch employee on the board. However, board officials and observers do not perceive policy direction coming from these appointments. Elected policy makers appear to defer to the board's autonomous authority to manage the plan in the manner it sees as prudent. Further, board officials believe that elected policy makers do not relish taking responsibility for the decisions encompassed in managing a health insurance program for state employees and retirees.

The board has inferred policy decisions that affect the plan.

As a result, the board has inferred the overall purpose of providing high quality health care services and containing costs. According to professional literature, this is the purpose that most employers express in offering health care benefits. However, lacking specific policy direction, the board has inferred many other policy decisions that affect that overall purpose. For example, the board has made the decision to cover retirees in the plan even though statute does not include them. Because the board has also subsidized retiree premiums, this decision has an impact on the overall plan costs.

Without policy direction, the board determines how to

Without specific policy direction, the board uses the state contribution in ways that it determines best serve the plan and its participants. For example, the most recent increase in the state contribution was approved by the Legislature in response to the Governor's request to offset premium increases. However, lower than expected claims in the current year enabled the board to put part of the increased contribution toward increasing wellness benefits. This change benefits participants, and potentially lowers future claims, but also increases overall plan costs. However, elected policy makers' intent may have been to offset

use state contribution increases.

employee premium costs rather than obligate the plan to a higher level of benefits.

Autonomous Board Isolated from Compensation Policy Planning

Benefits controlled by EGI board are critical to a total compensation plan.

Also inhibiting the board's ability to act strategically is its organizational isolation from the other state planning efforts. For example, in the 2000 legislative session, lawmakers authorized the Compensation Commission, an advisory group to the Governor, to study state employees' benefits for the purpose of developing a total compensation package. The Legislature did not direct this policy to the EGI board, even though group health insurance, as well as the other benefits controlled by the EGI board, are critical to a total compensation plan, should the state eventually implement one.

Board decisions may not correspond with policy makers' compensation plans.

If it moves toward a total compensation approach, the state will need the autonomous EGI board to modify its plan to fit state objectives. As noted, the board does not oppose a total compensation approach, but its focus is on the financial solvency of the plan. Developing a benefits package with more choice will increase the complexity of managing the EGI plan, and likely its costs. With different objectives, the board may make decisions in managing and modifying health care benefits that may not correspond with policy makers' compensation plans for the state workforce.

Already, board members have faced this dilemma. One former member noted that the board makes philosophical decisions that, in the private sector, are typically made by management. However, board members make these decisions with "only half the equation." The board member noted that it was uncomfortable increasing premiums without knowing how that affected the organization's overall compensation strategy.

Board Maintains Minimal Administrative Resources

Administrative costs affect plan premiums, so board purposefully keeps them low.

Having insufficient administrative resources also inhibits the board's ability to be strategic. EGI has a goal, as part of its strategic plan, to keep administrative costs at less than five percent of revenue collected. Board members have an incentive to keep these costs as low as possible, since administrative costs affect plan premiums. Also, board officials note that the Legislature has not approved EGI requests to increase the amount of plan revenue it allocates for administrative expenses.

The EGI plan, with a current biennial authorization of more than $98 million, is considered to be one of the largest entities providing health insurance in the state. However, only one staff member, the director, has technical expertise in the health insurance field. As a result, the director has a varied range of responsibilities, including determining plan premiums, monitoring plan financial data, providing technical assistance to the board, responding to complaints and grievances, and interpreting policy. Further, of the staff of seven, only the equivalent of two staff persons is fully dedicated to the health insurance program. Extensive turnover among the staff also diminishes administrative resources.

The plan has only one staff member, the director, with professional health insurance expertise.

According to the literature, plan policy makers need benefit personnel to analyze and summarize information and make recommendations in order to make informed decisions. Experts and administrators of other plans indicated that a higher level of professional staffing is more common. One expert noted, that given the size of the plan, it is more typical to have at least three professional staff positions, including the director.

Experts indicated a higher level of professional staffing is more common for plans of this size.

The EGI board retains a consultant to assist it in managing the plan. The consultant provides advice on industry practices and technical matters, an annual evaluation of the plan, and a neutral position to obtain bids and negotiate with contractors. However, the consultant does little actuarial study specific to the plan and primarily uses national standards for its recommendations. According to the EGI director, the board uses the consultant less because the director has the actuarial background necessary to manage the plan, and because consultant costs have increased.

Variable Board Expertise Impedes Strategic Planning

Reliance on professional advice is especially important to EGI board members because only one member is required by statute to have related expertise: the member representing the insurance industry. Further, board members may not serve long enough to develop their own expertise. The three elected board members serve non-staggered, two-year terms, and they reportedly tend to be voted off the board if it makes unpopular decisions, such as significantly raising premiums. Board officials and observers noted that board turnover affects the board because it takes one or two years for most new members to develop an understanding of board operations. Most board

Because of turnover, board members may not serve long enough to develop their own expertise.

members with whom we spoke indicated they relied on staff and the consultant for advice in managing the plan.

Attending to plan management details leaves little time for the board to develop a strategic approach.

The EGI board has struggled to develop a strategic, policy-level approach. The board has intentions to hold retreats to develop a more strategic focus. However, the logistics of coordinating schedules and bringing board members together from across the state have reportedly limited its ability to plan. Dealing with plan management already takes members away from their own work and responsibilities for eight to ten board meetings each year. Board committee work occurs, but is ad hoc. The board chair no longer assigns a committee that earlier boards used to look at policies, issues, and potential plan changes.

EGI Plan Lacks Management Information

Plan's management information capacity has not improved from that reported in 1994 LSO report.

A final impediment to being strategic is the board's lack of plan-specific information. The 1994 LSO report stated that EGI's data systems "prevent the easy generation of basic information." We found the same situation to exist today. To respond to our requests for basic information relating to the number of participants and financial information since 1996, EGI staff had to compile information from various computer spreadsheets and hard copy reports, some of which had to be retrieved from the state archives. Although EGI agreed with the 1994 LSO recommendation to develop an integrated management information system, this has not been done. EGI officials maintain that this has not been possible because the plan deals with payrolls from nine employers, and because state government lacks a comprehensive human resources database.

Information is necessary to identify plan design problems.

In order to strategically manage health insurance benefits, experts say that plan managers need data that allows a constant examination of the plan. Information is necessary to identify plan design problems and develop logical changes that address them. It is also necessary to monitor and evaluate responses to previous changes. Tracking such information as demographics of both current and potential participants, comparisons of the plan over time and with other plans, and claims utilization experience, is also recommended. Information helps managers decide how to adjust the plan or even to confirm the course of action being taken.

Although EGI lacks the system to generate this information for itself, it has access to much more information about plan participants than it currently uses through its claims administrator, Great West. Third party administrators typically have sophisticated systems and can gather claims and participant data. Plan managers must carefully

Plan managers do not request information available from the claims administrator.

design TPA contracts to get, in summary form, the information necessary to make decisions about the plan. The current Great West contract requires minimal information reporting, although the board could get more. According to the director, the board could obtain a variety of reports from Great West at no cost, but it does not request them because it does not use them.

Plan lacks sufficient professional staff to analyze and interpret available data.

It may not be feasible for the board to use more of the information available to it because it does not have sufficient professional staff to analyze and interpret the data. Experts maintain that while claims administrators can gather the data, the plan managers must take on the responsibility of using it to guide the plan. Our observation is that the EGI director cannot take on additional analytical duties. Without additional professional staff, the board is limited by the director's capacity to request, obtain, analyze, and present information.

Recommendation: The Legislature should establish a strategic framework to manage group health insurance.

