Report 19-2
February 2019

Administration and Oversight of Group Insurance Programs

Department of Employee Trust Funds

STATE OF WISCONSIN

Legislative Audit Bureau

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Department of Employee Trust Funds

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From the Secretary of the Department of Employee Trust Funds
From the Legislative Audit Bureau

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Joe Chrisman
State Auditor

February 15, 2019

Senator Robert Cowles and
Representative Samantha Kerkman, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Cowles and Representative Kerkman:

As requested by the Joint Legislative Audit Committee, we have completed an evaluation of the oversight the Group Insurance Board (GIB) provided for group insurance programs the Department of Employee Trust Funds (ETF) administered, including the Group Health Insurance, Income Continuation Insurance (ICI), Long-term Disability Insurance, and Group Life Insurance programs. These programs are available to state employees and certain local government employees. Expenditures for all four programs totaled $1.7 billion in 2017. GIB determines program benefits, approves premiums, spends program reserves, awards contracts, and makes other decisions based on information provided by ETF.

Program reserves help cover the cost of future benefits. Group Health Insurance program reserves increased from $90.6 million in December 2015 to $225.5 million in December 2017, or by $134.9 million. GIB did not vote to spend any program reserves in 2016 and 2017, in part, because it was considering whether all medical benefits should be self-insured. In December 2017, reserves for the state component of the Group Health Insurance program were $142.4 million more than the targeted amount approved by GIB. Reserves for the state component of the ICI program were in a deficit from 2008 through 2017, and funds may be inadequate to pay future benefits if the deficit continues.

ETF has taken steps to improve its administration of the group insurance programs. However, we found that ETF did not consistently provide adequate administration of contracts with the firms that help administer the group insurance programs, including by not determining the extent to which firms achieved contractually specified performance measure goals. ETF also did not consistently prepare and provide GIB with its written analyses of key programmatic information. However, most state agencies and local governments responding to our survey indicated satisfaction with the Group Health Insurance program and the assistance ETF provided them.

We found that oversight of the programs can be further improved by ETF consistently providing timely, relevant, and complete programmatic information to GIB, which can consider this information before making decisions. We make recommendations for further improving program administration and oversight.

A response from the ETF secretary follows the appendix.

Respectfully submitted,

Joe Chrisman
State Auditor

JC/DS/ss

Report Highlights ▪

ETF did not consistently provide adequate administration of contracts with the firms that helped administer the group insurance programs.

ETF did not consistently prepare and provide GIB with its written analyses of key programmatic information.

Most state agencies and local governments responding to our survey indicated satisfaction with the Group Health Insurance program and the assistance ETF provided them.

ETF has taken steps to improve its administration of the group insurance programs, and we recommend further improvements.

The 11-member Group Insurance Board (GIB) oversees group insurance programs that the Department of Employee Trust Funds (ETF) administers. These programs, which are available to state employees and certain local government employees, include the Group Health Insurance, Income Continuation Insurance (ICI), and Group Life Insurance programs. Until January 2018, GIB also oversaw the Long-term Disability Insurance program, which is closed to new benefit claims. Expenditures for these four programs totaled $1.7 billion in 2017. The four programs were funded primarily by premiums paid by employers and participants and by investment income earned on program reserves.

In calendar year 2017, 262,732 participants were in the Group Health Insurance program, 59,726 participants were in the ICI program, and 257,413 participants were in the Long-term Disability Insurance program. As of December 31, 2017, 203,001 participants were in the Group Life Insurance program.

To complete this evaluation, we analyzed:

- ETF’s administration and GIB’s oversight of the four programs in recent years;
- the administration of program reserves, particularly for the Group Health Insurance program; and
- the opinions of state agencies and local governments about the Group Health Insurance program.

Contract Administration

ETF administers the group insurance programs with assistance from various firms. Program administrators process benefit claims and make benefit payments. Program actuaries estimate future benefit payments and recommend changes to program premiums. Auditors independently assess the performance of program administrators and other firms that help administer the programs.

Some firms have helped administer the programs for many years. For example, the same firm has been the program administrator for the Group Life Insurance program since 1958. ETF indicated that this contract has not been rebid since 2010, in part, because it and GIB were busy with tasks related to the potential transition of the State to self-insured medical benefits.

We found that ETF did not consistently provide adequate administration of contracts with firms. For example:

- ETF did not determine the extent to which firms achieved contractually specified performance measure goals or the extent to which it could have assessed financial penalties when firms did not achieve these goals;
- not all firms were contractually required to submit audits of information technology (IT) controls, and ETF did not consistently collect audits or review submitted audits; and
- ETF executed contract amendments for actuarial services without the approval of GIB or the ETF Board.

We also found that ETF did not consistently prepare and provide GIB with the results of its written analyses of key programmatic information provided by firms that helped administer the programs. For example, ETF did not consistently prepare and provide GIB with the results of its written analyses of recommendations from consultants hired to identify improvements to the Group Health Insurance program or key information provided by the program actuary.

Program Reserves

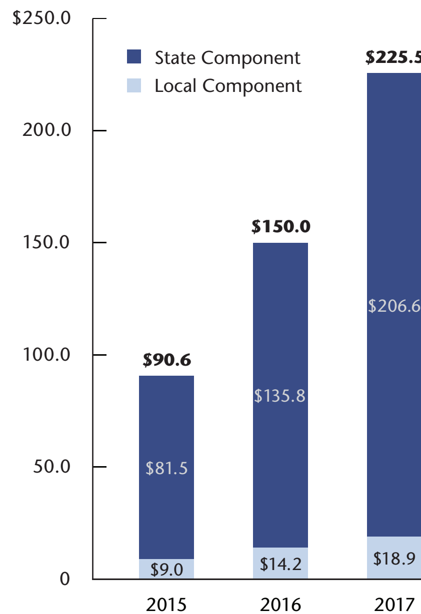
Statutes require GIB to use excess funds from operating the programs to reduce premiums or establish program reserves, which help cover the costs of future benefits. Reserves are tracked separately for the state and local components of the Group Health Insurance program.

GIB annually votes on the amount of program reserves to spend in a given year, based on recommendations from the program actuary.

As shown in Figure 1, total Group Health Insurance program reserves increased by $134.9 million from 2015 through 2017. Program reserves change from year to year based on factors such as investment income earned on the program reserves and the amounts GIB votes to spend. GIB did not vote to spend any program reserves in 2016 or 2017, in part, because it was considering whether all medical benefits should be self-insured. In addition, the amount GIB votes to spend may differ from the amount actually spent, in part, because GIB cannot know how much pharmacy and dental benefits will cost when it votes to spend program reserves. Instead, these costs are estimated by the program actuary.

Figure 1

Group Health Insurance Program Reserves
As of December 31
(in millions)



GIB intends to maintain Group Health Insurance program reserves within minimum and maximum amounts that are termed the "target range." GIB did not establish such target ranges until August 2011, it did not modify them until August 2017, and it did not establish a policy requiring a periodic review of them to ensure they continue to be appropriate.

In August 2017, GIB approved a plan to spend Group Health Insurance program reserves from 2018 through 2021 in order for program reserves to be at the midpoint of the target ranges after 2021. We found that program reserves for the state component totaled $206.6 million as of December 2017, which was $142.4 million more than the midpoint of the target ranges.

In August 2018, the program actuary projected to GIB that Group Health Insurance program reserves for the state component would increase to $228.3 million as of December 2018, rather than decrease to $155.9 million as it had projected in August 2017. The program actuary anticipated that the State would pay $53.4 million less in pharmacy benefits in 2018 than it had projected and that investment income would total $19.0 million in 2018.

We found that ETF did not consistently provide key programmatic information to GIB. In August 2018, the Group Health Insurance program actuary recommended that GIB spend $49.1 million in program reserves for the state component in 2019, even though the midpoint of the target ranges GIB approved in August 2017 specified that $111.8 million should be spent. ETF indicated to us that it had directed the program actuary to recommend spending fewer program reserves than specified in order to have more program reserves available to maintain or reduce premiums in 2020 and later.

ETF did not require the program actuary to consider future investment income earned on program reserves when recommending the amount of program reserves to spend. Investment income can be substantial and totaled $29.9 million in 2017. From 2008 through 2017, ETF also did not require the program actuary to explain to GIB why the annual changes in program reserves differed from the amounts GIB had voted to spend. In 2018, the program actuary provided such an explanation.

GIB did not establish target ranges for program reserves for the other three group insurance programs. Reserves for the state component of the ICI program were in a deficit from 2008 through 2017, and funds may be inadequate to pay future benefits if the deficit continues. In February 2017, GIB approved a redesign proposal for the ICI program to improve its long-term stability, but statutory modifications are required to fully implement it.

Employer Opinions

We surveyed all state agencies and local governments that participated in the Group Health Insurance program as of July 2018. Most survey respondents indicated that they were satisfied with the program and the assistance ETF provided them.

Governance

GIB makes decisions about the group insurance programs based, in part, on programmatic information provided by ETF. We found that ETF at times provided information to GIB members only after they had arrived at meetings.

ETF has taken steps to improve its administration of the group insurance programs. However, it should compile additional information about the performance of program administrators, program actuaries, and auditors. GIB can use this information to make programmatic decisions, such as determining whether to continue to contract with a given firm or rebid the contract. ETF should also establish a written plan to periodically contract for actuarial audits to assess the appropriateness of information provided by program actuaries and provide GIB with the actuarial audit results.

Recommendations

We include recommendations for ETF to report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to:

☑ require staff to track on an ongoing basis how they spend their time (*p. 19*);

☑ improve administration of the Group Health Insurance program (*pp. 29, 31*, and *34*);

☑ improve administration of Group Health Insurance program reserves (*pp. 42, 43,* and *45*);

☑ improve administration of the ICI program (*pp. 66* and *71*);

☑ improve administration of the Group Life Insurance program (*pp. 78* and *81*);

☑ improve IT security (*pp. 84* and *86*); and

☑ work with GIB to improve its oversight of the group insurance programs (*pp. 90, 92, 93,* and *95*).

Issues for Legislative Consideration

The Legislature could consider modifying statutes to:

- require ETF to annually provide it with information about program reserves (*p. 47*);
- specify that the Administrator of the Department of Administration's (DOA's) Division of Personnel Management is a GIB member (*p. 95*); and
- clarify the membership requirements of four GIB members (*p. 95*).

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Introduction ▪

The ETF Board is responsible for the overall direction and supervision of ETF.

The ETF Board is responsible for the overall direction and supervision of ETF. The 13 members of the ETF Board include:

- the Governor, or the Governor's designee;
- the Administrator of the Division of Personnel Management in DOA, or the Administrator's designee;
- 4 members of the Teachers Retirement Board, which advises the ETF Board on issues pertaining to the Wisconsin Retirement System (WRS);
- 4 members of the Wisconsin Retirement Board, which advises the ETF Board on issues pertaining to the WRS;
- 1 member nominated by the Governor and appointed with the advice and consent of the Senate, who is a public representative, is not a WRS participant, and has at least five years of actuarial, insurance, or employee benefits plan experience;
- 1 annuitant elected by retired WRS participants; and

- 1 active WRS participant who must be a technical college or school district employee who is not a teacher, and is elected by participating employees who meet the same employment criteria.

Section 40.03 (1), Wis. Stats., requires the ETF Board to appoint the Secretary of ETF, select and retain actuaries to perform all necessary actuarial services for the group insurance programs ETF administers, and approve the contribution rates and actuarial assumptions determined by these actuaries. The ETF Board oversees several programs, including the WRS.

Statutes require GIB to oversee certain group insurance programs that are available to certain state and local government employees, retirees, and their families.

Statutes require GIB to oversee certain group insurance programs that are available to certain state and local government employees, retirees, and their families. GIB includes 11 members, 6 of whom are appointed by the Governor for two-year terms. The 11 members include:

- the Governor, or the Governor's designee;
- the Attorney General, or the Attorney General's designee;
- the Secretary of DOA, or the Secretary's designee;
- the Commissioner of Insurance, or the Commissioner's designee;
- the Administrator of DOA's Division of Personnel Management, or the Administrator's designee;
- an individual appointed by the Governor, with no other statutorily specified membership requirements;
- an insured participant in the WRS who is a teacher and is appointed by the Governor;
- an insured participant in the WRS who is not a teacher and is appointed by the Governor;
- an insured participant in the WRS who is retired and is appointed by the Governor;
- an insured employee of a local government who is appointed by the Governor; and

- the chief executive or member of the governing body of a local government participating in the WRS and who is appointed by the Governor.

The appendix lists the members of GIB as of November 2018.

The four primary group insurance programs overseen by GIB during some or all of the period from January 2008 through December 2018 included:

- the Group Health Insurance program, which provides medical, pharmacy, and dental benefits to active and retired state and local government employees and their families;

- the ICI program, which provides disability benefits to state and local government employees;

- the Long-term Disability Insurance program, which provides disability benefits to state and local government employees but since January 2018 has been overseen by the ETF Board and has been closed to new benefit claims, although benefit payments continue for program participants who had submitted benefit claims before that date; and

- the Group Life Insurance program, which provides life insurance coverage to active and retired state and local government employees.

Statutes require GIB to contract with authorized insurers to provide the insurance coverage under the group insurance programs. Statutes also require that GIB:

- not enter into any agreement to modify or expand benefits under any group insurance program unless required by law or unless doing so would maintain or reduce premium costs for the State or its employees in the current year or any future years;

- use excess funds that become available through operating a group insurance program to reduce premiums or establish program reserves to stabilize costs in subsequent years;

- take prompt action to liquidate any actuarial or cash deficit in the funds supporting the group insurance programs; and
- notify the Joint Committee on Finance that it intends to execute a contract to provide self-insured group health plans to state employees but may not execute such a contract without the approval of the Joint Committee on Finance.

In administering the group insurance programs, ETF staff respond to questions from employers and participants. They also perform a variety of other tasks, including those related to program planning, program finance, and certain IT services.

ETF administers the group insurance programs with assistance from program administrators, program actuaries, and auditors.

ETF administers the group insurance programs with assistance from program administrators, program actuaries, and auditors. Program administrators process benefit claims and make benefit payments, and they determine the eligibility of applicants to some programs. Program actuaries estimate future benefit payments and recommend changes to the premiums paid by employers and participants. Auditors independently assess the performance of program administrators and other firms that help administer the programs.

Concerns have been raised about GIB's oversight and ETF's administration of the group insurance programs. In May 2017, GIB requested approval from the Joint Committee on Finance to provide self-insured group health plans to state employees beginning in January 2018, but this request was denied in June 2017. 2017 Assembly Bill 64, the 2017-19 Biennial Budget Bill, included a nonstatutory provision that requested the Joint Legislative Audit Committee to direct the Legislative Audit Bureau to audit the group health insurance programs, but the Governor vetoed this provision. On December 20, 2017, the Joint Legislative Audit Committee directed us to evaluate GIB's oversight and ETF's administration of the group insurance programs, with particular focus on the Group Health Insurance program.

To complete this evaluation, we interviewed ETF staff and all 11 GIB members as of September 2018, and we contacted 12 organizations involved with issues related to the group insurance programs. We obtained information about the oversight of group insurance programs in Illinois, Indiana, Iowa, Michigan, Minnesota, and Ohio. We reviewed the relevant minutes and materials of all open sessions of GIB meetings from January 2008 through December 2018, and we attended all GIB meetings in 2018. We reviewed the contracts that ETF and GIB executed with all program administrators and with

selected other firms, as well as reports from program actuaries, from January 2011 through December 2018. We analyzed expenditure and revenue data for the group insurance programs, obtained demographic data about Group Health Insurance program participants in 2017, and surveyed all participating state and local governments about their opinions regarding GIB's oversight and ETF's administration of the Group Health Insurance program. We did not attempt to obtain data on the extent to which program participants obtained health care services.

We also determined if the actuarial methods, assumptions, procedures, and analyses that GIB's actuary used to develop the current reserve goals for the Group Health Insurance program were actuarially sound, consistent with insurance industry practices and standards, and consistent with generally accepted actuarial standards of practice. To do so, we issued a request for proposals (RFP) and then contracted in May 2018 with an independent actuary, which provided us with its report in December 2018.

At times, ETF took longer than anticipated to provide information we requested. For example, on March 23, 2018, we requested demographic data about Group Health Insurance program participants. Although we did not request the names or the Social Security numbers of these participants, ETF did not provide all of these demographic data until July 25, 2018, which was four months after our request. Although the Joint Legislative Audit Committee had directed us to obtain and analyze these data, ETF indicated that it was reluctant to provide us these data and attempted to require us to justify our need for each type of requested data, such as the counties where participants resided.

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Expenditures and Staffing ▪

We determined expenditures and revenues for four group insurance programs from January 2009 through December 2017.

We determined expenditures and revenues for the Group Health Insurance, ICI, Long-term Disability Insurance, and Group Life Insurance programs from January 2009 through December 2017. Expenditures for these four programs totaled $1.7 billion in 2017. The four programs were funded primarily by premiums paid by employers and participants and by investment income earned on program reserves. In analyzing ETF's staffing levels in recent years, we found that most ETF staff did not track the amount of time they used to complete work on individual group insurance programs. We make a recommendation that ETF require its staff to track the amount of time they use to complete work on each group insurance program, which will allow ETF to know the accurate amount of administrative fees to charge each program.

Expenditures

The group insurance programs have three main types of expenditures:

- participant benefits, such as payments for medical services;
- program administration provided by third-party administrators; and

- other administrative services, including ETF's costs to administer the programs as well as actuarial, auditing, and consulting services.

We used the State's accounting systems to determine expenditures for the Group Health Insurance, ICI, and Long-term Disability Insurance programs. Because the State's accounting systems do not contain comprehensive expenditure information for the Group Life Insurance program, we used summary expenditure information reported to GIB by the program's administrator, which received program revenues directly from local governments participating in the program and has information about program expenditures. Because these four programs are administered on a calendar-year basis, we determined program expenditures on a calendar-year basis rather than a fiscal-year basis.

Total expenditures for four group insurance programs increased from $1.4 billion in 2009 to $1.7 billion in 2017.

As shown in Table 1, total expenditures for the Group Health Insurance, Long-term Disability Insurance, Group Life Insurance, and ICI programs increased from $1.4 billion in 2009 to $1.7 billion in 2017. In 2017, more than 90.0 percent of all expenditures were for participant benefits, and the remaining expenditures were primarily for program administration and other administrative services, including ETF's costs to administer the programs. Subsequent chapters of our report present in greater detail the expenditures of each of these four programs and the revenues that funded each program, including the premiums paid by employers and participants.

Table 1

Group Insurance Program Total Expenditures, by Calendar Year[1]
(in millions)

Program	2009	2017	Percentage Change
Group Health Insurance	$1,331.1	$1,566.3	17.7%
Group Life Insurance	51.6	66.7	29.3
Long-term Disability Insurance	43.5	53.3	22.5
Income Continuation Insurance	13.4	20.6	53.7
Total	**$1,439.6**	**$1,706.9**	18.6

[1] Group Health Insurance, Long-term Disability Insurance, and ICI program expenditure information is from the State's accounting systems. Group Life Insurance program expenditure information is from the program administrator.

The amounts paid to the private firms that worked as program administrators, program actuaries, auditors, and consultants increased from $20.3 million in 2009 to $32.2 million in 2017, or by 58.6 percent. In 2017, program administrators were paid $30.2 million, program actuaries were paid $367,300, auditors were paid $145,700, and consultants were paid $1.5 million for services such as helping ETF establish a data warehouse for the Group Health Insurance program.

Staffing Levels

We determined ETF's full-time equivalent (FTE) staffing levels in June 2016, June 2017, and June 2018. We chose these three dates because consistent staffing information was readily available in State Transforming Agency Resources (STAR), which is the State's enterprise resource planning system and includes accounting, payroll, and purchasing functions.

Authorized FTE permanent staff positions at ETF increased from 267.20 in June 2016 to 272.20 in June 2018.

As shown in Table 2, authorized FTE permanent staff positions at ETF increased from 267.20 in June 2016 to 272.20 in June 2018, or by 1.9 percent. The total number of filled FTE staff positions decreased from 250.05 in June 2016 to 248.45 in June 2018, or by 0.6 percent. ETF indicated that positions were unfilled for short periods of time because of staff turnover.

Table 2

Authorized Full-Time Equivalent Staff Positions at ETF[1]
As of June 30

	June 2016	June 2017	June 2018
Filled	250.05	247.95	248.45
Unfilled	17.15	21.25	23.75
Total	**267.20**	**269.20**	**272.20**

[1] Includes permanent staff only.

In addition to full-time staff, ETF was authorized to hire limited-term employees (LTEs). The number of authorized LTEs was 41 in June 2016, 42 in June 2017, and 30 in June 2018.

Most ETF staff did not track on an ongoing basis the amount of time they used to complete work for the group insurance programs.

We found that most ETF staff did not track on an ongoing basis the amount of time they used to complete work for the group insurance programs. Instead, ETF managers estimated the amount of time most staff used to complete work for individual programs, based on factors such as workload statistics, position descriptions, and their best judgment. ETF then used these estimates to charge administrative fees to each of the four group insurance programs. The accuracy of these estimates is unknown. ETF indicated that it would not be worthwhile to require staff to track the amount of time they used to complete work for individual programs because these administrative fees are only a small proportion of total program expenditures. However, we note that many state agencies require their staff to track how they use their time in systems such as STAR.

As shown in Table 3, ETF's information indicates that an estimated 55.40 FTE staff positions completed work for the four group insurance programs in 2017, including 44.30 FTE staff positions that responded to questions about the Group Health Insurance program from employers and participants and completed other programmatic work. ETF allocated the costs of executive, legal services, communications, certain IT, and internal audit staff positions to individual programs.

