John Nygren
WISCONSIN STATE REPRESENTATIVE ★ 89TH ASSEMBLY DISTRICT
Co-Chair, Joint Committee on Finance

January 6, 2016

Jon Litscher
Chair, Group Insurance Board
C/o Board Liaison
Department of Employee Trust Funds
PO Box 7931
Madison, WI 53707

Lisa Ellinger
Director, Office of Strategic Health Policy
PO Box 7931
Madison, WI 53707

Dear Mr. Litscher and Ms. Ellinger:

Thank you for holding a meeting regarding the Segal report outlining the possible implications should Wisconsin move to a self-funded program, general observations, and recommendations for 2017 and beyond. While I think that the information in the report is valuable, I would like to take this opportunity to highlight a few unanswered questions and concerns.

As the Assembly Co-chair of the Joint Finance Committee (JFC), the fiscal impact of large governmental changes, like a move to self-funding, is very important to me. That being said, the Segal report shows that self-funding has the potential to save our state over $42 million. Is this assuming 100% enrollment in a self-funded plan? Unlike the recent Deloitte report of the State Health Program, Segal didn't calculate Wisconsin's financial risk. Does this missing calculation assume that Segal sees no financial disadvantage to the state budget?

There are instances in the Segal report where there is assumed cost savings. Specifically, the report states that Wisconsin can save up to $80 million through changes in health management, although these health management strategies are never outlined. What kinds of health management changes have the ability to produce $80 million in savings, and where will this savings come from?

Many times in JFC, it's our goal to build revenues up and hold the line – if not lower – taxes. That being said, there is a suspension of the Health Insurer tax for 2017 and a 2-year delay of the Cadillac Tax until 2020. The Segal report, however, does not cover how these tax suspensions and delays would impact the move to a self-funded program. Will these factors affect cost-savings projections described in the report?

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Lastly, the Segal report uses premiums from the federal exchange as a point of reference for State Group Health Program premiums. However, the report does not explain if or why this correlation is reliable. Consumers who use the federal exchange make up a very different demographic than those who utilize the State Group Health Program. Why is the program's correlation to the federal exchange reliable and accurate?

Thank you for your attention to these important matters. I appreciate all of the time and effort you've put into analyzing and vetting the report. Moreover, I appreciate the opportunity to voice my concerns as we move forward in this process. If you have any questions, please don't hesitate to contact my office by email at Rep.Nygren@legis.wisconsin.gov or by phone at (608) 266-2343.

Regards,

John Nygren
State Representative
Assembly District 89

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Wisconsin Association of Health Plans

The Voice of Wisconsin's Community-Based Health Plans

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Mr. Litscher and Ms. Ellinger:

Wisconsin Association of Health Plans member health plans serve nearly 70% of the enrollees in the State Group Health Program. Over the years, Association members have provided access to quality health care for state employees and helped Wisconsin save hundreds of millions of dollars through one of the most effective, competitive health benefits models in the country.

In 2016 alone, modifications within the current model will enable Wisconsin to save $89 million. Association members are concerned the Segal Consulting November 17, 2015, recommendations to abandon the current, effective model will:

- Increase risk and costs for the state;
- Disrupt access for state employees;
- Lower health care quality; and
- Create instability in Wisconsin's competitive health insurance market, harming consumers, employers and local economies.

Given the proven track record of the current, competitive model, and the cost, risk and disruption caused by self-funding, the state would be better served by identifying cost savings strategies within the current competitive, fully insured model.

The Wisconsin Association of Health Plans respectfully requests your consideration of the following observations, questions and concerns as the Group Insurance Board (GIB) discusses the Segal Consulting recommendations:

The Affordable Care Act (ACA) tax burden is evaporating, neutralizing self-funding as an ACA tax haven - Segal specifically cites the ACA Market Share Fees and Excise (Cadillac) Tax as top reasons to self-fund the State Group Health

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Program. But the recently signed Consolidated Appropriations Act of 2016 suspends the Market Share Fees for 2017, eliminating $18.3 million of the projected annual savings Segal attributes to self-funding. Further, the Act delays the Excise Tax for two years until 2020, eliminating the $3 million to $7 million cost of the tax for 2018 and 2019. And, there is growing bipartisan support for permanently eliminating the ACA Market Share Fees and Excise Tax.

