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CORRESPONDENCE MEMORANDUM

DATE: October 20, 2015

TO: Group Insurance Board

FROM: Cheryllynn Wilkins, Board Liaison
Office of the Secretary

SUBJECT: Group Insurance Board Correspondence

This memo is for informational purposes only. No Board action is required.

On occasion, the Department of Employee Trust Funds (ETF) receives correspondence from participants who wish to convey their point-of-view to the Group Insurance Board (Board) regarding proposed changes to the state health insurance program. To keep the Board apprised of communication ETF receives, "Group Insurance Board Correspondence" has been added as a routine item in Operational Updates.

Two communications have been submitted for the Board's review.

1. Letter from Charlie Forsmo, submitted via email October 14, 2015
2. Letter from Sharon E. Hutchinson, submitted via email October 15, 2015

Staff will be at the Board meeting to answer any questions.

Attachment A: October 14, 2015 Correspondence – Charlie Forsmo
Attachment B: October 15, 2015 Email Correspondence – Sharon E. Hutchinson
Attachment C: October 15, 2015 – Report from Sharon E. Hutchinson

Reviewed and approved by A. John Voelker, Deputy Secretary

Electronically Signed 10/27/15

Board	Mtg Date	Item #
GIB	11.17.15	8C

October 14, 2015

As a retired state employee, my total increase to pension since 2007 has been $150.

Next year alone the cost for Unity/UW-Health will rise by nearly $100.00. And that's just next year.

In the years since my retirement I'm at a net loss primarily due to healthcare, which now consumes, between my wife and I, both retired state employees with over 30 years of service, 44% of our gross income from WRS pension.

And yet Unity as well as the other providers unabashedly request, year after year from the Group Insurance Board, a rate increase, knowing full-well that those they're serving are getting near-zero increases in income. And knowing that you, the board, stuffed chock-a-block with appointees of Scott Walker, will without fail rubber-stamp their request, leaving doctors and insurance company parasites to make more and more money to the detriment of civil servants.

Just as Senator Duey Stroebel, Governor Walker and their Republican ilk continue their war on state workers, the Group Insurance Board has proven again this year that they're woefully out of touch with working people. It's unconscionable that you can't just say no to the bandits in the healthcare industry, instead taking cover in cost-shifting gambits that save nothing and only serve to weaken families, those that the Republican right claim to be "helping".

And speaking of taking cover, the only door through which those of us whom you ostensibly serve can enter your world, is this: A letter.

I'm sure it's hard for those of you operating at the appointee-level of state government to understand, but after a career as a state employee, it's getting just a little hard to swallow the hypocrisy of the Wisconsin Republican caucus and their appointees. And with the repudiation of the governor on the national level, don't you think it's about time to read through the ETF document entitled "Ethics and Fiduciary Duty"? (Revised April, 2012), which says, in salient part "Fiduciaries are to act **solely** for the benefit of the beneficiaries." (Emphasis added by ETF.)

When I see increases in my healthcare costs year after year, I find it difficult to believe that you're acting solely for my benefit.

Charlie Forsmo

Item 8A Attachment – Forsmo Correspondence

To: Distinguished Members of ETF's GIB

Re: A novel strategy for protecting the State of Wisconsin and Wisconsin taxpayers from "looming" ACA excise fees on so-called "Cadillac" Health Plans.

I write with "good news" for the State of Wisconsin and all Wisconsin taxpayers, and especially good news for ETF's GIB members. It is possible for the State to reduce its future liabilities with respect to ACA excise fees to almost nothing by restructuring or eliminating ONE health plan from ETF's suite of more than 20 healthcare plans. That plan is the State's "self-insured" Standard Plan (SD), recently renamed ETF's "Access" Health Plan.

The State's Standard Plan is unique because it enables participants to receive healthcare coverage and benefits anywhere in the USA, without network restrictions. This Standard Plan is precisely the sort of "high value" health plan to be targeted by the ACA and IRS. Current 2015 premium rates for SD contacts are very high ($1,392.80 per month for single coverage and $3,447.80 per month for family coverage). These monthly premium rates are roughly double premium rates of "fully insured," Tier One, HMOs. Where as none of the HMOs are, at this point, destined to exceed "Cadillac" plan thresholds of $10,200 for "self-only" coverage and and $27,500 for "other than self-only" coverage. Even if active HMO participants maximized associated "Flexible Health Savings Accounts."