Table 3

Estimated Full-Time Equivalent ETF Staff Positions Completing Work for Programs[1]
2017

Program	Number	Percentage of Total
Group Health Insurance	44.30	16.5%
Group Life Insurance	5.10	1.9
Long-term Disability Insurance	3.60	1.3
Income Continuation Insurance	2.40	0.9
Subtotal	55.40	20.6
Other Programs[2]	120.50	44.8
Other[3]	93.30	34.7
Total	**269.20**	**100.0%**

[1] According to ETF's information; includes permanent staff only.

[2] Includes all other programs, including the WRS and the Deferred Compensation and Duty Disability programs.

[3] ETF allocated the costs of executive, legal services, communications, certain IT, and internal audit staff to individual programs.

Charging accurate administrative fees to the group insurance programs is important because these fees affect the premiums paid by employers and participants. Because ETF relies only on estimates of the amount of time its staff used to complete work for individual programs, it cannot be assured that the administrative fees it charges are accurate. Therefore, ETF should require its staff who work on individual programs to track on an ongoing basis the amount of time they used to complete work for each program.

☑ Recommendation

We recommend the Department of Employee Trust Funds:

- *require its staff who work on individual group insurance programs to track on an ongoing basis the amount of time they used to complete work for each group insurance program; and*
- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement this recommendation.*

■ ■ ■ ■

Group Health Insurance Program ▪

The Group Health Insurance program provides medical, pharmacy, and dental benefits to active and retired state and local government employees as well as to family members of these employees.

The Group Health Insurance program provides medical, pharmacy, and dental benefits to active and retired employees of the State, the University of Wisconsin (UW) Hospitals and Clinics Authority, and other state authorities as well as to their families. As of July 2018, active and retired employees of 368 local governments also participated as well as family members of these employees. The program includes a state component for state participants and a local component for local government participants. A program actuary recommends the total premiums to charge for pharmacy and dental benefits and advises on the reasonableness of premiums that insurers propose to charge for medical benefits. In 2017, program expenditures totaled $1.6 billion. We found that ETF did not consistently prepare and provide GIB with the results of its written analyses of consultant recommendations for improving the program, did not consistently establish the intended outcomes of programmatic changes, and did not appropriately manage contracts with health insurers and program administrators. We make recommendations for improvements.

Expenditures and Revenues

Program expenditures included payments for:

- participant benefits, including medical, pharmacy, and dental benefits;
- program administration services, including fees paid to the pharmacy benefits administrator that negotiated prescription drug prices on GIB's behalf and the dental benefits administrator; and

- other administrative services, including ETF's costs to administer the program, as well as consulting, actuarial, and auditing services.

Program expenditures increased from $1.3 billion in 2009 to $1.6 billion in 2017.

As shown in Table 4, program expenditures increased from $1.3 billion in 2009 to $1.6 billion in 2017. Expenditures for participant benefits accounted for 97.8 percent of total expenditures in 2017. Expenditures for program administration increased in 2017 primarily because $7.2 million was paid to a firm to administer a wellness program that provided $150 annually to each participating employee, retiree, and spouse who completed a medical screening and a health risk assessment questionnaire. Expenditures for this wellness program, which had been administered by health insurers, were included in participant benefits before 2017. In 2017, expenditures totaled $1.4 billion for the state component of the program and $209.9 million for the local component. Segal Consulting, which was the program actuary, was paid $282,900 in 2017.

Table 4

Group Health Insurance Program Expenditures, by Calendar Year
(in millions)

Year	Participant Benefits[1]	Administration		Total
		Program Administration	Other[2]	
2009	$1,313.9	$12.0	$ 5.2	$1,331.1
2010	1,433.1	15.8	5.6	1,454.6
2011	1,518.8	11.3	7.2	1,537.3
2012	1,469.9	14.6	6.8	1,491.3
2013	1,537.4	11.0	6.7	1,555.2
2014	1,614.4	13.6	8.7	1,636.6
2015	1,669.6	13.7	6.7	1,690.0
2016	1,544.0	15.0	11.1	1,570.1
2017	1,531.7	22.9	11.7	1,566.3

[1] Includes the estimated cost of approved benefits for which the program had not yet paid.

[2] Includes ETF's costs to administer the program and consulting, actuarial, and auditing services.

Expenditures for medical benefits made up most program expenditures.

As shown in Table 5, expenditures for medical benefits, including administration, made up most program expenditures. Expenditures for medical benefits decreased in 2012 and 2016 because of benefit changes approved by GIB. In addition, dental benefits were separated from medical benefits beginning in 2016.

Table 5

Group Health Insurance Program Expenditures, by Benefit Type and Calendar Year
(in millions)

Year	Medical	Pharmacy	Dental[1]	Other[2]	Total
2009	$1,109.2	$221.9	$ 0.0	$ 0.0	$1,331.1
2010	1,223.4	231.2	0.0	0.0	1,454.6
2011	1,302.1	235.2	0.0	0.0	1,537.3
2012	1,256.4	234.9	0.0	0.0	1,491.3
2013	1,313.2	242.0	0.0	0.0	1,555.2
2014	1,372.0	269.7	0.0	(5.1)	1,636.6
2015	1,397.4	292.2	0.0	0.4	1,690.0
2016	1,253.9	264.9	55.4	(4.1)	1,570.1
2017	1,226.3	269.8	55.6	14.7	1,566.3

[1] Dental benefits were separated from medical benefits beginning in 2016.

[2] Includes the high-deductible health plan beginning in 2015 and the wellness program in 2017, as well as transactions we could not categorize because of incomplete data.

The program is funded primarily by premiums paid by employers and participants.

The program is funded primarily by premiums paid by employers and participants. It is also funded by investment income of program reserves, which are invested by the State of Wisconsin Investment Board (SWIB) in the Core Fund. As shown in Table 6, total program revenues increased from $1.3 billion in 2009 to $1.6 billion in 2017.

Table 6

Group Health Insurance Program Revenues, by Calendar Year
(in millions)

Year	Premium Revenue[1]	Investment Income	Other[2]	Total
2009	$1,323.9	$25.5	$<0.1	$1,349.4
2010	1,470.4	16.8	<0.1	1,487.3
2011	1,564.1	2.1	<0.1	1,566.3
2012	1,460.4	23.2	<0.1	1,483.5
2013	1,524.8	21.7	<0.1	1,546.5
2014	1,594.2	8.0	<0.1	1,602.2
2015	1,664.7	(0.9)	0.1	1,664.0
2016	1,618.5	11.0	<0.1	1,629.5
2017	1,610.7	29.9	1.2	1,641.8

[1] Includes Medicare subsidies for providing pharmacy benefits to certain retirees.

[2] Includes penalties charged to firms for contractual noncompliance and interest charged to firms for amounts due.

Participants

In 2018, participants were typically given the option to choose single or family health care benefits, including pharmacy benefits, under:

- a traditional health maintenance organization (HMO) plan;
- an "access plan" that had fewer restrictions on the health care providers participants could select but had premiums higher than those of price-competitive, traditional HMO plans;
- a "maintenance plan" that had fewer restrictions on the health care provider networks participants could select, compared to those of traditional HMO plans, but was available only when a price-competitive, traditional HMO plan was unavailable in a given county; and
- a high-deductible health plan that was available under traditional HMO, access, or maintenance plans and that required participants to pay a deductible before insurance began to cover health care costs.

In 2018, active and retired employees could choose to pay additional amounts for dental benefits. They could also choose to pay for supplementary benefits, such as those for vision and dental services.

In 2018, medical benefits were provided through fully insured plans, while pharmacy and dental benefits were provided through self-insured plans. In a fully insured plan, an insurer is paid a premium for each participant, and the insurer covers the costs of benefits and bears the financial risk that such costs may exceed premiums. In a self-insured plan, an employer collects the premiums, covers the costs of benefits, and bears the financial risk.

In 2017, there were 262,732 program participants, including family members.

We used ETF's data to determine the demographics of the 262,732 program participants in 2017, which was the most-recent calendar year for which this information was available during our audit. These participants included active and retired employees and their family members. As indicated in Table 7, 51.7 percent of participants were female, 65.3 percent were between the ages of 18 and 64, and 38.8 percent lived in Dane County. ETF indicated that it did not collect information on the race or ethnicity of participants.

Table 7

Demographics of Group Health Insurance Program Participants
2017

Description	Number	Percentage of Total
Gender		
Female	135,775	51.7%
Male	126,957	48.3
Total	**262,732**	**100.0%**
Age		
Under 1	2,623	1.0%
1 through 4	11,201	4.3
5 through 14	30,745	11.7
15 through 17	9,696	3.7
18 through 24	25,176	9.6
25 through 34	38,159	14.5
35 through 44	33,797	12.9
45 through 54	35,100	13.4
55 through 64	39,255	14.9
65 through 74	23,415	8.9
75 and older	13,565	5.2
Total	**262,732**	**100.0%**

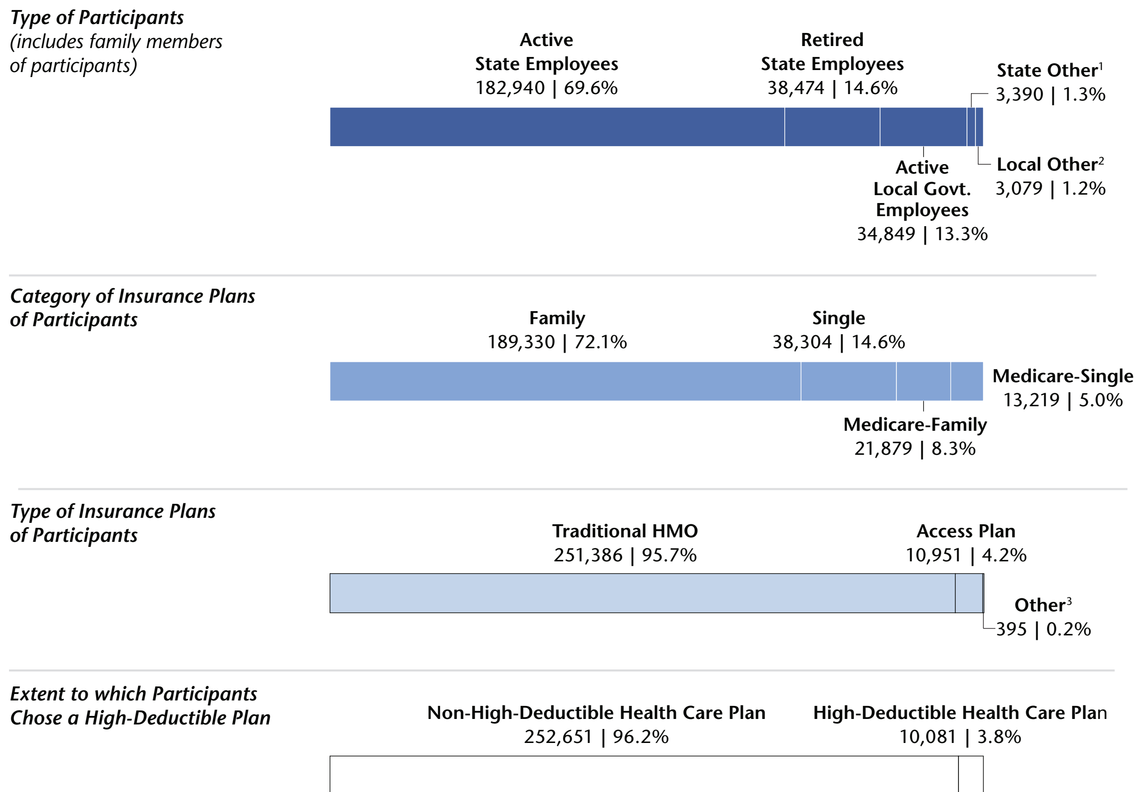
Description	Number	Percentage of Total
County of Residence		
Dane	102,008	38.8%
Milwaukee	15,711	6.0
Out of State	9,128	3.5
Winnebago	8,186	3.1
Waukesha	7,098	2.7
Jefferson	6,525	2.5
Rock	6,040	2.3
Dodge	5,866	2.2
Columbia	5,559	2.1
Eau Claire	5,468	2.1
Brown	4,919	1.9
Racine	4,890	1.9
Fond du Lac	4,786	1.8
La Crosse	4,636	1.8
Other Counties	70,118	26.7
Unknown	1,794	0.7
Total	**262,732**	**100.0%**

Figure 2 provides additional information about program participants in 2017. ETF's data indicate that:

- 85.6 percent of participants were insured through state employees, and 14.4 percent were insured through local government employees;
- 80.4 percent of participants were covered through family plans, and 19.6 percent were covered through single plans;
- 95.7 percent of participants were in a traditional HMO plan; and
- 96.2 percent of participants did not choose a high-deductible health care plan.

Figure 2

Information about Participants in the Group Health Insurance Program
2017



[1] Includes 2,926 dependents of former state employees.

[2] Includes 2,837 local government retirees and family members.

[3] Includes 222 participants insured through a Medicare Supplement plan and 173 participants insured through the maintenance plan.

Program Administration

We assessed ETF's administration of the program. Effective program administration requires ETF to:

- analyze consultant recommendations for improving the program and provide the results to GIB;
- establish the intended outcomes of programmatic changes, assess progress toward achieving those outcomes, and provide the assessment results to GIB; and

- appropriately manage contracts with health insurers and program administrators.

Consultant Recommendations

ETF did not consistently prepare and provide GIB with the results of its written analyses of recommendations from consultants hired to identify program improvements.

We found that ETF did not consistently prepare and provide GIB with the results of its written analyses of recommendations from consultants hired to identify program improvements. In November 2014, ETF contracted with Segal to provide consulting services, including recommendations for program improvements. Segal wrote two reports, including a March 2015 report with recommendations that could be implemented in 2016 and a November 2015 report with recommendations that could be implemented in 2017 and in later years. Segal was paid a total of $604,500 for these two reports. ETF advised GIB in writing to implement some of Segal's recommendations, and GIB did so. However, GIB meeting minutes and materials do not indicate that ETF advised GIB on whether to implement other Segal recommendations, including offering participants not only single and family coverage but also options such as "participant plus spouse" and "participant plus child(ren)" coverage.

ETF indicated that it did not document its analyses of the reasons it decided to advise GIB to implement certain recommendations from Segal, but not to implement others. ETF indicated that key officials who had analyzed these recommendations no longer worked at ETF. As a result, it is unclear whether and how ETF analyzed the recommendations not discussed at GIB meetings. After we asked to discuss these recommendations, ETF indicated that it planned for the first time to comprehensively analyze Segal's recommendations and provide this information to GIB. In November 2018, ETF provided information to GIB about most, but not all, of these recommendations.

ETF should consistently prepare and provide GIB with the results of its written analyses of recommendations from consultants. GIB can then decide whether and how to use the recommendations to improve the program. Documenting recommendations is important because key officials may leave ETF employment, and their knowledge may be lost if the written analyses do not exist. A lack of documentation may also hinder ETF's ability to explain to GIB members the recommendations from consultants.

☑ **Recommendation**

We recommend the Department of Employee Trust Funds:

- *consistently prepare and provide the Group Insurance Board with the results of its written analyses of recommendations from consultants for the Group Health Insurance program; and*
- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement this recommendation.*

Programmatic Changes

ETF did not consistently establish the intended outcomes of programmatic changes and then assess progress toward achieving those outcomes.

We found that ETF did not consistently establish the intended outcomes of programmatic changes and then assess progress toward achieving those outcomes. For example, the wellness program began in 2014 and provided $150 annually to each participating employee, retiree, and spouse who completed a medical screening and a health risk assessment questionnaire. In 2017, wellness program expenditures totaled $14.6 million. ETF indicated that the wellness program is intended to encourage participants to more effectively manage their health and thereby reduce Group Health Insurance program costs at some point in the future. ETF requires the firm that administers the wellness program to annually report various information, such as the number of wellness program participants and the health trends of all Group Health Insurance program participants. However, ETF did not establish any intended outcomes, such as the intended number of participants or amount of savings, and it did not attempt to determine the extent to which Group Health Insurance program costs declined as a result of the wellness program. Similarly, no intended outcomes were established for the high-deductible health plan that began in 2015, such as the number of participants who choose this health plan or amount of savings from participants who choose it.

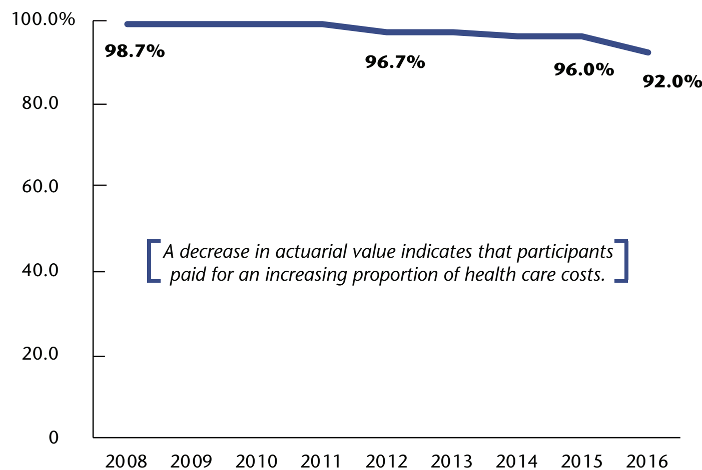
Programmatic changes can affect the actuarial value of a health plan, which is the proportion of total health care costs paid for by a plan. At the December 2017 hearing of the Joint Legislative Audit Committee, ETF estimated that the actuarial value of the traditional HMO plan, in which 95.7 percent of participants were enrolled in 2017, was approximately 90.0 percent. Although legislators expressed an interest in obtaining additional information about the actuarial values, we found that ETF did not know the actuarial values of the program's health plans, including the traditional HMO and high-deductible health plans, in 2017 and 2018. Segal was not

contractually required to provide actuarial values, and ETF indicated that Segal would likely charge an additional fee to calculate them. We twice requested that ETF obtain an estimate of the amount Segal could charge, which we intended to consider before requesting that Segal calculate the actuarial values, but ETF did not provide us with an estimate. Thus, we are unable to present actuarial values for 2017 or 2018. ETF indicated that there was less need to know actuarial values from 2016 through 2018 because program benefits did not change significantly in those years.

As shown in Figure 3, the actuarial value of the traditional HMO plan in the state component of the Group Health Insurance program decreased from 98.7 percent in 2008 to 92.0 percent in 2016, according to information the program actuaries provided to GIB. A decrease in actuarial value indicates that a plan paid for a decreasing proportion of health care costs and, as a result, participants paid for an increasing proportion of health care costs.

Figure 3

Actuarial Value of the Traditional HMO Plan in the Group Health Insurance Program, by Calendar Year[1]
State Component



[1] According to information provided by program actuaries. ETF did not know the actuarial values for 2017 or 2018.

ETF should work with GIB to establish intended outcomes for programmatic changes and then annually assess progress toward achieving these outcomes. For example, it could contractually require the program actuary to annually calculate and report the

actuarial values of health plans in the program. Knowing the actuarial values of health plans would allow ETF to inform GIB and the Legislature about the extent to which benefits are paid for by these health plans rather than by participants. ETF should provide the results of its annual assessments, including the actuarial values, to GIB. Such information will help GIB make informed decisions about how to oversee the program effectively.

☑ **Recommendation**

We recommend the Department of Employee Trust Funds:

- *work with the Group Insurance Board to establish intended outcomes for changes to the Group Health Insurance program;*
- *annually assess progress toward achieving these intended outcomes and provide the results of these assessments to the Group Insurance Board; and*
- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement these recommendations.*

Contract Administration

In 2018, GIB and ETF contracted with various firms to help administer the program, including:

- the 10 insurers that provided 17 medical plans in different locations throughout Wisconsin;
- the administrator of pharmacy benefits;
- the administrator of dental benefits; and
- the auditor that independently assessed the performance of the pharmacy benefits administrator, including the accuracy of payment requests the administrator submitted to ETF for providing these benefits.

Insurers that provided medical plans were contractually required to achieve performance measure goals pertaining to issues such as customer service, benefit claims processing, and non-disclosure of confidential data. In 2018, insurers were contractually required to

report quarterly on their performance at meeting most of these goals, and ETF was contractually permitted to assess financial penalties each quarter if these goals were not achieved.

ETF did not determine the extent to which insurers that provided medical plans achieved contractually specified performance measure goals.

ETF did not determine the extent to which insurers that provided medical plans achieved contractually specified performance measure goals or the extent to which it could have assessed financial penalties. ETF indicated that it did not assess financial penalties because it wanted to work with insurers to achieve contractual compliance rather than penalize them financially. ETF indicated that it will be better able to assess financial penalties in the future because the 2018 contracts for the first time contain specific financial penalties that can be assessed if insurers do not achieve each goal, rather than one financial penalty applicable to all goals.

In November 2015, Segal reported to GIB that ETF was unable to evaluate and analyze health care costs and utilization, health care provider quality, and the performance of insurers because the available data covered different time periods and varied in format and quality. Segal recommended that a data warehouse be established to store insurer-provided data, such as the amounts paid to health care providers and the services provided to participants. In March 2017, GIB contracted with Truven Health Analytics to implement a data warehouse. ETF indicated that this data warehouse became operational in April 2018 and that it intends to use the data to measure the quality and cost-effectiveness of insurers, including the extent to which insurers achieved performance measure goals. At the time of our audit, insufficient time had passed to allow us to assess ETF's use of the data warehouse to improve its program administration. Through December 2017, Truven was paid $667,000 to implement the data warehouse.

Some contracts with program administrators did not sufficiently specify how to calculate performance measures.

We found that some contracts with program administrators did not sufficiently specify how to calculate performance measures, including GIB's contract with Wisconsin Physicians Service Insurance Corporation (WPS), which administered self-insured medical benefits through 2017. WPS and Claim Technologies, the auditor that assessed the performance of WPS, used different methodologies to calculate three performance measures pertaining to the accuracy of payment requests that WPS submitted to ETF. These different methodologies resulted in disagreement on whether WPS achieved the three performance measure goals. For example:

- WPS reported to ETF that it achieved all three goals in 2015, but Claim Technologies reported that WPS did not achieve any of these three goals;

- WPS reported to ETF that it achieved all three goals in 2016, but Claim Technologies reported that WPS achieved only two of these three goals; and

- WPS reported to ETF that it achieved two of the three goals in the first six months of 2017, but Claim Technologies reported that WPS did not achieve any of these three goals.

