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State Employee High Deductible Health Plans and Health Savings Accounts (Employee Trust Funds)

[LFB 2013-15 Budget Summary: Page 145, #6]

CURRENT LAW

The Group Insurance Board (GIB) in the Department of Employee Trust Funds (ETF) offers group health care coverage plans for state employees, local government employees, and Wisconsin Retirement System (WRS) annuitants. For state employees, GIB must offer at least two insured or self-insured health care coverage plans providing substantially equivalent hospital and medical benefits, including a health maintenance organization or a preferred provider plan, if those health care plans are determined by GIB to be available in the area of the employee's place of employment and are approved by the Board. The Board is required to place each of the plans into one of three premium payment tiers (termed tiers 1, 2, and 3) established in accordance with standards adopted by the Board. The tiers must be separated according to the employee's share of premium costs, with tier 1 plans being the most cost efficient. The Board does not currently offer, as an option to state employees, coverage under a high deductible health plan (HDHP) with an associated health savings account (HSA).

Under federal law, the term "high deductible health plan" means a health plan that has an annual deductible not less than $1,250 for self-only coverage, and not less than $2,500 for family coverage. In addition, the sum of the annual deductible and any other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits may not exceed $6,250 for self-only coverage and $12,500 for family coverage. These minimum deductible and maximum out-of-pocket amounts reflect the 2013 limits under federal law. These amounts are adjusted annually to reflect inflation.

Under federal law, the term "health savings account" means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing

instrument creating the trust conforms to certain limitations on total individual and employer contributions. In 2013, these limits are $3,250 for individuals and $6,450 for families. These amounts are adjusted annually. Those 55 years of age and older may also make annual catch-up contributions up to $1,000. Since tax year 2011, Wisconsin has recognized the federal treatment of HSAs.

GOVERNOR

Provide that, beginning on January 1, 2015, the Group Insurance Board must offer to all state employees, in addition to currently available health care coverage plans, the option of receiving health care coverage through a high-deductible health plan and the establishment of a health savings account. An employee choosing this option would be required to receive health care coverage through the HDHP. The state would also be required to make contributions, if any, into each employee's HSA in an amount specified by the Director of the Office of State Employment Relations (OSER). In designing an HDHP, GIB would be required to ensure that the plan may be used in conjunction with an HSA.

Provide that, beginning on January 1, 2015, to the extent practicable, any agreement with any insurer or provider to provide health care coverage to state employees must require the insurer or provider to also offer an HDHP that may be used in conjunction with an HSA.

Provide that the definitions of an HDHP and an HSA would conform to the definitions of these terms in federal law. [See the current law federal definitions above.]

Require the OSER Director to determine annually the amount of contributions, if any, that the state must contribute into an employee's HSA and the amount that employees are required to pay for health insurance premiums for the HDHP that is offered. Provide that any state employee may request in writing through the state agency in which the employee is employed that a specified part of the employee's salary be deducted and paid by the state into an HSA.

Require ETF to establish and maintain a separate account in the employee trust fund to which all moneys received from employees and employers in connection with HSAs are credited. The Secretary of ETF would also be required to promulgate, with the approval of GIB, all rules required for the administration of the HSAs.

Require GIB to establish HSAs for state employees who select coverage under an HDHP and authorize GIB to contract with any person to provide administrative and other services relating to HSAs established under these provisions. Provide that GIB may collect fees from state agencies to pay all administrative costs relating to the establishment and operation of health savings accounts established under these provisions. The Board would also be required to develop a methodology for determining each state agency's share of the administrative costs. Moneys collected would be credited to a newly created ETF continuing appropriation account for health savings account plans.

