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

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

May 8, 2017

The Honorable Alberta Darling, Co-Chair
Joint Committee on Finance
317 East, State Capitol
Madison, WI 53701

The Honorable John Nygren, Co-Chair
Joint Committee on Finance
309 East, State Capitol
Madison, WI 53701

Dear Senator Darling and Representative Nygren:

We are pleased to notify the Joint Committee on Finance (Committee) that the Department of Employee Trust Funds (Department) has successfully negotiated three year self-insurance contracts with optional renewals to save the State of Wisconsin at least $60 million in General Purpose Revenue (GPR) over the 2017-2019 biennial budget.

The contracts presented do not change the benefits that the employees receive, rather they change the financing of those benefits. As a result of the Department's proposed shift to a self-insurance model, these contracts will realize the $60 million of savings included in the biennial budget. Under current law, an additional $32.5 million in Affordable Care Act (ACA) taxes will be avoided annually.

The Department is prepared to execute contracts with the following Third Party Administrators (TPAs):

Statewide/Nationwide Vendor
- Compcare Health Services Insurance Corporation (Anthem Blue Cross Blue Shield)

Eastern Regional Vendors
- Compcare Health Services Insurance Corporation (Anthem Blue Cross Blue Shield)
- Network Health Administrative Services, LLC

Northern Regional Vendor
- Security Administrative Services

Southern Regional Vendors
- Dean Health Plan Inc.
- SPWI TPA, Inc. (Quartz)

Western Regional Vendor

- HealthPartners Administrators, Inc.

The contracts provide self-insured group health plans on a regional and statewide basis to state employees, effective January 1, 2018. Consistent across the vendors, the contracts are for a three-year term, with options for three, two-year renewals. This letter and the attached contracts are being submitted as required under Wis. Stats. § 40.03 (6)(L).

To ensure financial performance, the contracts include discount guarantees, and shared-savings arrangements tied to quality-of-care performance measures to incent cost containment and improved quality. The contracts also include performance guarantees that will hold vendors financially accountable for performance pertaining to customer service, claims processing, enrollment, account management, and other measures.

We ask that the Committee recognize the unique nature of the statewide/ nationwide contract. This contract replaces the current self-insured health benefit program and Medicare Supplement program administered by Wisconsin Physicians Service (WPS). This is the only benefit offering that provides members with nationwide coverage options. The current contract with WPS expires December 31, 2017. If the Committee rejects this contract, it would leave the Department without an administrator for these programs for 2018, and without sufficient time to execute a procurement process. Special consideration for this contract is appreciated.

To ensure the Department has been responsive to Committee members' questions about the self-insurance and regionalization recommendations, the following is a discussion of the issues raised by Committee members during its meeting on March 28, 2017.

Why Self-Insure: Research & Analysis

The Group Insurance Board (Board) began investigating the merits of self-insuring the program in 2012. Like many large employers that were fully-insured at the time, the Board was concerned about exposure to a new tax on insurers included in the Affordable Care Act (ACA), which could be avoided by self-insuring. In researching the issue over the past several years, the Board and the Department learned the following:

- The National Conference on State Legislatures indicates that 46 states either completely or partially self-insure their health benefits.
- Almost all large employers self-insure their health benefits (94% of employers with more than 5000 employees).
- Self-insuring health care benefits ensures that employers have access to data about their plans' health care costs and utilization.
- Employers that self-insure save money by avoiding Wisconsin premium taxes, insurer risk charges, and the ACA insurer tax.

- The current fully-insured managed competition model has been successful at keeping annual rate increases low over time and yet costs remain high compared to other states, even when controlling for benefit design.
- Self-insurance can be implemented within a regional model to maintain competition among the health plans, maintain provider choice, maximize savings, and maintain benefits for members.

Self-insurance is a widely used strategy by both private and public sector employers. Self-insuring also lays the groundwork for additional Board initiatives to reduce costs and improve care by ensuring access to program data and by allowing the Board and the Department to establish long-term partnerships with a small corps of high-quality, competitive health plans.