Although ETF was aware of these different methodologies, it did not advise GIB to modify the contract with WPS to specify how the performance measures were to be calculated. In addition, ETF waived all financial penalties through June 2016 because WPS and Claim Technologies disagreed about the performance of WPS. The available information also indicates that ETF assessed no financial penalties on WPS through June 2017.

An October 2018 RFP for auditing services did not sufficiently specify how to calculate performance measures.

We found that GIB's most-recent contracts with Navitus (the pharmacy benefits administrator), Delta Dental (the dental benefits administrator), and Tricast (the auditor that assessed the performance of Navitus) contained similar performance measures and did not sufficiently specify how they were to be calculated. In February 2018, ETF indicated to GIB that it planned to modify future contracts to sufficiently specify how to calculate these performance measures. However, we found that an October 2018 RFP for auditing services pertaining to the pharmacy benefits administrator and the dental benefits administrator contained the same language that was in GIB's most-recent contracts with Navitus, Delta Dental, and Tricast, and this language did not sufficiently specify how to calculate contractually required performance measures. Although ETF indicated that this RFP should not be expected to specify how to calculate performance measures, we note that the contracts with Claim Technologies and Tricast relied on the associated responses to the two RFPs to specify how to calculate these performance measures.

ETF should improve its administration of program contracts. It should work with GIB to ensure that contracts sufficiently specify how to calculate performance measures, consistently determine whether firms achieve contractually specified performance measure goals, and assess contractually specified financial penalties when firms do not achieve these goals. In addition, it should report to GIB on the financial penalties it assesses. Such information will help GIB make informed decisions about how to oversee the program effectively.

☑ Recommendation

We recommend the Department of Employee Trust Funds:

- *work with the Group Insurance Board to ensure contracts sufficiently specify how to calculate performance measures;*
- *consistently determine whether firms achieved contractually specified performance measure goals and assess contractually specified financial penalties when firms do not achieve these goals;*
- *report to the Group Insurance Board on the financial penalties it assesses; and*
- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement these recommendations.*

■ ■ ■ ■

Group Health Insurance Program Reserves ▪

GIB intends to maintain reserves for the Group Health Insurance program within minimum and maximum amounts that are termed the "target range."

Statutes require GIB to use excess funds that become available through operating the Group Health Insurance program to reduce premiums or establish program reserves to stabilize costs in subsequent years. Program reserves help cover the cost of future benefits. With assistance from ETF and the program actuary, GIB intends to maintain program reserves within minimum and maximum amounts that are termed the "target range." We found that ETF should take additional action to help GIB decide how to spend program reserves. We also found that GIB did not establish target ranges for program reserves until August 2011 or establish a policy requiring a periodic review of these target ranges. In addition, ETF did not consistently prepare and provide GIB with the results of its written analyses of key information provided by the program actuary. We make recommendations for improvements.

Program Reserve Amounts

Program reserves are tracked separately for the state and local program components, as well as for medical, pharmacy, and dental benefits in both program components. ETF indicated that:

- program reserves for medical benefits, which were primarily fully insured through 2017, are spent to minimize large annual fluctuations in premiums paid by employers and participants; and

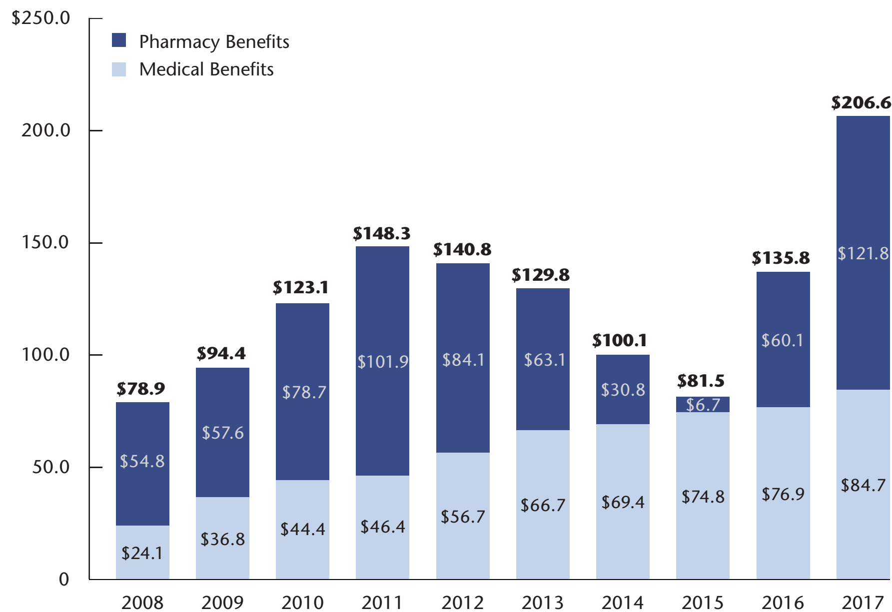
- program reserves for pharmacy and dental benefits, which are self-insured, protect against the risk that benefits in a given year will exceed the amount of premiums collected and are spent to minimize large annual fluctuations in premiums paid by employers and participants.

Program reserves for the state component increased by $125.1 million from December 2015 to December 2017.

As shown in Figure 4, program reserves for the state component increased from $81.5 million in December 2015 to $206.6 million in December 2017, or by $125.1 million. Program reserves for dental benefits increased from a deficit of $1.2 million in 2016, when they were first separated from program reserves for medical benefits, to $184,700 in 2017. The overall amounts of program reserves shown in the figure include program reserves for dental benefits. SWIB invests program reserves in the Core Fund.

Figure 4

Group Health Insurance Program Reserves for the State Component, by Benefit Type[1]
As of December 31
(in millions)

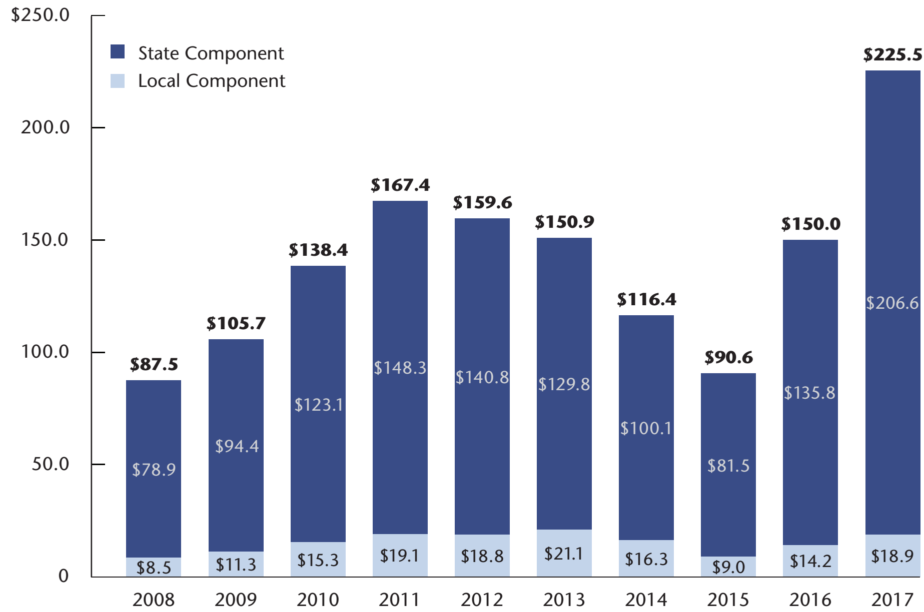


[1] The overall amounts of program reserves include program reserves for dental benefits.

We also determined program reserves for the state and the local components combined. As shown in Figure 5, program reserves for both components increased from $90.6 million in December 2015 to $225.5 million in December 2017, or by $134.9 million.

Figure 5

Group Health Insurance Program Reserves, by Program Component
As of December 31
(in millions)



Program reserves change from year to year primarily because of net premium revenue and investment income earned on program reserves. Net premium revenue in a given year is positive if premium revenue exceeds program expenditures, and it is negative if program expenditures exceed premium revenues. In 2017, premium revenue totaled $1.611 billion and program expenditures totaled $1.566 billion, which resulted in $44.4 million in net premium revenue.

As shown in Table 8, program reserves increased by $59.4 million in 2016 and by $75.5 million in 2017. In both years, net premium revenue and investment income were positive.

Table 8

Group Health Insurance Program Reserves, by Calendar Year
State and Local Components
(in millions)

Year	Net Premium Revenue[1]	Investment Income	Other Income[2]	Change in Program Reserves	Total Program Reserves
2009	$ (7.2)	$25.5	<$0.1	$ 18.3	$105.7
2010	15.9	16.8	<0.1	32.7	138.4
2011	26.9	2.1	<0.1	29.0	167.4
2012	(30.9)	23.2	<0.1	(7.8)	159.6
2013	(30.4)	21.7	<0.1	(8.7)	150.9
2014	(42.5)	8.0	<0.1	(34.5)	116.4
2015	(25.2)	(0.9)	0.1	(26.0)	90.6
2016	48.4	11.0	<0.1	59.4	150.0
2017	44.4	29.9	1.2	75.5	225.5

[1] Includes Medicare subsidies for providing pharmacy benefits to certain retirees.

[2] Includes penalties charged to firms for contractual noncompliance and interest charged to firms for late payments.

GIB voted to spend program reserves for the state component in 9 of the 11 years from 2009 through 2019.

Based on recommendations from the program actuary, GIB annually votes on the amount of program reserves to spend in a given year. As shown in Table 9, GIB voted to spend program reserves for the state component in 9 of the 11 years from 2009 through 2019 and for the local component in 8 of the 11 years. It did not vote to spend any program reserves in 2016 or 2017, in part, because it was considering whether all medical benefits should be self-insured. As noted, an employer bears the financial risk in a self-insured plan and may maintain a greater amount of program reserves to protect against this risk. Voting to spend program reserves reduces the premiums that otherwise would have been paid by employers and participants.

Table 9

Group Health Insurance Program Reserves GIB Voted to Spend, by Calendar Year
(in millions)

	State Component			Local Component		
Year	Medical Benefits	Pharmacy Benefits	Total	Medical Benefits	Pharmacy Benefits	Total
2009	$ 5.8	$12.8	$18.5	$0.1	$2.1	$2.2
2010	4.4	1.7	6.1	0.1	0.3	0.4
2011	0.2	0.0	0.2	0.0	0.8	0.8
2012	0.0	30.0	30.0	0.0	1.0	1.0
2013	0.0	32.8	32.8	0.2	1.0	1.2
2014	0.0	20.5	20.5	0.0	3.1	3.1
2015	0.0	20.0	20.0	0.0	5.0	5.0
2016	0.0	0.0	0.0	0.0	0.0	0.0
2017	0.0	0.0	0.0	0.0	0.0	0.0
2018	13.0	16.0	29.0	0.0	0.0	0.0
2019	0.0	49.1	49.1	0.0	8.7	8.7

In effect, the amount of program reserves GIB votes to spend is intended to equal the net premium revenue in a given year. For example, if GIB were to vote to spend $25.0 million in program reserves, the net premium revenue is intended to be negative by that amount. However, the amount of program reserves GIB votes to spend may differ from the amount actually spent. Because GIB pays contractually specified amounts for fully insured medical benefits, these costs are known, and GIB can accurately determine the amount of program reserves to spend in order to reduce premiums by given amounts. In contrast, it cannot know how much self-insured pharmacy and dental benefits will cost in a given year when it votes to spend program reserves. Instead, the program actuary estimates these costs, and GIB votes to spend program reserves according to these estimates. If these estimates are inaccurate, the actual amount of program reserves spent will differ from the amount GIB had voted to spend. Pharmaceutical expenditures, which totaled $269.8 million in 2017, can be difficult to accurately predict because they depend on the particular pharmaceuticals prescribed to participants and the prices of those pharmaceuticals.

As shown in Table 10, the $25.0 million in program reserves that GIB voted to spend in 2015 almost equaled the $25.2 million in net premium revenue. In contrast, net premium revenue was considerable in both 2016 and 2017, even though GIB did not vote to spend any program reserves in either year. This indicates that Segal's estimates of pharmaceutical expenditures or dental expenditures, or both, differed from the actual expenditures.

Table 10

Program Reserves GIB Voted to Spend versus Net Premium Revenue, by Calendar Year
State and Local Components
(in millions)

Year	Program Reserves GIB Voted to Spend	Net Premium Revenue[1]
2009	$20.7	$ (7.2)
2010	6.5	15.9
2011	1.0	26.9
2012	31.0	(30.9)
2013	34.0	(30.4)
2014	23.6	(42.5)
2015	25.0	(25.2)
2016	0.0	48.4
2017	0.0	44.4

[1] Includes Medicare subsidies for providing pharmacy benefits to certain retirees.

ETF did not require the program actuary to consider an estimate of future investment income when recommending the amount of program reserves to spend.

We found that ETF did not require the program actuary to consider an estimate of future investment income when recommending the amount of program reserves to spend. In effect, this presumes there will be no investment income in a given year. As shown in Table 8, investment income can be substantial and totaled $29.9 million in 2017, which contributed to the considerable increase in program reserves in that year.

We identified other concerns with the information program actuaries provided to GIB. From 2008 through 2017, the program actuaries annually indicated the extent to which program reserves had changed from the prior year. However, ETF did not require the program actuaries to explain why these changes differed from the amounts of program reserves GIB had voted to spend.

In August 2018, Segal provided such an explanation for the first time. Segal projected that program reserves for the state component would increase to $228.3 million on December 31, 2018, rather than decrease to $155.9 million as it had projected to GIB in August 2017. Segal anticipated this increase would occur, even though GIB had voted to spend $29.0 million in program reserves in 2018, because it projected that:

- the State would pay $53.4 million less in pharmacy benefits than Segal had projected in August 2017; and

- investment income would increase program reserves by $19.0 million in 2018, even though Segal had excluded investment income from the projection provided to GIB in August 2017.

From 2008 through 2018, the program actuaries annually provided GIB with information about program reserves on a fiscal-year basis, rather than the calendar-year basis on which GIB makes spending decisions. The program actuaries did so because the balances as of June 30 of a given year are the most-recent information available when GIB meets in August. However, the change in program reserves in a given fiscal year is affected by decisions GIB made in two calendar years. As a result, providing information on a fiscal-year basis makes it difficult to understand how GIB's calendar-year decisions affected changes in program reserves.

ETF should take additional action to help GIB make informed decisions about spending program reserves.

ETF should take additional action to help GIB make informed decisions about spending program reserves. ETF should require the program actuary to take investment income into account when recommending to GIB the amounts of program reserves to spend. One way to do so could be to use the expected long-term annual rate of return on the funds invested in the Core Fund, as determined by SWIB. The average annual return on the Core Fund was 8.6 percent over the 5-year period from 2013 through 2017, 5.9 percent over the 10-year period from 2008 through 2017, and 7.1 percent over the 20-year period from 1998 through 2017. During this 20-year period, investment returns were positive in 15 years and negative in 5 years. ETF should also require the program actuary to explain why the change in program reserves differed from the amount that GIB had voted to spend and to provide GIB with calendar-year information.

☑ **Recommendation**

We recommend the Department of Employee Trust Funds:

- *require the program actuary to take investment income into account when it recommends the amount of Group Health Insurance program reserves to spend;*
- *require the program actuary to annually explain why the change in Group Health Insurance program reserves differed from the amount the Group Insurance Board had voted to spend;*
- *require the program actuary to provide the Group Insurance Board with calendar-year information on Group Health Insurance program reserves; and*
- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement these recommendations.*

Administration of Program Reserves

Effective administration of program reserves requires ETF to:

- work with GIB to periodically review the target ranges for program reserves; and
- sufficiently understand key information from the program actuary so that it can effectively help GIB make informed decisions about program reserves.

Target Ranges for Program Reserves

GIB did not establish target ranges for program reserves until August 2011.

We found that GIB did not establish target ranges for program reserves until August 2011, and it did so based on a recommendation from the program actuary, which was Deloitte Consulting at that time. GIB did not modify these target ranges until August 2017, based on a recommendation from the program actuary, which had changed to Segal. Segal recommended that GIB establish a target range of 3.0 percent to 5.0 percent of premiums for medical benefits, 3.0 percent to 5.0 percent of claims for dental benefits, and 8.0 percent to 10.0 percent of claims for pharmacy benefits. Segal also recommended that GIB spend program reserves over a four-year period in order for program reserves to be at the midpoint of the combined total of the three target ranges after 2021. GIB approved these recommendations in August 2017.

We obtained information about target ranges in other midwestern states. Indiana, Michigan, Minnesota, and Ohio had established target ranges for program reserves, but Illinois had not done so because its program had no reserves and was late in making payments to health care insurers. Iowa did not respond to our inquiries. Because each state's program differs, it is difficult to compare target ranges among states.

GIB did not establish a policy requiring periodic reviews of the target ranges for program reserves.

We found that GIB did not establish a policy requiring periodic reviews of the target ranges for program reserves, in order to ensure that the target ranges continue to be appropriate for the current priorities and structure of the program. In August 2011 and August 2017, GIB approved target ranges after relevant legislative action. 2011 Wisconsin Act 13, which was enacted in April 2011, required ETF to spend $28.0 million in program reserves to reduce program costs for state employers. In June 2017, the Joint Committee on Finance amended 2017 Assembly Bill 64, the 2017-19 Biennial Budget Bill, to require GIB to review how it maintains program reserves for fully insured benefits, submit a plan to the Committee for spending program reserves for the state component in 2018 and 2019, and spend $68.8 million in program reserves for the state component during the 2017-19 biennium in order to reduce premiums paid by state employers. In September 2017, the Governor vetoed these requirements because of an objection to having the Legislature interfere with the responsibilities of GIB.

Other state agencies require periodic reviews of the target ranges for program funds. The Board of Governors of the Office of the Commissioner of Insurance (OCI) established a policy that requires OCI to contract every three years for an actuarial audit of the Injured Patients and Families Compensation Fund, which insures health care providers against medical malpractice claims that exceed the primary malpractice insurance thresholds in statutes. As noted in report 16-4, OCI agreed that it is appropriate for the actuarial audit to review the target range for the Fund's net position.

☑ Recommendation

We recommend the Department of Employee Trust Funds:

- *work with the Group Insurance Board to establish a policy requiring periodic reviews of the target ranges for Group Health Insurance program reserves and provide the results of these reviews to the Group Insurance Board; and*

- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement this recommendation.*

Information Provided by the Program Actuary

The program actuary regularly provides programmatic information, including recommendations for spending program reserves. Nine of the 11 GIB members indicated to us that they believe ETF is responsible for understanding information provided by program actuaries.

ETF did not consistently prepare and provide GIB with the results of its written analyses of key information provided by the program actuary.

We found that ETF did not consistently prepare and provide GIB with the results of its written analyses of key information provided by the program actuary. ETF did not document its analyses of the target ranges for program reserves that Segal recommended to GIB in August 2017 or why certain information Deloitte had provided to GIB in August 2011 differed from information Segal provided in August 2017. For example:

- Deloitte had indicated that GIB should maintain five times more program reserves for self-insured benefits than for fully insured benefits, but Segal indicated that the amount of program reserves should be determined based on the type of benefit, such as medical or pharmacy, rather than how those benefits are insured.

- Deloitte had indicated that maintaining program reserves protects against the risk of health insurers leaving the program, but Segal indicated that higher-cost health insurers were more likely than lower-cost health insurers to leave the program and, thus, reduce program costs.

- Deloitte had recommended target ranges for program reserves based on a National Association of Insurance Commissioners' method of determining the minimum amount of capital an insurer needed to support its operations, but Segal recommended target ranges based on a survey of health insurers that reflected market conditions and historical prices of health insurance.

ETF did not consistently prepare and provide GIB with the results of its written analyses of why it believed GIB should not comply with the target ranges for program reserves that GIB had previously approved.

We found that ETF did not consistently prepare and provide GIB with the results of its written analyses of why it believed GIB should not comply with the target ranges for program reserves that GIB had previously approved. For example:

- Segal recommended in August 2018 that GIB spend $49.1 million in program reserves for the state component in order to maintain premiums in 2019, even though the midpoint of the target ranges for program reserves approved in

August 2017 specified that GIB should spend $111.8 million. ETF indicated to us that it had directed Segal to recommend spending fewer program reserves than specified by the target ranges in order to have more program reserves available to maintain or reduce premiums in 2020 and later. However, ETF did not document that it had done so. GIB approved the recommendation from Segal.

- Segal recommended in August 2016 that GIB not spend any program reserves for the state component in 2017 because of the potential transition of the State to self-insured medical benefits, even though the target ranges for program reserves that GIB had approved in August 2011 specified that GIB should spend between $24.7 million and $80.8 million. ETF did not document the discrepancy between Segal's recommendation and the target ranges for program reserves. GIB approved the recommendation from Segal.

Although ETF indicated that it analyzed information from the program actuary about program reserves, it should consistently prepare and provide GIB with the results of its written analyses of this information. For example, it could have verified that higher-cost health insurers were more likely than lower-cost health insurers to leave the program, as Segal indicated. Documenting analyses is important because key officials may leave ETF employment, and their knowledge may be lost if the written analyses do not exist. A lack of documentation may also hinder ETF's ability to explain to GIB members the information provided by the program actuary. If ETF does not possess the expertise necessary to analyze information from the program actuary, it may wish to obtain such expertise, such as by hiring staff with actuarial expertise. ETF should also indicate in writing to GIB if the program actuary makes a recommendation that is inconsistent with a prior GIB decision.