However, the State's future "excise fee" exposure with respect to Standard Plan members is truly alarming. On the basis of 2015 premium rates alone, the State will be responsible for paying a minimum of $2605.44 in ACA "excise fees" for EVERY "self-only" SD contract and a minimum of $5693.44 for EVERY "Family/other-than-self-only" SD contract (see endnote for details).

In addition, the State will be dunned by the IRS 40 cents for EVERY DOLLAR active SD plan participants deposit in individual, "pre-tax" Flexible Health Savings Accounts. The good news is that, if the State tackles develops a way to restructure or eliminate the SD plan before 2013, the State's future liabilities for ACA excise taxes all but dissolves.

More good news: the number of Standard Plan contracts is miniscule, comprising less than 2% of all people enrolled ETF's Group Health Insurance Program (See ETF's 2014 "Fact Sheet"). SD Plan "contract counts" totaled 407 single contracts, 378 family contracts and 6752 retiree contracts, most being held by Medicare-covered retirees. This compares to contract counts for non-State insured HMOs and PPOs, totaling 25,563 active single contracts, 44,066 active family contracts and 18,599 retiree contracts.

Even better news: despite what many people have been told, the State is NOT the party responsible for paying any future ACA excise fees, if applicable, on the 98% of contract holders enrolled in competing and "fully insured" HMOs. ACA statutes are explicit about the fact that it is the "insurer" of "insured health plans" who "must pay" any ACA fees, NOT the employer, NOT the premium payer, NOT the employee and, most definitely, NOT Wisconsin taxpayers. This responsibility cannot be modified through IRS rule-making processes. Senior IRS Attorney, Mr. Kevin Knop, who is responsible for overseeing the ACA rule-making, has confirmed this "fact" in recent telephone conversations with both me and with, at less, one member of staff within ETF's Office of Strategic Health Policy.

All of this should come as excellent news for worried Wisconsin taxpayers, most of whom have been led to believe that the State of Wisconsin will be liable for paying any applicable ACA excise fees on all group health plans overseen by the ETF's Group Insurance Board. This is incorrect: the State's fiscal responsibilities in this respect do NOT extend beyond the State "self-insured" health plans to encompass "fully insured" HMO/PPOs.

What follows is a deeper analysis of these discoveries, which are fully supported by public record documents and interviews with various IRS and ETF staff. Key documents include the 25 March 2015 "Segal Report," written by a for-profit consultancy firm engaged by the DOA and ETF's Group Insurance Board to recommend changes in ETF's Healthcare Programs with an eye to avoiding ACA excise taxes. Other public record documents referenced include current (2015) premium rates, ETF's latest available Comprehensive Annual Financial Report (2013) and Group Health "Fact Sheet" (2014) as well as the full, 25 March "Segal Report" and "IRS Notice 2015-16" soliciting public commentary on ACA excise fee issues--all readily available on-line.

Informed decision-making requires knowledge and deliberation. When the chain of knowledge's transmission is distorted, and the scope for deliberation radically restricted, wise decision cannot be made. I trust that you will read the following analysis of ACA excise issues with an open mind.

Sincerely,

Dr. S. E. Hutchinson,
Madison, WI
Email: sehutchi.wisc@gmail.com

A LETTER/STATEMENT PRESENTED TO ETF'S GIB AND THE JCER SEVERAL DAYS PRIOR TO THEIR MAY 19, 2015 MEETING BY DR. S. E. HUTCHINSON

RE: Proposed Group Insurance Plan Changes for 2016

To Members of the Joint Committee on Employee Relations:

