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**Department of Employee Trust Funds**
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# *CORRESPONDENCE MEMORANDUM*

**DATE:** October 8, 2013

**TO:** Group Insurance Board Strategic Planning Workgroup

**FROM:** Lisa Ellinger, Administrator
Division of Insurance Services

**SUBJECT:** Self-Insurance Model Request for Proposals

**Staff believes that it is prudent to further investigate whether a self-insured model may be able to provide the same level of health benefits to employees at a reduced employee and employer cost. As a result, staff recommends that the Group Insurance Board (Board) direct the Department of Employee Trust Funds (Department) to develop a Request for Proposals (RFP) to gather additional information necessary to determine the potential costs and savings associated with a self-insured health insurance program.**

## Background

At the August 27, 2013 Board meeting, Deloitte Consulting LLP (Deloitte) – the Board's consulting actuary -- presented the Self-Insurance Advisability Assessment and Actuarial Cost Benefit Analysis. The Executive Summary from the Deloitte analysis outlines the rationale and approach for the study:

> *"Recent market and legislative changes to the health insurance industry, particularly the additional fees associated with the Affordable Care Act (ACA) and the current premium taxes paid on fully-insured plans has prompted the State of Wisconsin to consider the advisability of adopting a self-insurance arrangement for its state employee medical plan. Within a self-insured program, these fees and taxes are avoided and represent a potential savings to the State.*
>
> *A formal Request for Information (RFI) was released publicly to any interested third party administrator (TPA)/carriers who are not incumbent plans of ETF's fully-insured program. Concurrently, a Supplemental Information Request was sent to the incumbent health plans. In total, 17 plans responded that they are able to provide self-insurance coverage. Of the total submissions, 15 are incumbent medical plans (out of 18 total incumbent plans), with additional interest from two new TPA/carriers.*

| Reviewed and approved by | Electronically Signed |
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| Lisa Ellinger | 10/08/13 |

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> *There were limitations with regards to the completeness and accuracy of the health care provider reimbursement financial information submitted by the potential TPA/carriers. Incomplete and non-credible submissions were discarded which limited the actuarial cost analysis."*

Given the limitations of the RFI data, the Deloitte analysis concluded with the following recommendation:

> *"A comprehensive RFP process is strongly recommended to further refine the analysis and validate the provider discount/reimbursement rates and potential cost savings. In particular, the impact of potential health provider disruption and any potential cost-shifting to employees due to provider disruption needs to be further investigated.*
>
> *Based on the need to complete a comprehensive RFP process before implementation of a self-insurance arrangement, a 2014 effective date is not feasible for a pilot program. If the State decides to pursue a formal comprehensive RFP to select potential self-insured TPA/carriers for a pilot program anticipated to be effective January 1, 2015, the timing will need to be carefully managed. Such an RFP would require significant lead time and would likely need to be released in early 2014."*

The Board agreed that the Strategic Planning Workgroup (Workgroup) would discuss this topic further at its October 11, 2013 and forward a recommendation for the Board to consider at its November 12, 2013 meeting.

**Items for Discussion**

If the Board approves the development and issuance of a RFP, there are several approaches that can be employed. The Board will need to weigh the benefits and issues involved with the timing of the RFP, associated actuarial costs, and potential impacts on the program costs and our members. The chart on the following page outlines some of the considerations involved. In addition, such an RFP would need to be carefully drafted to achieve the goals and priorities of the Board.

If the workgroup recommends proceeding with the RFP, staff will continue to investigate these approaches and provide additional information for final approval at the November Board meeting. Staff would appreciate feedback and guidance from the Workgroup on these various approaches, as well as the Workgroup's key goals and priorities.

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

| **Action** | RFP Issues | Potential Program Impacts |
|---|---|---|
| No RFP | No timing issues, no actuarial costs, no new information on potential cost saving opportunities. | Continue to experience benefits/savings of managed competition model, no member disruption, subject to ACA fees in 2015. |
| RFP for Single Statewide TPA | Moderate timing and staffing issues, actuarial costs, and limited new information on potential cost saving opportunities due to limited number of potential TPA's. | Potential cost savings, potential avoidance of ACA fees in 2015, administrative simplicity, potential to lose benefits/savings of managed competition model, potential for significant member disruption, negotiation leverage of single TPA, least flexibility in options -- either major statewide transition or status quo. |
| RFP for Pilot Region | Limited timing and staffing issues, actuarial costs, and limited new information on potential cost saving opportunities. | Potential cost savings, potential avoidance of some ACA fees in 2015, administrative simplicity, limited/concentrated member disruption, potential to lose some benefits/savings of managed competition model, potential for some member disruption. |
| RFP for Multiple Options (RFI model) | Timing and staffing issues, most expensive actuarial costs, and more extensive new information on potential cost saving opportunities. | Potential cost savings, potential avoidance of ACA fees in 2015, potential to lose benefits/savings of managed competition model, potential for significant member disruption, most flexibility in terms of options to consider -- major statewide transition or status quo or regional pilot(s). |