☑ Recommendation

We recommend the Department of Employee Trust Funds:

- *consistently prepare and provide the Group Insurance Board with the results of its written analyses of key information about program reserves that was provided by the actuary for the Group Health Insurance program;*

- *indicate in writing to the Group Insurance Board if the program actuary makes a recommendation that is inconsistent with a prior Group Insurance Board decision; and*

- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement these recommendations.*

Actuarial Audit

The actuary with which we contracted found that Segal used a reasonable and appropriate method to develop the recommended target ranges for program reserves.

We issued an RFP and then contracted in May 2018 with Lewis & Ellis, an actuary, to independently determine if the actuarial methods, assumptions, procedures, and analyses that Segal used to develop the target ranges for program reserves it recommended to GIB in August 2017 were actuarially sound, consistent with insurance industry business practices and standards, and consistent with generally accepted Actuarial Standards of Practice. In its December 2018 report, Lewis & Ellis found that Segal used a reasonable and appropriate method to develop the target ranges for program reserves.

Lewis & Ellis recommended target ranges for program reserves similar to those that Segal recommended and GIB approved in August 2017. Both actuaries recommended a target range of 3.0 percent to 5.0 percent of premiums for medical benefits. However, Lewis & Ellis recommended a target range of 8.0 percent to 12.0 percent of claims for pharmacy benefits, rather than the 8.0 percent to 10.0 percent recommended by Segal, and 5.0 percent to 7.0 percent of claims for dental benefits, rather than the 3.0 percent to 5.0 percent recommended by Segal.

In December 2017, program reserves for the state component were $142.4 million more than the targeted amounts.

Although the target ranges for program reserves that GIB approved in August 2017 were applicable beginning in January 2018, we determined the extent to which program reserves for the state component exceeded these target ranges in December 2017. As shown in Table 11, program reserves for the state component were $142.4 million more than the targeted amounts, which is the midpoint of the target ranges for program reserves.

Table 11

Extent to which Group Health Insurance Program Reserves Exceeded the Targeted Amounts
State Component
As of December 31, 2017
(in millions)

Benefit Type	Actual Amount	Targeted Amount[1]	Difference
Medical	$ 84.7	$41.9	$ 42.8
Pharmacy	121.8	20.2	101.6
Dental	0.2	2.1	(1.9)
Total	**$206.6**	**$64.2**	**$142.4**

[1] In August 2017, GIB voted to approve Segal's recommendation to spend program reserves over a four-year period in order for program reserves to be at the midpoint of the total of the target ranges after 2021.

Issue for Legislative Consideration

The Legislature could consider modifying statutes to require ETF to provide certain information about program reserves to the Legislature by June 30 of each year.

Statutes do not require ETF to annually provide the Legislature with information about the amount of program reserves. However, such information would allow the Legislature to determine the extent to which program reserves had changed in recent years and obtain an explanation from ETF about why program reserves had changed. Therefore, the Legislature could consider modifying statutes to require ETF to provide to the Legislature by June 30 of each year information about program reserves for the state and the local components, including the amounts of program reserves as of December 31 of the prior two years and the reasons why program reserves had changed over that period of time.

■ ■ ■ ■

Employer Opinions about the Group Health Insurance Program ■

We surveyed all state agencies and local governments about their satisfaction with the Group Health Insurance program and the assistance ETF provided them.

We surveyed all state agencies and local governments that participated in the Group Health Insurance program as of July 2018 about their satisfaction with the program and the assistance ETF provided them. We also surveyed all local governments that did not participate, in order to determine why they chose not to participate. A total of 22 of 49 state agencies (44.9 percent), 156 of 351 participating local governments (44.4 percent), and 575 of 2,136 non-participating local governments (26.9 percent) responded to our survey. Not all state agencies and local governments responded to each survey question. Most state agencies and participating local governments indicated that they were satisfied with the program and the assistance ETF provided them.

Satisfaction with the Program

The 156 participating local governments that responded to our survey included 7 counties, 27 cities, 48 villages, 36 towns, 4 school districts, and 34 other entities such as library systems and public housing authorities. Survey respondents were located in 46 counties, and 155 respondents indicated the number of their employees, including:

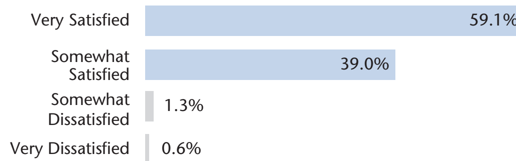
- 33 that had 1 to 5 employees;
- 66 that had 6 to 25 employees;
- 17 that had 26 to 50 employees;
- 17 that had 51 to 100 employees; and
- 22 that had more than 100 employees.

We asked participating local governments to indicate their overall satisfaction with the program and their satisfaction with certain aspects of the program, as shown in Figure 6.

Figure 6

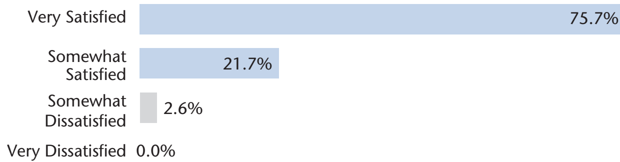
Satisfaction of Participating Local Governments with the Group Health Insurance Program[1]

Overall Satisfaction with the Program

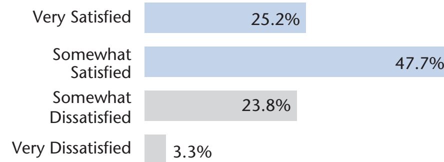


Satisfaction with Certain Aspects of the Program

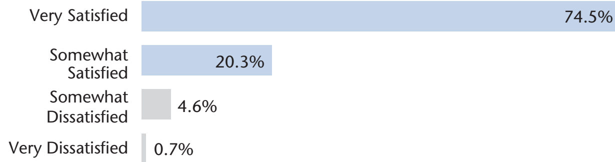
Quality of Health Plans



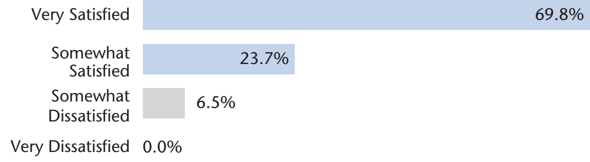
Price to the Employer Organization of Health Plans



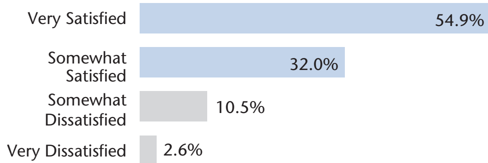
Scope of Coverage of Health Plans



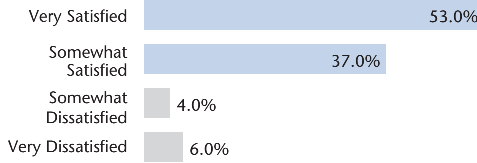
Attractiveness of Programs Benefits to Recruit and Retain Skilled Employees



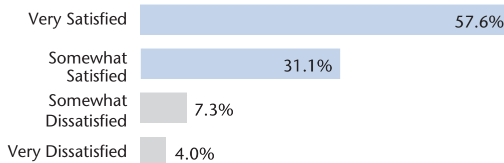
Choice of Health Plans



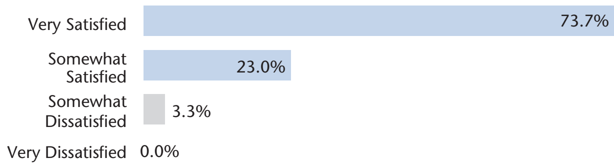
Access to Summary Programmatic Information



Choice of Health Care Providers



Open Enrollment Process



[1] As indicated by survey respondents.

Overall, 98.1 percent of local government respondents indicated that they were either very satisfied or somewhat satisfied with the program.

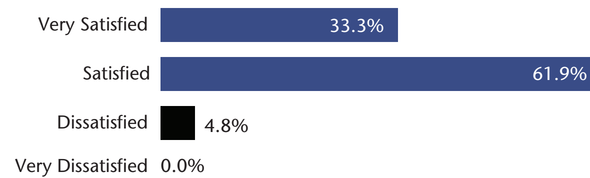
Overall, 98.1 percent of local government respondents indicated that they were either very satisfied or somewhat satisfied with the program. Respondents were similarly satisfied with various aspects of the program, but they were somewhat less satisfied with the price to employer organizations of health plans.

In total, 95.2 percent of state agencies responding to our survey indicated that they were either very satisfied or satisfied with the open enrollment process.

We asked state agencies to indicate their overall satisfaction with the open enrollment process, which is when employees select their health plans for the following year. As shown in Figure 7, 95.2 percent of the 21 state agencies responding to this question indicated that they were either very satisfied or satisfied with the open enrollment process.

Figure 7

Satisfaction of State Agencies with the Open Enrollment Process[1]



[1] As indicated by survey respondents.

State agencies and participating local governments that responded to our survey commented on their satisfaction with the program. For example:

- One respondent indicated that "we are truly grateful and appreciate the great coverage we receive! Thank you!"

- A second respondent indicated that "our [organization] loves the Group Health Insurance program. The benefits and services are excellent."

- A third respondent indicated that employees "have no complaints [and] all employees seem to be satisfied. Believe the premiums to be fair. Any drastic change in the program could be detrimental to our organization."

A larger number of survey respondents commented on their dissatisfaction with the program, including the costs of health plans for employers and participants. In addition:

- Some respondents indicated dissatisfaction with the availability of health care providers and health plans, including one who noted that "the availability of physicians in our immediate area for the most affordable health plans…has been an issue when employees are in need of services from a specialist," and another who noted that "there are not enough insurance plans to [choose] from…"

- Other respondents indicated dissatisfaction with various administrative aspects of the program, including one who noted that "there are so many different scenarios and forms that are required that it is difficult to stay informed of what all needs to be done. I think if there was a quicker response time to phone calls or emails that would help."

- Still other respondents indicated dissatisfaction with how the program operates, including one who indicated that the open enrollment deadline "should be moved up. [It's] currently at the end of October. Municipality budgets are approved in November [and must be] published in the newspaper prior to the approval date. Our budget is set before we receive all of the health insurance changes."

Satisfaction with Information and Assistance that ETF Provided

Almost all state agencies and participating local governments responding to our survey indicated that they were very satisfied or somewhat satisfied overall with information ETF provided about the program.

As shown in Figure 8, almost all state agencies and participating local governments responding to our survey indicated that they were very satisfied or somewhat satisfied overall with information ETF provided about the program. Overall, both types of respondents were generally satisfied with information ETF provided about certain aspects of the program, but participating local governments were generally more satisfied than state agencies.

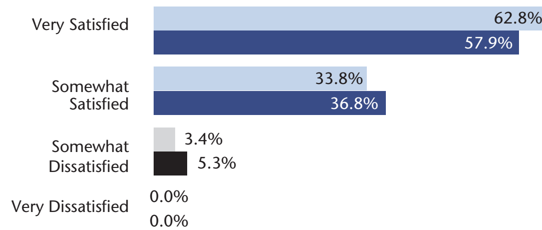
Figure 8

Satisfaction with the Information ETF Provided about the Group Health Insurance Program[1]

Very Satisfied or Somewhat Satisfied
- Participating Local Governments
- State Agencies

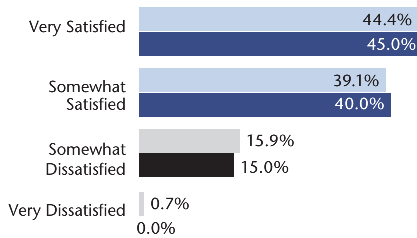
Very Dissatisfied or Somewhat Dissatisfied
- Participating Local Governments
- State Agencies

Overall Satisfaction with the Information ETF Provided

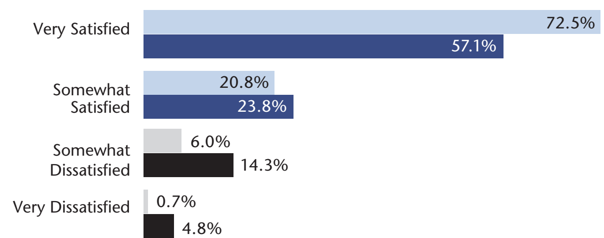


Satisfaction with the Information ETF Provided about Certain Aspects of the Program

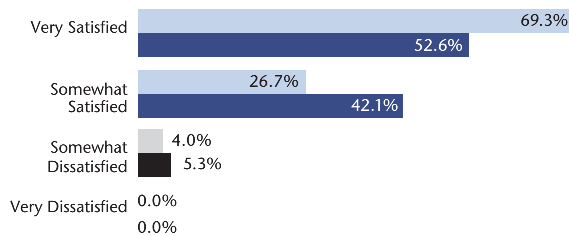
Price to the Employer Organization of Health Plans



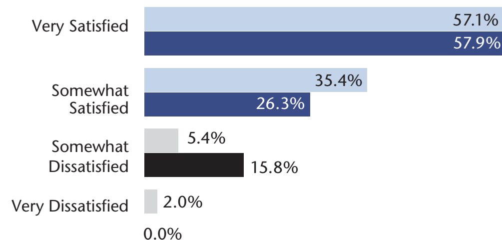
Open Enrollment Process



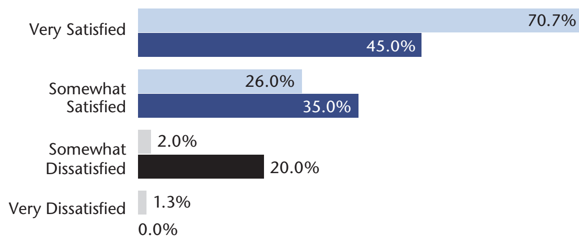
Quality of Health Plans



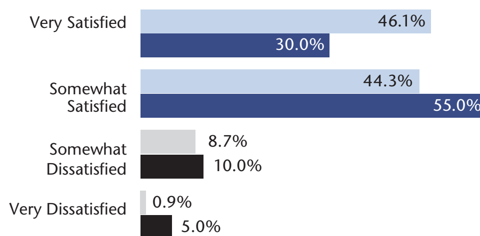
Health Plan Details



Scope of Coverage of Health Plans



Group Insurance Board Decisions



[1] As indicated by survey respondents.

Overall, almost all state agencies and participating local governments responding to our survey indicated that they were either very satisfied or somewhat satisfied with the assistance ETF provided.

A total of 14 state agencies and 105 participating local governments indicated that they had asked ETF for assistance with the program in the past year. Overall, almost all of them indicated that they were either very satisfied or somewhat satisfied with the assistance ETF provided, as shown in Figure 9.

Figure 9

Satisfaction with the Assistance ETF Provided with the Group Health Insurance Program[1]

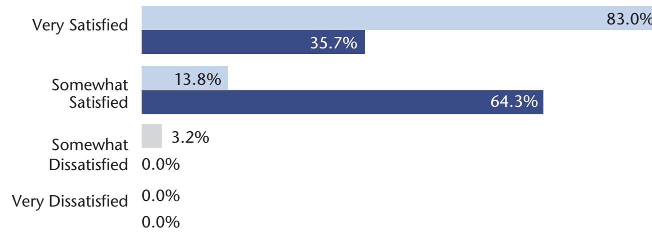
Very Satisfied or Somewhat Satisfied

Participating Local Governments
State Agencies

Very Dissatisfied or Somewhat Dissatisfied

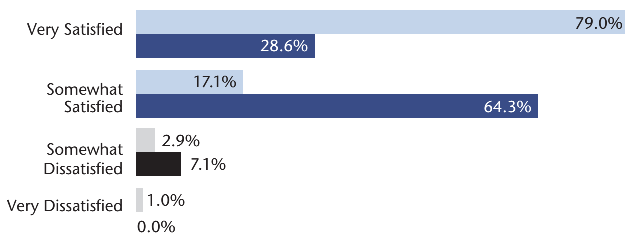
Participating Local Governments
State Agencies

Overall Satisfaction with the Assistance ETF Provided

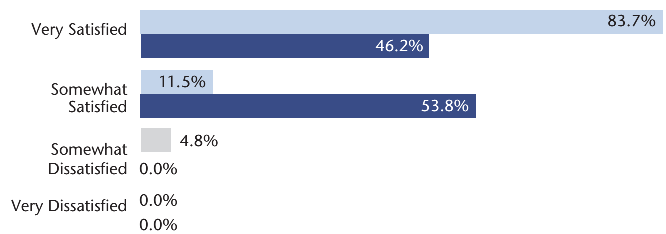


Satisfaction with the Assistance ETF Provided about Certain Aspects of the Program

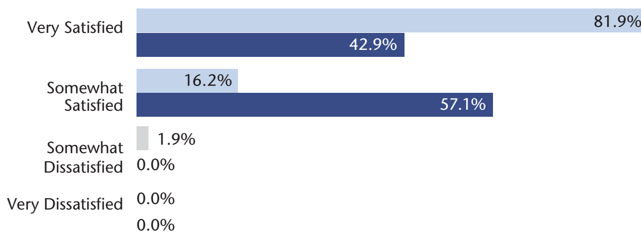
Timeliness of ETF's Assistance



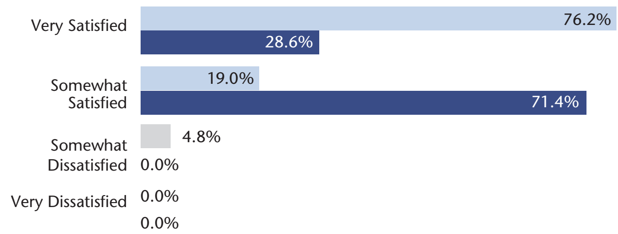
Accuracy of ETF's Assistance



Completeness of ETF's Assistance



Clarity of ETF's Assistance



[1] As indicated by survey respondents.

Satisfaction with GIB

We asked state agencies and participating local governments whether they had in the past year submitted a comment, question, or complaint to GIB. One state agency and three participating local governments indicated that they had done so. The state agency and two of the three participating local governments indicated that GIB had adequately addressed their issues. One participating local government indicated that GIB had not adequately addressed its issue, which related to its desire for an additional high-deductible health plan option.

Non-Participating Local Governments

We surveyed local governments that did not participate in the program.

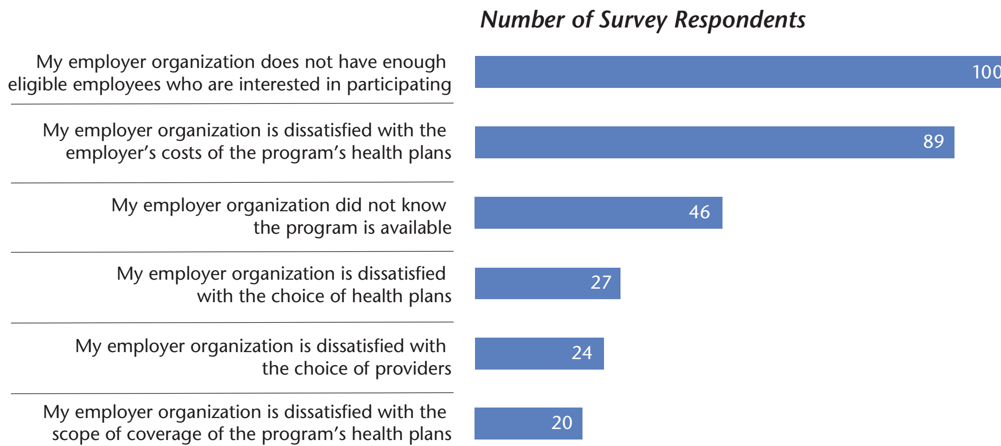
The 575 non-participating local governments that responded to our survey included 25 counties, 57 cities, 76 villages, 207 towns, 179 school districts, and 31 other entities such as public housing authorities and sewerage districts. Survey respondents were located in all 72 counties, and 568 respondents indicated the number of their employees, including:

- 165 that had 1 to 5 employees;
- 116 that had 6 to 25 employees;
- 44 that had 26 to 50 employees;
- 69 that had 51 to 100 employees; and
- 174 that had more than 100 employees.

As shown in Figure 10, survey respondents indicated that a number of factors contributed to their decisions not to participate. Most respondents that indicated they did not know the program is available also indicated they had five employees or fewer.

Figure 10

Factors Contributing to the Decisions of Local Governments Not to Participate in the Group Health Insurance Program[1]



[1] Survey respondents could indicate multiple factors.

Survey respondents provided additional information about why they did not participate. A total of 156 respondents indicated that they did not provide health insurance, including 41 respondents who indicated that they had no full-time employees. In addition, 101 respondents indicated that they had purchased health insurance outside the program, and 57 respondents indicated that program costs were too high.

Expenditures and Revenues
Participants
Program Administration
Program Redesign

Disability Insurance Programs ▪

The ICI and Long-term Disability Insurance programs provide disability benefits to participating state and local government employees.

The ICI and Long-term Disability Insurance programs provide disability benefits to participating state and local government employees. GIB contracted with a program administrator to verify the eligibility of program applicants and process benefit claims for both programs under one contract. In February 2017, GIB approved transferring oversight of both programs to the ETF Board, in order to place oversight of all disability insurance programs under the ETF Board, but statutes must be modified before oversight of the ICI program can be transferred. Since January 2018, the Long-term Disability Insurance program has been overseen by the ETF Board and has been closed to new benefit claims, although benefit payments continue for participants who had submitted benefit claims before that date. We found that ETF did not consistently provide GIB with audit reports on the performance of the program administrator and that it did not work with GIB to establish target ranges for program reserves for the ICI program or establish a strategy and timeline for achieving them. We make recommendations for improvements.

Expenditures and Revenues

The ICI program is an elective program that replaces 75.0 percent of the wages of participants who become disabled. Any active state employee in the WRS may participate, and any active local government employee may participate if his or her local government employer is in the WRS, has elected to provide program coverage, and enrolls at least 65.0 percent of its eligible employees. Benefits are

provided to participants who because of their disability are unable to perform the duties of their current positions for 12 months or less or, if they remain disabled for longer than 12 months, are unable to work in positions for which they are reasonably qualified. The program includes state and local components that are administered separately.