The March 2015 Segal Report recommends major changes for all Wisconsin's Group Health Insurance Program, with the stated aim of reducing the State's future exposure to Affordable Care Act "excise taxes" on the so-called "Cadillac" health plans, beginning in 2018. However, the Report's analysis is incorrect. The only plans for which the State will be responsible for paying any future ACA excise taxes, if applicable after IRS rules have been finalized, are: the Standard Plan (SP), the State Maintenance Plan (SMP) and the recently introduced High Deductible Health Plan (HDHP), which in combination currently cover "less than 2%" of state and local government active employees and their dependents and retirees and their surviving spouses. The remaining 98% of ETF employees and annuitants are enrolled in one of many fully self-insured and competitive HMOs, each of which has its own "plan administrator" and its own insurers who will be responsible for paying any and all ACA excise taxes, if applicable, on its own plan. CONSEQUENTLY, THE STATE IS NOT THE PARTY RESPONSIBLE FOR PAYING ACA TAXES FOR THE 98% OF PEOPLE CURRENTLY ENROLLED IN HMOS. Consequently, the Segal Report's analysis of and recommendations regarding the State's "looming liabilities" with respect to any future ACA excise taxes is incorrect. For every current HMO-plan participant that is "induced" by the negative and positive financial "incentives" recommended by Segal Consulting to switch from an HMO-insured health plan to a State-insured health plan will INCREASE the State's liabilities with respect to ACA's "Cadillac Plan"/excise taxes, not REDUCE them.

<u>This fiscal "certainty" may be independently verified by telephoning the IRS Associate Counsel responsible for drafting and finalizing IRS rules regarding ACA excise tax on high-cost health insurance plans, Mr. Karen B. Levin, 202-317-5500. Also see IRS "Notice 2015-16" attached.</u>

Whereas the plan changes recommended in the Segal Report's will do nothing to address the State's very real and "looming" ACA tax vulnerabilities with respect to the 2% of participants currently enrolled in one of the three State "self-insured" plans, the recommended changes will dramatically lower the quality of care coverage and dramatically raise the out-of-pocket costs for the 98% of consumers now enrolled in HMOs. (The recommended shift from the current system of pharmaceutical "co-pays" to pharmaceutical "co-insurance" will be especially devastating for "medicare retirees," whose "net cost" to ETF and the State, even the Segal Report recognizes, is ZERO dollars (Segal Report, p.11). In fact, these changes will heavily "penalize" all HMO-plan retirees (medicare and non-medicare retirees alike), all of whom currently pay 100% of their premium costs (including pharmaceutical insurance costs) from their own money, without any State "subsidy" for their healthcare costs at all. In fact, the State currently receives a net cost "benefit" from medicare and non-medicare retirees enrolled in HMO

plans from the investment earnings gained on earned, individual, sick-leave accounts of past and present retirees, which are never paid to the owners of such accounts but, rather, contribute to ETF's Group Insurance Trust Fund, which had accumulated assets in 2013 of over $334 million (see ETF's 2013 Comprehensive Annual Financial Report, the latest CAFR available on-line).

Consequently, if the Segal Report's recommended plan changes are rubber stamped by the Joint Committee on Employee Relations and the State Legislature, without a critical look at their analytical and actuarial veracity, the net impact will be to increase the State's liabilities to any future ACA excise taxes on its three State-insured health plans, while simultaneously financially "penalizing" the 98% of the HMO-insured contract holders for which the State bears no ACA excess tax liabilities. In short, the Segal Report's analysis is incorrect and fundamentally wrong-headed.

What follows is a step-by-step explanation of this reality.

ACA "EXCISE TAX" BASICS: WHAT THE SEGAL REPORT DOES NOT EXPLAIN

1. WHO "SHALL PAY" THE EXCISE TAX?

According to the IRS, Affordable Care Act, "Section 49801(c)(1) and (2) specify that "the entity that 'shall pay' the excise tax is: (1) the "health insurance issuer" in the case of the applicable coverage provided under an insured plan, (2) "the employer" if the applicable coverage "consists of coverage under which the employer makes contributions to "an HSA or Archer MSA," and (3) "the person that administers the plan" in the case of any other applicable coverage. In each case, the employer must calculate the tax and notify the entity liable for the excise tax (and the IRS) of the amount of excise tax "at such time and in such manner as the Secretary my prescribe." Any excise tax paid is not deductible for federal tax purposes." (See IRS Notice 2015-16, p.3)

ANSWER: THE "PLAN ADMINISTRATOR"

2. QUESTION: IS THE STATE "PLAN ADMINISTRATOR" FOR ALL GROUP HEALTH PLANS PRESENTLY GOVERNED BY ETF AND GIB?

ANSWER: NO.