DISCUSSION POINTS

State Employee Health Plan Background

1. The current system for providing health insurance coverage to state employees is comprised of: (a) fully insured HMO plans with 25 insurance carriers in Wisconsin providing a uniform schedule of benefits; (b) a state maintenance plan (SMP) that is only available in counties that lack a qualified tier 1 HMO plan; and (c) the standard plan, a self-insured, preferred provider plan (members have comprehensive freedom of choice among hospitals and physicians) with a somewhat different, but substantially equivalent, schedule of benefits. The standard plan has a higher premium cost and a higher employee premium contribution amount than required of those choosing the HMO plans. The standard plan also requires a deductible to be paid before the plan provides cost coverage; the HMO plans do not require a deductible. Finally, the standard plan has higher annual out-of-pocket limits than the HMO plans. The GIB also contracts with a pharmacy benefits manager to provide uniform prescription drug benefits across all carriers. Approximately 95% of state employees utilize the HMO plans.

2. State employee health insurance costs in 2013 are projected by ETF to total $1,084.2 million, including $954.1 million (88%) in employer contributions and $130.1 million (12%) in employee contributions.

3. The eleven-member Group Insurance Board oversees the administration and the establishment of policies for the major insurance plans for state employees and certain local government employees. Five members of the Board serve ex officio as a result of the positions that they hold. These ex officio members are the Governor, the Attorney General, the Commissioner of Insurance, the Secretary of the Department of Administration, and the Director of the Office of State Employment Relations. Any of these ex officio members may appoint a designee to serve on the Board in his or her stead. The remaining six members of the Board are appointed by the Governor to two-year terms. The statutes require that at least five of the six appointees represent specific constituencies in order to ensure a diversity of views on the Board. At least one gubernatorial appointee must be an insured teacher who is a WRS participant, a second must be an insured nonteacher WRS participant, a third must be an insured local employee WRS participant, a fourth must be an insured retired WRS participant, and a fifth must be the chief executive or a member of the governing body of a local unit of government that is a participating employer in the WRS. There is no specific membership requirement for the sixth gubernatorial appointee to the Board.

4. As noted above, GIB is required to place each of the plans into one of three premium payment tiers established in accordance with standards adopted by the Board. The tiers must be separated according to the employee's share of premium costs. Tier 1 plans (the most cost efficient plans) require the lowest monthly contribution on the part of employees. Tier 2 plans (less efficient) require a higher employee contribution, and tier 3 plans (least efficient) require the highest employee contributions. In 2013, 23 HMO plans and the SMP are classified in tier 1 plans, no plans are in tier 2, and two HMO plans and the standard plan are classified as tier 3 plans.

5. The three-tier approach utilized by GIB is a managed competition approach that requires the HMOs to manage costs and the health status of members to meet certain target levels each year. If targets are not met, the plans will be classified as tier 2 or 3 plans that require higher

employee contributions; therefore, fewer employees will utilize the less efficient plans. In a study of cost containment strategies utilized by selected states, the GIB's health insurance actuary concluded, for Wisconsin, that the "Experience-based average annual trend on allowed charges from 2008 - 2013 was 5.2%, a level 4.1% less than normative national average trend surveys of 9.3%. As such, there is strong evidence that the approach … being used is having an impact on lowering … and containing costs."

6. Arguably, the current provision of health insurance coverage for state employees provides good access across the state and a strong schedule of benefits. Employees are incentivized to select the most efficiently performing plans and the Board's managed competition approach appears to control costs more effectively than the national average.

High Deductible Health Plans/Health Savings Accounts

7. Federal law now permits the establishment of new types of savings arrangements for health care. The two most common are health savings accounts (HSAs) and health reimbursement arrangements (HRAs). [HRAs will be discussed below.] For an employee HSA, which is proposed under the bill, contributions may be made by the employee, or his or her employer, or both. Contributions to an HSA, as well as interest earnings on the account, are not taxed and the account balance carries forward each year. However, there may be certain other costs associated with the accounts (administration and transaction fees). The HSA remains an asset of the employee, even if the employee leaves for a new job or retires. An individual may withdraw money from the HSA for qualified medical expenses or for nonmedical expenses. However, if used for nonmedical expenses, the amount withdrawn is subject to taxation and, if the individual is under the age of 65 years, a 20% penalty.