Fundamentals of Self-Insurance

Risk Transfer

In a self-insured structure, the state will assume the risk for claims costs. In a fully-insured environment, the state pre-pays premiums for anticipated health care costs. If actual claims are lower than anticipated, the insurer profits. If claims are higher than anticipated, the insurer profits less, or potentially loses money in that year. However, the insurer will aim to make up for those losses by charging higher premiums the following year.

In a self-insured environment, the state pays medical claims as those claims occur, and therefore realizes the costs of those claims sooner. If claims are lower than anticipated, the state realizes the savings instead of the insurer. If claims are higher than anticipated, the state incurs the higher cost immediately, rather than experiencing higher premiums the following year. To mitigate against the risk of potential higher than anticipated costs, the state has established, and will continue to maintain, adequate reserves.

Establishing Reserves

Claim reserves must be set up to pay for services that are received, and can also temporarily protect an employer if revenue from premium payments are not sufficient to cover claims if risk is unusually high. However, if used for such purposes, an employer should take steps to restore reserves for the future through future higher premium payments.

Because a portion of the State Group Health Benefit Program is already self-insured, reserves already exist. As of December 31, 2016, those reserves are $165 million. The Board, based on the advice of its actuaries, has a policy that reserves should be set at 15-25% of annual claims. The current reserves are sufficient to comply with the Board reserves policy in a completely self-insured program restructure.

Elimination of the Risk Charge

The health risk of employees can be better or worse from year to year. In a fully-insured model, insurers anticipate this in their premium and build in a risk charge to compensate themselves for the uncertainty of whether they are going to have a good year (meaning state employees had fewer catastrophic costs) or a bad year (they had more catastrophic costs). In a good year, the insurer earns a profit. In a bad year, the insurer experiences a loss and tries to make up for that loss in the premium bid the following year. Regardless of whether an insurer has a good year or a bad year, the insurer includes that risk charge each year and it is currently estimated at 1-2% of premium across all the plans. The risk charge is completely eliminated in a self-insurance model.

Stop Loss Insurance

Stop loss insurance is often purchased by self-insured employers to protect themselves against exceptionally high cost claims. However, employer groups the size of the state program would not normally purchase stop loss insurance since experience should be relatively stable in a group of this size, and reserves should be sufficient to absorb such catastrophic claims. Segal Consulting (Segal), the Board's consulting actuary, has advised the Board that stop loss insurance is unnecessary and would create an additional, unnecessary expense.

If the Legislature is concerned about this low probability occurrence, the state could choose to initially purchase stop loss insurance to protect against claims fluctuation concerns and provide greater stability and predictability in the initial implementation. Stop loss insurance is typically purchased based on an attachment point, the point at which the insurance starts to pay on a specific claim. Segal has calculated that a stop loss policy with a $1 million attachment point would cost $4 million annually. Estimates are available based on a different attachment points; however, more precise estimates would require a formal bid process with stop loss insurance carriers.

Learning from Previous Experiences

The Board and the Department are taking steps to ensure experiences of the past are not repeated by including the following provisions in the health plan contracts:

- Including TPA discount guarantees which provide protection that provider prices will not increase beyond certain reasonable inflationary amounts;
- Requiring improvements in provider pricing over the course of the contract to ensure the health plans are seeking to improve their contracts with health care providers over time;
- Including gain sharing incentives tied to performance on quality benchmarks to reward those health plans that perform well on quality measures and achieve additional savings above and beyond those savings anticipated in their initial bids.

While these provisions cannot guarantee that the state will not have some high risk years, they will offer protections that were not in place previously and put the state in a

much better place to mitigate against the risk of cost and/or utilization increases in the future.

Impact on Members

Under our current structure, premiums can fluctuate from year to year and employees experience annual disruptions in available providers and health plans. The contracts negotiated by the Department will create more premium stability via the contract duration and the anticipated disruptions are not greater than in any other year.

Premiums

The Division of Personnel Management at the Department of Administration is responsible for establishing the employee share of premium for most state employees, but typically the employee share trend has followed the overall trend in premium. For 2018, it is expected that both the state and employee share of premiums will be relatively flat, assuming these contracts are executed.