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# *CORRESPONDENCE MEMORANDUM*

**DATE:** October 10, 2013

**TO:** Group Insurance Board Strategic Planning Workgroup

**FROM:** David H. Nispel, General Counsel

**SUBJECT:** Self-Insured Plans

**This memo is for information purposes only. No action is required.**

This memorandum is offered to respond to inquiries about the statutory authority of the Group Insurance Board (GIB) to allow for the self-funding of the State of Wisconsin Group Health Insurance Program (Program) and to either maintain or eliminate the existing self-funded Standard Plan. As I understand it, the inquiries also have wondered about any statutory changes that may be required in order to establish a self-insured plan.

It appears that statutory authority for establishing a self-funded Program exists in Wis. Stat. s. 40.03 (6) (a) 2. That statute provides that the GIB:

> 2. May, wholly or partially in lieu of subd. 1., on behalf of the state, provide any group insurance plan on a self-insured basis in which case the group insurance board shall approve a written description setting forth the terms and conditions of the plan, and may contract directly with providers of hospital, medical or ancillary services to provide insured employees with the benefits provided under this chapter.

In addition, Wis. Stat. s. 40.03 (6) states that the GIB:

> May provide other group insurance plans for employees and their dependents and for annuitants and their dependents in addition to the group insurance plans specifically provided

Reviewed and approved by Robert Marchant, Deputy Secretary

Electronically Signed
10/10/13

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> under this chapter. The terms of the group insurance under this paragraph shall be determined by contract, and shall provide that the employer is not liable for any obligations accruing from the operation of any group insurance plan under this paragraph except as agreed to by the employer.

However, depending on the particular features of the self-insured Program that may be under consideration at this time, it might be advisable for the appropriate parties to review two additional provisions in Wis. Stat. ch. 40 and determine whether any statutory changes are required. Those statutes concern health maintenance organizations (HMOs) and preferred provider plans (PPOs), and also the existing self-funded Standard Plan.

Wis. Stat. s. 40.51 (6) concerns insured and uninsured health plans and also references HMOs and PPOs. That statute reads:

> This state shall offer to all of its employees at least 2 insured or uninsured health care coverage plans providing substantially equivalent hospital and medical benefits, including a health maintenance organization or a preferred provider plan, if those health care plans are determined by the group insurance board to be available in the area of the place of employment and are approved by the group insurance board. The group insurance board shall place each of the plans into one of 3 tiers established in accordance with standards adopted by the group insurance board. The tiers shall be separated according to the employee's share of premium costs.

On the one hand, that statute could be interpreted to mean that at least one of the insured or uninsured health plans offered by the state must include an HMO or a PPO. On the other hand, the statute could be interpreted to mean that an HMO or PPO must be offered "if those health care plans are determined by the group insurance board to be available in the area of the place of employment *and are approved by the group insurance board" (emphasis added)*. In my opinion, the second interpretation is more likely to be viewed as the correct interpretation. However, proponents of a self-insured program may wish to review this statute and determine whether it would need to be amended in order to accomplish their vision of a self-insured Program.

I am not certain if consideration is being given to maintaining or eliminating the existing Standard Plan. That plan, currently administered for the state by WPS Health Insurance (WPS), is created by Wis. Stat. s. 40.52 (1). The beginning of that statute, which is followed by the required features of the plan, reads:

> (1) The group insurance board shall establish by contract a standard health insurance plan in which all insured employees shall participate except as otherwise provided in this chapter. The standard plan shall provide: . . . .

If the Standard Plan will be eliminated under a self-insured Program, it appears that Wis. Stat. s. 40.52 (1) may need to be repealed. However, if the current Standard Plan or some version of a Standard Plan will exist alongside the self-insured Program, then conceivably this statute would not need to be repealed or perhaps even amended.

In addition, Wis. Stat. ss. 40.05 (4) (b) and (be) concern payment of health insurance premiums by using accumulated sick leave credits, if the health insurance plan or policy involved offers coverage that is "substantially equivalent to the standard health insurance plan established under s. 40.52 (1)." Consequently, depending on how a standard plan may figure into the vision of a self-insured Program, it may be necessary to either amend Wis. Stat. s. 40.05 (4) (b) and (be).

Please let me know if there are additional questions regarding either the GIB's authority to establish a self-insured program or other provisions in Wis. Stat. ch. 40 that may require review and analysis.

Staff will be at the meeting to answer any questions.