WISCONSIN LEGISLATIVE COUNCIL

Terry C. Anderson, Director *Jessica Karls-Ruplinger, Deputy Director*

TO: SENATOR JON ERPENBACH

FROM: Margit S. Kelley, Senior Staff Attorney MSK

RE: Brief Description of Selected Differences in Providing Health Care Coverage for State Employees Under a Self-Insured Structure Versus an Insured Structure

DATE: March 24, 2017

This memorandum, prepared at your request, briefly describes the current statutory structure for the provision of health care coverage to state employees and their dependents. Also, as you requested, this memorandum briefly describes certain aspects of providing coverage that could be affected by changing the funding mechanism for the health care coverage from an insured to self-insured model. A self-insured approach is sometimes referred to as a self-funded plan, or an uninsured plan, and provides direct payments to providers for services.

This memorandum focuses on five potential differences in the management of a self-insured health care plan from the current approach that is primarily offered through insurance contracts. These include the terminology for "premiums," applicable mandates, local public employers, regional networks, and anticipated savings.

CURRENT LAW

Department of Employee Trust Funds

The State of Wisconsin has created an employee trust fund, as a public trust, to aid public employees in protecting themselves and their beneficiaries against the financial hardships of old age, disability, death, illness, and accident. The trust fund maintains separate accounts for retirement investment, group health, income continuation, life insurance, reserve funds, administration expenses, and other purposes. The funds are administered by the Department of Employee Trust Funds (ETF) under the direction and supervision of the ETF board. [ss. 15.16, 40.01, and 40.04, Stats.]

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Group Insurance Board

The Group Insurance Board (GIB or "the board") is attached to ETF to manage the provision of group insurance plans for employees, retirees, and dependents. The board, as trustees, may take any action deemed advisable to carry out the purpose and intent of the group insurance plans, unless an action is specifically prohibited or delegated to a different agency. [ss. 15.165 (2) and 40.03 (6), Stats.]

Permissible actions include choosing to enter contracts with insurers or providing any plan on a self-insured basis,[1] setting eligibility and enrollment periods, and establishing reserves, among other actions. The board is not permitted to modify or expand benefits under an insurance plan unless required by law or in order to maintain or reduce premium costs. [s. 40.03 (6), Stats.]

Additionally, the statutes specify that any rights or benefits are due as a contractual right, and cannot be withdrawn by a subsequent legislative act, except as to future exercising of rights or future accrual of benefits. Likewise, with the focus on the benefit of employees, the board is required to apportion all excess moneys becoming available to it through operation of the group insurance plans to either reduce premium payments in following contract years or establish reserves. [ss. 40.06 (6) (e) and 40.19 (1), Stats.]

Health Care Coverage

Under current law, the state must offer to its employees at least two health care coverage plans, which may be either insured or self-insured. The coverage must provide full or partial payment of the financial expense incurred by employees and dependents as the result of injury, illness, or preventive medical procedures. This may include coverage that is sometimes referred to as "major medical," and may include wellness or disease management programs. [ss. 40.02 (37) and 40.51 (6), Stats.]

The plans must offer substantially equivalent hospital and medical benefits, and must provide certain categories of mandated coverage. In order to manage these statutory requirements, the board uses a system of approved "uniform benefits." [s. 40.51 (3) to (6), (8), and (9), Stats.]

Plans are placed into one of three tiers according to the employee's share of premium costs. The offered plans must include a health maintenance organization (HMO) or a preferred provider plan (PPP), if those health care plans are determined by the board to be available in the area of the place of employment and are approved by the board. [s. 40.51 (6), Stats.]

For 2016, 18 health plans were available in 28 service areas. They included HMOs and PPPs, and each plan offered an option to be structured as a high-deductible health plan (HDHP) with an accompanying health savings account (HSA). Two group health plan options were funded on a self-insured basis: the "It's Your Choice Access Health Plan," and the "state

[1] 1981 Wisconsin Act 96 created the option for the board to self-insure any group plan.

maintenance plan" for areas that do not have a standard plan. [ETF, *Group Health Insurance Fact Sheet 2016*, Doc. No. ET-8902 (Feb. 29, 2016).]

In the 2015 biennial session, the Legislature added a requirement that the board, in consultation with the Division of Personnel Management in the Department of Administration, must notify the Joint Committee on Finance (JFC) if it intends to execute a contract to provide self-insured group health plans on a regional or statewide basis. JFC has a 21-working day period upon that notification to determine if a meeting will be held to review the contract. [s. 40.03 (6) (L), Stats.; 2015 Wisconsin Act 119.]