Benefit Design

The Board is committed to maintaining benefits and not shifting additional costs to members for 2018. Uniform Benefits, the standard benefit package that all health plans administer, will continue to cover all benefits mandated under state law, as well as all Essential Health Benefits required under the federal Affordable Care Act.

Communicating changes about which health plans will be available will require a significant communication effort to plan members. Acknowledging this communication effort, the Board determined that additional benefit design changes would be undesirable for 2018.

Provider Disruption

Members will largely have access to the same doctors and hospitals available today in the new program structure. This includes the Group Health Cooperative – South Central, Gundersen, and Physicians Plus provider networks, which have partnered with the new Quartz offering.

Based on commitments made from the health plans, Segal has determined that 98% of the providers that are currently available in Wisconsin will continue to be available with the health plans that the Board has selected to contract with in 2018. Of the two percent of providers that may not be available in 2018, most are considered “ancillary” or other providers, as opposed to primary care providers. As stated above, annual provider disruption also occurs in the current fully insured model.

Health Plan Disruption

The number of health plans in the State Health Benefit Program will decrease from 18 to six under the restructuring approved by the Board. The plans were selected for their improved cost and their demonstrated success on quality and focus on customer service. These plans will be held to performance standards to ensure they maintain that level of service delivery.

Further, the regionalization of the new structure ensures that there will be more stability in terms of which plans are available in counties. Working with fewer plans will also improve the Department's ability to develop strategic partnerships with the plans and focus on strategies to improve health and quality of care.

Estimated Savings

Estimated Savings

As stated above, contract negotiations successfully position the program to achieve the $60 million GPR savings included in the biennial budget. To achieve similar savings under a fully insured model, 2018 premium increases would have to be limited to a low, single-digit percent increase. If the current Affordable Care Act fees remain in place for fully insured plans in 2018, participating health plans would essentially experience a net premium freeze for 2018.

The biennial budget correlates with savings estimates reported to the Board by Segal Consulting. Savings are primarily due to reduced administrative fees and discounted claims costs.

The administrative fee savings are due to the elimination of the insurer risk fee and other administrative efficiencies reflected in the vendors' bids. The claims savings are based on improved provider pricing available from the health plans selected through the RFP process. These savings are not strictly associated with the transition to a self-insured model, but rather the result of selecting the most cost efficient health plans.

In preparing these estimates, Segal had to make numerous assumptions about medical trend, loss ratios, and to which plans members would move. Segal ran several scenarios to develop a range of estimates. The estimate presented to the Board represents the mid-point, or most-likely scenario, for the restructuring option the Board selected.

Affordable Care Act Insurer Assessment Fees

The savings estimates do not include the savings associated with avoiding the insurer tax that would be paid in 2018 if the State Health Benefit Program stayed fully-insured and if the Affordable Care Act remains current law. The fees for this assessment are estimated to be $32.5 million annually (All Funds) for 2018 based on data reported by the health plans.

Previous Actuarial Estimates

The Department continues to respond to inquiries from legislators, media, and members of the public about differences between the actuarial estimates prepared by two different Board consultants over the last few years. Below is a summary of those actuarial estimates which highlight why the most recent estimates adopted by the Board are the most reliable.

The Board has been researching self-insurance since 2012. It asked its then actuary, Deloitte Consulting, to conduct an initial high level estimate of the impact of moving to

self-insurance. Deloitte initially estimated the impact to range between savings of $20 million annually to costing up to $100 million annually. This estimate assumed the state would save money through the avoidance of taxes and fees. However, the estimate also made numerous assumptions about plan design and vendor selection and lacked concrete data to inform the analysis. The primary conclusion was that the actuary needed to collect additional data to refine the estimates.

In 2013, the Department and Deloitte completed a Request for Information collecting information from 17 health plans and third-party administrators. Based on this report, Deloitte assessed some of the opportunities and challenges associated with self-insuring with one statewide carrier versus multiple regional carriers. Deloitte did not revise its earlier estimates, but rather indicated that self-insurance was worth pursuing and recommended the Board proceed with a comprehensive Request for Proposal (RFP) to further refine and assess information from potential bidders.