Question: *Is it responsible to increase the state's costs and create new financial risks for "projected" savings that now are much smaller than previously estimated and, in the long run, may not materialize?*

Forcing health plans into gerrymandered regions is inconsistent with the regional structure of health care delivery in Wisconsin - The current approach is already naturally regionalized, as defined by population centers, health plans and provider systems. The geographic regions proposed by Segal split health plan service areas and don't fully match provider delivery systems and referral patterns. The resulting disruption will increase costs, harm patient access and reduce care quality and coordination.

Question: *Where is the evidence that Segal's recommendation to break up Wisconsin's quality health care service areas and structures will reduce costs and improve access and health care delivery in Wisconsin?*

Question: *With a regional strategy, is Segal assuming 100% coverage of the region by each of the two health plans left operating in the region? If so, how did Segal factor in the cost of establishing and ramping up new additions to health plan provider networks outside current health plan service areas?*

Consolidation will reduce competition and eliminate choice, a recipe for increasing the state's costs and raising state employee dissatisfaction - Competition matters. Experience and health insurance studies have shown a competitive health insurance market results in greater access to lower cost health care coverage. Offering consumers the ability to choose between multiple, high-quality health plan options results in lower costs and higher consumer satisfaction.

Question: *What evidence does Segal have that reducing competition and taking away consumer choice in Wisconsin's historically competitive, multi-choice environment will reduce costs and improve the State Group Health Program?*

Taking some of the best players off the field will increase the state's costs and lower health care quality - Wisconsin's integrated and community-based health plans consistently perform better in cost control, care management and ensuring proper utilization.

Consolidation of health plans to a maximum two per region and self-funding the State Group Health Program will eliminate many of Wisconsin's highest quality, lowest cost health plans from the Program. As a consequence, the state will lose plan-provider integration and alignment on cost control and care management. The resulting disruption will increase the state's costs, harm care management and coordination and create gaps in care.

Question: *How did Segal factor into its projected savings the costs associated with the disruption and disintegration that will result from its regionalization and consolidation strategy?*

Question: *How will the proposed self-funded arrangement ensure levels of effectiveness or improvement in care management and cost control beyond what can be achieved through current plan-provider collaboration?*

Ignoring the downside risk of self-funding and increased cost from lost favorable provider discounts doesn't eliminate that risk - In previous reports, Deloitte identified the potential cost of self-funding as well as the potential savings. Deloitte's 2012 report said the potential cost to the state from self-funding could be more than $100 million, and Deloitte's analysis following requests for information in 2013 remained cautious about self-funding in light of potential higher risk and costs to the state. The Segal report identifies only potential savings. Segal assumes self-funding administrators will negotiate better provider discounts than the current regional health plans produce in a fully insured, competitive environment. That's a bad assumption. Health plan experience has also found that, over time, the size of provider discounts diminishes in a self-funded arrangement.

Question: *What data is Segal relying on to guarantee there will be no downside cost or risk from self-funding?*

Question: *Has Segal factored in diminished provider discounts over time in the proposed self-funding arrangement?*

Premiums on the federal exchange are not a reliable benchmark for State Group Health Program premiums - The populations served on the exchange are significantly different than the State Group Health Program population, the exchange premiums are subsidized, health plans are compensated for higher risks and continued participation on the exchange is in question for some national health plans.

Question: *Why is Segal using an Obamacare product as the benchmark for the State Group Health Program?*

Question: *In the long run, does Segal recommend moving state employees to the federal exchange?*

Improving health management is possible using the current participating health plans - The Segal report claims there is an estimated "$267 million of unnecessary and avoidable medical services annually" in the State Group Health Program, and up to $80 million in savings is achievable through changes in health management.

