Vermont Legislative Joint Fiscal Office

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FISCAL NOTE

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H.81 An act relating to statewide public school employee health benefits – As Passed By The House

https://legislature.vermont.gov/Documents/2022/Docs/BILLS/H-0081/H-0081%20As%20Passed%20by%20the%20House%20Unofficial.pdf

Summary

H.81 makes a small change to the operations of the Commission on Public School Employee Health Benefits. Funding the Commission now requires an appropriation of $35,000 for per diem compensation and reimbursement of expenses for Commission members. Currently this is not a state cost.

The bill makes two significant changes to Commission responsibilities. First, it removes the requirement that each plan tier—single, two-person, parent/child, and family configurations—shall have the same premium responsibility percentage for all participating licensed employees and all participating non-licensed employees. Second, it removes the requirement that each plan tier shall have the same out-of-pocket expenses for all participating licensed employees and all participating non-licensed employees.

State revenue needs and future employee/employer premiums will depend on the bargaining decisions made. The costs could be increased in future years, however, if participating employees face less financial exposure to medical and pharmaceutical costs through lower premium shares and/or smaller out-of-pocket expenses. Employees who do not pay much for health care are likely to use more of it, driving up premiums for all participants. Already, the plans are more generous than most, as seen in their actuarial value, and premium increases have surpassed increases in the cost of care and enrollment. Allowing more leeway in bargaining could lead to even higher actuarial value and further exacerbate the incentive to use more services because the user pays so little.

Commission Appropriation

The bill establishes an appropriation to pay Commission members the usual per diem of $50 and expense reimbursement of $76 per day for a maximum of 20 meetings per year. Including the alternate members implies a total appropriation of $35,000 in FY 22. Commission members who would be eligible for the per diem are representatives of school employees and school employers.

Commission Duties regarding Premium Responsibility Percentages

The Vermont Education Health Initiative (VEHI) is a non-profit organization that offers health insurance plans to school district employers and employees. Under the collective bargaining agreement (CBA) now in effect through December 31, 2022, all licensed employees such as teachers pay 20 percent of the health insurance premium for VEHI Gold CDHP and Silver CDHP; the employer pays 80 percent (see Table 1). For employees enrolled in VEHI Gold or Platinum plans, the employer pays the equivalent of 80 percent of the Gold CDHP plan, and the employee pays the rest. Non-licensed employees in 2021 pay the premium share for the various plans according to the status quo that reflects locally negotiated agreements. As of January 1, 2019, the median and mean share of premiums paid by year-round non-licensed employees such as support staff was 15 percent.[1] The median and mean share of premiums paid by school-year non-licensed employees was 16 percent. Those shares may be different today, but the current CBA did not impose changes. In 2022, however, the CBA requires the employee share to increase up to 2 percentage points to move closer to 20 percent.[2]

Table 1. Employee Premium Share in the Current Collective Bargaining Agreement, ending Dec. 31, 2022, and the Next; VEHI Gold CDHP

	CY 2021	CY 2022	CY 2023: Next CBA
Licensed Employees			
Tiers			
Single	20%	20%	statewide: ?
Two Person	20%	20%	statewide: ?
Parent/Child	20%	20%	statewide: ?
Family	20%	20%	statewide: ?
Non-licensed Employees			
Tiers			
Single	local, ~16%*	local + 2 ppts**	statewide: ?
Two Person	local, ~16%*	local + 2 ppts**	statewide: ?
Parent/Child	local, ~16%*	local + 2 ppts**	statewide: ?
Family	local, ~16%*	local + 2 ppts**	statewide: ?
Notes:			
*Locally bargained; average is about 15% for year-round employees, about 16% for school-year employees			
**Add 2 percentage points to the locally bargained share up to a maximum of 20%			

Negotiations will begin on April 1, 2021 to determine premium shares in the next CBA that will become effective January 1, 2023. This bill would allow statewide bargaining to negotiate

[1] Available at http://vthealthbargainingteam.org/

[2] Act 11 of 2018 that created the Commission on Public School Employee Health Benefits did not set premium cost shares. Act 85 of 2017 set the target of 80/20 premium shares for the first round of local negotiations, but local negotiations produced a variety of premium share arrangements. Both “last best offers” presented to the Commission as of January 1, 2020 contained 80/20 premium shares for all employees, but the proposal selected by the arbitrator retained the status quo for non-licensed employees until December 31, 2021 and then required the 2 percentage point increase toward the 80/20 split as of January 1, 2022.

different premium shares across different plan tiers—single, two-person, parent/child, and family—and across licensed and non-licensed employees.

That change could have fiscal implications for employers (the state) as well as employees. The total premium paid for public school plans is about $250 million in FY22. Applying the average rate of VEHI premium increases from FY19 to FY22 suggests that premiums might increase 11.3 percent annually between FY 22 and FY 24, leading to premium costs of about $311 million in FY 24. Any 1 percentage point shift in the premium share of all participating employees represents $3.1 million. For example, if the premium share for all participating employees shifted down 1 percentage point, employees would pay $3.1 million less and employers (the state) would pay $3.1 million more. If only non-licensed employees negotiated a 1 percentage point change in the premium share, the shift would be about $1 million.

Commission Duties regarding Out-of-Pocket Expenses

Under the CBA now in effect through December 31, 2022, the employer contribution to a Health Reimbursement Account (HRA) for each Gold CDHP subscriber differs for licensed and non-licensed employees. The Health Reimbursement Account pays out-of-pocket expenses for covered benefits beginning with the first dollar.