In 2014, Deloitte's contract with the Board expired and Segal Consulting was selected to replace Deloitte through a competitive RFP process.

In 2015, Segal completed two comprehensive reports to the Board on the State Group Health Benefit Program, including an analysis of self-insurance. Segal recommended pursuing self-insurance and estimated that the program could save $42.1 million, but this estimate was based purely on the avoidance of taxes and risk charges, and administrative savings. It did not take into account changes in provider discounts or benefit design or other program changes. Segal separately recommended combining a self-insurance model with other regional program changes.

Both actuaries recommended the Board pursue getting bids from potential vendors through an RFP process to accurately assess the impact of self-insurance. As a result, the Department released an RFP in 2016. The current cost savings estimates reflect actual bids guaranteed by vendors through that RFP process, providing the first fully-informed and contractually-bound cost projection.

Impact of Regionalization

The Board approved maintaining a competitive marketplace for state employees by selecting six different vendors. Employees will have multiple options in every region of the state.

Today, employees can choose from 18 different health plans. Performance by plan in terms of customer service and health care quality metrics varies widely. By using a competitive process to select health plans, and including unprecedented performance requirements, the new contracts ensure that the plans available in the program are the top choices in terms of cost, quality and value.

Not all current health plans chose to participate in the recent competitive bid process. For many of them, the state health plan is not a significant portion of their business. For

others, they determined the cost, quality, and performance requirements included in the RFP were prohibitively restrictive.

Some opponents to the restructure have argued that the state is subsidizing the larger insurance market and that private employers' costs will increase if the state self-insures. Others have made the exact opposite argument – that insurers currently give the state artificially low premium rates that are being subsidized by the private sector. Neither argument is backed by any concrete evidence.

The insurance market – in Wisconsin and elsewhere – is evolving in unprecedented fashion due to forces beyond the state employee program. Mergers and acquisitions preceded this change, and will continue into the foreseeable future.

Impact on Retirees

The savings achieved from self-insuring the health plans are passed through directly to our retirees since they pay 100% of premiums, so this population will benefit the most directly from the savings achieved under the new model. Pre-Medicare retirees will continue to have the same health plan options as active employees in the new program structure.

In 2018, Medicare-eligible retirees will continue to have the Medicare coverage options that are available today:

- IYC Medicare – administered by the regional and statewide/nationwide vendors
- IYC Medicare Plus – a Medicare supplement health plan to be administered by Anthem
- IYC Medicare Advantage – administered by Humana

The Board is considering expanding Medicare-eligible retiree options to include additional, more affordable Medicare offerings for 2019 and beyond. Department staff will bring recommendations to the Board at its May 24, 2017 meeting.

Impact on Local Government Employers

Participants in the Wisconsin Public Employer (WPE) Health Benefit Program will experience the same program structure changes as state employees in 2018, and will also benefit from the projected program cost savings.

Legal Authority to Self-Insurer for Local Employers

Recently, a Legislative Council memo raised questions about whether the Board has the authority to self-insure health benefits for local employers. The question was raised based on a 1987 Attorney General Opinion that found that self-insuring benefits for local employers could create a debt obligation for the state and would therefore be unconstitutional. Attorneys for the Department recently completed a review of that Attorney General's Opinion and performed its own analysis of the relevant statutes. In

short, the attorneys found that the Board does have the authority to self-insure health benefits for local employers for the following reasons:

- Self-insuring for health benefits for local employees does not create "an absolute obligation to pay monies or its equivalent," i.e. debt, for the state. Health benefits for local employees are currently separately funded; meaning reserves, premium rates, and financial risk for local employees are entirely separate from state employees.
- The Legislative Council memo indicates that if funding for local employee benefits is kept separate (as noted above), a self-insurance model would be constitutional.

In addition, the Board currently self-insures dental and pharmacy benefits for local government employers participating in the Wisconsin Public Employer (WPE) health benefit program.