8. Under federal law, the combined annual employee and employer contributions to HSAs are limited to $3,250 for individuals and $6,450 for families. These amounts are adjusted annually. Individuals 55 years of age and older may also make annual catch-up contributions up to $1,000. It should be noted that contributions to an HSA are not required of the employer or the employee and such contributions may vary significantly year-to-year.

9. An HSA may only be provided to an employee who is covered by a high deductible health plan (HDHP). An HDHP is defined in federal law as a health plan that: (a) has an annual deductible not less than $1,250 for self-only coverage, and not less than $2,500 for family coverage; and (b) limits the sum of the annual deductible and any other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits to not more than $6,250 for self-only coverage and $12,500 for family coverage.

10. High deductible health plans and HSAs are viewed by some as a means to control the growth in health care costs by providing financial incentives for covered individuals to make careful choices about their health care and to seek the most cost-effective treatment options. Individuals making these careful choices may, thereby, minimize spending on deductible payments and retain a greater share of HSA contributions for future health care needs. The HDHP/HSA approach is generally viewed as an example of consumer-driven health care.

11. Consumer driven health care is not defined in law, but is generally an approach that

requires routine health care claims to be paid using a consumer-controlled account versus a fixed health insurance benefit paid by a coverage plan; therefore, patients are provided greater control over their own health care budgets. Under a consumer-driven health care approach, it is thought to be important that employer-sponsored health benefit plans be designed to educate employees about the true cost of medical services and to provide the necessary cost data to ensure that employees can be more responsible for their medical purchase decisions. Consumer-directed plans are generally viewed as a lower-cost option for employers.

12. The HDHP/HSA option may be especially attractive to younger and healthier employees. Such employees do not expect significant health care expenses, so the large deductible and out-of-pocket maximum amounts are of less concern than for older employees or any employee who is facing potentially larger health care expenses. Employees who are comfortable with these requirements of a HDHP would be incentivized by the availability of an HSA that receives employer contributions. The HDHP/HSA option is also said to be attractive to higher compensated individuals interested in sheltering some income in a tax-free arrangement.

ETF Analyses of Past HDHP/HSA Proposals

13. Under 2011 Wisconsin Act 32, the OSER Director and the Secretary of ETF were required to study the feasibility of several health insurance alternatives, including the option of receiving health care coverage through a high-deductible health plan and the establishment of a health savings account, as defined in federal law. The study was published on October 31, 2011, and provided to the Governor and the Joint Committee on Finance.

The study reported three key findings: (a) "There are numerous ways to structure a high deductible benefits package, depending upon the intent of the policy change. Policymakers should outline the major objectives to be achieved and consider the limitations involved with these mechanisms to guide the development of such a proposal."; (b) "To effectively implement a 'consumer-driven' model, it is imperative that employees have access to reliable, meaningful information about cost, quality of care, effectiveness and efficiency of health-care services and providers."; and (c) "Analysis is mixed regarding whether participation in a high-deductible health plan fosters appropriate, timely treatment or whether higher out-of-pocket costs discourage participants from seeking appropriate care."

14. The OSER/ETF study also noted that "If an HDHP/HSA option is offered alongside other health plan options such as Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs), there could be long-term impacts on those alternative plan offerings." This approach is being recommended under the bill. Fiscal estimates for prior HDHP/HSA legislation illustrate these potential impacts.

15. Analyses of the fiscal effect of the HDHP/HSA option were made for 2003 Assembly Bill 939, and 2005 Senate Bill 131 and 2005 Assembly Bill 341. These bills were substantially identical bills to provide an HDHP/HSA option for state employees. These earlier proposals were more specific with respect to the state's annual contributions to employee HSAs than is the case with the AB 40 provision. The contribution was to be equal to the difference between the state's share of the annual premium cost of the high-deductible health plan and the state's share of the annual premium cost of the lowest tier plan that is available in the county in which the employee resides. However, these bills did not specify the design features of the HDHP, such as

deductible levels and out-of-pocket maximums for the plan.