EGI plan participants have faced the high costs we discuss in Chapter 2 for at least the last decade, as two previous reports have documented. This report, in Chapter 3, adds to the discussion by identifying plan design and demographic causes for the high costs. These problems require a strategic resolution, something the current plan management structure has not been able to accomplish. Now, as the state moves toward a total compensation concept and the integrated benefit strategies it would entail, these long-standing issues may become even more problematic.

High participant costs are long-standing issues that could become more problematic.

In this chapter we have identified several factors that impede plan management's capacity to address these issues strategically: a lack of policy direction, an organizational structure isolated from other state compensation operations, minimal administrative resources and management information systems, and a board with variable expertise providing overall direction. Addressing these factors is necessary to create a framework capable of strategically managing the plan.

Several factors must be addressed to improve plan

These causes, which limit the plan's strategic capacity, could be addressed while still maintaining the plan's current autonomous

management's capacity to address issues strategically.

structure. The EGI board could increase its staffing and management information resources to more strategically use information and personnel to manage the plan. Further, the executive branch could more purposefully use its appointments and statutory authority to provide policy direction to the board, and to reduce its isolation from other compensation planning activities. Finally, the Legislature could modify the statutes affecting board member terms and appointments to enhance board expertise.

Eliminate the current structure and create a professional plan administration function within A&I.

However, we believe that eliminating the current structure and creating a new framework for plan management may be the best way to address the causes that limit strategic management of the plan. Further,because of state government's move towards a total compensation approach, we believe the plan management should be directly combined with other compensation operations. Therefore, we recommend the Legislature disband the current policymaking board and create a professional plan administration function within A&I.

This integration will provide policy direction and coordinate benefit and compensation planning.

We believe that this integration is critical to address both the lack of policy direction and the isolation that exists under the current structure. Despite statutory provisions for A&I to advise the boardand serve as a liaison with the rest of state government, sufficient integration is not occurring under the current organization.

Taking this step will integrate the program with other compensation planning and will allow the Governor to directly provide policy direction to the plan. However, simply moving the function, without addressing the need for enhanced administrative resources and expertise, will likely not improve the state's ability to proactively manage this benefit. In particular, we see the need to ensure the plan is advised and staffed by more than one person with health insurance expertise. The plan's organizational location has already been changed a number of times over the years in an attempt to address long-standing frustrations with plan management. However, we believe the core of the problem is the factors identified in this chapter relating to policy direction, isolation, and insufficient resources and expertise. These factors must be addressed regardless of the plan's organizational placement.

Enhancing plan administrative resources and expertise is also critical.

If the Legislature chooses to integrate the group insurance program into A&I, it should also consider how to obtain input from participants. To ensure ongoing input, the Legislature should consider creating an

employee advisory board to provide participants' perspectives because participants fund the majority of their health care costs, when out-of-pocket as well as premium costs are considered. Further, such an advisory board would allow the university and community colleges, which also participate in the plan, to provide input regarding their employees' needs.

An employee advisory board could provide important participant input.

In addition to identifying organizational structure as a core problem for the plan, this report suggests that the current employer contribution for dependent coverage may not be adequate to avoid adverse selection. Once a strategic framework for plan management has been put in place, a first priority should be to conduct the necessary studies to determine if and how the state contribution might be increased and targeted to affect the plan's demographic composition. With that information, the plan managers would be in a position to more effectively advocate for an increase to the contribution. Additionally, the new framework will be better positioned to address other plan disincentives that appear to be affecting the pool's demographics and costs, as identified in Chapter 3.

With a strategic framework, plan managers can determine whether to increase or target the state contribution to change plan demographics.

CHAPTER 5

Conclusion

Employees are not receiving the expected level of management of their health insurance benefit.

Despite continuing attention to the plan, the core problems identified in this report have not been addressed. Simply moving the plan will not address these core problems: management resources and policy direction are also needed.

In the recent A&I survey, 90 percent of employees responding said health insurance is among the most important benefits provided by the state, and 85 percent ranked health insurance as one of the benefits needing improvement. By participating in an employer-sponsored plan, employees are relying upon their employer to provide the expertise to design and manage a comprehensive and complex benefit. However, we do not believe employees are receiving the expected level of management for this most important of all benefits.

For the past decade, and likely even longer, the state's group health insurance plan has been a high-profile program. The Legislature placed the plan with two different agencies before making it autonomous, and has changed its board composition several times. In recent years, the Legislature has increased the plan's funding twice and policy makers have discussed changing the board's organizational status. Despite this degree of attention, the core problems we identify in this report have not been addressed.

While we believe moving the plan into A&I to integrate it with broader compensation operations is necessary, simply moving it will not address these core problems. Plan administration also needs to have the resources and policy direction to enable it to operate more strategically. Strategic capacity will become more imperative as the state faces emerging workforce trends that will shape the type of benefits necessary to recruit and retain employees.

We conducted this evaluation at the same time another major effort is underway in the state's benefit arena. During the 2000 Session, the Legislature authorized the Compensation Commission to study the feasibility of implementing a total compensation package. Along with two other recent evaluations focused on personnel issues (employee turnover and deferred compensation), this report provides policy makers with additional information to use in conjunction with the Compensation Commission's work in deciding how best to meet the state's total compensation goals.

AGENCY RESPONSE

NOTE: Agency responses submitted on diskette are included on the Legislative Web Site (HTTP://WYOLEG.GOV). Letters submitted in written form are on file at LSO.

November 30, 2000

Senator Jim Twiford, Chairman
Management Audit Committee
Legislative Service Office
213 State Capitol
Cheyenne, WY 82002

Dear Senator Twiford:

On behalf of the Wyoming State Employees' and Officials' Group Insurance Board of Administration (Board), I am responding to your Report on Employees' Group Insurance (EGI).

The Board is pleased that State Legislators have requested a program evaluation of EGI. As the Employer, the State of Wyoming must be concerned that benefits provided promote the recruitment and retention of quality employees. It is vital that this program be reviewed and changed as needed to function as desired by the Employer. The Statutes grant to the Board the responsibility to administer the program, which they have, but it does not set forth a process by which the Employer can provide timely direction to the Board on major issues. This evaluation is the beginning of a process that will assist the Board to function, or cease to function, as intended by the Employer.

All Board members have received a copy of the Program Evaluation Report. Each Board Member was asked to submit their comments to me so that they could be included in my response to you. Because of the limited time to respond, the Board was not able to meet and discuss the details of the report.

The Board has no objections to the recommendations made in the report. One Board Member, Bruce Hooper from the University, suggested that "policy direction" should be of utmost consideration and that decisions with respect to that direction need to be made first and prior to decisions on resources, enhanced expertise and dramatically changing the structure.

The Board recognizes that decisions on the organizational structure and the major components of the program must be made by the Employer. The Board also recognizes that the amount that the Employer contributes toward employee benefits is determined by the Employer's total compensation policy and its ability to pay.

Restructuring the Group Insurance Program has often been considered in the past. It is appropriate that this issue be addressed and resolved.

In the meantime, the Board will continue to administer the current program during their elected or appointed term.

The Board and the staff of Employees' Group Insurance wish to thank the members of LSO staff, who conducted the review, for their courteous and professional approach.

Sincerely,
Darald Dykeman, Board Chairman
Employees' and Officials' Group Insurance Board of Administration
cc: Board

APPENDIX A

Group Insurance Statutes

ARTICLE 2: INSURANCE PLANS

9-3-201. Group prepaid plans authorized; agreements with insurance companies authorized; limitation on authorized plans and companies; payroll deductions; self-insurance programs.