The State is the "plan administrator" for only three group health insurance plans: namely, the Standard Plan, the State Maintenance Plan and High-Deductible Health Plan. These plans encompass less than 2% of the more than 570,000 people (25 March 2015 Segal Report, page 11) presently insured in ETF group health plans for state and local employees and annuitants. The remaining 98% are enrolled in one of 18 competing HMOs (Segal Report), each of which is fully insured and has its own "plan administrator," who will be responsible for paying any applicable ACA excise taxes in the future to the IRS in 2018 or thereafter. The state will have some record-keeping responsibilities for tallying "applicable coverage" costs for both the IRS and various HMO plan administrators. However, the State will be legally and fiscally responsible for paying excise taxes on ONLY for State 'self-insured' health plans", currently limited to the three State-administered and State-insured plans noted above.

3. QUESTION: WILL ACA EXCISE TAXES BE ASSESSED "ON THE TOTAL VALUE AMOUNT" OF ANY HEALTH BENEFIT PLAN THAT EXCEEDS THE

RELEVANT ACA DOLLAR THRESHOLD?

The 25 March 2015, "Segal Consulting Report" states: "The 40% Excise tax is assessed on the total value of any health benefit plans provided to an employee or retiree through an employer plan that exceeds a threshold of $10,200 for single coverage and $27,500 for all other coverage tiers. In certain cases, the threshold amounts can be increased to $11,850 (single) and $30,950 (other coverage tiers) for retirees and employees in hazardous duty employment. The Excise Tax dollar thresholds are indexed to the Consumer Price Index for Urban Consumers (CPI-U) for years after 2018."(SR, page 6, emphasis added)

The ACA dollar "threshold" figures quoted above are "correct" as far as current federal statutes state define them. However, the statutes the ACA excise provision is currently scheduled to go into effect in 2018 (see IRS Notice 2015-16). However, the Segal Report's statement quoted above is both inaccurate and misleading in asserting that "the 40% excise tax" will be assessed "on the total value of any health plan" that exceeds these dollar thresholds. Finalized IRS rules for determining what health care costs will be defined as "applicable coverage" for the purpose of determining "high-value" employer-sponsored health plans have not yet been determined. Indeed, there is still time for ETF's GIB to offer rules suggestion in this regard to the IRS. There will be, at least, one more IRS call for public comments on ACA Section 49801, one such call closed on 15 May. ACA statutes and draft IRS rules have already determined that all "pre-tax" health insurance premium payments and all "pre-tax" deposits made in Health Savings Accounts (including Flex, Archer and Health Savings accounts) will be counted as "applicable coverage" for excise tax purposes.

Otherwise, IRS rules for purposes of determining ACA excise taxes specify only that "applicable coverage" costs MUST be disaggregated into "Self-Only" and "Other-Than-Self-Only" plan types. What the IRS has not yet determined is whether or not it will "permit" plan administrators to "aggregate" or "disaggregate," what it refers to as, "similarly situated individuals" beyond this two-pronged division (See IRS "Notice 2015-16," pp.15ff.) For this reason it is impossible to predict with any certainty future State liabilities with respect to any future ACA excise taxes. Consequently, the alarming projections contained in the Segal Report are not justifiable at this time. Not surprisingly, the Segal Report offers no explanation for its $7 million dollar "figure for 2018 and its $193 million figure for 2027.

ANSWER: NO, ACA EXCISE TAXES WILL BE ASSESSED ONLY ON THE "APPLICABLE [PLAN] COSTS" THAT EXCEED THE RELEVANT ACA DOLLAR THRESHOLD.

3. QUESTION: ARE ANY OF STATE-ADMINISTERED AND STATE 'SELF-INSURED' PLANS DESTINED TO EXCEED ACA DOLLAR THRESHOLDS ON THE BASIS OF THEIR PREMIUM RATES ALONE?