For licensed employees in the Gold CDHP plan, the employer currently contributes up to $2,100 for medical or pharmaceutical out-of-pocket (OOP) expenses for single plans and up to $4,200 for the other tiers. Employees in single plans pay the last $400 of out-of-pocket expenses, if needed, and those in other tiers pay the last $800 (see Table 2). For non-licensed employees in the current CBA, the employer contributes up to $2,200 to the HRA for single plans and up to $4,400 for the other tiers. Non-licensed employees pay the last $300 in single plans and the last $600 in the other tiers.

Current law does not specify the amount of out-of-pocket expenses in future years. The bill allows statewide bargaining over out-of-pocket expenses across tiers. To illustrate the fiscal impact of changing employer contributions, an increase of $100 in the maximum employer contribution for all subscribers with Health Retirement Accounts implies about $75 of actual contributions because not all enrollees use the full HRA contribution, and it must be used within 12 months.[3] Based on HRA take-up in calendar year 2021, the employer (the state) would pay out almost an additional $1 million if all enrollees with HRA accounts were promised an extra $100 in HRA contributions. If that offer were made to licensed employees only, the additional cost to the employer would be about $620,000; if made to non-licensed employees only, the additional cost to the employer would be about $350,000. Differences among plan tiers would result in smaller increased cost if limited to single plans and larger increased cost if applied to other tiers (two-person, parent/child, and family).

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[3] School districts must book the entire $100 increase for the calendar year, however, to protect against the risk of greater-than-expected utilization.

Table 2. Employee Responsibility for Out-of-Pocket, Last Dollar, in the Current Collective Bargaining Agreement, ending Dec. 31, 2022, and the Next; VEHI Gold CDHP				
		CY 2021	CY 2022	CY 2023: Next CBA
Licensed Employees				
Tiers	HRA pays up to:	Then employee pays:		
Single	$2,100	$400	$400	statewide: ?
Two Person	$4,200	$800	$800	statewide: ?
Parent/Child	$4,200	$800	$800	statewide: ?
Family	$4,200	$800	$800	statewide: ?
Non-licensed Employees				
Tiers				
Single	$2,200	$300	$300	statewide: ?
Two Person	$4,400	$600	$600	statewide: ?
Parent/Child	$4,400	$600	$600	statewide: ?
Family	$4,400	$600	$600	statewide: ?
Notes:				
***Health Reimbursement Account pays first dollar up to the difference between maximum OOP and employee responsibility				

Implications of Reducing Employee Premium Share and Out-of-Pocket Responsibilities

The annual cost of reducing employee premium shares by 1 percentage point or reducing employee out-of-pocket responsibility by $100 may not appear to be very large. However, the follow-on implications of such changes can be consequential for premiums in future years.

Utilization of health care depends in part on the exposure of individuals and families to premium contributions and out-of-pocket expenses. The smaller the premium contributions or out-of-pocket cost, the more health care people use.[4] Conversely, the more a consumer has to pay for services, the more likely they are to ask questions and avoid excessive health care services. One-third or more of VEHI's double digit increases the past four years was not tied to rising prices or enrollment but is attributed to the HRA covering a greater share of out-of-pocket expenses which resulted in higher use of health care services.

Greater utilization of health care also causes VEHI to increase its reserve target, set at 15 percent of expenses. Those expenses increase or decrease with enrollment and with utilization. Part of recent increases in VEHI premium stem from an increase in required contributions to reserves as health care expenses rose faster than anticipated.

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[4] For example, see the VEHI FY 19 Rate Renewal Announcement. HRAs with first-dollar coverage, no rollover provisions, and high funding ratios (2200/2500=88%) led to higher utilization than anticipated and the need to raise premiums in future years. https://vehi.org/client_media/files/FY-19-Rate-Renewal-Announcement-9.29.17-FINAL.pdf

One summary measure that gives a good indication of a health plan's coverage of medical and pharmaceutical expenses is the actuarial value (AV) of a plan. The VEHI rate filing for FY 2022 reported high actuarial values after including the HRA (see Table 3).

Table 3. Actuarial Value (AV) of the VEHI Gold CDHP from the FY 2022 Rate Filing			
FY 2022	AV	AV with HRA, licensed	AV with HRA, non-licensed
Gold CDHP	84.4%	97.5%	98.1%

An actuarial value of 97.5 percent for licensed employees means that the plan plus HRA cover all but 2.5 percent of medical and pharmaceutical costs for covered benefits, on average. For non-licensed employees, the AV of 98.1 percent means that the plan plus HRA cover, on average, all but 1.9 percent of medical and pharmaceutical costs of covered benefits. In other words, the average subscriber pays an extremely small portion of health care expenses per year. The AV will increase further if the employee premium share falls and HRA contribution from employers increases. In contrast, Gold plans on Vermont Health Connect pay 80 percent of the cost of covered benefits on average, and the typical preferred provider organization (PPO) plan sponsored by employers paid 83 percent of covered healthcare costs.[5] For people with large employer coverage across the country, deductibles increased more than 200% from 2007 to 2017, and out-of-pocket expenses were almost $800 per year on average in 2017.[6]

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[5] L. Quincy and D Okrent, "Creating a usable measure of actuarial value.*" Consumers Union Policy and Action from Consumer Reports*, synopsis of October 17, 2011 meeting, http://www.consumersunion.org/wp-content/uploads/2013/04/CU_Actuarial_Value_2012_Report.pdf.
[6] Kaiser Family Foundation analysis of IBM MarketScan Commercial Claims and Encounters Database, https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/.