Question: *What specific changes does Segal believe will produce the $80 million savings?*

Question: *Why does Segal believe health management would be more effective through a self-funded arrangement versus the current model including integrated health plans with existing patient and provider relationships?*

Thank you for the opportunity to submit the above observations, comments and questions on the Segal Consulting recommendations. The staff and members of the Wisconsin Association of Health Plans remain willing to work with GIB and DETF staff to improve the State Group Health Program while controlling the state's costs, protecting patient-provider relationships and choice and "doing no harm" to Wisconsin's uniquely competitive health insurance market.

Sincerely,

Nancy J. Wenzel
Chief Executive Officer
Wisconsin Association of Health Plans

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December 23, 2015

Jon Litscher, Chair
Wisconsin Group Insurance Board
% Board Liaison, Department of Employee Trust Funds
PO Box 7931
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Dear Mr.Litscher

I applaud your decision to schedule a special public Group Insurance Board (GIB) meeting to more thoroughly review the recommendations of the Segal Group with regards to the Wisconsin group health system.

If I were a Board member, I would respectfully offer these questions to SEGAL in order to obtain a more thorough understanding of the possible ramifications of their recommendations, and to better explore alternative options for Board action.

1. BENEFIT/COST ANALYSIS AT THE PARTICIPANT LEVEL: While the Segal reports cover a number of components and factors within systems of group health insurance, I do not find a thorough specific analysis of the impact of each major recommendation on each current group of participants within the existing health plans. For instance, what has been and will be the positive and negative effects (financial and non-financial) and trend for a current active participant, (single and family, HMO and standard plan) of the recommendation to re-calibrate all health plans to tier 2, or to go to a fully self-insured system, or to reduce the number of regions, or to increase co-pays and deductibles? What is the differentiated effect of each major recommendation for each of the current groups within the State and local system: active/retired/retired with Medicare HMO vs standard plan participants? How much more will a participant pay over time for each of these recommendations?

2. SUBSIDY REQUIRED: From some charts in the Segal report #2 and the Deloitte 2014 report, it would appear that GIB/ETF has had to subsidize the current self-insured plans by drawing down over $50 million from the GIB reserves during the last two years. It would also appear that the retirees with Medicare do not exceed the revenue attributed to them, but rather the State system 'profits' from their plans and premiums. If the standard plan requires overall subsidy and the retirees with Medicare do not, why are the major thrusts of the Segal recommendations for retirees focused on encouraging enrollment in the standard plan or Medicare advantage plan?

3. HISTORICAL ANALAYIS: Where is Segal's (or the GIB) analysis of the Wisconsin experience with self-insured health care in the early 1980's? What are those lessons learned for design of a State system from the costly self-insured failures of the 1980's? How do the current Segal recommendations mitigate the greater risk assumed by the State for costs beyond projections? And what is Plan B if the new Segal recommended 'self-insured system' repeats the same results of the early 1980's?

4. COMPETITION AND NUMBER OF PROVIDERS: The Segal recommendations (page 75, November report) suggest reducing the number of providers and plans to two per region, within a

smaller number of State-defined regions. The net effect would offer participants only 2 providers per region, a total of 6 or 7 providers instead of the current 19 statewide. Generally, one would expect that more competition would lead to better participant choices, less expense and more innovation in health care quality. Why does Segal seek to reduce the number of offerings to individual participants, and enter into a State-commanded limited market system?

5. GREATER STATE RISK: Everything that Segal has recommended thus far seems to shifts costs to the individual participants, costs such as co-pays and deductibles, (page 1-2, April Report and page 3-5, November report, and page 44, Power Points) while not addressing the "value" of the one current State plan that will most likely meet the ACA thresholds for the Cadillac excise fee, the standard plan with its enrollment of 2% of the group insurance board's health care plan contracts. The ACA appears to assign responsibility for payment of the excise fee to the HMO providers that serve those 98% covered under the non-standard plans. Why is Segal recommending that the State of Wisconsin increase its exposure and costs by suggesting that we all should be encouraged to enroll in the sole current plan that qualifies for the ACA excise fee, that is, standard plan?

I appreciate the opportunity to offer some suggested questions, and I hope that they will be answered in some form by the Segal group or ETF staff.

Sincerely,

Hickory R. Hurie

CC: Other members of the GIB, where addresses are available