(a) The state of Wyoming and its political subdivisions and school districts may obtain group prepaid plans or insurance for life, health, accident or hospitalization for their employees and for elected officials, except for members of the legislature, and enter into agreements with prepaid plans or insurance companies to provide this coverage.

(b) Prepaid plans or insurance shall be procured only from prepaid plans authorized to do business in the state of Wyoming or from insurance companies authorized to do business in the state of Wyoming and under the full jurisdiction of the Wyoming insurance commissioner.

(c) Upon a request in writing from any employee of the state of Wyoming, the state treasurer or the proper officer in any political subdivision or school district may deduct from the wages of the employee the amount of the premium which the employee has agreed to pay for the prepaid plans or insurance, and to pay or remit the payment directly to the prepaid plan or insurance company issuing the group plan or insurance.

(d) The state and any political subdivision are authorized to utilize a self-insurance program, provided that a defined plan with proper funding is first adopted and the cost of the plan is included in the annual budget and provided the self-insurance program includes any coverage mandated by Wyoming insurance law. Any self-insurance program, including the Wyoming state employees' and officials' group insurance plan, adopted pursuant to this section shall be within the jurisdiction of the insurance commissioner under the provisions of title 26, Wyoming statutes.

9-3-202. Short title.

This act shall be known and may be cited as the "State Employees and Officials Group Insurance Act".

9-3-203. Definitions.

(a) As used in this act:

(i) "Board" means the Wyoming state employees' and officials' group insurance board of administration;

(ii) "Carrier" means a private insurance company or health maintenance organization, as defined in W.S. 26-34-102(a)(vii) [26-34-102(a)(xvi)], holding a valid outstanding certificate of authority from the state insurance commissioner, or a nonprofit hospital service plan or a nonprofit medical service plan incorporated as a nonprofit corporation, either of which has had successful experience in the group health insurance field as determined by the commissioner of insurance;

(iii) "Dependent" means an employee's spouse, each unmarried child under the age of eighteen (18), including adopted children, stepchildren and foster children, and each unmarried child

between the age of eighteen (18) and twenty-three (23) years who is a full-time student in an accredited educational or vocational institution, and for whom the employee is the major source of financial support;

(iv) "Employee" means any official or employee of the state of Wyoming whose salary is paid by state funds, including employees and faculty members of the University of Wyoming and various community colleges in the state, except persons employed on intermittent, irregular, or less than halftime basis and any at-will contract employee who does not meet the requirements established under W.S. 9-2-1022(a)(xi)(F)(III) or (IV). Until July 1, 2004, "employee" shall not include employees of the agricultural extension service of the University of Wyoming who hold federal civil service appointments, are required to participate in federal civil service retirement and who elect to participate in the federal employees' health benefit program as authorized in W.S. 9-3-210(d);

(v) "Group insurance plan" means the health and life insurance plans defined in this section, the flexible benefits plan or any other group insurance coverages contracted for by the board, including disability insurance, as defined in W.S. 26-5-103(a);

(vi) "Health insurance plan" means a group insurance policy or contract or a medical or hospital service agreement or other health care delivery system provided by a carrier or carriers for the purpose of paying for or reimbursing the cost of hospital and medical care;

(vii) "Hospital and medical benefits" means hospital room and board, other hospital services, certain outpatient benefits, maternity benefits, surgical benefits, including obstetrical care, in-hospital medical care, diagnostic X-ray and laboratory benefits, physician's services provided by house and office calls, prescription drugs, outpatient psychiatric services and other benefits determined by the board. Benefits may be provided on a coinsurance basis, the insured to pay a proportion of the cost of benefits;

(viii) "Life insurance plan" means a group insurance policy or contract provided by a carrier for the purpose of providing life insurance;

(ix) "Official" means any elected or appointed state official who receives compensation other than expense reimbursement from state funds, except officials serving on an intermittent, irregular or less than halftime basis;

(x) "Supplemental health insurance plan" or "supplemental plan" means a group insurance contract or a medical or hospital service agreement provided by a carrier for the purpose of paying for or reimbursing the cost of hospital and medical care in excess of or supplemental to medicare or medicaid, or both, which employees or officials and their dependents may be eligible to receive. Supplemental coverage may consist of one (1), a combination of, or alternative plans in the discretion of the board;

(xi) "This act" means W.S. 9-3-202 through 9-3-213;

(xii) "Flexible benefits plan" means a plan of benefits established by board rules and regulations and adopted pursuant to the Internal Revenue Code of 1986, Title 26 of the United States code and qualified under § 125 of the Internal Revenue Code of 1986. The plan may include benefits authorized by the Internal Revenue Code of 1986 and related federal regulations which are consistent with Wyoming law.

9-3-204. Creation of state employees' and officials' group health insurance board of administration; members; meetings; quorum; officers; compensation.

(a) The state employees' and officials' group health insurance board of administration is created, consisting of seven (7) members. One (1) member of the board shall be the state treasurer who shall not send a designee. Three (3) members shall represent the employees of the state of Wyoming. One (1) member shall be a retired employee of the state of Wyoming, one (1) member shall be a person with a background in health insurance and one (1) member shall be the administrator of the human resources division of the department of administration and information. The attorney general shall serve as legal advisor to the board, attend all board meetings but have no vote. The insurance commissioner shall serve as insurance advisor to the board and attend all board meetings, but have no vote.

(b) The board members representing the employees shall be elected for terms of two (2) years, but not more than two (2) employees shall be elected from the same agency. The procedure for the election shall be established by the two (2) state officials designated as board members in subsection (a) of this section. Elections shall be held between May 1 and May 31 in odd-numbered years. At elections, all employees who are enrolled in the health insurance plan at the time of the election are entitled to vote. The vacancy of an elected employee board member shall be filled by the employee receiving the highest number of votes at the preceding election who is not employed by an agency which already has two (2) employees on the board. The board member who is a retired employee and the board member with a background in health insurance shall be appointed by the governor for a term of two (2) years and may be reappointed.

(c) The board shall meet within thirty (30) days after each biennial election of the representatives of the state employees, and at the meeting, the board shall select a chairman and vice-chairman from among its members who shall serve until their successors are selected.

(d) A majority of the members of the board constitutes a quorum for the transaction of official business. The board shall meet upon call of the chairman as often as necessary to carry out its responsibilities under this act.

(e) The board shall employ a director, who shall also serve as secretary of the board. The board shall employ personnel as provided in W.S. 9-2-1005(b)(iv) and 9-2-1022.

(f) State employee members of the board shall suffer no loss of wages for the time devoted to the duties of the board. All members who are state employees and employees of the board shall be reimbursed for their expenses incurred through service on the board at the same rate provided under W.S. 9-3-102 and 9-3-103. Each board member not employed by the state shall while engaged in official board duties, receive salary and per diem allowance in the same amounts provided for members of the legislature under W.S. 28-5-101 and transportation reimbursement provided state employees under W.S. 9-3-103.

9-3-205. Administration and management of group insurance program; powers and duties; adoption of rules and regulations.