ANSWER: YES. THE STATE'S 'SELF-INSURED' "STANDARD PLAN" IS PRECISELY THE KIND OF "CADILLAC PLAN" THAT THE ACA EXCISE TAX IS DESIGNED TO TARGET.

On the basis of 2015 Standard Plan Premiums alone, the State will be assessed ACA "excises taxes" totaling, a minimum, $2605.44 for EVERY "individual" or "self-only" contract and $5693.44 for EVERY "Family/Self-Plus" coverage contract covered by the STANDARD PLAN. The State is also liable to be assessed 40% excise fees on EVERY DOLLAR that Standard Plan participants deposit in any "pre-tax" Flexible Health Savings Plans (See Appendix)

The State's future "excise tax exposure" with respect to Standard Plan members represents a serious, financial liability risk for the State of Wisconsin that the GIB must address, urgently and directly. Remarkably, the Segal Report does

not explicitly acknowledge this glaring fiscal liability, let alone offer any plan changes or proposals that would address it!

Instead, many of the Segal Report's recommendations blur the distinction between State-administered and HMO-administered plans by falsely representing "the State" as the party responsible for paying ALL future ACA tax liabilities. Instead of analyzing the State's "looming" vulnerabilities to ACA taxes with respect to the Standard Plan, it proposes both negative and positive financial "incentives" designed to "induce" HMO participants to shift into State-insured HDHP/HSA plans or to opt out of group health insurance plans entirely. However, none of these recommendations identify or address the problem of central concern.

4. QUESTION: WILL ANY OTHER STATE-ADMINISTERED PLANS BE LIKELY TO TRIGGER ACA EXCISE TAXES IN 2018 ON THE BASIS OF PRESENT-DAY (2015) PREMIUMS?

ANSWER: YES. "SELF-ONLY" COVERAGE PREMIUMS FOR STATE MAINTENANCE PLAN AND "SELF-ONLY" HDHP COVERAGE CONTRACTS ARE DESTINED TO DO SO, BUT NOT BY MUCH.

At a minimum, the State's "Self-Only" SMP and HDHP contracts will be assessed $57.60 each on the basis of premiums alone. In contrast, ACA excise taxes will not be triggered by "Self-Plus" SPM or "Self-Plus" HDHP contracts on the basis of current premium rates and the ACA dollar thresholds noted above. The State will also be assessed 40 cents on every dollar deposited in "individual" SMP and HDHP HSAs, up to maximum deposit limits of $3350, or $1340 in ACA excess fees. "Family" Coverage SMP and HDHP contracts, in contrast, run little risk of triggering ACA taxes, even with maxed-out HSAs. (See appendix for details).

5. QUESTION: WHAT ABOUT "FULLY INSURED" HMO PLANS? ARE ANY SUCH PLANS DESTINED TO TRIGGER ACA EXCISE TAXES ON THE BASIS OF PRESENT PREMIUMS ALONE?

ANSWER: NO

GIB members can easily calculate out annual premium rates for other "non-State insured" health plans listed on the 2015 premium rate sheets, if they wish. Here are the annual premium (single/family) figures for the four largest HMO plans (in terms of numbers of participants), none of which trigger relevant ACA dollar thresholds: Dean Care ($9503/$21868), Group Health of SW Wisconsin ($7783/$19369), Physicians Plus ($8196/$20400) and Unity Health-UW ($8330/$20736).

6. QUESTION: WILL HMO PLAN ADMINISTRATORS BE LIKELY TO BE ASSESSED ACA EXCISE TAXES ON FLEXIBLE HEALTH SAVINGS PLANS ASSOCIATED USED BY THEIR PLAN PARTICIPANTS?

ANSWER: YES, IF THE ACA DOLLAR THRESHOLDS FOR SOME "SELF-ONLY" COVERAGE CONTRACTS ARE NOT RAISED BY 2018.