The Long-term Disability Insurance program replaced 40.0 percent or 50.0 percent of the wages of active state and local government employees in the WRS, all of whom were automatically eligible for coverage if they became disabled. The percentage of wages replaced depended on whether a given employee was eligible for Social Security benefits. Benefits were provided to participants who because of their disabilities were unable to work in positions for which they were reasonably qualified and who met certain criteria, including if they had at least 0.33 years of creditable service in the WRS in at least five of the prior seven calendar years. Participants received benefits regardless of their years of WRS creditable service if their disabilities resulted from their employment.

Benefits from other federal and state disability programs, including the Long-term Disability Insurance program and those administered by the U.S. Social Security Administration, offset ICI program benefits. WRS benefits offset benefits from both programs, while income from earnings and unemployment benefits offset ICI benefits.

Expenditures for both programs included payments for:

- participant benefits;
- program administration services provided by Aetna; and
- other administrative services, including ETF's costs to administer the programs, as well as consulting, actuarial, and auditing services.

ICI program expenditures varied from 2009 through 2017, primarily because participant benefits varied annually.

As shown in Table 12, expenditures for the state and the local components of the ICI program varied from 2009 through 2017, primarily because participant benefits varied annually. In 2014, expenditures for participant benefits and program administration differed considerably from such expenditures in other years because ETF changed how it accounted for future program costs, based on advice from the program actuary and as required by accounting standards. Milliman, which was the actuary for both programs, was paid $45,000 in 2017 for its actuarial services.

Table 12

Income Continuation Insurance Program Expenditures, by Calendar Year
(in millions)

Year	Participant Benefits[1]	Administration		Total
		Program Administrator[2]	Other[3]	
State Component				
2009	$11.0	$1.3	$0.4	$ 12.7
2010	16.3	1.4	0.4	18.2
2011	30.6	1.4	0.7	32.7
2012	10.6	1.4	0.4	12.4
2013	26.9	1.4	0.5	28.8
2014	8.6	4.7	0.6	13.9
2015	22.6	1.4	0.2	24.3
2016	24.3	2.2	0.6	27.1
2017	17.2	1.2	0.5	18.9
Local Component				
2009	0.6	0.1	0.1	0.7
2010	0.9	0.1	0.1	1.1
2011	1.8	0.1	0.1	1.9
2012	1.8	0.1	0.1	2.0
2013	0.8	0.1	0.1	0.9
2014	(0.4)	0.3	0.1	(<0.1)
2015	1.5	0.1	<0.1	1.6
2016	2.0	0.2	0.1	2.3
2017	1.5	0.1	0.1	1.7

[1] Includes the estimated cost of benefit claims for which the program had not yet paid. Beginning in 2014, ETF changed how it accounted for future program costs.

[2] Beginning in 2014, ETF changed how it accounted for future program costs.

[3] Includes ETF's costs to administer the program and consulting, actuarial, and auditing services.

Total expenditures for the Long-term Disability Insurance program varied from 2009 through 2017, primarily because participant benefits varied annually.

As shown in Table 13, total expenditures for the Long-term Disability Insurance program varied from 2009 through 2017, primarily because participant benefits varied annually. In 2014, expenditures for participant benefits and program administration differed considerably from such expenditures in other years because ETF changed how it accounted for future program costs, based on advice from the program actuary and as required by accounting standards.

Table 13

Long-term Disability Insurance Program Expenditures, by Calendar Year
(in millions)

Year	Participant Benefits[1]	Administration		Total
		Program Administrator[2]	Other[3]	
2009	$41.3	$ 1.8	$0.4	$ 43.5
2010	45.6	1.6	0.4	47.6
2011	42.5	1.7	0.4	44.6
2012	57.4	1.8	0.7	59.8
2013	57.8	1.9	0.4	60.1
2014	90.3	13.2	0.6	104.1
2015	76.9	3.1	0.5	80.5
2016	65.3	5.6	0.9	71.7
2017	50.3	2.2	0.8	53.3

[1] Includes the estimated cost of benefit claims for which the program had not yet paid. Beginning in 2014, ETF changed how it accounted for future program costs.

[2] Beginning in 2014, ETF changed how it accounted for future program costs.

[3] Includes ETF's costs to administer the program and consulting, actuarial, and auditing services.

Both programs are funded primarily by premiums paid by employers and participants and investment income on program reserves, which SWIB invests in the Core Fund.

As shown in Table 14, ICI program revenues varied from 2009 through 2017. GIB increased premiums for the state component in seven of the eight years from 2010 through 2017. However, GIB waived premiums for the local component beginning in February 2012 because program reserves had increased as a result of investment income typically exceeding program expenditures in a given year.

Table 14

Income Continuation Insurance Program Revenues, by Calendar Year
(in millions)

Year	Premium Revenue	Investment Income	Other[1]	Total
State Component				
2009	$13.0	$ 9.6	$ 0.1	$22.7
2010	14.1	6.0	0.1	20.2
2011	13.7	0.6	0.1	14.4
2012	14.3	6.4	0.1	20.8
2013	15.0	6.6	0.1	21.7
2014	15.7	2.8	0.1	18.7
2015	16.8	(0.3)	0.1	16.6
2016	20.4	3.9	0.1	24.3
2017	24.3	8.3	0.1	32.7
Local Component				
2009	1.8	4.3	<0.1	6.2
2010	1.9	3.0	<0.1	4.9
2011	1.9	0.3	<0.1	2.3
2012	0.3	3.9	<0.1	4.2
2013	0.0	4.2	<0.1	4.2
2014	0.0	1.9	<0.1	1.9
2015	0.0	(0.3)	<0.1	(0.3)
2016	0.0	2.8	<0.1	2.8
2017	0.0	5.6	<0.1	5.6

[1] Includes penalties charged to firms for contractual noncompliance and interest charged to firms for amounts due.

As shown in Table 15, Long-term Disability Insurance program revenues varied from 2009 through 2017. GIB waived premiums from 2008 through 2013 because it wanted to decrease program reserves to the amount recommended by the program actuary.

Table 15

Long-term Disability Insurance Program Revenues, by Calendar Year
(in millions)

Year	Premium Revenue	Investment Income	Other[1]	Total
2009	$ 0.0	$49.3	$<0.1	$49.3
2010	0.0	29.8	<0.1	29.8
2011	0.0	3.0	<0.1	3.0
2012	0.0	29.9	<0.1	29.9
2013	0.0	28.2	<0.1	28.2
2014	42.3	11.9	0.0	54.2
2015	43.3	(1.6)	<0.1	41.7
2016	71.3	19.1	<0.1	90.3
2017	58.6	–[2]	<0.1	–[2]

[1] Includes penalties charged to firms for contractual noncompliance and interest charged to firms for amounts due.

[2] Beginning in 2017, investment income was combined with WRS investment income, as required by accounting standards.

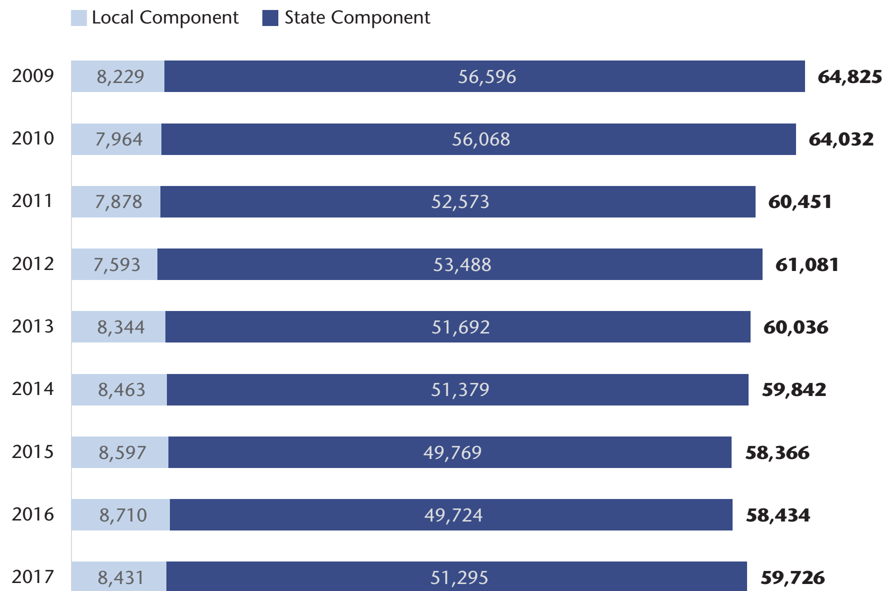
Participants

From 2009 through 2017, participants in the state component of the ICI program decreased by 9.4 percent.

As shown in Figure 11, participants in the state component of the ICI program decreased from 56,596 in 2009 to 51,295 in 2017, or by 9.4 percent. This decrease likely occurred, in part, because premiums increased by 92.6 percent during this time period. Participants in the local component decreased from 8,229 in 2009 to 7,593 in 2012, but they then increased to 8,431 in 2017. This increase likely occurred, in part, because of the premium waiver that began in February 2012. In 2017, 2,582 participants received benefits, including 2,399 participants in the state component and 183 participants in the local component.

Figure 11

Income Continuation Insurance Program Participants, by Component and Calendar Year



As noted, all active state and local government employees in the WRS automatically participated in the Long-term Disability Insurance program. In 2017, there were 257,413 participants, and 2,684 participants received benefits.

Program Administration

We assessed ETF's administration of both programs. Effective program administration requires ETF to:

- ensure its written administrative policies and procedures comply with statutes;
- appropriately manage the contract with the program administrator; and
- appropriately manage program reserves, which help to pay benefits and stabilize premiums paid by employers and participants.

Administrative Policies and Procedures

ETF established its own written administrative policies and procedures, including those intended to help the program administrator determine participant eligibility, process benefit claims, and make benefit payments. ETF did not provide these policies and procedures to GIB for its approval because they are administrative in nature.

We found that one ETF procedure in effect through 2016 conflicted with statutory requirements for the state component of the ICI program. Statutes stipulate the percentages of the total premiums that employers and participants must pay. These percentages vary depending on several factors, including the amount of unused sick leave a given participant has accumulated. After GIB annually approved premiums for the following year, ETF relied on its procedure to determine the premiums actually paid by employers and participants. This procedure resulted in ETF increasing by up to $0.09 per month the amounts that many participants paid, but some participants were not overcharged. This procedure also resulted in employers paying slightly more than statutorily stipulated and approved by GIB in many instances. ETF indicated that DOA requested that it establish this procedure, which allowed DOA to easily determine the percentages of total premiums paid by participants.

From 2009 through 2016, we estimate that ETF charged employers and participants $197,300 more than statutorily stipulated and approved by GIB for the ICI program.

From 2009 through 2016, we estimate that ETF charged employers and participants $197,300 more than statutorily stipulated and approved by GIB for the ICI program, or approximately 0.2 percent of the total premiums paid during that eight-year period. We estimate that participants overpaid approximately $112,900 and employers overpaid approximately $84,400. In 2017, ETF discontinued its procedure and began charging premiums as statutorily stipulated and approved by GIB.

Contract Administration

GIB last re-bid its program administrator contract for both programs in February 2008.

When GIB last re-bid its program administrator contract for both the ICI and Long-term Disability Insurance programs in February 2008, Aetna, the incumbent, was the only bidder and proposed a $260,000 increase (9.2 percent) in its annual fee. ETF indicated that this increase was justified because it was satisfied with the services Aetna provided and because continuing to contract with Aetna avoided costs associated with transferring program administration to a firm unfamiliar with the programs. GIB contracted with Aetna from January 2009 through December 2013 and subsequently extended the contract through December 2017, as permitted by two optional two-year extensions. In February 2017, ETF recommended that GIB amend the contract to include two

additional one-year extensions, in order to allow the contract to remain in effect through December 2019, and to exercise the first one-year extension. GIB approved this recommendation unanimously. In September 2018, the GIB chairperson executed the second one-year extension, which was not discussed or approved by GIB as a whole. In November 2018, ETF recommended that GIB amend the contract to include an additional two-year extension, in order to allow the contract to remain in effect through December 2021, and to exercise this extension. GIB approved this recommendation unanimously. Beginning in January 2019, Aetna no longer administers the Long-term Disability Insurance program.

Aetna is contractually required to submit to ETF monthly, quarterly, and annual reports, some of which include information on whether it achieved contractually specified performance measure goals, such as notifying participants in writing about its decisions within 15 days of receiving benefit claims. Aetna self-reports on whether it achieved these goals, and it is contractually required to pay financial penalties if it does not achieve them or submits these reports later than the specified deadlines. From January 2009 through December 2017, ETF assessed a total of $21,100 in financial penalties, including $15,000 because Aetna submitted 9 reports late and $6,100 because Aetna did not achieve goals on 13 occasions.

In June 2009, the ETF Board delegated to ETF the authority to contract with an auditor to determine every three years the extent to which the program administrator complied with certain contractual provisions, including some performance measure goals. In January 2010, ETF executed a contract with Wipfli for the six-year period through December 2015, with an optional three-year extension that ETF subsequently executed.

Wipfli's three most-recent audits identified errors Aetna had made when processing benefit claims. For example:

- In November 2012, Wipfli completed an audit report of Aetna's administration of both programs from January 2009 through December 2011 and found that 12.0 percent of the benefit claims it randomly sampled contained errors or were missing documents.

- In September 2015, Wipfli completed an audit report of Aetna's administration of both programs from January 2012 through December 2014 and found that 2.7 percent of the benefit claims it randomly sampled contained errors or were missing documents.

- In August 2018, Wipfli completed an audit report of Aetna's administration of the ICI program from January 2015 through December 2017 and found that 1.3 percent of the benefit claims it randomly sampled were missing documents. Wipfli also found that Aetna's data on benefits provided to participants did not consistently match the requests Aetna had submitted to ETF for reimbursement of the benefits provided. Monthly inconsistencies were as large as $52,500 but were never greater than 1.0 percent of paid benefits. Wipfli also found that Aetna had insufficient internal controls over confidential information about participants.

When ETF provided the first audit report to GIB in February 2013, ETF indicated in a summary memorandum that Aetna had complied with the contract, ETF had already addressed the one recommendation in the audit report, and Wipfli had identified no concerns with Aetna's performance. As noted, however, Wipfli had found that 12.0 percent of the benefit claims it randomly sampled contained errors or were missing documents. ETF indicated that it did not provide GIB with the second audit report because of an oversight. ETF provided the third audit report to GIB, which discussed it in November 2018. ETF's summary memorandum and presentation to GIB in November 2018 indicated the extent to which Wipfli found that Aetna had not complied with contractual requirements. ETF indicated that summary memoranda and presentations it will prepare in the future will be similar to those it provided to GIB in November 2018.

ETF should consistently provide GIB with audit reports on the performance of the ICI program administrator and with memoranda that accurately summarize these audit reports, including by indicating the extent to which the program administrator did not comply with contractual requirements. Such information will help ensure that GIB is adequately informed about the performance of the program administrator.

☑ Recommendation

We recommend the Department of Employee Trust Funds:

- *consistently provide the Group Insurance Board with audit reports of the performance of the Income Continuation Insurance program administrator and memoranda that accurately summarize these audit reports; and*

- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement this recommendation.*

In August 2015, ETF's Office of Internal Audit identified concerns with the ICI program.

In August 2015, ETF's Office of Internal Audit completed an audit of the accuracy of the information employers had reported to ETF about ICI program participants in 2014. The audit found that ETF did not maintain a central database of participants but instead relied on aggregated information about participants and premium payments, which was insufficient to verify the accuracy of these payments. In reviewing a random sample of program applications, the audit found that 21.3 percent contained missing or incorrect information about premiums and 5.0 percent contained missing or incorrect dates for when insurance coverage began. In response to the audit, Aetna indicated that it was contractually required to verify applications were completed, but not to verify the accuracy of premiums. ETF indicated that it had a limited ability to determine the accuracy of premiums because employers reported only aggregated information about employees, but now STAR automatically calculates premiums.

The Office of Internal Audit identified concerns with the administration of the ICI program, including:

- controls were inadequate to ensure that eligibility requirements were met, enrollments were processed in a timely manner, and employers reported enrollments and premiums accurately and in a timely manner;
- accountability for enrollment processes was lacking because no one office at ETF oversaw the program, and communication between ETF offices was insufficient;
- training for employers and Aetna was inadequate;
- premium information submitted by employers was not verified by ETF; and
- employers did not uniformly calculate premiums.

In October 2015, ETF provided GIB with the audit report and a plan to address the report's 11 recommendations. As of June 2018, ETF had complied with 6 of the 11 recommendations, partially complied with 2 recommendations, and not yet complied with 3 recommendations.

Program Reserves

Statutes require GIB to use excess funds that become available through operating group insurance programs to reduce premiums or establish program reserves to stabilize costs in subsequent years.

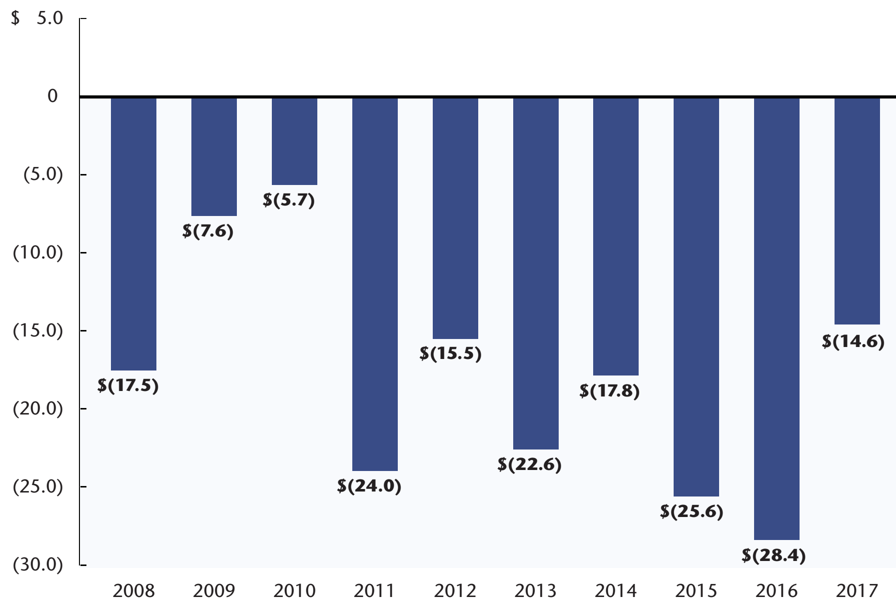
Program reserves help cover the cost of future benefits. The program actuary annually recommends that GIB maintain or change premiums in the following year, based on the extent to which program assets are projected to be sufficient to cover estimated liabilities. If program expenditures exceed program revenues, including premiums and investment income, program reserves must be spent. In contrast, if program revenues exceed expenditures, program reserves will increase.

Reserves for the state component of the ICI program were in a deficit from 2008 through 2017.

As shown in Figure 12, reserves for the state component of the ICI program were in a deficit from 2008 through 2017. ETF indicated this deficit occurred, in part, because of increased expenditures associated with benefit claims lasting longer than one year. It also indicated that program enrollment declined because an increasing proportion of state employees chose not to participate, which resulted in a decrease in program revenue.

Figure 12

Income Continuation Insurance Program Reserves, by Calendar Year
State Component
As of December 31
(in millions)



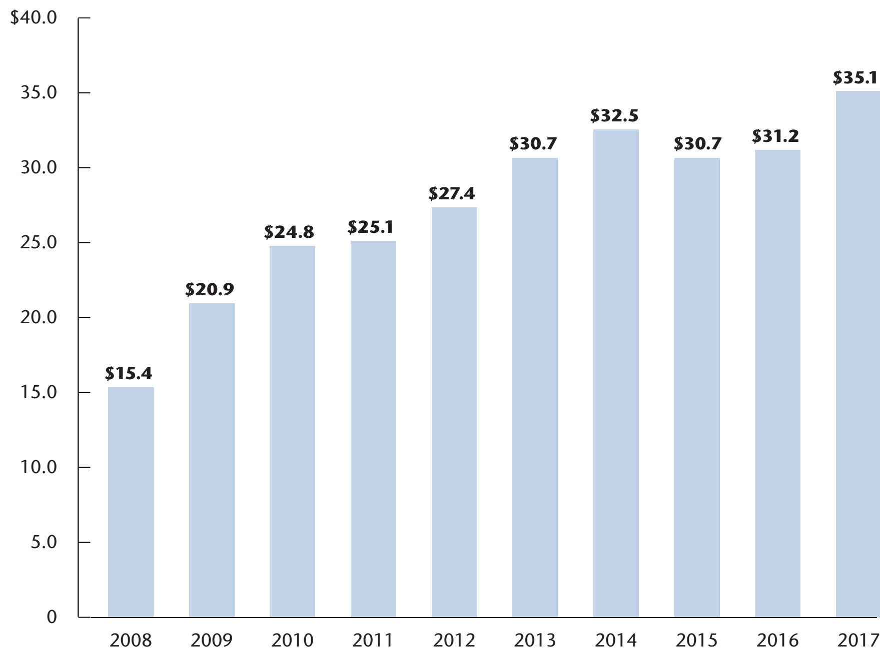
To increase program reserves for the state component of the ICI program, GIB approved premium increases of 4.5 percent to 7.0 percent in five of the six years from 2010 to 2015 and 20.0 percent annually from 2016 to 2020. In 2017, program reserves increased by $13.8 million because of the premium increase and because investment income totaled $8.3 million. However, funds may be inadequate to pay future benefits if the deficit continues.

Reserves for the local component of the ICI program increased from $15.4 million in 2008 to $35.1 million in 2017.

As shown in Figure 13, reserves for the local component of the ICI program increased from $15.4 million in 2008 to $35.1 million in 2017. Although GIB has waived premiums since February 2012, program reserves increased because investment income exceeded program expenditures in five of the six years since the premium waiver began. ETF indicated that it has discussed how to address the increasing program reserves and has decided that maintaining the premium waiver is appropriate.