(a) The board shall administer and manage the state employees' and officials' group insurance program and, subject to the provisions of this act:

(i) Shall prepare specifications for the health insurance plan and a supplemental plan, the life insurance plan and any other group insurance plan contracted for by the board;

(ii) Shall contract with carriers to underwrite group or supplemental insurance plans;

(iii) Shall determine the methods of claims administration under group insurance or supplemental plans, whether by the state or carrier or both;

(iv) Shall determine the eligibility of employees, officials and their dependents to participate in group insurance and supplemental plans;

(v) Shall determine the amount of employee payroll deductions;

(vi) Shall establish a procedure by which the board shall hear complaints by insured employees concerning the allowance and payment of claims, eligibility for coverage and other matters. Unless otherwise provided in the group insurance or supplemental plan or plans, any decision of the board upon complaints is not binding upon either the employee or carrier and the provisions of the Wyoming Administrative Procedure Act shall not apply to the proceedings. The group insurance or supplemental plan or plans may provide that the decision of the board shall be binding upon both the employee and the carrier as to certain disputes and in such event the procedure adopted by the board shall conform to the provisions of the Wyoming Administrative Procedure Act;

(vii) Shall administer state group insurance reserve monies; and

(viii) Shall continuously study the operation of the group insurance plan including such matters as gross and net costs, administrative costs, benefits, utilization of benefits and claims administration;

(ix) May enter into a contract with a carrier to underwrite a supplemental plan and negotiate and enter into amendments to existing health insurance contracts to provide a supplemental plan and determine an effective date;

(x) May determine that employees, officials and their dependents who are eligible for medicare or medicaid, or both, shall be eligible for a supplemental plan and, upon the effective date of the supplemental plan as to employees, officials and their dependents presently covered by the health insurance plan, may transfer them from the health insurance plan to the supplemental plan;

(xi) May negotiate and enter into amendments to existing contracts providing group insurance and supplemental plans to provide appropriate coverage for employees and officials who may become eligible for coverage after the effective date of those contracts and to provide for their enrollment;

(xii) May contract with carriers to underwrite optional group insurance plans which may be additions to or supplemental to those plans contracted under this act and which are paid for entirely by state employees and officials, entirely by the state, or by both. The contracts shall be designed to provide the fullest benefits at the lowest cost, and the board may contract with the same carriers for the optional group insurance plans as for the other plans contracted for under this act;

(xiii) May contract with any person for the furnishing of actuarial services, the preparation of specifications for group insurance plans and other specialized services which cannot be performed by the board or by state employees. Contracts for these services shall be awarded through responsible competitive bidding at intervals as the board determines, and shall be reviewed annually by the board;

(xiv) May develop, implement and administer a flexible benefits plan and may contract with carriers, third-party administrators or other professionals to develop, administer and implement a flexible benefits plan;

(xv) May delegate to its executive director any administrative duties as are necessary to the daily functioning of the board including the ability to authorize payments from the trust and agency fund as set forth in W.S. 9-3-213(b).

(b) The board shall adopt rules and regulations consistent with the provisions of this act as necessary to carry out its statutory duties and responsibilities.

(c) For the purposes of determining financial condition, ability to fulfill and the manner of fulfillment of its statutory duties, the nature of its operations and compliance with law, the insurance commissioner shall examine the affairs, accounts, records and assets of the Wyoming state employees' and officials' group insurance plan, as often as he deems advisable but not less frequently than every three (3) years.

9-3-206. Specifications for insurance plan; submission of bids; change of carriers; notice of rate changes or intent of carrier not to renew; premium tax exemption.

(a) The specifications drawn by the board for the health insurance plan shall include hospital and medical benefits, and comparable benefits for employees who rely solely on spiritual means for healing. The specification drawn by the board for the life insurance plan and any other group insurance plan shall include benefits as determined by the board. Bids shall be submitted to the board within time limits established by the board and, in addition to the carrier's cost proposal, shall include an explanation of the method of claims administration proposed by the carrier and the cost thereof, the amount of total premiums to be retained by the carrier, the purpose for which these retained funds would be allocated, and other information requested by the board.

(b) The board may:

(i) Call for bids and change carriers at its discretion;

(ii) Terminate an existing contract at any time upon sixty (60) days notice in the event of unsatisfactory performance or noncompliance with the terms of the contract by the carrier.

(c) Any carrier under contract with the board shall give the board sixty (60) days notice of any proposed rate change in the contract specifications or intent not to renew the contract. If the board and the carrier agree during the sixty (60) day period to any rate change in the specifications, the board may renew the contract, as changed, without reopening to bids.

(d) If the board decides to change carriers or to reopen bids on the underwriting of any aspect of the group insurance plan, it shall follow the same procedures in the selection of a subsequent carrier as it did in awarding the initial contract.

(e) Any carrier underwriting any portion of the state's group insurance plan is exempt from paying premium taxes under W.S. 26-4-103 on that portion of its business representing premiums collected from the group insurance plan.

9-3-207. Eligibility for membership in plan; state employees; 31 day period to elect enrollment; new employees; later enrollment.

(a) Any state employee eligible for membership in the group insurance plan at the time the plan becomes effective shall have thirty-one (31) days to either elect to be enrolled or not be enrolled in the plan. The board shall establish the procedure by which eligible employees shall notify the board of their decision within the prescribed thirty-one (31) day period.

(b) An eligible state employee who enters state service has thirty-one (31) days from the initial date of employment to elect to be enrolled or not be enrolled in the group insurance plan.

(c) Employees who elect not to be enrolled within the time prescribed in subsections (a) and (b) of this section may be enrolled at a later date upon conditions the board may impose, such as a physical examination or the exclusion of preexisting conditions from coverage.

9-3-208. State officials; 31 day period to elect enrollment; newly appointed or elected officials; later enrollment.

(a) State officials eligible for membership in the group insurance plan at the time the plan becomes effective shall have thirty-one (31) days to either elect to become enrolled or not become enrolled in the plan. The election shall be made according to procedures established by the board.

(b) Eligible state officials appointed or elected after the effective date of the group insurance plan have thirty-one (31) days after the date they officially take office to elect to become enrolled or not become enrolled in the plan.

(c) Eligible state officials who elect not to become enrolled within the time prescribed in subsections (a) and (b) of this section may be enrolled at a later date upon conditions the board may impose, such as a physical examination or the exclusion of preexisting conditions from coverage.

9-3-209. Dependents; election of coverage; later election; change in number of dependents.

(a) Any eligible employee or official may elect to have his dependents covered by the group insurance plan. The election shall be made at the time the employee or official becomes enrolled in the plan, under procedures the board may establish. If dependent coverage is not elected at the time that an employee or official becomes enrolled in the plan, dependent coverage may be elected at a later date under conditions the board may impose, such as physical examination or the exclusion of preexisting conditions from coverage.

(b) Any employee or official who has elected to have his dependents covered as provided in subsection (a) of this section, and who subsequently has a change in the number of his dependents, may at the time of the change increase or decrease the number of his dependents covered by the group insurance plan under procedures established by the board.

(c) Any employee or official who has no eligible dependents at the time he becomes enrolled in the group insurance plan, and who later has an eligible dependent may, at the time his dependency status changes, elect coverage for the dependent under procedures established by the board.

9-3-210. Amount of state's contribution; estimates submitted to state budget officer; specified employees participation in federal program.

(a) The state shall contribute monthly the amount established and appropriated by the legislature for each employee and official enrolled in the plan in accordance with subsections (b) and (c) of this section.

(b) Any state agency, department or institution, including the University of Wyoming and the community colleges in the state, shall pay monthly to the board the amount established and appropriated by the legislature for each eligible employee or official electing to become covered by any portion of the group insurance plan as the contribution of the state to that plan during the period the employee or official is enrolled in the plan. If the monthly premium for coverage of the employee or official is less than the amount established and appropriated by the legislature, the balance may be applied to the premium for coverage of dependents, or to the premium for any optional group insurance coverage made available by the board, if so elected.

(c) Each state agency, department or institution, including the University of Wyoming and the community colleges in the state shall estimate the amount required for its participation in the group insurance plan for the next biennium and shall submit the estimate to the state budget officer at the time the state budget officer makes the request.