The deposit limits for Flexible Health Savings Accounts ($2250/$5000) are lower than those for HSAs ($3350/$6650). For three of the four largest HMO plans (PP, GH and Unity-UW), the risk of reaching ACA dollar thresholds, even with maxed-out HFSAs for "Family" coverage contracts is ZERO. Dean Health, however, could a maximum possible excise fee of $252 for "maxed-out" FHSAs.

"Self-Only" Coverage HMO Contracts with annual premiums totaling more than $7950 will incur excess fees for maxed-out "individual" FHSAs, with the "highest" ACA tax "exposure" for Dean Care, being $621 dollars. These risks, however, are likely to be smaller than they appear. According Segal Report only 10% of HMO plan users deposit ANYTHING in annual FHSAs. And according to ETF's 2013 Comprehensive Annual Financial Report, the average deposit of those who do is just over $1100.

Any move made by the GIB to impose or raise HMO-plan deductibles and co-pay/co-insurance rates for pharmacy costs and doctors visits, however, will likely raise the percentage of actively employed HMO contract holders to make use of "pre-tax" FHSA deposits. These negative financial "inducements" will unnecessarily stress the HMO system supporting "the 98%", for no justifiable reason.

7. WILL THE ADDED OUT-OF-POCKET RISE IN HEALTH CARE COSTS FOR HMO-ADMINISTERED PLANS RECOMMENDED BY THE SEGAL REPORT IN THE FORM OF DEDUCTIBLES AND CO-PAYS REDUCE THE LIKELIHOOD THAT HMO PLANS WILL REACH ACA DOLLAR THRESHOLDS?

ANSWER: NO. ACCORDING TO SEGAL, THEY WILL INCREASE THAT RISK.

The full, March 2015, Segal Report recognizes this fact on page 6, where it states: "The [Cadillac/excise] tax is based on the total cost for the health benefit programs, not on the value of the plans or the employer portion of the cost. For that reason, it is not possible for a plan to avoid the tax by shifting premium cost to the employee or retiree." If HMO premiums are not reduced in direct proportion to the higher out-of-pocket costs for deductibles, co-pays and co-insurance that the Segal Report recommends be imposed on HMO plan participants, these added costs may result in catapulting some HMO plans into being re-categorized as "high-cost" plans for IRS and ACA tax purposes, whereas there is no risk of HMO-insured plans breaching ACA dollar thresholds under current conditions.

8. QUESTION: WON'T HMO PLAN ADMINISTRATORS SIMPLY PASS ON ANY ACA EXCISE TAXES TO THEIR PARTICIPANTS THROUGH HIGHER PREMIMUMS?

ANSWER: POSSIBLY.

However, HMO plan administrators and HMO-insurers would still serve as a financial "buffer" that protects the State and Wisconsin taxpayers in this regard. Unless burdened with the negative financial incentives recommended by Segal Consulting, most, if not all, HMO plan administrators will face little or no vulnerability to ACA excise fees in 2018 or the years beyond. This is decidedly NOT the case with the three State-administered health plans, for which the State will be directly responsible for any ACA excise taxes, where applicable.

However, if the State Legislature moves forward with Segal's recommendations by imposing higher co-pays for doctors visits, new deductibles (per illness?), new co-insurance costs for pharmaceuticals and higher out-of-pocket limit on HMO plan participants without proportionately lowering HMO premiums accordingly, HMO plans will be much more likely to exceed ACA tax dollar thresholds--something that may threaten their financial viability and thus, threaten the economic development gains these plans have supported at the State and local level since the early 1980s.

9. QUESTION: **WILL THE NEGATIVE AND POSITIVE FINANCIAL "INCENTIVES" DESIGNED TO "INDUCE" PEOPLE TO ABANDON HMO-ADMINISTERED HEALTH PLANS IN FAVOR OF STATE "SELF-INSURED" PLANS RECOMMENDED BY SEGAL CONSULTING HELP TO REDUCE THE**

STATE'S FUTURE "EXPOSURE" TO ACA EXCISE TAXES?

ANSWER: ABSOLUTELY NOT!