16. In an analysis of SB 131 and AB 341 for the Joint Committee on Finance on January 15, 2006, is was noted that ETF estimated that the provisions under SB 131 and AB 341 would result in additional state costs of approximately $32.0 million (all funds) annually. While the estimate was based on costs and other parameters applicable in 2005-06, the principal factors contributing to the fiscal estimate are still important today. These factors are: (a) a certain number of state employees who currently "opt-out" of health care coverage under the state plans would likely enroll in the HDHP in order to receive the state's HSA contribution; (b) HSA contributions become the property of the employee and any unused portion of these contributions at the end of each year would be retained by the employee; and (c) the adverse selection effect the establishment of the HDHP/HSA health care option could have for the current state health care coverage pool. These factors are discussed in the following points.

17. Currently, an estimated 5% of state employees choose not to be covered under the state's health insurance plans. If an HSA is made available to these state employees, the number choosing to enroll in the HDHP/HSA would depend on how premium rates, deductible amounts, out-of-pocket maximum amounts, and employer contribution levels to the employee HSA are set. In the earlier legislation mentioned above, the ETF actuary estimated that 60% of the 5% (or 3% of state employees) would enroll in the HDHP/HSA, creating additional state costs.

18. The second component of the fiscal effect is that any unused portion of the state HSA contributions becomes the property of the employee at the end of each year. In effect, the state would be paying each year for medical costs that will not be incurred until some future date, perhaps long after the employee has left state service. In addition, because HSAs, under federal law, may be used to pay medical expenses that are not covered under the uniform schedule of benefits that apply to the regular state plans, the state would be funding benefits that are not provided to employees covered by the plans under current law. These additional benefits are discussed below.

19. Third, adverse selection concerns the effect that the establishment of an HDHP/HSA option could have for the state HMO insurance pool. To the extent that younger and healthier employees choose the HDHP/HSA option, the remaining participants in the HMO plans will have higher average claims costs. The HMO health care pool would, in effect, be deprived of those individuals who help keep average costs down. This may result in higher premium rates for the HMO plans, cancelling and possibly exceeding the savings anticipated for offering the HDHP/HSA option. The negative effect for the HMO insurance pool could progressively worsen over time.

20. Adverse selection may be fostered by another potential factor that could also reduce potential savings associated with the HDHP/HSA approach. It appears that individuals who choose the HDHP/HSA option one year would not have to retain this option in the future. That is, during each annual open enrollment period for state employee health care coverage, individuals who formerly enrolled in the HDHP/HSA option could opt-back into coverage under the state's regular health care options. Individuals who know that they or their family face higher health care costs in the coming year could opt-out of the high deductible plan by enrolling in one of the state's regular plans and thus avoid using their HSA accounts for the higher health care costs. This factor would further

increase premium costs for the state's HMO health insurance pool.

21. It was the combination of these three factors that resulted in the ETF estimated fiscal effect for 2005 SB 131 and AB 341 of additional state costs of approximately $32.0 million (all funds) annually.

22. For the Department's analysis of these older bills, assumptions were made about the deductible amounts, the out-of-pocket maximum limits, and the employer contributions to the HSAs. The assumptions used were within the federal guidelines and limits that applied at the time. The fiscal effect of the current HDHP/HSA proposal would also depend on what assumptions are used for these factors.

23. The levels established for deductible amounts, out-of-pocket maximum limits, and employer contributions to the HSAs will have significant bearing on the number of state employees who will choose to be covered under an HDHP and the longer-term effects on the cost of HMO coverage for other employees. According to ETF officials, an HDHP/HSA option could be designed to minimize negative fiscal effects for the state; however, this design has not yet been developed and will require a significant amount of planning by GIB.