Figure 13

Income Continuation Insurance Program Reserves, by Calendar Year
Local Component
As of December 31
(in millions)

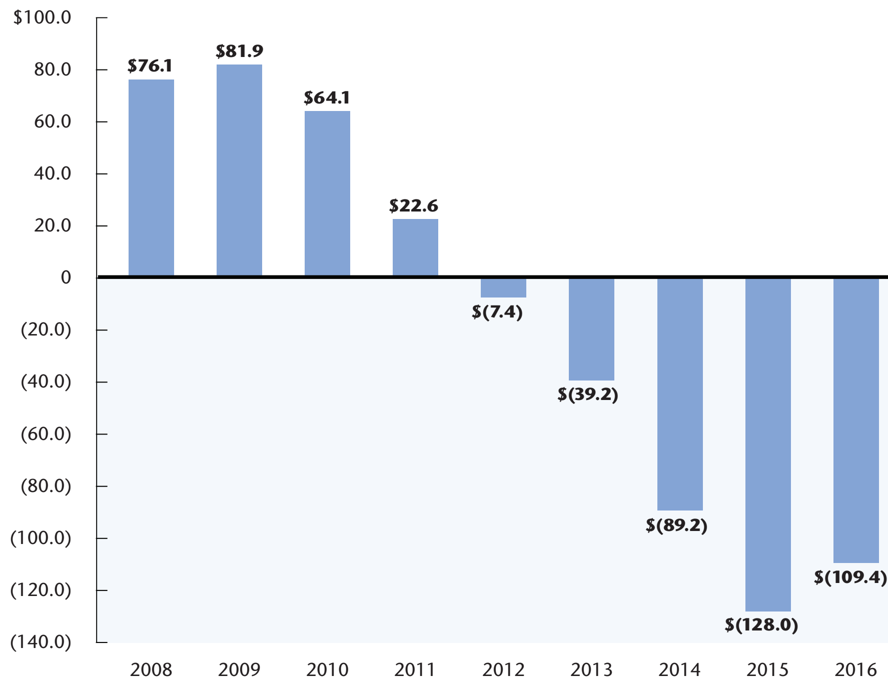


Reserves for the Long-term Disability Insurance program decreased from $76.1 million in 2008 to a $109.4 million deficit in 2016.

As shown in Figure 14, reserves for the Long-term Disability Insurance program decreased from $76.1 million in 2008 to a $109.4 million deficit in 2016. The decrease occurred, in part, because GIB waived premiums from 2008 through 2013 in order to decrease program reserves. However, program reserves continued to decrease even after GIB reinstated premiums from 2014 through 2016, indicating that GIB should have ended the premium waiver sooner than it did.

Figure 14

Long-term Disability Insurance Program Reserves, by Calendar Year
As of December 31
(in millions)



GIB did not establish target ranges for program reserves for the ICI or Long-term Disability Insurance programs.

We found that GIB did not establish target ranges for program reserves for the ICI or Long-term Disability Insurance programs. Deloitte, which was the program actuary from October 2007 through September 2014, recommended target ranges for program reserves for both programs. GIB did not vote on whether to approve these target ranges but made decisions about premiums based on them. Since October 2014, Milliman has been the program actuary, and it did not recommend target ranges for either program through December 2018.

ETF should work with GIB to establish target ranges for program reserves for the state and local components of the ICI program, as well as a strategy and timeline for achieving them. Establishing these target ranges and a strategy and a timeline for achieving them can help GIB set premiums appropriately. ETF should also work with GIB to establish a policy requiring periodic reviews of these target ranges, in order to ensure that they continue to be appropriate for the current priorities and structure of the program, and it should provide the results of these reviews to GIB. Such information will help GIB make informed programmatic decisions. ETF indicated to us that it has asked Milliman to begin considering target ranges for ICI program reserves. The ETF Board is now responsible for managing target ranges for program reserves for the Long-term Disability Insurance program, which has been overseen by the ETF Board and has been closed to new benefit claims since January 2018.

☑ **Recommendation**

We recommend the Department of Employee Trust Funds:

- *work with the Group Insurance Board to establish target ranges for program reserves for the state and the local components of the Income Continuation Insurance program, as well as a strategy and a timeline for achieving them;*

- *work with the Group Insurance Board to establish a policy requiring periodic reviews of the target ranges for Income Continuation Insurance program reserves and provide the results of these reviews to the Group Insurance Board; and*

- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement these recommendations.*

Program Redesign

In 2011, GIB and ETF began to consider redesigning both programs and improving their long-term stability, in part, because ETF believed their complexity dissuaded firms from submitting bids to administer them, thereby reducing competition and potentially increasing administrative costs. ETF also believed that a redesign could simplify the programs for participants. In March 2015, Milliman's contract was amended to require it to provide recommendations for redesigning the programs. Milliman was paid $33,500 for its work, which ETF used to develop a proposal to redesign the programs. In September 2016, ETF presented its redesign proposal to the ETF

Board, which unanimously approved closing the Long-term Disability Insurance program to new benefit claims and transferring program oversight from GIB to the ETF Board.

In February 2017, GIB approved a redesign proposal for the ICI program.

In February 2017, ETF presented its redesign proposal to GIB, which unanimously approved transferring oversight of the Long-term Disability Insurance program to the ETF Board, effective in January 2018. GIB also unanimously approved ETF's proposal to change the ICI program. These changes, the last five of which would require statutory modifications, include:

- reducing benefits from 75.0 percent to 70.0 percent of a participant's wages;

- capping at 18 months the length of time benefits are provided;

- transferring program oversight to the ETF Board;

- changing premiums for state employees other than those employed by UW System from the current structure that is based on an employee's accumulated sick leave balance to a structure that is based on an employee-chosen period of time from 30 days to 180 days, which is termed an "elimination period," only after which benefits will be paid;

- changing premiums for UW System employees from the current structure that is based on an elimination period and whether the employee has more than one year of state service to a structure that does not consider length of state service; and

- changing the structure of the state component, which currently provides that benefits begin after the later of the elimination period or when an employee's sick leave balance is zero, to a structure in which benefits begin after the employee-chosen elimination period.

In its 2019-21 biennial budget request, ETF included the five statutorily required modifications that would be necessary to implement in January 2021 the program redesign approved by GIB. ETF indicated that if these statutory modifications are not made, premiums for the state component of the ICI program will likely need to increase, although past premium increases were insufficient to eliminate the program's deficit.

▪ ▪ ▪ ▪

Group Life Insurance Program ■

The Group Life Insurance program provides life insurance coverage to active and retired state and local government employees.

The Group Life Insurance program provides life insurance coverage to active and retired state and local government employees. Any active or retired state employee in the WRS may participate, while active and retired local government employees may do so if their local governments have elected to participate. As of December 31, 2017, 738 local governments participated. GIB contracted with a program administrator to verify the eligibility of program applicants and process benefit claims made by participants. Securian has been the program administrator since 1958. We found that ETF did not provide sufficiently detailed information to GIB regarding the annual financial reports from the program administrator, and it did not work with GIB to determine target ranges for program reserves or establish a strategy and timeline for achieving them. We make recommendations for improvements.

Expenditures and Revenues

Through December 2017, ETF collected life insurance premiums paid by participating state employers and employees and transferred them to Securian, which holds all program funds. In contrast, participating local government employers and employees paid premiums directly to Securian and not through the State's accounting system. Therefore, we relied on expenditure and revenue information Securian provided to GIB. Securian has invested all program funds since the program's inception in 1958 and is contractually obligated to guarantee the principal amount of program funds and annually provide investment income to the program reserves.

Program expenditures included payments for:

- participant benefits, including those provided to beneficiaries of participants;
- program administration services provided by Securian; and
- other administrative services, including ETF's costs to administer the program, for which Securian reimbursed ETF, as well as consulting, actuarial, and auditing services.

Program expenditures increased from $51.6 million in 2009 to $66.7 million in 2017, or by 29.3 percent.

As shown in Table 16, program expenditures increased from $51.6 million in 2009 to $66.7 million in 2017, or by 29.3 percent. Each year, participant benefits accounted for almost 90.0 percent of total program expenditures.

Table 16

Group Life Insurance Program Expenditures, by Calendar Year[1]
(in millions)

		Administration			
Year	Participant Benefits	Program Administrator	Other[2]	Other Expenditures[3]	Total
2009	$45.6	$4.5	$0.5	$1.0	$51.6
2010	53.6	4.8	0.6	1.2	60.2
2011	54.1	4.9	0.8	0.9	60.7
2012	55.6	4.7	0.7	1.4	62.4
2013	56.5	4.8	0.0[4]	1.6	62.9
2014	55.4	5.0	1.6	1.9	63.8
2015	58.9	5.1	0.6	2.3	66.9
2016	61.1	5.3	1.2	2.7	70.4
2017	58.3	5.4	0.7	2.3	66.7

[1] According to information Securian provided to GIB.

[2] Includes ETF's costs to administer the program and consulting, actuarial, and auditing services.

[3] Includes life insurance withdrawals that participants used to pay health and long-term care insurance premiums, as well as certain other charges associated with paying benefits.

[4] Securian reimbursed ETF's 2013 administrative fees in 2014.

Program revenues decreased from $85.0 million in 2009 to $76.7 million in 2017.

Program revenues included the premiums paid by employers and participants, as well as investment income earned on program reserves. As shown in Table 17, program revenues decreased from $85.0 million in 2009 to $76.7 million in 2017, or by 9.8 percent. Securian indicated that the decrease in investment income over this period occurred because of declining interest rates in the bonds in which it invested a portion of program funds.

Table 17

Group Life Insurance Program Revenues, by Calendar Year[1]
(in millions)

Year	Premium Revenue	Investment Income	Total
2009	$50.4	$34.6	$85.0
2010	52.7	34.1	86.8
2011	51.1	32.3	83.3
2012	48.5	30.6	79.1
2013	48.4	29.4	77.8
2014	49.4	28.1	77.5
2015	50.5	27.2	77.6
2016	51.8	25.6	77.4
2017	52.5	24.2	76.7

[1] According to information Securian provided to GIB.

Participants

As of December 31, 2017, there were 203,001 participants.

As shown in Table 18, there were 203,001 participants as of December 31, 2017. From 2009 through 2017, the number of active state and local employees in the program decreased by 2.2 percent and 3.4 percent, respectively. In contrast, the number of retired state employees in the program increased by 42.5 percent, and the number of retired local government employees in the program increased by 41.3 percent.

Table 18

Group Life Insurance Program Participants, by Type and Calendar Year[1]
As of December 31

	State Employees		Local Government Employees		
Year	Active	Retired	Active	Retired	Total
2009	52,614	22,465	78,384	31,019	184,482
2010	51,467	23,187	77,229	32,270	184,153
2011	49,482	26,038	75,117	34,553	185,190
2012	49,074	26,620	72,491	36,945	185,130
2013	49,279	27,262	72,162	38,406	187,109
2014	49,683	28,137	72,879	39,642	190,341
2015	49,096	29,494	73,266	41,030	192,886
2016	50,946	30,894	75,681	42,498	200,019
2017	51,438	32,005	75,719	43,839	203,001

[1] According to information Securian provided to GIB.

Program Administration

We assessed ETF's administration of the program. Effective program administration requires ETF to:

- appropriately manage the contract with the program administrator; and
- appropriately manage program reserves, which help pay benefits and stabilize premiums paid by employers and participants.

Contract Administration

When the program administration contract was last bid in February 2010, Securian and one other firm submitted bids. Securian's current contract was for the five-year period from January 2011 through December 2015 and contained two optional one-year extensions, but GIB has extended it multiple times:

- in November 2014, GIB voted unanimously to approve ETF's recommendation to exercise the first one-year extension through December 2016;

- in February 2016, GIB voted unanimously to approve ETF's recommendation to exercise the second one-year extension, amend the contract to include an additional two-year extension, and exercise that two-year extension through December 2019; and

- in November 2018, GIB voted to approve ETF's recommendation to amend the contract to include an additional two-year extension and exercise that two-year extension through December 2021.

ETF indicated that the program administrator contract was not rebid in recent years, in part, because it and GIB were busy with tasks related to the potential transition of the State to self-insured medical benefits. However, ETF indicated that it plans to re-bid the contract late in 2019.

Securian is contractually required to verify the eligibility of program applicants, collect premiums, process benefit claims made by participants, establish program reserves, and credit investment income to program reserves. ETF is contractually required to help Securian communicate program provisions to participants, decide whether to approve applications from local governments interested in participating, and maintain information about participant beneficiaries and provide this information to Securian.

As contractually required, Securian provides ETF with an annual financial report on program expenditures, revenues, and reserves. This detailed report contains recommendations to GIB, including the premiums to charge participants in the following year. ETF prepares a memorandum to GIB that summarizes these recommendations and advises GIB on actions to take. GIB uses the financial report, ETF's memorandum, and a presentation by Securian to determine premiums.

The memoranda ETF prepared for GIB from 2009 through 2018 did not provide sufficient information about Securian's annual financial reports.

We found that the memoranda ETF prepared for GIB from 2009 through 2018 did not provide sufficient information about Securian's annual financial reports. ETF's memoranda did not explain why Securian had made recommendations or specify the amount of benefits paid in the prior year, the amount of program reserves, or by how much and why program reserves had changed. ETF's memoranda explained that Securian's recommendations for the premiums to charge participants in the following year were based on whether program reserves were within target ranges established by Securian, but ETF's memoranda did not specify the target ranges or indicate whether program reserves were within them.

ETF should provide sufficiently detailed information in its memoranda to GIB regarding the annual financial reports from the program administrator. In order to determine the premiums to charge, GIB needs to know the amounts of program reserves, whether program reserves were higher or lower than expected, and the reasons for changes over time in program reserves.

☑ Recommendation

We recommend the Department of Employee Trust Funds:

- *provide sufficiently detailed information in its memoranda to the Group Insurance Board regarding the annual financial reports from the program administrator of the Group Life Insurance program; and*

- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement this recommendation.*

Securian is contractually required to submit quarterly reports on whether it achieved nine contractually specified performance measure goals, such as processing 99.0 percent of applications within seven days of receiving them. ETF indicated that it reviewed these quarterly reports to determine whether Securian achieved these goals. The quarterly reports contained summary information on whether Securian achieved each goal during the three-month period covered by a given report, but they did not contain information indicating how Securian handled the cases of individual participants.

In January 2010, ETF executed a contract with an auditor, Wipfli, to determine the extent to which Securian complied with certain contractual provisions, including achieving performance measure goals, over three-year periods since January 2006. All three of the audit reports submitted since January 2010 indicated that Securian complied with all contractual provisions that Wipfli reviewed. Wipfli examined a small sample of cases to determine compliance. For example, in the most recently completed audit report for the three-year period from January 2012 through December 2014, Wipfli sampled:

- 60 of 7,036 claims paid, or 0.9 percent of the total, to determine whether Securian paid benefits in a timely manner, which is a performance measure, and whether it correctly calculated benefit payments;

- 60 of 18,242 applications for new enrollments, or 0.3 percent of the total, to determine whether Securian processed applications in a timely manner, which is a performance measure, and whether it correctly calculated, billed, and collected premiums; and

- 30 of 11,492 participants who retired, or 0.3 percent of the total, to determine whether Securian correctly processed relevant information.

ETF is contractually permitted to assess financial penalties if Securian does not achieve the performance measure goals. ETF indicated that it did not assess any financial penalties from January 2009 through June 2018 because Securian achieved all of these goals, based on information in Securian's quarterly reports and Wipfli's three-year audit reports. ETF also indicated that Securian had consistently and competently fulfilled its contractual obligations.

Program Reserves

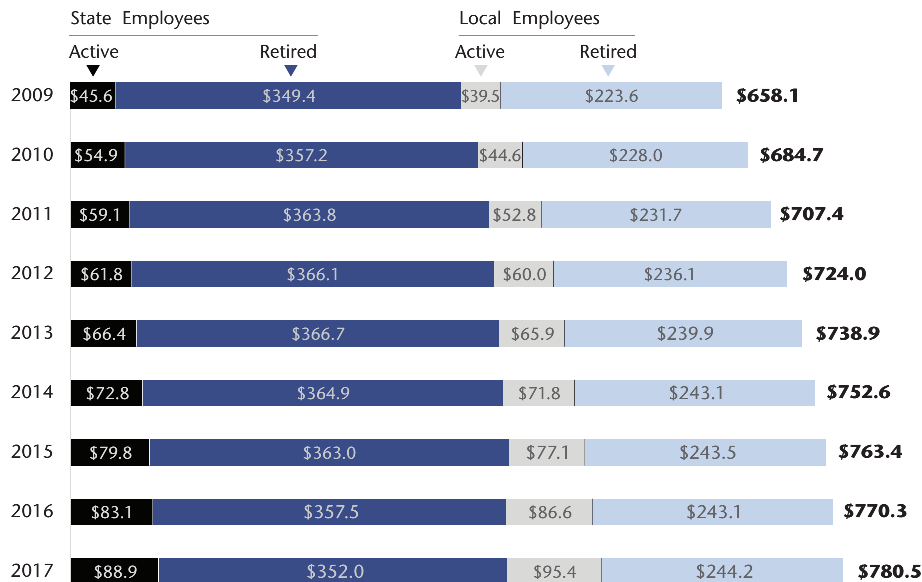
Statutes require GIB to use excess funds that become available through operating the program to reduce premiums or establish program reserves to stabilize costs in subsequent years. Program reserves help cover the cost of future benefits. Separate program reserves are maintained for active state employees, retired state employees, active local government employees, and retired local government employees. Separate program reserves are maintained, in part, because of accounting standards that since 2008 have required a separate accounting of post-retirement benefits for employees.

Total program reserves increased from 2009 through 2017.

As shown in Figure 15, total program reserves increased from 2009 through 2017. Program reserves for active state employees and active local government employees increased each year, in part, because relatively few benefits are paid for active employees. In contrast, program reserves for retired state employees steadily increased through 2013 but then steadily decreased through 2017. ETF and Securian indicated that these decreases occurred, in part, because of interest rate declines in the bonds in which is a portion of the program reserves were invested.

Figure 15

Group Life Insurance Program Reserves, by Type[1]
As of December 31
(in millions)



[1] According to information Securian provided to GIB.

We found that ETF did not work with GIB to establish target ranges for program reserves needed to cover benefits in future years for the state and local components of the program or a strategy and a timeline for achieving them. In report 18-10, we reported on the extent to which the projected liability for benefit payments exceeded reserve amounts as of December 31, 2017, for retired employees.

We found that ETF could not explain why Securian, rather than SWIB, invests program reserves. As noted, SWIB invests Group Health Insurance, ICI, and Long-term Disability Insurance program reserves in the Core Fund. In addition to guaranteeing the principal amount of program funds, Securian is contractually required to cover the cost of program benefits that exceed a certain amount in a given year, and it may earn interest income from investing program reserves. If program reserves were invested instead by SWIB, the State and local governments might need to pay for the cost of program benefits without financial assistance from the program administrator, and a program administrator might charge additional administrative fees if it could not earn interest income from investing program reserves. Therefore, it is unclear whether it is

preferable to continue to allow the program administrator to invest program reserves.

ETF should work with GIB to establish the target ranges for program reserves for the state and local components of the program and create a strategy and a timeline for achieving them. Doing so will help ensure that sufficient amounts of program reserves are accumulated so that the program is able to pay benefits in future years. ETF should also work with GIB to establish a policy requiring periodic reviews of these target ranges for program reserves, in order to ensure that these target ranges continue to be appropriate for the current priorities and structure of the program. In addition, ETF should assess the benefits and costs of allowing the program administrator or SWIB to invest program reserves and provide the results of its assessment to GIB. Doing so will allow GIB to make an informed decision about how program reserves should be invested. Such a decision is particularly important, given that the projected liability for benefit payments exceeds reserve amounts.

☑ Recommendation

We recommend the Department of Employee Trust Funds:

- *work with the Group Insurance Board to establish target ranges for program reserves for the state and the local components of the Group Life Insurance program, as well as a strategy and a timeline for achieving them;*

- *work with the Group Insurance Board to establish a policy requiring periodic reviews of the target ranges for Group Life Insurance program reserves and provide the results of these reviews to the Group Insurance Board;*

- *assess whether the program administrator or the State of Wisconsin Investment Board should invest program reserves and provide the results of this assessment to the Group Insurance Board; and*

- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement these recommendations.*

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Information Technology Security ■

ETF and the firms that help administer the group insurance programs maintain confidential information about participants, such as medical records and Social Security numbers. ETF has taken steps to secure this information, such as by contractually requiring some firms to contract for independent audits of IT controls and submit the audits to ETF. However, we found that not all firms were contractually required to contract for these audits, and ETF did not consistently review the submitted audits. Failure to provide an appropriate level of protection increases the risk that confidential information, such as personally identifiable information, could be accidentally or maliciously exposed. In addition, ETF sent us confidential information through an inappropriate means of communication, thereby increasing the risk that third-parties could have inadvertently obtained and read this confidential information. We make recommendations for improvements.

Audits of IT Controls

Not all firms that help administer the group insurance programs were contractually required to submit audits of IT controls to ETF.

We found that not all firms that help administer the group insurance programs were contractually required to submit audits of IT controls to ETF. The health insurers in the Group Health Insurance program, the administrators of pharmacy and dental benefits, and the auditor of the firm that administers pharmacy benefits were required to submit audits of IT controls before executing contracts with GIB or ETF. These firms were also contractually required to submit audits of IT controls periodically thereafter, but their

contracts did not specify the frequency for doing so. In contrast, the program administrators, program actuary, and auditor for the ICI, Long-term Disability Insurance, and Group Life Insurance programs were not contractually required to submit audits of IT controls to ETF.

We found that ETF did not have policies specifying which firms should be contractually required to submit audits of IT controls, how it should review submitted audits, and the actions it or GIB should consider taking if concerns were identified in such audits.