Every single health insurance contract holder induced to move from a fully-insured, HMO-administered plan into a State-administered (HDHP, SMP or SD) plan will INCREASE the State's vulnerability in this regard. Nowhere does the Segal Report call attention to this fact. Instead, Segal Consulting recommends imposing positive financial "inducements" to support of state-administered plans and negative financial incentives to undercut HMO-administered plans.

Historically, the State of Wisconsin's Group Health Program is among the most solidly constructed group health program in the entire country, and its current success stems from its 98% dominant, independently funded, competitive HMO structure. The weak links in the program are currently State-administered health plans, with the State's Standard Plan being unsustainably structured. Consequently, why should the GIB saddle "the 98%" of State and local government employees and enrolled in HMO plans with new, open-ended and unpredictable "co-insurance fees" in place of fixed "co-pays" for pharmaceuticals, when there is absolutely NO EVIDENCE that the current HMO system is operating inefficiently? Why deny potentially thousands of HMO-covered minor children preventive dental coverage that they now enjoy? Why suddenly redefine the concept of "Universal Benefit Design" from being a minimum "floor" for the quality of health benefits into an unbreakable "ceiling" that expressly forbids HMOs that currently offer preventive dental exams to shed them? How does this support the "capitalist spirit" driving for-profit HMOs to improve the efficiency and quality of healthcare coverage?

For the Segal Report to recommend, and for the GIB to potentially accept, a more doubling of out-of-pocket health care costs for HMO-affiliated "Uniform Benefit Design" plans--EXCEPT ON THE STATE-INSURED STANDARD AND HD PLANS--on the grounds that these changes are "revenue neutral" for the ETF is simply unjust!

10. WILL THE NEW DEDUCTIBLES, INCREASED CO-INSURANCE COSTS AND OTHER INCREASES IN THE OUT OF POCKET COSTS RECOMMENDED FOR 2016 HELP TO REDUCE THE STATE'S LIABILITIES FOR ANY FUTURE ACA EXCISE TAXES?

ANSWER: NO.

Although IRS rules regarding any future ACA excise taxes on so-called "Cadillac" health plans have not been finalized, the IRS has determined that "plan administrators" will NOT be allowed to lower the total dollar value of any "high-cost" health plans by shifting such costs onto plan members through deductibles and co-pays. The dollar value of deductibles and co-pays paid "out of pocket" by plan participants will simply be added together with cost of basic premiums to determine whether or not the plan is a "Cadillac" plan subject to any future ACA excise taxes. (See especially, p. 6 of the 25 March 2015 Segal Report as well as the attached IRS Notice 2015-16.)

For all of these reasons, I strongly urge the Joint Committee on Employee Relations and all members of the Wisconsin State Legislature to step back and take the time necessary to investigate the leaps in logic and actuarial assumptions at the heart of the 25 March 2015 Segal Report for both accuracy and validity. What the Segal Report lacks is any "cost/benefit analysis" of its plan change recommendations that balances the rights, interests and healthcare needs of all plan-type participants with those of state taxpayers. This analysis must go beyond a simplified equation of "higher level benefits" with "lower member cost share," as the Segal does consistently (beginning on page 4). Such a cost/benefit analysis must also consider the quality of healthcare coverage

provided to plan participants. Radically reducing the quality of coverage and out-of-pocket health care costs for the 98% for a looming ACA excise tax problem with respect to health plans covering the 2% will not work. It is fundamentally wrong-headed and will end up increasing costs and reducing quality of coverage for the 98% of current state and local annuitants and employees contracted through ETF, while leaving the State's "looming" ACA tax vulnerabilities with respect to the 2% of participants currently enrolled in State-administered/insured unaddressed.

I hope that this information will prove helpful in your deliberations.

Sincerely,

Dr. S. E. Hutchinson,
Madison, WI

ORIGINALLY SUBMITTED TO ETF'S GROUP INSURANCE BOARD ON MAY 16, 2015, SEVERAL DAYS PRIOR TO THE BOARD'S MAY 19, 2015 MEETING.
(For subsequent confirmation of many of the points made in this analysis with respect to Questions 9 and 10 above, see as well Segal's "2016 Plan Design Recommendations," dated May 19, 2015, p. 7)