(d) Until July 1, 2004, notwithstanding any other provision contained in W.S. 9-3-201 or the State Employees' and Officials' Group Insurance Act, employees of the agricultural extension service of the University of Wyoming who hold federal civil service appointments and are required to participate in federal civil service retirement may elect to participate in the federal employees' health insurance program. For eligible employees participating in the federal employees' health insurance program the state shall contribute monthly an amount toward the federal employees health insurance program costs which is in excess of the federal contribution thereto but which does not exceed the amount which would otherwise be paid under subsection (a) of this section if the employee were enrolled in the state group insurance plan.

9-3-211. Deductions from salaries of monthly contributions by employees and officials; establishment of procedure.

The amount of monthly contribution to be made by eligible employees and officials enrolled in the group insurance plan for themselves and their dependents shall be deducted from the monthly salaries of the employees and officials by the various agencies and remitted to the board. The procedure for deductions and remittances shall be established by the board. If a flexible benefits plan is chosen, the employees' and officials' contribution shall be applied to the chosen benefits in an amount determined by the employee or official.

9-3-212. Repealed by Laws 1987, ch. 194, § 3.

9-3-213. Treasurer of monies; bond; deposit in trust and agency fund of premium cost payments, dividend payments and return of premiums; expenditures; investment of excess portions.

(a) The state treasurer shall be the treasurer of monies under this act, and his general bond to the state of Wyoming shall cover all liabilities for his acts as treasurer. The board shall remit to the treasurer for deposit in the trust and agency fund all payments received by the board for the group insurance premium costs from employees and officials, and the state agencies, departments and institutions. The board shall also remit to the treasurer for deposit in the trust and agency fund any dividend payments and return of premium received by the board from any carrier underwriting the group insurance plan. All remittances shall be made as soon as possible after they are received.

(b) Expenditures shall be made from the trust and agency fund, upon certification of the board to the office of the state auditor, only for the following purposes:

(i) The payment of premiums to any carrier underwriting the group insurance or supplemental plan or plans; and

(ii) The state's cost of administering group insurance and supplemental plans, subject to annual appropriation by the legislature based on the submission by the board of a budget request containing detailed information on current and projected administrative costs.

(c) The board shall certify in writing to the state treasurer for investment portions of the monies which in its judgment will not be needed for the payment of premiums to the carriers underwriting the group insurance or supplemental plans.

9-3-214. Repealed by Laws 1987, ch. 194, § 2.

9-3-215. Repealed by Laws 1987, ch. 194, § 2.

9-3-216. Repealed by Laws 1987, ch. 194, § 2.

9-2-2008 Department of administration and information created; director appointed; structure.

(d) The Wyoming state employees' and officials' group insurance board of administration is assigned to the department as follows:

(i) The department shall provide budget, fiscal, administrative and clerical services to the Wyoming state employees' and officials' group insurance board of administration, if it requests these services, but shall not affect its authority. The positions, personnel, property, appropriated funds of the board and any funds the board administers under W.S. 9-3-202 through 9-3-213 shall not be transferred to the department. If the board requests any of the services described in this paragraph it shall compensate the department for them at a reasonable rate established by the department. In addition to offering the optional services specified in this paragraph, the department shall:

(A) Provide administrative oversight of the board's procedures to assure that it is in compliance with existing statutes that created it and that govern its functions;

(B) Provide guidance to the board in matters pertaining to budget preparation, administration, personnel and other procedural functions;

(C) Function as a liaison between the board and other agencies within state government;

(D) Review the current practices of the board and make recommendations to it which might improve its efficiency.

APPENDIX B

EGI Major Medical Plan Features

EGI Benefits and Coverage

Summary of Medical Benefits	
CALENDAR YEAR DEDUCTIBLE	
The calendar year deductible applies to all covered expenses except those payable at 100% and wellness services.	
• Medical Expenses – Option I (not available to Retirees eligible to Medicare)	$350.00
Individual	$700.00
Family	
• Medical Expenses – Option II	$750.00
Individual	$1,500.00
Family	
MEDICAL MANAGEMENT PENALTY COINSURANCE FOR INPATIENT HOSPITAL EXPENSES	60%
MEDICAL MANAGEMENT PENATY FOR OUTPATIENT SURGERY	$250.00
PERCENTAGE PAYABLE FOR COVERED SERVICES	
Cost-Effective Services	
• Home Health Care	100%
• Hospice Care	100%
Inpatient and Outpatient Hospital Care	
• Wyoming Network Hospitals	85%
• Wyoming Non-Network Hospitals	80%
• Network Hospitals outside of Wyoming	80%
• Non-network Hospitals outside of Wyoming	60%
Physician charges for Surgery and Hospital Care	
• Wyoming Network Physicians	85%
• Wyoming Non-Network Physicians	80%
• Network Physicians outside of Wyoming	80%
• Non-network Physicians outside of Wyoming	60%
Office visits including Wellness Care	
• Wyoming Network Physicians	85%
• Wyoming Non-Network Physicians	80%
• Network Physicians outside of Wyoming	80%
• Non-network Physicians outside of Wyoming	60%
Emergency Room Treatment	
• Emergency services	80%
• Non-emergency services	
- If surgery is not performed	80%
- If surgery is performed	
✶ Wyoming Network Hospitals	85%
✶ Wyoming Network Physicians	85%
✶ Wyoming Non-Network Hospitals	80%
✶ Wyoming Non-Network Physicians	80%

✶ Network Hospitals outside of Wyoming	80%
✶ Network Physicians outside of Wyoming	80%
✶ Non-network Hospitals outside of Wyoming	60%
✶ Non-network Physicians outside of Wyoming	60%
Other Covered Expenses	80%
CALENDAR YEAR BREAKPOINT – NON-NETWORK PROVIDERS OUTSIDE OF WYOMING	
• Individual	$15,000.00
• Family	$30,000.00
CALENDAR YEAR BREAKPOINT – ALL OTHER PROVIDERS	
• Individual	$10,000.00
• Family	$20,000.00
BENEFIT MAXIMUMS	
• Lifetime inpatient mental/nervous	60 days
• Lifetime inpatient substance abuse	2 series of treatments
- First series of treatment of substance abuse	20 days
- Second series of treatment of substance abuse	10 days
• Calendar year outpatient mental/nervous and substance abuse	50 visits
• Lifetime outpatient mental/nervous and substance abuse maximum	420 visits
• Calendar year home health care visits	100
• Calendar year skilled nursing facility days	180
• Hospice inpatient days	180
• Hospice bereavement	$300.00
• Specified therapies per visit (covered amount)	
- Manual manipulation of the musculo-skeletal system	$37.50
- Other specified therapies	$50.00
• Calendar year specified therapies	30 visits
• Air ambulance per trip	$5,000.00
• Organ transplant maximums	
- Organ and tissue procurement per transplant benefit period	$25,000.00
- Transportation, lodging and meals per transplant benefit period	$10,000.00
✶ Covered lodging and meals per day	$200.00
- Private duty nursing care per transplant benefit period	$10,000.00
• Maximum Benefit for ALL covered expenses (per covered person)	$2,000,000.00
Summary of Prescription Drug Benefits	
Percentage Payable	
• Generic Drugs	100% after $10.00 co-pay
• Brand Name Drugs	
- Preferred Drugs and Neutral Drugs	100% after $20.00 co-pay
- Non-Preferred Drugs	100% after $40.00 co-pay
Prescription drug co-payments do not count toward the health plan deductible or calendar year breakpoints.	

Source: The Wyoming State Employees' and Officials' Group Insurance Plan Employee Benefit Booklet.