ETF did not consistently collect and review the submitted audits of IT controls.

We found that ETF did not consistently collect and review the submitted audits of IT controls. ETF reviewed one such audit submitted by the firm responsible for implementing the data warehouse and found no concerns. However, ETF did not collect the audits of IT controls of health insurers or review audits submitted by the pharmacy benefits administrator or the dental benefits administrator. All of these firms send confidential information about participants to the data warehouse.

In the past, we have identified similar concerns with how ETF handled other types of audits of program administrators. In April 2017 (report 17-7), we found that ETF did not contractually require all program administrators to have audits completed of their internal controls and did not consider the impact of the results of submitted audits. These audits provide assurances that internal controls are effective and identify any deficiencies in how program administrators process programmatic transactions. As a result of these findings, we made several recommendations that ETF improve its operations. In December 2017 (report 17-20), we found that ETF had addressed our recommendations.

ETF should work with GIB to establish sufficient policies pertaining to audits of IT controls. Such policies should, at a minimum, specify the firms that will be contractually required to submit such audits, the frequency with which these audits should be submitted, and how ETF will review submitted audits. ETF should collect all contractually required audits and review all submitted audits, which will help ensure that confidential information about participants remains secure, and provide the results of its reviews to GIB.

☑ Recommendation

We recommend the Department of Employee Trust Funds:

- *work with the Group Insurance Board to establish sufficient policies pertaining to audits of information technology controls;*

- *collect all contractually required audits of information technology controls, review all submitted audits, and provide the Group Insurance Board with the results of its reviews; and*
- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement these recommendations.*

Confidential Information

At the start of our audit, we established a secured means by which ETF could electronically provide us confidential information. ETF used this secured means of communication to provide us with most, but not all, of the confidential information we requested.

ETF emailed us confidential information, including 34,600 Social Security numbers.

In May 2018 and June 2018, ETF emailed us confidential information, including:

- 34,600 Social Security numbers of active and retired employees participating in the Group Health Insurance program;
- confidential information ETF used to negotiate with health insurers; and
- confidential information about the business practices of a program administrator on two occasions.

ETF emailed the 34,600 Social Security numbers to our audit team that was completing work for the Comprehensive Annual Financial Report (CAFR) for ETF. After receiving these Social Security numbers, we contacted the ETF staff member who had emailed us this information in order to bring to this staff member's attention our concerns about using email to communicate confidential information.

ETF verbally indicated that it had investigated the incident involving the 34,600 Social Security numbers that had been emailed. ETF indicated that Social Security numbers should not have been emailed to us and that the staff member who had emailed them had been directed to use an alternate means of communicating confidential information to us in the future.

In response to our request for any written results of its investigation, ETF provided us with a memorandum dated August 15, 2018, which was five days after we had requested it. This memorandum indicated that the investigation had concluded "no security incident had taken place" because the June 26, 2018 email had been sent over an encrypted connection within the State's email system.

We believe the State's email system is an inappropriate means of communicating confidential information.

We believe the State's email system is an inappropriate means of communicating confidential information. Although encrypted connections were established between ETF and the Legislative Audit Bureau, none of the confidential information in the four email messages from ETF was encrypted. If ETF had inadvertently emailed a third-party this confidential information or if a phishing attempt within ETF were successful, a third-party could have read this confidential information.

Communicating confidential information without sufficient security increases the risk that third-parties may obtain this information and use it for malicious purposes. ETF should ensure that the security awareness training it provides its staff adequately addresses the appropriate ways to securely communicate confidential information.

☑ Recommendation

We recommend the Department of Employee Trust Funds:

- *ensure that the security awareness training it provides its staff adequately addresses the appropriate ways to securely communicate confidential information; and*
- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement this recommendation.*

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Governance Issues ■

We analyzed how effectively GIB fulfilled its statutorily required oversight of four group insurance programs.

We interviewed all 11 GIB members as of September 2018 and assessed how effectively GIB fulfilled its statutorily required oversight of the Group Health Insurance, ICI, Long-term Disability Insurance, and Group Life Insurance programs. As noted, the Long-term Disability Insurance program has been overseen by the ETF Board since January 2018 and is closed to new benefit claims. Based on programmatic information provided by ETF, GIB determines program benefits, approves premiums, spends program reserves, awards contracts, and makes other decisions. Oversight of the programs can be improved by ETF consistently providing relevant and complete programmatic information to GIB, which can consider this information before making decisions. ETF can also help GIB assess options for improving program oversight. We make recommendations for improvements.

Programmatic Information

GIB makes decisions about the group insurance programs based, in part, on programmatic information provided by ETF, including information submitted to ETF by program administrators, program actuaries, and auditors. To prepare GIB members for their meetings, ETF provides information such as actuarial reports on program funding, audit reports on the extent to which program administrators complied with contractual provisions, and ETF's summaries of these reports. GIB members indicated to us that they

were generally satisfied with the timeliness, accuracy, clarity, and completeness of the information ETF provided them.

From January 2008 through November 2018, GIB approved 97.7 percent of the motions pertaining to the group insurance programs.

To make decisions about the group insurance programs, GIB votes on motions, many of which are based on recommendations from ETF. Unanimous approval of motions may indicate that the decisions were straightforward or the recommendations from ETF were appropriate. In contrast, unanimous approval may indicate that GIB was overly reliant on ETF to make decisions. We reviewed the open session minutes of all GIB meetings from January 2008 through November 2018 and found that GIB approved 256 of the 262 motions (97.7 percent) pertaining to the group insurance programs, including:

- 218 motions it approved unanimously (83.2 percent of the total);
- 32 motions it approved by a majority vote (12.2 percent);
- 6 motions (2.3 percent) it approved, but the meeting minutes are unclear whether it approved these motions unanimously or by a majority vote; and
- 6 motions (2.3 percent) it did not approve.

At times, GIB members discussed issues at length before voting on motions. For example, ETF recommended six changes to Group Health Insurance program benefits in August 2018. We attended this meeting and observed that GIB members discussed these recommendations, asked ETF questions and considered their responses, and did not always agree with each other or ETF. GIB unanimously approved three motions pertaining to three of the six recommendations, approved by a majority vote one motion pertaining to one recommendation, and did not approve two motions pertaining to two recommendations.

ETF at times provided information to GIB members only after they had arrived at a meeting because ETF was concerned that GIB members would share the information with the public.

We found that ETF at times provided information to GIB members only after they had arrived at their meetings. For example, not until the August 2018 meeting did ETF provide GIB members with a 63-page report from Segal pertaining to the amount of Group Health Insurance program reserves to spend and the premiums to charge in 2019. ETF indicated to us that it had received this information from Segal early in August 2018 but did not provide it to GIB members until the meeting because of concerns that GIB members would share the information with the public.

ETF indicated to us that it had directed Segal to recommend spending fewer program reserves than specified by the target ranges GIB had established.

At the August 2018 meeting, GIB members asked Segal few questions during a 35-minute presentation of information that ETF had provided them only at this meeting. Later in this meeting, GIB members asked no further questions before voting unanimously to approve Segal's recommendation for spending program reserves in 2019. As noted, this decision to spend $49.1 million in program reserves for the state component of the Group Health Insurance program was significantly less than the $111.8 million specified by the target ranges for program reserves that GIB had established in August 2017. ETF indicated to us that it had directed Segal to recommend spending fewer program reserves than specified by the established target ranges in order to have more program reserves available to maintain or reduce premiums in 2020 and later.

Our audit report makes a number of recommendations for ETF to consistently provide GIB with relevant and complete programmatic information, such as:

- the written results of ETF's analyses of recommendations consultants make for improving the Group Health Insurance program, the progress made toward achieving intended outcomes of programmatic changes, and information provided by the program actuary;
- the financial penalties ETF assessed on firms that did not achieve contractually specified performance measures;
- audit reports of the ICI program administrator and memoranda summarizing these audit reports;
- the results of ETF's periodic reviews of the target ranges for ICI and Group Life Insurance program reserves, after these target ranges are established; and
- sufficiently detailed information regarding the annual financial reports from the Group Life Insurance program administrator.

This programmatic information will help GIB make decisions that can significantly affect employers and participants, including decisions about program benefits and premiums. ETF should ensure that it consistently provides programmatic information to GIB at least one week before meetings. Doing so will help ensure GIB has sufficient time to consider this information before making decisions. We note that four GIB members indicated that they would like additional time to review information before meetings.

☑ **Recommendation**

We recommend the Department of Employee Trust Funds:

- *consistently provide the Group Insurance Board with programmatic information at least one week before meetings; and*
- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement this recommendation.*

ETF did not consistently post on its website nonconfidential programmatic information until the day of GIB meetings.

We also found that ETF did not consistently post on its website nonconfidential programmatic information until the day of GIB meetings. For example, not until the day of GIB's August 2018 meeting did ETF post information about a potential change in program benefits and the 63-page report from Segal pertaining to the amount of Group Health Insurance program reserves to spend and the premiums to charge in 2019. ETF should post all nonconfidential information that GIB will consider at its meetings at least one day before these meetings. Posting such information will allow employers, participants, and the public to understand issues GIB is considering and be able to decide if they would like to provide input on these issues.

☑ **Recommendation**

We recommend the Department of Employee Trust Funds:

- *post on its website at least one day before a given meeting all nonconfidential information that the Group Insurance Board will consider at that meeting; and*
- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement this recommendation.*

Contracting

A number of contracts with firms that help administer the group insurance programs have been in effect for many years.

As noted, a number of contracts with firms that help administer the group insurance programs have been in effect for many years. For example:

- Securian has been the program administrator for the Group Life Insurance program since 1958. Its current contract has been in effect since January 2011, and GIB has approved extending it through December 2021,

which is an 11-year period. ETF indicated that this contract was not rebid in recent years, in part, because it and GIB were busy with tasks related to the potential transition of the State to self-insured medical benefits.

- Aetna has been the program administrator for the ICI and Long-term Disability Insurance programs since February 2006. Its current contract has been in effect since January 2009, and GIB has approved extending it through December 2021, which is a 13-year period. ETF indicated that this contract was not rebid in recent years because it believes any potential cost savings from a new program administrator would be outweighed by the cost of a new firm familiarizing itself with the programs, and because of plans to redesign both programs.

As noted, statutes require the ETF Board to select and retain actuaries to perform all necessary actuarial services for the group insurance programs. In September 2014, the ETF Board delegated to GIB the responsibility to contract for an actuary for the Group Health Insurance program, as permitted by statutes. Through November 2018, the ETF Board did not delegate the responsibility to contract with actuaries for other group insurance programs.

ETF executed contract amendments for actuarial services without the approval of GIB or the ETF Board.

We found that ETF executed contract amendments for actuarial services without the approval of GIB or the ETF Board. For example:

- ETF executed five amendments to the contract with the actuary for the Group Health Insurance program from January 2016 through February 2018. Two amendments extended the contract period by one year each, two amendments expanded the contract scope, and one both extended the contract period by one year and expanded the contract scope. GIB meeting minutes do not indicate that ETF requested approval to execute the five amendments. The three amendments that expanded the contract scope added a total not-to-exceed cost of $700,600.

- ETF executed seven amendments to the contract with the actuary for the ICI, Long-term Disability Insurance, and Life Insurance programs from March 2015 through October 2018. Four amendments expanded the contract scope, two amendments extended the contract period by one year each, and one amendment both extended the contract period and expanded the contract scope. GIB and ETF Board

meeting minutes do not indicate that ETF requested approval to execute the seven amendments. The five amendments that expanded the contract scope added a total not-to-exceed cost of $205,500.

Six GIB members indicated to us that GIB should approve all contract extensions. A seventh GIB member indicated to us that GIB should approve contract extensions that modify the fees charged or the services provided.

ETF should compile additional information about the performance of program administrators, program actuaries, and auditors, such as the extent to which these firms achieved key performance measure goals. Program administrators are contractually required to report on a monthly and quarterly basis on the extent to which they achieved these goals. GIB and the ETF Board can use this information to make programmatic decisions, such as determining whether to continue to contract with a given firm or rebid a contract. ETF should also help GIB and the ETF Board determine the maximum duration of contracts before rebidding them. Periodically rebidding contracts helps ensure that GIB and the ETF Board receive the best possible price for the contracted services. In addition, ETF should seek approval and direction from GIB or the ETF Board before executing contract amendments for actuarial services.

☑ Recommendation

We recommend the Department of Employee Trust Funds:

- *compile additional information about the performance of program administrators, program actuaries, and auditors and provide this information to the Group Insurance Board and the Employee Trust Funds Board;*

- *work with the Group Insurance Board and the Employee Trust Funds Board to determine the maximum duration of contracts with program administrators, program actuaries, and auditors;*

- *seek approval and direction from the Group Insurance Board or the Employee Trust Funds Board before executing contract amendments for actuarial services; and*

- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement these recommendations.*

Actuarial Audits

Different program actuaries can sometimes provide significantly different recommendations. As noted, the information Deloitte provided to GIB in August 2011 differed significantly from the information Segal provided to GIB in August 2017. Deloitte recommended target ranges for program reserves equal to 15.0 percent to 25.0 percent of claims for pharmacy benefits, while Segal recommended target ranges equal to 8.0 percent to 10.0 percent of claims for pharmacy benefits.

Lewis & Ellis, the actuary we hired to independently evaluate the work of Segal, indicated that actuarial audits of group insurance programs in other states are typically conducted every three to five years. However, it indicated that there are no requirements regarding the frequency of actuarial audits.

ETF should establish a written plan to periodically contract for actuarial audits to assess the appropriateness of information provided by program actuaries.

ETF should establish a written plan to periodically contract for actuarial audits to assess the appropriateness of information provided by program actuaries and provide GIB with the actuarial audit results. GIB can consider these results when making programmatic decisions, such as spending program reserves and determining premiums, that are based on information provided by program actuaries. ETF indicated that it has begun to consider contracting for periodic actuarial audits.

☑ Recommendation

We recommend the Department of Employee Trust Funds:

- *establish a written plan to periodically contract for actuarial audits to assess the appropriateness of information provided by program actuaries and provide the Group Insurance Board with the actuarial audit results; and*

- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement this recommendation.*

Potential Improvements to Program Oversight

Various aspects of GIB's structure compare favorably with the oversight entities in five other midwestern states.

We considered ways that GIB could potentially improve how it fulfills its oversight responsibilities. To help do so, we obtained information from Illinois, Iowa, Michigan, Minnesota, and Ohio about the entities in those states that oversee group insurance programs for government employees. We also contacted Indiana, but it does not have an oversight entity for the executive branch agency that administers such programs. We found that various aspects of GIB's structure compare favorably with the oversight entities in the five other midwestern states.

An oversight entity may be better able to provide oversight if it has a sufficient number of members. We found that GIB contains approximately as many or more members than the oversight entities in four of five other midwestern states. The oversight entity in Ohio had 20 members, while it had 12 members in Illinois, 10 members in Minnesota, 5 members in Iowa, and 4 members in Michigan. Similar to GIB, none of these five states requires members to possess any particular experience or qualifications pertaining to the programs they oversee, such as actuarial experience or qualifications.

Creating committees can potentially help an oversight entity complete work more effectively because members can devote additional attention to particular issues. Among the five midwestern states, only Ohio's oversight entity had established committees. Although GIB did not establish any standing committees, four of the six GIB members whom we asked about committees indicated that establishing committees could be beneficial.

An oversight entity needs to meet frequently enough to have sufficient time to adequately consider issues. From January 2009 through December 2018, GIB met 50 times, or an average of 5 times annually. We found that the oversight entities in the five midwestern states typically met four or fewer times annually. Six GIB members indicated to us that meeting more frequently would not improve their oversight, two members indicated that it would improve their oversight, and three members were uncertain.

ETF should assess options that GIB could implement to improve its oversight of group insurance programs. Such options could include creating committees that would allow certain members to devote additional time to particular issues. In addition, meeting more frequently would provide GIB additional time to consider programmatic issues. ETF should provide the results of its assessment to GIB, which can use the information to improve its program oversight.

☑ **Recommendation**

We recommend the Department of Employee Trust Funds:

- *assess options to improve oversight of group insurance programs and provide the results of its assessment to the Group Insurance Board; and*
- *report to the Joint Legislative Audit Committee by November 22, 2019, on its efforts to implement this recommendation.*

Issues for Legislative Consideration

The Legislature could consider modifying statutes to specify that the Administrator of DOA's Division of Personnel Management, or his or her designee, is a GIB member.

The Legislature could consider modifying statutes to specify that the Administrator of DOA's Division of Personnel Management, or his or her designee, is a GIB member. Section 15.165 (2), Wis. Stats., states that the Director of the Office of State Employment Relations (OSER), or his or her designee, is a GIB member. However, 2015 Wisconsin Act 55 eliminated OSER and transferred its functions to the Division of Personnel Management in DOA. As of November 2018, the designee of the Administrator of the Division of Personnel Management was a GIB member.

The Legislature could consider modifying statutes to clarify the membership requirements of four GIB members.

The Legislature could consider modifying statutes to clarify the membership requirements of four GIB members. Section 15.165 (2), Wis. Stats., requires one member of GIB to be "an insured employee of a local unit of government," but it does not indicate the type of insurance coverage this member must maintain. Statutes require three other members of GIB to be insured participants in the WRS, but statutes do not indicate the type of insurance coverage these members must maintain. Statutes could be modified to require these four members to participate in at least one of the group insurance programs overseen by GIB.

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Appendix ■

Appendix

Members of the Group Insurance Board

As of November 2018

Member	Membership Criteria	Board Member Since	Term Expires
Michael Farrell (chair)	Appointed by the Governor; no membership requirements	March 2012	May 2019
Stacey Rolston (vice chair)	Designee of the Administrator of DOA's Division of Personnel Management	November 2015	Ex Officio
Herschel Day (secretary)	Appointed by the Governor; insured participant in the WRS who is a teacher	May 2013	May 2019
Charles Grapentine	Appointed by the Governor; insured participant in the WRS who is retired	March 2012	May 2019
Waylon Hurlburt	Designee of the DOA Secretary	October 2017	Ex Officio
Theodore Neitzke	Appointed by the Governor; insured employee of a local government	February 2014	May 2019
Jennifer Stegall	Appointed by the Governor; insured participant in the WRS who is not a teacher	June 2017	May 2019
Nancy Thompson	Appointed by the Governor; chief executive or member of the governing body of a local government participating in the WRS	February 2012	May 2019
J.P. Wieske	Designee of the Commissioner of Insurance	June 2016	Ex Officio
Bob Wimmer	Designee of the Attorney General	August 2018	Ex Officio
Bob Ziegelbauer	Designee of the Governor	May 2016	Ex Officio

Responses ▪

STATE OF WISCONSIN
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

February 12, 2019

JOE CHRISMAN, STATE AUDITOR
LEGISLATIVE AUDIT BUREAU
22 E MIFFLIN ST SUITE 500
MADISON WI 53703

Re: Audit of the Group Insurance Board and ETF

Dear Mr. Chrisman:

Thank you for the opportunity to review and comment on the Legislative Audit Bureau's (LAB) evaluation of the oversight the Group Insurance Board (GIB) provided for group insurance programs the Department of Employee Trust Funds (ETF) administered and the State Group Insurance Programs. Overall, this report documents the fact that the GIB has kept health insurance costs in check and satisfaction among employers is high. ETF is pleased that no significant concerns were identified.

This response, it should be noted, reflects only the comments of ETF as we were not allowed to share the draft Audit Report with the GIB. Accordingly, while ETF has already implemented changes that will address some of the recommendations included in the Report, we will provide a full response to the Audit's recommendations by November 22, 2019, after we've had the opportunity to discuss them with the GIB.

The LAB's report covers a wide-range of topics concerning large, multifaceted insurance programs. Rather than address every topic and recommendation, this response instead focuses on the four areas where we either disagree with LAB's conclusion or recommendations or believe additional information would provide readers additional necessary context. Absent this context, the reader may not have a complete picture of the administration of the group health insurance programs.

Administration of Group Insurance Programs

Since 2010, the Group Health Insurance Program (GHIP) has gone through significant change and the role of the GIB has expanded. While the Report provides useful facts and figures on the annual costs and demographics of the GHIP, it does not provide any meaningful analysis of how the program has changed and the many things ETF and the GIB have done to adapt to those changes. It is important to note that many of the Report's findings are the by-product of a program, Board and agency evolving to accommodate those changes.

ETF and the GIB work collaboratively to administer the group health insurance program. The GIB meets at least four times a year for at least four to six hours. Before each meeting, board members are expected to review numerous staff, consultant and vendor generated reports and are asked to approve premiums, program changes, reserve draws and member appeals, as well as periodically selecting vendors through the RFP process. Members are reimbursed for their necessary expenses in attending GIB meetings and receive a per diem of $25 for each meeting.

Before 2010, the GIB's primary responsibility was negotiating contracts with health insurance plans. The GIB had limited authority to modify benefits, and, as noted above, primarily focused on cost containment through the negotiation process. Since 2011, considerable legislative and administrative energy has been focused on the GHIP. The GIB progressed to meet these new responsibilities, becoming a much more active board, and ETF has supported the GIB in this effort.

Beginning in 2011, Act 10 required the GIB to reduce the cost of health plans by at least 5%. For the first time, the GIB implemented employee paid co-insurance and deductibles for the health insurance programs. 2011 Act 10 also required that employers pay no more than 88% of the average premium cost. This ensured that employees would pay a larger portion of future premium increases. Additionally, employees were responsible for paying an increased portion of the health insurance premiums. ETF was tasked with implementing these changes and communicating the changes to employers and employees, along with implementing other changes included in Act 10 affecting public employee retirement benefits.