Potential Modifications to HDHP/HSA Provisions

24. As noted above, the OSER/ETF study of health insurance options required under 2011 Act 32 concluded that offering an HDHP/HSA option alongside the other health plans the state currently offers, could result in long-term impacts on those other plan offerings. Prior analyses of an HDHP/HSA option for state employees have estimated significant state cost increases. Arguably, given the potential that the HDHP/HSA option under the bill could result in higher state costs, the Committee could require more precise information on the proposed HDHP/HSA design prior to offering the option to state employees.

25. The Committee could require, as a condition for offering an HDHP/HSA option to state employees, that GIB and the OSER Director develop an HDHP/HSA program plan that specifies the key actuarial parameters for such a program, including the required deductible amounts, the out-of-pocket maximum limits, projected premium rates, the employer contributions to the HSAs, and any other relevant factors to complete the program plan. The Board would be required to submit the plan for an actuarial analysis so that the fiscal effect, if any, for overall state health insurance costs may be assessed. If the actuarial analysis shows that, under the program plan, overall state employee health insurance costs, both near-term and long-term, will not increase, GIB would be authorized to offer the HDHP/HSA option to state employees, as provided under the bill. If the proposed plan is found to increase overall state costs, the actuary would be required to recommend changes in the program design to make the plan more cost neutral. The Board and the OSER Director would then have the authority to determine a final program plan. [Alternative 2]

26. This alternative would create a one-time assessment process that could be completed by March, 2014. Under this alternative, the HDHP/HSA option could still be made available by January 1, 2015, as provided under the bill.

27. The GIB is generally responsible under the bill for the design of the HDHP, but the OSER Director would be required to determine annually the amount of contributions, if any, that

the state must contribute into an employee's HSA, and the amount that employees are required to pay for health insurance premiums for the HDHP that is offered. Both the state's HSA contribution and the employee-required contribution for the HDHP premium are critical actuarial factors that would affect the number of employees choosing HDHP coverage, and the fiscal effect on the remaining pool of HMO-covered employees. The Committee may wish to require the OSER Director to determine annually the amount of contributions, if any, that the state must contribute into an employee's HSA, and the amount that employees are required to pay for health insurance premiums for the HDHP that is offered, *in consultation with GIB.* [Alternative 3]

28. It has been noted that state payments into HSAs would result in creating assets for employees that may not be needed for medical expenses incurred during their state service. It has also been noted that, because HSAs, under federal law, may be used to pay medical expenses that are not covered under the uniform schedule of benefits that apply to the regular state plans, the state would be funding benefits that are not provided to employees covered by the plans under current law. [Allowable or qualified medical expenses for which an HSA can be used are generally those that qualify for medical or dental expense deductions on one's tax return. Examples of benefits an HSA may pay for that are generally not provided to state employees would include: acupuncture; artificial teeth (unless required due to injury); expenses for special medical equipment installed in one's home, including certain home improvements; adaptations for driving a car; glasses and contact lenses; laser eye surgery; certain fertility services; lead-based paint removal from one's home; legal fees associated with medical care; psychiatric care; psychoanalysis; certain educational services for children; and transportation and certain lodging expenses related to medical care.]

29. Both of these effects could be avoided with another employer option in federal law that would also be less costly to the state than HSAs. Instead of providing employees with HSAs, the state could establish health reimbursement arrangements (HRAs) for employees who choose the HDHP option. An HRA must be funded solely by an employer; that is, contributions to an HRA cannot be made by employees. Employees are reimbursed for qualified medical expenses up to a maximum dollar amount (established by the employer) for a coverage period. An HRA may be offered with any health plan, including HDHPs. Employers have complete flexibility to offer various combinations of benefits in designing the HRA. The state, for example, could provide reimbursement only for the benefits specified in the uniform benefit schedule for its regular HMO plans.

30. The employer HRA contributions are not included in the employee's income and employees do not pay federal income taxes or employment taxes on the HRA amounts. There is no limit on the amount of money an employer can contribute to the HRA. Further, the maximum reimbursement amount credited each year under the HRA may be (but is not required to be) increased by amounts not previously used.