APPENDIX C

EGI Participant Costs 1996-2000

Low-Deductible Option (Individual)	2000	1999	1998	1997	1996
Individual Premium	$195.00	$168.10	$156.50	$156.50	$143.58
Employee Share of Individual Premium	$0	$0	$0	$0	$0
Employer Share of Individual Premium	$225	$200	$175	$175	$175
Percent Paid by Employer[1]	115%	119%	112%	112%	122%
Deductible	$350	$350	$250	$250	$250
Prescription Drug Deductible[2]	N/A	$250	N/A	N/A	N/A
Co-Insurance Maximums [3]	$10,000	$10,000	$10,000	$10,000	$5,000
Co-Insurance Max (Out-of-state non-network)[3]	$15,000	$15,000	$15,000	$15,000	$15,000
Co-Insurance (In-state network)	85%	85%	80%	80%	80%
Co-Insurance (In-state non-network)	80%	80%	80%	80%	80%
Co-Insurance (Out-of-state network)	80%	80%	80%	80%	80%
Co-Insurance (Out-of-state non-network)	60%	60%	60%	60%	70%
Co-Pays[4]	$10, $20, $40	N/A	N/A	N/A	N/A
Lifetime Maximums	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
High-Deductible Option (Individual)	**2000**	**1999**	**1998**	**1997**	**1996**
Individual Premium	$169.94	$146.50	$136.40	$136.40	$125.14
Employee Share of Individual Premium	$0	$0	$0	$0	$0
Employer Share of Individual Premium	$225	$200	$175	$175	$175
Percent Paid by Employer[1]	132%	137%	128%	128%	140%
Deductible	$750	$750	$750	$750	$750
Prescription Drug Deductible[2]	N/A	$250	N/A	N/A	N/A
Co-Insurance Maximums [3]	$10,000	$10,000	$10,000	$10,000	$5,000
Co-Insurance Max (Out-of-state non-network)[3]	$15,000	$15,000	$15,000	$15,000	$15,000
Co-Insurance (In-state network)	85%	85%	80%	80%	80%
Co-Insurance (In-state non-network)	80%	80%	80%	80%	80%
Co-Insurance (Out-of-state network)	80%	80%	80%	80%	80%
Co-Insurance (Out-of-state non-network)	60%	60%	60%	60%	70%
Co-Pays[4]	$10, $20, $40	N/A	N/A	N/A	N/A
Lifetime Maximums	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Low-Deductible Option (Family)	**2000**	**1999**	**1998**	**1997**	**1996**
Family Premium	$451.28	$389.04	$362.20	$362.20	$332.30
Employee Share of Family Premium	$226.28	$189.04	$187.20	$187.20	$157.30
Employer Share of Family Premium	$225	$200	$175	$175	$175
Percent Paid by Employer[1]	50%	51%	48%	48%	53%
Deductible	$700	$700	$500	$500	$500
Prescription Drug Deductible[2]	N/A	$500	N/A	N/A	N/A
Co-Insurance Maximums [3]	$20,000	$20,000	$20,000	$20,000	$10,000
Co-Insurance Max (Out-of-state non-network)[3]	$30,000	$30,000	$30,000	$30,000	$30,000

Co-Insurance (In-state network)	85%	85%	80%	80%	80%
Co-Insurance (In-state non-network)	80%	80%	80%	80%	80%
Co-Insurance (Out-of-state network)	80%	80%	80%	80%	80%
Co-Insurance (Out-of-state non-network)	60%	60%	60%	60%	70%
Co-Pays[4]	$10, $20, $40	N/A	N/A	N/A	N/A
Lifetime Maximums	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
High-Deductible Option (Family)	**2000**	**1999**	**1998**	**1997**	**1996**
Family Premium	$390.68	$336.80	$313.56	$313.56	$287.66
Employee Share of Family Premium	$165.68	$136.80	$138.56	$138.56	$112.66
Employer Share of Family Premium	$225	$200	$175	$175	$175
Percent Paid by Employer[1]	58%	59%	56%	56%	61%
Deductible	$1,500	$1,500	$1,500	$1,500	$1,500
Prescription Drug Deductible[2]	N/A	$500	N/A	N/A	N/A
Co-Insurance Maximums [3]	$20,000	$20,000	$20,000	$20,000	$10,000
Co-Insurance Max (Out-of-state non-network)[3]	$30,000	$30,000	$30,000	$30,000	$30,000
Co-Insurance (In-state network)	85%	85%	80%	80%	80%
Co-Insurance (In-state non-network)	80%	80%	80%	80%	80%
Co-Insurance (Out-of-state network)	80%	80%	80%	80%	80%
Co-Insurance (Out-of-state non-network)	60%	60%	60%	60%	70%
Co-Pays[4]	$10, $20, $40	N/A	N/A	N/A	N/A
Lifetime Maximums	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Low-Deductible Option (Pre-Medicare Individual)	**2000**	**1999**	**1998**	**1997**	**1996**
Individual Premium	$223.62	$192.78	$179.48	$179.48	$143.58
Retiree Share of Individual Premium	$223.62	$192.78	$179.48	$179.48	$143.58
Employer Share of Individual Premium	$0	$0	$0	$0	$0
Percent Paid by Employer[1]	0%	0%	0%	0%	0%
High-Deductible Option (Pre-Medicare Individual)	**2000**	**1999**	**1998**	**1997**	**1996**
Individual Premium	$194.92	$168.04	$156.44	$156.44	$125.14
Retiree Share of Individual Premium	$194.92	$168.04	$156.44	$156.44	$125.14
Employer Share of Individual Premium	$0	$0	$0	$0	$0
Percent Paid by Employer[1]	0%	0%	0%	0%	0%
Low-Deductible Option (Pre-Medicare Family)	**2000**	**1999**	**1998**	**1997**	**1996**
Family Premium	$533.04	$459.52	$427.82	$427.82	$342.24
Retiree Share of Family Premium	$533.04	$459.52	$427.82	$427.82	$342.24
Employer Share of Family Premium	$0	$0	$0	$0	$0
Percent Paid by Employer[1]	0%	0%	0%	0%	0%
High-Deductible Option (Pre-Medicare Family)	**2000**	**1999**	**1998**	**1997**	**1996**
Family Premium	$461.36	$397.72	$370.28	$370.28	$296.20
Retiree Share of Family Premium	$461.36	$397.72	$370.28	$370.28	$296.20
Employer Share of Family Premium	$0	$0	$0	$0	$0
Percent Paid by Employer[1]	0%	0%	0%	0%	0%
Deductible	$1,500	$1,500	$1,500	$1,500	$1,500
Low-Deductible Option (Medicare Individual)	**2000**	**1999**	**1998**	**1997**	**1996**
Individual Premium	N/A	$134.30	$125.04	$125.04	$108.72
Retiree Share of Individual Premium	N/A	$134.30	$125.04	$125.04	$108.72

Employer Share of Individual Premium	N/A	$0	$0	$0	$0
Percent Paid by Employer[1]	N/A	0%	0%	0%	0%
High-Deductible Option (Medicare Individual)	**2000**	**1999**	**1998**	**1997**	**1996**
Individual Premium	$174.06	$115.90	$107.90	$107.90	$93.82
Retiree Share of Individual Premium	$174.06	$115.90	$107.90	$107.90	$93.82
Employer Share of Individual Premium	$0	$0	$0	$0	$0
Percent Paid by Employer[1]	0%	0%	0%	0%	0%
Low-Deductible Option (Medicare Family)	**2000**	**1999**	**1998**	**1997**	**1996**
Family Premium	N/A	$265.86	$247.52	$247.52	$215.22
Retiree Share of Family Premium	N/A	$265.86	$247.52	$247.52	$215.22
Employer Share of Family Premium	N/A	$0	$0	$0	$0
Percent Paid by Employer[1]	N/A	0%	0%	0%	0%
High-Deductible Option (Medicare Family)	**2000**	**1999**	**1998**	**1997**	**1996**
Family Premium	$344.06	$229.10	$213.30	$213.30	$185.46
Retiree Share of Family Premium	$344.06	$229.10	$213.30	$213.30	$185.46
Employer Share of Family Premium	$0	$0	$0	$0	$0
Percent Paid by Employer[1]	0%	0%	0%	0%	0%