In 2013, the GIB was provided authority to modify benefits to maintain or reduce premiums. Before this law change, the GIB was not authorized to enter into an agreement to modify or expand any group insurance coverage in a manner that conflicts with laws or rules promulgated by the ETF or that materially affects the level of premiums or the level of benefits under any group insurance coverage. Additionally, as noted above, the 2013 legislative sessions included several directives that the GIB and ETF were responsible for implementing, including: creating a wellness initiative, creating high deductible health plans and health savings accounts, and conducting a study to exclude domestic partners from the health insurance program.

In addition to implementing legislatively mandated programs, since 2011, the administration and legislature have directed the GIB to decrease the state's cost of the program. The GIB has successfully met mandated insurance savings included in multiple biennial budgets. In 2015, Act 55 directed the GIB to work with its benefits consultant to make appropriate changes to realize $81 million in efficiencies and savings over the biennium. To meet this mandate, significant plan design changes were introduced in 2016, including increasing employee paid deductibles and out of pocket maximums. These changes significantly decreased the actuarial value of the plan and what the state pays for health insurance. The changes again increased what employees are required to pay. The 2015 biennial budget also created, and ETF implemented, an employee incentive to opt-out of the state health insurance program to further reduce costs to the state.

The 2017 proposed budget directed the GIB to find at least $63.9 million in savings. The GIB and ETF implemented $72.6 million in savings mainly through plan design changes and negotiating with health plans. The GIB and ETF recognized that public employees have seen significant changes to their health insurance and sought to achieve these savings with minimal impact to employee benefits.

As noted above, over this time period, the Group Health Insurance Program was used as one of the tools to help balance the budget. Due to these budgetary directives, the primary focus of the GIB and ETF was on identifying ways to implement cost savings versus further improving program administration. That being said, even though the focus was on cutting cost, the GIB and ETF made great strides looking for ways to improve the program, create a healthier workforce and achieve administrative efficiencies.

Cost Effective and Satisfying

Overall, the Group Health Insurance Program has used a managed competitive market model to keep costs in check. The report notes that costs increased from approximately $1.3 billion in 2009 to $1.7 billion in 2017, an average annual increase of 3.7%. According to the PricewaterhouseCoopers Medical Cost Trend, the national average increase over the same time period was 7.7%. The increases in the GHIP are substantially less than the industry trend. If the group health insurance costs would have been consistent with industry trend, the state health insurance spend would be hundreds of millions of dollars higher.

ETF and the GIB have been able to limit cost growth through competitive negotiations with the health plans. Negotiations with health plans reduced estimated premium expenditures by approximately $31 million annually and the GIB used reserves to further limit premium increases in 7 of the 9 years.

In addition to managing costs through competitive negotiations, since 2011, the GIB has been required to generate substantial savings to help meet the State's Biennial Budget targets. As noted above, the GIB has successfully met mandated insurance savings included in multiple biennial budgets.

The Report clearly shows that almost all state and local government employers are satisfied with the program and ETF and the GIB's efforts.

Providing Consultant's Information and Recommendations to the GIB

To meet their changing roles, ETF and the GIB hired a benefits consultant (Segal Consulting) in 2014 to examine the GHIP and make recommendations for program changes designed to reduce both short-term and long-term costs. The Audit Report suggests that ETF did not consistently advise the GIB on which recommendations to implement. ETF disagrees with this.

All board members were provided the full reports from Segal in March and November 2015. The consultants attended these meetings and walked the GIB through the full reports in detail. At these meetings, board members asked clarifying questions, requested additional information and provided ETF directives on what they would like to pursue. In February 2016, ETF presented a proposed implementation plan to the GIB regarding Segal's recommendations. This memo discussed the proposed recommendations of the consultants, resource availability for ETF and asked the GIB to provide direction on its priorities. In response to the two Segal reports, the GIB identified pursuing a shift to Self-Insurance as its top priority and directed staff to prepare and issue an RFP. In addition, the GIB approved creating a uniform statewide wellness program, implementing a data warehouse and analytics function, re-contracting for the state's pharmacy benefit manager and a delayed implementation of a Medicare Advantage plan for retirees. In addition, the GIB determined it appropriate to minimize benefit changes during these initiatives. ETF provided numerous memos on the status of these initiatives to the GIB. ETF staff are always responsive to inquiries and additional analysis when requested by the Board. In late 2018, with the completion of most of these initiatives and the rejection by the Legislature of a shift to self-insurance in 2017, ETF provided an update to the GIB on the remainder of the recommendations of the benefit consultant and potential next steps.

Providing Materials to the GIB

The Audit Report noted that ETF did not consistently provide GIB materials in advance of meetings when it observed that one report was provided to GIB members at the August 2018

meeting and not prior to it. ETF's goal is to provide GIB materials to members one to two weeks prior to the meeting. In 2016, during the heat of the self-insurance evaluation when the GIB met eight times during the year, the GIB was provided 107 ETF and consultant generated documents. Only 16 of those were provided the day of the meeting. In 2018, out of the 103 documents provided to GIB, only 3 were provided the day of the meeting. ETF does everything possible to ensure that GIB receives accurate and relevant information in a timely manner. When substantive reports are provided on the day of the meeting, ETF staff or the consultants who generated the report are at the meeting and present the materials to the GIB and are available to answer questions. Overall, the vast majority of materials are provided at least a week in advance of the meeting.

Performance Measures for Programs

The Audit Report notes that ETF and the GIB did not determine program goals for several of the GHIP programs, namely the Wellness Program and High Deductible Health Plan. Both programs were legislative initiatives and no program goals were identified in the legislation. ETF and the GIB, in an overall effort to provide these additional tools to control health care costs, focused on implementing these mandates in a short time period. As detailed below, ETF and the GIB have made a number of changes to improve these programs and continue to see improved performance.

HDHP Plan – The GIB was directed by the Legislature to implement HDHP options beginning with the 2015 plan year. ETF created and implemented a communications plan and tools to educate employees on the benefits of the HDHP plan. Enrollment has increased each year since the program started. **Plan year 2019 experienced a 37% increase in HDHP enrollment** over plan year 2018. ETF continues to work with employers to educate benefits staff and employees about the HDHP plan option. Based on anecdotal evidence, ETF believes that the lack of prefunding the employer share of the Health Savings Account may be a barrier to further significant expansion of the HDHP program.

Wellness Program – While the 2013 budget included a directive to develop a wellness plan, the GIB's benefit consultant, Segal, recommended a total health management program as an integral part of a long-term plan to better manage health care costs. The GIB adopted a program to contract for a single wellness vendor to consolidate the offering of incentives to members who complete a health screening, a health risk assessment and participate in wellness improving activities.

Since contracting with a wellness vendor**, enrollment in wellness programming has increased significantly, from 28,762 in 2016 to 49,064 for 2018 – a 70% increase**. The overall risk of the state employee group has decreased during the same time frame, and a number of wellness programs have been initiated including a blood pressure management program, a back-health program and a pilot program aimed at helping employees with weight management. For 2019, the wellness vendor is partnering with the state's pharmacy benefits manager to improve diabetes management and to improve compliance with medication management for persons with asthma and other chronic breathing programs. Programming for 2019 also includes a program on improving member sleep quality and additional access to mobile programming to assist members. The 2019 wellness contract includes performance metrics, as well as a return on investment (ROI) evaluation.

Contract Administration Authority

The Report suggests that the ETF Secretary does not have the authority to sign amendments to contracts for actuarial services. ETF disagrees with this interpretation. Under state law, authority with respect to contracts for actuarial services is blended between the ETF Board and the ETF Secretary. Specifically, state law indicates that contractual agreements for actuarial services run to the Department. The law further requires the ETF Board to direct the ETF Secretary to sign, on behalf of the Department, contractual agreements for actuarial services that have been approved by the board.

This overlapping authority exists because both the board and ETF as a Department are required to engage the actuaries to perform services for them. For example, the contractual agreements with the actuaries contemplate work as needed for ETF. In addition, by law, the actuaries serve as technical experts to the Department.

The ETF Secretary has all of the powers necessary to carry out the purposes of Chapter 40, except as otherwise specified by state law. Nothing in law prohibits the Secretary from signing amendments to these contractual agreements with the actuaries and signing such amendments is consistent with Chapter 40.

Accordingly, the ETF Secretary signed each of the 5 contract amendments with the actuary for the Group Health Insurance program and each of the seven contract amendments with the actuary for the Income Continuation Insurance, Long-term Disability Insurance, and Life Insurance programs that are discussed in the Audit Report.

The twelve amendments concern four types of activity:

1) Four of the amendments involved annual inflationary increases for the retainer fee allowed for in the RFPs which are part of the contracts. ETF had authority to sign these contract amendments because the ETF Board and Group Insurance Board approved the RFPs that allowed for the inflationary increase in the retainer fee.
2) Four of the amendments included scope expansion for additional actuarial work to assist ETF. ETF informed the Group Insurance Board or the ETF Board, as appropriate, about the content and purpose of each amendment. That action by ETF occurred at board meetings and is documented by board agendas, board minutes, memoranda provided to the boards, and in certain instances there were presentations to the boards by either the actuaries or ETF staff.
3) Two of the amendments contained inflationary increase for the retainer fee and expanded the scope of the contract. For the reasons noted in #1 and #2, ETF had the authority to sign these contract amendments.
4) Two of the amendments accommodated another State agency (DOA) through an interagency agreement for actuarial work related to the State’s CAFR. The interagency agreement was between ETF and DOA. Consequently, the two boards did not need to authorize that action.

Going forward, in order to improve transparency for the Boards, ETF has instituted a quarterly report to the Boards regarding amendments signed between board meetings along with a brief explanation of each amendment and the cost impact, if any. In addition, ETF will better document the source of its authority to sign contractual agreements with the actuaries.

Contract Administration – Performance Goals

The Report states that ETF 1) did not sufficiently specify how to calculate performance measures; 2) did not determine the extent to which vendors achieved contractually specified

performance goals and assess financial penalties for failure to meet the goals and 3) the October 2018 RFP for auditing services did not specify how to calculate performance measures. These findings do not fully explain ETF's efforts regarding performance based contracting. ETF has made a number of changes to improve its contract administration as the programs have evolved and continues to improve its performance-based service contracting.

Since the implementation of an effective performance program can be challenging in the health care arena, ETF continues to work on developing meaningful metrics that are realistic, measurable, and enforceable. This work includes 1) fully dedicating two positions to contract administration; 2) developing and tracking vendor deliverables and 3) providing the GIB a report of all contract activity including any assessment of penalties. Additionally, ETF's Office of Internal Audit has begun working on a scheduled review of the contract administration function for ETF to ensure effective contract administration.

Tracking Employee Time

The Audit Report recommends that ETF staff track the amount of time expended to complete work for each group insurance program. We were surprised by this recommendation and believe the potential bureaucracy required to comply with it is an unwarranted cost to the programs. ETF employs a reasonable approach to allocating internal costs to the programs administered by ETF. Every year as part of ETF's Financial Audit, LAB staff reviews ETF's methodology and financial calculations for allocating administrative costs and there has never been concern regarding the methodology. ETF allocates costs using a consistent and reasonable methodology.

Most group insurance program staff time is allocated to the specific programs they manage. The time of other staff that work on higher level broad issues and/or are involved in tasks related to multiple programs are also allocated to the programs but in a proportion based on the insurance program staff time. We do not believe tracking time would lead to a material change in the administrative costs charged to the programs. However, we will periodically reassess our allocation methodology for opportunities to improve it. As in the past, we will share any proposed changes in the methodology with the LAB financial auditors.

Approach to Managing Reserves

The GIB's use and administration of health insurance program reserves is a key issue of interest for the Legislature and we are pleased to see that LAB's independent actuary concluded that the reserve methodology used by the GIB and its actuary is reasonable. One of the main purposes of the reserves is to stabilize premiums so as to avoid large premium swings from year to year. As noted above, the LAB's independent auditors found that the GIB's reserve methodology is reasonable and appropriate. Segal proposed a four-year plan for spending the reserves which was approved by the Board in 2017. This plan does not require the GIB to use a certain amount each year, but serves as a guide. ETF, Segal and the GIB evaluate how successful the negotiations process has been in that year and what they believe may be some of the future cost challenges to the GHIP when deciding how much of the reserves to use in a given year. The GIB has used reserves in nine of the 11 past years. Reserves were not used in two years because the GIB was preparing to move the GHIP program to a self-insured model, which requires a significantly higher reserve balance.

The report recommends that the reserve calculation include projected investment income. While we believe that this approach will add complexity and volatility to the reserve model, and we

note that it was not recommended by LAB's actuarial consultant, we will discuss the matter with Segal Consulting and the GIB.

Additionally, program reserves information is included in ETF's Comprehensive Annual Financial Report (CAFR). The CAFR is audited by LAB and published each fall. The transmittal letter in the CAFR highlights reserves as a percentage of annual expenses by program with additional details within the report. ETF will continue to provide this reporting.

The Audit Report also recommends that ETF provide the GIB with ETF's written analysis of the information provided by the actuary regarding the estimation and use of the reserves. This recommendation seems to be based on a misunderstanding of the roles of the actuary and staff. ETF staff have never attempted to supplant the actuary's role because the actuary is hired based on his or her industry expertise, actuarial skill and knowledge, and availability of specialized resources. By law, the actuary serves as the expert consultant to both the GIB and ETF. ETF and the actuary are in regular communication and work to support the GIB in its responsibilities. Should the actuary recommend something to the GIB that ETF disagrees with, we will bring that to the GIB's attention.

Member Privacy and Data Security

Data Information Requests

The Audit Report notes that at times, ETF took longer than anticipated to provide the data that LAB requested as part of the audit. ETF was surprised by this finding and disagrees with it. Federal law required ETF to disclose only the minimum necessary protected health information to LAB in response to their requests for private member information, including demographic, employment, and medical claims.

LAB's own Protection of Information Policy is consistent with ETF's limitations under federal law, as that policy indicates that only data needed to complete audit work should be obtained or accessed and that LAB Staff should work with agencies so that only pieces of information needed are obtained.

To provide additional context, because ETF administers health insurance-related programs, ETF is a covered entity under the Health Insurance Portability and Accountability Act (HIPAA). That means that ETF is required to protect ETF member data in connection with the health programs that ETF administers. For the purpose of LAB's evaluation, ETF had the difficult task of harmonizing the requirements of federal privacy law and LAB's statutory authority under state law.

As a covered entity, ETF must safeguard HIPAA protected health information (PHI). PHI includes identifiers such as name, Social Security Number and demographic information when tied to health insurance enrollment. See 45 C.F.R. 160.103. Additionally, federal law requires that information provided for health oversight activities, like audits, must also comply with the minimum necessary provisions of the Privacy Rule. Because of the federal rules and LAB's policy, we were surprised that ETF's efforts to ensure compliance resulted in an observation in the report.

In late March, LAB requested ETF's health insurance enrollment file. That file contains identifying information including names and Social Security Numbers, as well as the address, participant status (active, annuitant, dependent), employer, and ETF Member ID for all State Group Health Insurance Program participants.

The request led to ongoing discussions (April-July) with LAB's auditors, attorney, and IT staff to: (1) clarify their request; (2) draft a Memorandum of Understanding; and (3) ensure the information LAB needed was provided in a secure manner. ETF believed that ETF and LAB had successfully arrived at an agreement that would provide LAB the information needed for its evaluation, and that would allow ETF to comply with federal law.

Audits of Information Technology Controls

The Audit Report recommends that ETF work with the GIB to establish sufficient policies pertaining to audits of IT controls of its vendors. ETF initiated more rigorous vendor controls in 2017. These efforts started with ETF strengthening the security related requirements of ETF contracts, with the first contract going into effect the fall of 2017. Since then, ETF has updated the audit and security language included in all ETF standard contracts. As of January 1, 2019, all the new contracts and amendments to existing contracts require vendors to submit audits of IT controls to ETF. Additionally, ETF formalized the Service Organization Control 2 (SOC 2) review process in 2018 and will follow this process to collect and review vendor's 2018 plan year IT audit reports in 2019.

Electronic Communication of Confidential Information

The Audit Report noted that ETF communicated confidential information to the LAB over the state's email system and that the email system is an inappropriate means of communicating confidential information. The staff's communication of social security numbers was not consistent with ETF policy or the protocol we had in place with LAB to exchange information. However, the message was still sent securely, and the staff person was reminded of the appropriate communication mechanism for this type of information. ETF believes that the state's email is a secure and appropriate means of communicating certain types of confidential information between state agencies. We believe the LAB does, too, as it routinely transmits confidential information to ETF over the state's email system.

While LAB cites the possibility of mistakenly sending an email containing confidential information to a person outside of the system, the state's email system used by ETF contains a software program (IronPort) which stops emails with confidential information from being sent to external recipients without message encryption. In addition, the Report notes that the emails could be subject to a phishing attempt. Based on the common definition of phishing, phishing is the fraudulent practice of sending emails, sometimes purporting to be from a reputable company, in order to induce individuals to reveal personal information or to infect the recipient's computer with malware. That does not seem to apply to the emails identified by the Report.
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Redesign of Disability Programs

The Audit Report notes that reserves for the state component of the Income Continuation Insurance Program were in a deficit from 2008 through 2017. Reasons for this decline include increased expenditures from long-term benefit claims and decreased enrollment, possibly due to employees paying higher amounts for employer provided health and retirement benefits. In response to this program deficit, the GIB increased premiums every year, except one, since 2010. In the report, the LAB states that funds may be inadequate to pay future benefits. We disagree. According to the program actuary, the deficit is expected to be eliminated by 2021 due to the increased contributions. Furthermore, as discussed below, ETF has proposed several

changes to the ICI program that will provide sustainability and ensure that the program will be able to pay future benefits.

In 2013, ETF contracted with an actuary to evaluate ETF's disability programs. ETF staff worked with the actuaries to redesign the programs, which streamlines, simplifies, and reduces duplication of the state's disability programs. The end goal is to restructure the disability programs to have one short-term disability program (ICI) and one long-term disability program (Disability Retirement Annuity under s.40.63 Wis. Stats.). ETF has achieved most of the changes through modifications to administrative rules and contracts. The final pieces of the redesign require legislative change, which were included in ETF's 2019-21 budget request.

Finally, the Report notes that ETF did not follow statutory requirements to set premiums for the ICI program and charged employers and employees more than what was statutorily stipulated. The Report does not fully explain that DOA required ETF to round the premiums because, at the time, DOA's human resources system was unable to charge employers the non-rounded premiums. Once the state's new IT system, STAR, was implemented and DOA informed ETF that the rounding rules were no longer required, ETF immediately began providing premiums without rounding.

ETF Recommendations Concerning the GIB for Legislative Consideration

ETF offers the following recommendations for Legislative consideration:

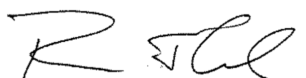
Terms: Public members of the GIB serve two-year terms expiring on May 1 of odd-numbered years. In some years in which a change of administration occurs, like 2019, it is possible for the GIB to experience total or near total turnover. The loss of institutional memory on the GIB can be problematic for the programs it oversees. We recommend that public members of the GIB have staggered four-year terms.

Per diem: Given the responsibilities of the GIB, it seems that the $25 per diem is inadequate. We recommend that GIB members be eligible for a higher per diem.

Reporting relationships: Recently, the GIB had two employees of the Office of Commissioner of Insurance as members. One was a statutory ex officio member and the other was appointed by the Governor. While their expertise in insurance matters was welcome, having a board member who reports for employment purposes to another board member may affect the appearance of independence that all board members are expected to exercise. We recommend such reporting relationships be prohibited on the GIB.

We appreciate the time and level of effort that was necessary by LAB staff to complete this expansive audit.

Sincerely,



Robert J. Conlin
Secretary

STATE OF WISCONSIN | Legislative Audit Bureau

22 East Mifflin St., Suite 500 ▪ Madison, WI 53703 ▪ (608) 266-2818 ▪ Hotline: 1-877-FRAUD-17 ▪ www.legis.wisconsin.gov/lab

Joe Chrisman
State Auditor

February 15, 2019

Senator Robert Cowles and
Representative Samantha Kerkman, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Cowles and Representative Kerkman:

I write to clarify two issues in the audit response signed by the Secretary of the Department of Employee Trust Funds (ETF).

First, page 7 of the response indicates ETF's surprise that the Bureau found that ETF had taken longer than anticipated to provide certain demographic information. The response appears to attribute the delay to the requirements of the Health Insurance Portability and Accessibility Act (HIPAA).

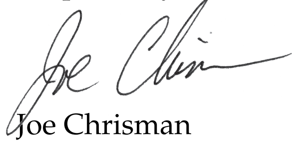
The Bureau understands the importance of safeguarding information under HIPAA. The Bureau is granted access to HIPAA-protected information under federal and state law. However, we respected ETF's request for a memorandum of understanding to provide additional assurances that any HIPAA-protected information would be safeguarded. We note that, for this audit effort, the Bureau requested limited demographic information for Group Health Insurance program participants. For example, we did not request participants' names, Social Security numbers, or medical claims.

We do not object to entering into memoranda of understanding with agencies specifying the terms of our use of information and data, and we routinely enter into these agreements with agencies. However, the process to create the memorandum of understanding with ETF was unusually lengthy and required review of several versions. For example, versions of the memorandum of understanding that were proposed to the Bureau included provisions related to HIPAA and information technology security that were inapplicable to the Bureau's specific request. In addition, one version introduced a proposal to require the Bureau to pay one-half of the costs of any breach of the information received from ETF regardless of whether the Bureau was the cause of the breach or not. Such provisions were not acceptable to the Bureau, and the Bureau worked respectfully with ETF to establish a memorandum of understanding acceptable to both parties.

Second, page 8 of the response indicates ETF's position that email is a secure and appropriate means of communicating "certain types" of confidential information between state agencies. As noted in this report, ETF emailed the Bureau 34,600 Social Security numbers of active and retired employees participating in the Group Health Insurance program. We strongly disagree that Social Security numbers should be communicated via the State's email system.

I hope you find this information helpful.

Respectfully submitted,



Joe Chrisman
State Auditor

JC/ss