Cost Containment & Quality Improvement Strategies

As stated above, self-insurance is only one strategy being pursued by the Board to reduce costs, and lays the groundwork for additional Board initiatives to reduce costs and improve care. The Board is in the early stages of several aligned initiatives to improve program costs or improve health, described below.

Wellness & Disease Management – The Board's short term strategic plan for wellness focused on centralized administration of the health assessment, biometric screenings, and wellness incentive to increase participation and employee engagement. This was achieved earlier this year with the implementation of the contract with StayWell. Also starting in 2017, the program is incorporating health and lifestyle coaching into the program. Over the next two years, the Board plans to improve participation in these programs through an improved incentive, and continue to develop targeted disease management programs to improve the overall health of the state employee population.

Data Warehouse & Analytics – The Board's long term strategic plan is focused on using data to inform plan design and targeted disease management programs. Earlier this year, the Board executed a contract with Truven Health Analytics to develop a data warehouse for the program data. The data warehouse is targeted to be fully functional for data analytics in early 2018.

In 2014, the Board prioritized gaining access to high quality medical and pharmacy claim data about the State Health Benefit Program in a central database to better manage the health of program participants and program costs. Contracting with a data warehouse vendor will give the Board the ability to move forward on a variety of strategic initiatives to control health care costs and improve service delivery. In February 2016, the Board approved moving forward with an RFP for a data warehouse and visual business intelligence vendor. In November 2016, the Board selected Truven Health Analytics, LLC to provide these services. The Department is currently working to

implement these tools and expects to have the data warehouse and reporting tools operational in early 2018.

Capturing medical and pharmacy claims data is critical for identifying cost drivers and managing health and costs in the health program whether it's a fully-insured or self-insured program. However, in a self-insured model, there is no question about whether the Department has the ability to collect health claims data. In a fully-insured model, health plans resist efforts to collect data, making it difficult to measure their results, identify gaps in care, disease prevalence and other cost drivers and therefore develop programs to target those cost drivers.

Note on Data Privacy: The Department understands the sensitive nature of member-level health information and has no business case or interest in having access to member-identifiable medical or pharmacy claims. Therefore, when building the data warehouse, Truven will mask, or de-identify, member level information so that neither the Department nor Segal will be able to identify the member on a claim. The contract with Truven and Non-Disclosure Agreements with the TPAs have extensive protections pertaining to member information, and are compliant with all pertinent federal regulations including HIPAA, GINA, and HITECH.

If the Department has a need to receive member-level information due to a grievance or customer inquiry, Department staff obtain an authorization from the member and work with the health plans to get this data, as they do today.

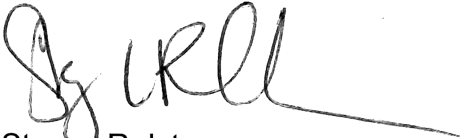
Benefit Design – For 2016, the Board adopted cost-sharing changes which encourage more consumerism among plan participants through the addition of a deductible, and more nuanced pharmacy benefit co-insurance design to encourage the most effective use of low-cost generic drugs. These changes shifted an estimated $84 million in health care costs to members in the 2015-17 biennium. In 2015, the Board introduced the High Deductible Health Plan and associated Health Savings Accounts, increasing the employer HSA contribution in 2016 to encourage enrollment in the plan. The Board also introduced co-insurance to the plan design in 2012, which reduced the value of the benefit package by 5%. In 2011, state employees' premium contribution doubled, requiring them to cover an additional 6% of premium costs.

Vendor Council on Health Program Improvement – In 2017, the Department kicked-off a vendor council that convenes all program TPAs (medical, pharmacy, wellness, dental, data warehouse) to discuss Department initiatives, and share trend and population health strategies. The goal of the council is to improve member health through a coordinated, data-informed strategy amongst vendors.

We hope this information successfully addresses the concerns Committee members have about the Board's proposal. If we can be of any additional assistance, please let us know.

Sincerely,

Michael Farrell, Chair
Group Insurance Board



Stacey Rolston
Division of Personnel Management