[1]Preventative dental is mandatory, which costs an additional$7.50 (single) and $8.28 (family). Life insurance premiums (vary) for employees also comeout of the employer contribution.
[2] From 1996 to 1998, there was an 80 percent co-insurancerate for prescription drugs, a $250 deductible applied in 1999,and the board"carved out"the prescription benefit in2000, using a co-pay rather than a deductible or co-insurance.
[3] Certain expenses do not work toward the breakpoint,including deductibles, drug co-pays, outpatient treatment ofmental/nervous conditions, and substance abuse.
[4]Co-pays are for prescription drugs, 100 percent paid afterco-pay
Source: LSO analysis of 1996, 1997, 1998, 1999, 2000 EmployeeBenefit Booklets, summary of state contributions and premiumsprovided by Employees' Group Insurance.

APPENDIX D

Comparator Plan Costs

EGI and Out-of-State Comparator Participant Costs

	EGI (Low)	EGI (High)	Alaska	Montana (Low)	Montana (High)	North Dakota (Basic)	North Dakota (PPO)	South Dakota (Low)	So Da (H
Individual Monthly Premium [1]	$195.00	$169.94	$597	$245	$227	$349.72	$349.72	$268.95	$2
Employee Share of Individual Premium	$0	$0	$82	($40)	($58)	$0	$0	$0.00	
Employer Share of Individual Premium	$225	$225	$515	$285	$285	$349.72	$349.72	$268.95	$2
Percent Paid by Employer [3]	115%	132%	86%	116%	126%	100%	100%	100%	
Deductible [4]	$350	$750	$250	$200	$750	$200	$200	$500	$
Co-Insurance [5]	85%	85%	80%	75%	75%	80%	85%	75%	
Co-Insurance Maximums [6]	$1,500	$1,500	$1,000	$950	$2,000	$1,250	$750	$1,500	$
Co-Pays [7]	NA	NA	$100	NA	$15	$20-$25	$10 - $25	NA	
Co-Pay Maximums [8]	NA	NA	Unlimited	NA	$2,000	$200	$100	NA	
Prescription Co-Pays [9]	$10,$20, $40	$10,$20, $40	$3, $11	$5-$45	$5-$45	$5-$10	$5-$10	$8, $18	$
Prescription Co-pay Maximums [10]	Unlimited	Unlimited	Unlimited	$500	$500	Unlimited	Unlimited	$400	
Lifetime Maximums [11]	$2,000,000	$2,000,000	Unlimited	$1,000,000	$1,000,000	$2,000,000	$2,000,000	$1,000,000	$1,0
Annual Maximum Paid by Employee [12]	$1,850.00	$2,250.00	$2,234.00	$1,150.00	$2,750.00	$1,450	$950	$2,000	$

	EGI (Low)	EGI (High)	Alaska	Montana (Low)	Montana (High)	North Dakota (Basic)	North Dakota (PPO)	South Dakota (Low)	So Da (H
Family Monthly Premium [1] [2]	$451.28	$390.68	$597	$349	$314	$349.72	$349.72	$252.51	$2
Employee Share of Family Premium	$226.28	$165.68	$82	$64	$29	$0.00	$0.00	($16.44)	($
Employer Share of Family Premium	$225	$225	$515	$285	$285	$349.72	$349.72	$268.95	$2
Percent Paid by Employer [3]	50%	58%	86%	82%	91%	100%	100%	107%	
Deductible [4]	$700	$1,500	$500	$600	$1,500	$600	$600	$1,250	$
Co-Insurance [5]	85%	85%	80%	75%	75%	80%	85%	75%	
Co-Insurance Maximums [6]	$3,000	$3,000	$1,000	$2,100	$4,000	$2,500	$1,500	$1,500	$
Co-Pays [7]	NA	NA	$100	NA	$15	$20-$25	$10 - $25	NA	
Co-Pay Maximums [8]	NA	NA	Unlimited	NA	$4,000	$400	$200	NA	
Prescription Co-Pays [9]	$10,$20, $40	$10,$20, $40	$3, $11	$5-$45	$5-$45	$5-$10	$5-$10	$8, $18	$
Prescription Co-pay Maximums [10]	Unlimited	Unlimited	Unlimited	$1,000	$1,000	Unlimited	Unlimited	$1,000	$
Lifetime Maximums [11]	$2,000,000	$2,000,000	Unlimited	$1,000,000	$1,000,000	$2,000,000	$2,000,000	$1,000,000	$1,0
Total Maximum Paid by Employee [12]	$6,415.36	$6,488.16	$2,484.00	$3,468.00	$5,848.00	$3,100.00	$2,100.00	$2,750.00	$4,(

[1] Montana includes core dental, core life, and vision coverage as part of its medical premium. The vision coverage includes an exam every 24 months with a $10 co-pay. The Alaska plan also includes vision coverage with no deductible, up to $350 in benefits annually for exams and lenses. Dental is included in Alaska's plan, with a $25 single deductible, and a $75 family deductible. Dental and vision benefits are offered in South Dakota through the flexible benefits plan at an additional premium. It does not appear that dental is offered as part of the North Dakota plan.

[2] Montana has two family tiers that have not been included on this chart. There is an Employee+Spouse tier, and an Employee+Child(ren) tier, which offer lower monthly premiums than the family rate. South Dakota has seven tiers, and age rates

premiums for spousal coverage. The chart reflects the highest tier (employee, spouse and two+ children) and takes the 45-49 age bracket, which is the midpoint on the premium schedule. Therefore, there are only three higher premiums than are listed on this chart and 20 tiers with lower premiums than those listed in the chart. South Dakota also adds another $30 per person per month for each participant who smokes.

(3) In Montana, the amount contributed by the employer above the premium is used for core dental coverage and core life coverage premiums. Excess above that can be used by participants for elective benefits. In Alaska, excess is deposited into an employee's health care reimbursement account. It is unknown what is done with the excess is South Dakota.

(4) In North Dakota, all members must contribute to the deductible and coinsurance amounts. However, a member's contribution cannot be more than the single coverage amount. Deductibles are only for non-physician services. Office visits have co-pays. Alaska has a family deductible, with no requirement that each family member meet a certain portion. Alaska has a separate $25 individual deductible for dental benefits, and a $75 deductible for family dental benefits. South Dakota only requires the family deductible for families of three or more. Otherwise, each participant pays the individual deductible. In Montana, the family deductible is for the whole family, not per individual.

(5) In the EGI plans, co-insurance can drop to 80 percent for the use of in-state non-network providers and out-of-state network providers, and drops to 60 percent for out-of-state non-network providers. The out-of-pocket calculations were based on the highest level of co-insurance paid by the employer (85%). Under the South Dakota deductible plans, the plan pays only 65 percent co-insurance if using a non-network provider.

(6) Co-insurance maximums are the actual amount an employee pays in co-insurance on covered services before the plan pays 100 percent. In the EGI plan, individuals are liable for co-insurance up to $15,000, if they use out-of-state, non-network providers and families are liable for co-insurance up to $30,000 before the plan will pay 100 percent if they use out-of-state, non-network providers. Out-of-pocket calculations were based on the assumption that the EGI participants use network providers. Alaska co-insurance maximums are per person for the family maximum. South Dakota is also per person for the family maximum and the co-insurance limit is higher for individuals who receive care from a non-network provider. North Dakota's out-of-pocket maximum is per family, but a certain amount must be paid by each participant. Montana's co-insurance limit is per family.