31. While unused HRA funds may be rolled over to a succeeding year, these funds are not an asset of the employee. If the employee leaves state service, the unused HRA funds are retained by the state. Further, because the employer may specify which medical expenses may be reimbursed, the state would not be required to pay the wide range of medical expenses allowed for HSAs. Finally, if unused HRA amounts are allowed to accumulate over the years, an employee under HDHP coverage may have an incentive to remain under the HDHP, rather than choosing to

switch to an HMO plan when higher health care costs are anticipated.

32. The Committee may wish to consider deleting the HSA component of the provision and instead provide HRAs for employees choosing an HDHP. The benefits eligible for reimbursement under the HRA would be determined by GIB, and the OSER Director would determine annually, in consultation with GIB, the amount of employer contributions, if any, that the state must contribute into an employee's HRA. [Alternative 4] If the Committee selects Alternative 4, it may also want to require a one-time assessment process analogous to the assessment specified in Alternative 2 for HDHP/HSAs. [Alternative 5]

33. The Committee could also delete the HDHP/HSA provisions. As noted, there is some potential for increasing the overall costs of state employee health care, particularly if the HDHP/HSA option is not well designed to minimize adverse selection on the HMO-coverage pool. Costs may also increase because employees may be able to switch between the HDHP/HSA and the HMO-coverage options depending on anticipated health care needs. Funding HSAs may result in payments of future benefits for those who leave state service, and would pay for benefits not provided to employees under HMO coverage. While the HDHP/HSA approach is considered less expensive for the employer to provide, critics of the consumer-driven health care view the approach as a means of shifting health care costs to employees. Further, as noted in the OSER/ETF Act 32 study, it is unclear at this time whether participation in a high-deductible health plan fosters appropriate, timely treatment, or discourages participants from seeking appropriate care due to higher out-of-pocket costs.

34. It should be noted that estimated reductions in state fringe benefit costs associated with the proposed HDHP/HSA provisions were factored into the calculation of the compensation reserves for most state agencies and the amounts appropriated separately to the University of Wisconsin System for increased unbudgeted compensation and fringe benefit costs in 2013-15. If the Committee should choose to delete the HDHP/HSA provisions, the assumed savings would not be realized and fringe benefit costs would increase from the levels projected for the compensation reserves and the UW System. The savings relating to the HDHP provisions were estimated by the administration at $3,807,300 GPR in 2014-15 for state agencies and $3,060,400 GPR in 2014-15 for the UW System. The Committee could place an additional $3,807,300 GPR in 2014-15 in the compensation reserves and appropriate $3,060,400 GPR in 2014-15 to the UW System to address higher fringe benefit costs associated with the deletion of the HDHP/HSA provisions. [Alternative 6]

35. If the HDHP/HSA provisions are deleted and no additional funding is provided to the GPR reserves or appropriated to the UW System, any unbudgeted costs would need to be absorbed by each state agency from existing resources. [Alternative 7]

ALTERNATIVES

1. Approve the Governor's recommendations to:

Provide that, beginning on January 1, 2015, the Group Insurance Board must offer to all state employees, in addition to currently available health care coverage plans, the option of

receiving health care coverage through a high-deductible health plan and the establishment of a health savings account. An employee choosing this option would be required to receive health care coverage through the HDHP. The state would also be required to make contributions, if any, into each employee's HSA in an amount specified by the Director of the Office of State Employment Relations (OSER). In designing an HDHP, GIB would be required to ensure that the plan may be used in conjunction with an HSA.

Provide that, beginning on January 1, 2015, to the extent practicable, any agreement with any insurer or provider to provide health care coverage to state employees must require the insurer or provider to also offer an HDHP that may be used in conjunction with an HSA.

Provide that the definitions of an HDHP and an HSA would conform to the definitions of these terms in federal law.