(7) Co-pays in Alaska are for non-emergency room visits to the emergency room. Co-pays in the Montana high-deductible plan are only for office visits. These co-pays do not count toward the deductible, but do count toward the out-of-pocket maximum. Other provider visits are covered by co-insurance. In North Dakota, there is are varying co-pays on office visits, emergency room visits, and for diagnostic services. In North Dakota, co-payments do not apply toward meeting the deductible. The deductible is only for non-physician services.

(8) In North Dakota, there is an out-of-pocket limit on the co-payments for diagnostic services in a year, ranging from $50 to $200 per individual depending on the plan, and a limit of $100 to $400 per family, depending on the plan. Office visit and emergency room visit co-payments are unlimited.

(9) EGI has a carved-out prescription benefit plan and the co-pays do not apply toward the deductible or the out-of-pocket maximums. Participants pay a $10 co-pay for generic drugs, $20 for preferred drugs, and $40 for non-preferred drugs. Alaska participates in a "carved-out" prescription drug program, and if a participant uses a participating pharmacy, requires a $3 co-pay on generic drugs ($5 for cafeteria plan) and an $11 co-pay on brand-name drugs ($10 for cafeteria plan). Those who use the mail-order prescription programs for maintenance drugs only have to pay a $2 co-pay for brand-name drugs and no co-pay at all for generic drugs. The plan pays 100 percent of generic mail-order maintenance drugs. Alaska participants can also elect to purchase prescriptions on a co-insurance option, rather than a co-pay option, if they do not use a network pharmacy. The plan pays 60 percent for brand-name drugs and 80 percent for generic drugs. Montana also has a carved-out prescription program and requires a 10 percent payment on generic drugs ($5 minimum and $15 maximum) and a 30 percent payment on brand-name drugs ($15 minimum and $45 maximum). Montana also participates in a mail-order program with a $15 co-pay on generics, and $45 co-pay on brand-name drugs. South Dakota also participates in a carved-out prescription drug program, and participants can use a mail-order service to obtain lower co-pays on 90-day supplies of maintenance drugs. In North Dakota, which also has a carved-out plan, participants pay a $5 co-pay on generic drugs with 15 percent co-insurance, and a $10 co-pay on brand name or non-formulary drugs with a 25 percent co-insurance.

(10) The Montana plan also has a $500 individual and $1,000 family cap on out-of-pocket prescription expenses. South Dakota participants are liable for only $400 per person or $1,000 for a family of three or more on out-of-pocket prescription co-pays. After that point, the plan pays at 100 percent.

(11) In North Dakota, South Dakota, and Montana the lifetime maximum is per member.

(12) This is the calculation for the total out-of-pocket expenses a participant would be liable for in a plan year, before the plan starts paying at 100 percent. It includes annual premiums, deductibles, and co-insurance. Additionally, in states that do not have maximum co-pays, participants would be liable for whatever co-pays are in effect, in addition to the calculation listed here.

Sources: 2000 EGI Employee Benefit Booklets; summary of state contributions and premiums for EGI; Alaska website; Alaska plan summary; Montana website; information provided by South Dakota; South Dakota website; North Dakota plan summary; information provided by North Dakota.

EGI and In-State Comparator Participant Costs

	EGI (Low)	EGI (High)	City of Casper	City of Cheyenne
Individual Monthly Premium	$195.00	$169.94	$154.75	$163.25
Employee Share of Individual Premium	$0	$0	$44.88	$21.00
Employer Share of Individual Premium	$225	$225	$109.87	$142.25
Percent Paid by Employer	115%	132%	71%	87%
Deductible [1]	$350	$750	$300	$150
Co-Insurance [2]	85%	85%	50%	80%
Co-Insurance Maximums [3]	$1,500	$1,500	$1,000	$1,000
Co-Pays	NA	NA	NA	NA
Co-Pay Maximums	NA	NA	NA	NA
Prescription Co-Pays [4]	$10,$20, $40	$10,$20, $40	$3, $8	$3, $8
Prescription Co-pay Maximums	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximums	$2,000,000	$2,000,000	$1,500,000	$1,000,000
Annual Maximum Paid by Employee [5]	$1,850.00	$2,250.00	$1,838.56	$1,402.00

	EGI (Low)	EGI (High)	City of Casper	City of Cheyenne
Family Monthly Premium	$451.28	$390.68	$353.60	$526.52
Employee Share of Family Premium	$226.28	$165.68	$102.54	$66.00
Employer Share of Family Premium	$225	$225	$251.06	$460.52
Percent Paid by Employer	50%	58%	71%	87%
Deductible [1]	$700	$1,500	$900	$300
Co-Insurance [2]	85%	85%	50%	80%
Co-Insurance Maximums [3]	$3,000	$3,000	$2,000	$2,000
Co-Pays	NA	NA	NA	NA
Co-Pay Maximums	NA	NA	NA	NA
Prescription Co-Pays [4]	$10,$20, $40	$10,$20, $40	$3, $8	$3, $8
Prescription Co-pay Maximums	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximums	$2,000,000	$2,000,000	$1,500,000	$1,000,000
Total Maximum Paid by Employee [5]	$6,415.36	$6,488.16	$4,130.48	$3,092.00

(1) The City of Casper has a $300 deductible for single participants, $600 for two participants, and $900 for a family.
(2) In the EGI plans, co-insurance can drops to 80 percent for the use of in-state non-network providers and out-of-state network providers, and drops to 60 percent for out-of-state non-network providers. The out-of-pocket calculations were based on the highest level of co-insurance paid by the employer (85%).

(3) We calculated the co-insurance maximums by multiplying the co-insurance percentage a participant pays by the maximum dollar amount of covered services a participant must pay co-insurance on, as listed in the plan summaries. Individuals in the EGI plans are liable for co-insurance up to $15,000, if they use out-of-state, non-network providers and families are liable for co-insurance up to $30,000 before the plan will pay 100 percent if they use out-of-state, non-network providers. Out-of-pocket calculations were based on the assumption that the participants use network providers.

(4) EGI participants pay a $10 co-pay for generic drugs, $20 for preferred drugs, and $40 for non-preferred drugs. The City of Cheyenne requires a $3 co-pay on generic drugs and 20 percent co-insurance, and an $8 co-pay and 20 percent co-insurance on brand-name drugs. Participants who use the mail-order prescription programs for maintenance drugs only have to pay the co-pay and not the co-insurance on their medications. Prescriptions that are not covered under the prescription program are reimbursed at 80 percent. Laramie County School District # 1 participants have the same prescription co-pay arrangement as the City of Cheyenne, but if the participant does not purchase maintenance drugs through the mail-order program, they must pay $6 for generic drugs and 20 percent co-insurance, and $16 for brand-name drugs and 20 percent co-insurance. Laramie County employees pay a 20 percent co-insurance on medications and a $5 co-pay on brand-name drugs. There is no co-pay on generic drugs. The co-insurance and co-pays on prescriptions cannot be used to satisfy the deductible or co-insurance maximums. The City of Casper employees also have the same prescription co-pay arrangement as the City of Cheyenne.

(5) This is the calculation for the total out-of-pocket expenses a participant would be liable for in a plan year, before the plan starts paying at 100 percent. It includes annual premiums, deductibles, and co-insurance.
Sources: 2000 EGI Booklets; summary of contributions and premiums for EGI; plan summaries from the City of Casper, City of Cheyenne, Laramie County and Laramie County School Dist #1