Require the OSER Director to determine annually the amount of contributions, if any, that the state must contribute into an employee's HSA and the amount that employees are required to pay for health insurance premiums for the HDHP that is offered. Provide that any state employee may request in writing through the state agency in which the employee is employed that a specified part of the employee's salary be deducted and paid by the state into an HSA.

Require ETF to establish and maintain a separate account in the employee trust fund to which all moneys received from employees and employers in connection with HSAs are credited. The Secretary of ETF would also be required to promulgate, with the approval of GIB, all rules required for the administration of the HSAs.

Require GIB to establish HSAs for state employees who select coverage under an HDHP and authorize GIB to contract with any person to provide administrative and other services relating to HSAs established under these provisions. Provide that GIB may collect fees from state agencies to pay all administrative costs relating to the establishment and operation of health savings accounts established under these provisions. The Board would also be required to develop a methodology for determining each state agency's share of the administrative costs. Moneys collected would be credited to a newly created ETF continuing appropriation account for health savings account plans.

2. In addition to Alternative 1, provide that as a condition for offering an HDHP/HSA option to state employees, that GIB and the OSER Director develop an HDHP/HSA program plan that specifies the key actuarial parameters for such a program, including the required deductible amounts, the out-of-pocket maximum limits, projected premium rates, the employer contributions to the HSAs, and any other relevant factors to complete the program plan. Require GIB to submit the plan for an actuarial analysis so that the fiscal effect, if any, for overall state health insurance costs may be assessed. Provide that, if the actuarial analysis shows overall state employee health insurance costs, both near-term and long-term, for the provision of optional HDHP/HSA coverage to state employees will not increase, GIB would be authorized to offer the HDHP/HSA option to state employees, as provided under the bill. If the proposed plan is found to increase overall state costs, require the actuary to recommend changes in the program design to make the plan more cost neutral. Authorize the Board and the OSER Director to then determine a final program plan.

3. In addition to Alternative 1, require the OSER Director to determine annually the amount of contributions, if any, that the state must contribute into an employee's HSA and the amount that employees are required to pay for health insurance premiums for the HDHP that is offered, in consultation with GIB.

4. Modify the Governor's recommendation by deleting the provisions relating to health savings accounts. Instead, provide that GIB must offer to all state employees, in addition to currently available health care coverage plans, the option of receiving health care coverage through a high-deductible health plan and the establishment of a health reimbursement arrangement (HRA). Provide that the benefits eligible for reimbursement under the HRA would be determined by GIB. Provide that the OSER Director determine annually the amount of contributions, if any, that the state must contribute into an employee's HRA, in consultation with GIB.

5. In addition to Alternative 4, provide that as a condition for offering an HDHP/HRA option to state employees, that GIB and the OSER Director develop an HDHP/HRA program plan that specifies the key actuarial parameters for such a program, including the required deductible amounts, the out-of-pocket maximum limits, projected premium rates, the employer contributions to the HRAs, and any other relevant factors to complete the program plan. Require GIB to submit the plan for an actuarial analysis so that the fiscal effect, if any, for overall state health insurance costs may be assessed. Provide that, if the actuarial analysis shows overall state employee health insurance costs, both near-term and long-term, for the provision of optional HDHP/HRA coverage to state employees will not increase, GIB would be authorized to offer the HDHP/HRA option to state employees, as provided under the bill. If the proposed plan is found to increase overall state costs, require the actuary to recommend changes in the program design to make the plan more cost neutral. Authorize the Board and the OSER Director to then determine a final program plan.

6. Delete the provision. In addition, provide $3,060,400 GPR in 2014-15 to the University of Wisconsin System, and place an additional $3,807,300 GPR in 2014-15 in the general fund compensation reserves to address higher fringe benefit costs associated with the deletion of the HDHP/HSA option.

ALT 6	**Change to Bill** Funding
GPR	$3,060,400
GPR-Reserves	3,807,300
Total GPR	$6,867,700

7. Delete provision. Under this alternative, funding would not be provided to the UW System or compensation reserves.

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