SELF-FUNDED PLAN

Background

On February 8, 2017, the board approved letters of intent to certain vendors, for the vendors to provide administrative services for state employee health care coverage on a self-insured basis. On February 9, 2017, the board informed the JFC Co-Chairs of the board's intent to award contracts, and is currently in contract negotiations with the selected vendors. To initiate the JFC review period, the board must notify JFC when it is prepared to execute a contract. It is anticipated that the group health plans would be self-insured beginning on January 1, 2018.

In a self-insured plan, the employer assumes the financial risk for providing health care benefits to employees. Rather than paying premiums for an insurance policy, the employer pays for all health care services on its own. Usually, a trust fund is established for the collection of employer and employee contributions and for the payment of claims. In some cases, a stop-loss insurance policy (also called a "reinsurance" or "excess" insurance policy) is obtained to protect the trust fund from catastrophic losses.[2] An employer may choose to administer the claims in-house, or may contract with a third-party administrator for that service.

Plan Structure

The board has selected multiple vendors to administer the self-insured state employee health care program. Under this structure, one vendor will provide a network that is available throughout the state and is also available nationwide, and six vendors will provide a network in four identified regions of the state. Among the six vendors that will provide only regional networks, two will provide a network in the eastern region, and two will provide a network in the southcentral-southwestern region. One regional-only vendor will provide a network in the northwestern area of the state, and the other will provide a network in the northcentral region. Contracts will be for three-year terms. [GIB, Correspondence to Senator Darling and Representative Nygren, JFC Co-Chairs (Feb. 9, 2017).]

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[2] For a comparison, the state requires a self-insured school district to obtain a stop-loss insurance policy if the self-insured plan covers less than 1,000 employees. [s. 120.13 (2) (c), Stats.]

Under this proposal, it appears that a participant may choose in which vendor's network to participate. In all cases, a participant could choose the statewide network or an offered regional network.

Working with the board's consulting actuary, Segal Consulting, the board anticipates that the proposal will reduce program costs by $60 million over the 2017-19 Biennium. The board states that there will not be a reduction in participant benefits, and that the anticipated savings are expected from reduced administrative fees, reduced insurer risk fees, and improved discounts. The board states that an additional $30 million per year could potentially be saved in taxes under the Affordable Care Act (ACA), though it states that the future of that Act is unknown. [*Id.*]

DISCUSSION

You asked for a general discussion on how the state's approach will differ with a self-funded health care coverage plan for state employees. This memorandum focuses on five potential differences in the management of a self-insured health care plan from the current approach that is primarily offered through insurance contracts. These include: the terminology for "premiums," applicable mandates, local public employers, regional networks, and anticipated savings.

Other differences, such as ownership of claims data under a self-insured approach, the effect of the excise tax on high value plans that is scheduled to begin in 2020, and funding of reserves, are not addressed.

Parts of the discussion may illustrate the evolving questions that could be further explored in considering a shift from a primarily insured structure to a self-insured structure of providing health care coverage for state employees, retirees, and dependents. Any issues may be addressed and resolved through further information from the board and Segal Consulting, specifications in the contract provisions, or legislation.[3]

Terminology for "Premiums"

In various locations of the provisions for group health care coverage for state employees, the statutes refer either to "premiums" or to "contributions" for health care coverage. Neither term is defined in this context.

Health care coverage plans, whether offered as an insurance policy or as an employer's self-funded plan, generally require the payment of premiums or other individual contributions. In general usage, the term "premium" is sometimes used interchangeably for both the purchase of insurance policies and contributions to self-funded plans, though historically the term referred to the amounts paid for an insurance policy. [See, for example, s. 600.03 (38), Stats.]

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[3] As introduced, the 2017-19 Biennial Budget Bill addresses certain revisions in funding associated with the proposal to self-insure health care coverage for state employees, but does not address any other statutory changes that could be associated with the proposal. [Companion bills 2017 Senate Bill 30 and Assembly Bill 64.]

In particular, the statutes specify that the tiers for the health coverage plans must be separated according to the employee's share of "premium costs," and specify that the state may pay no more than 88% of the average "premium cost" for plans offered in each tier. However, it is not clear whether the reference to premiums could be interpreted as limiting the costs that may be considered in determining the tiers or the employer and employee shares of costs. [ss. 40.05 (4) (ag) 2. and 40.51 (6), Stats.]

Applicable Mandates

A shift to self-insured funding could precipitate a shift in the applicability of statutes regarding health care mandates.[4]

Under Wisconsin law, a "health insurance mandate" is a state law requirement to provide a particular type of coverage. The mandates generally apply to all policies offered by insurance companies doing business in Wisconsin. However, as a general rule, the state itself is not subject to general laws, unless the state explicitly applies a law to itself. The state has done so for a number, but not all, of the mandates that apply to health insurance policies. [ss. 601.423, 631.93, 631.95, 632.85 to 632.897, Stats.; 76 OAG 311; *State Dep't. of Natural Res. v. City of Waukesha*, 184 Wis. 2d 178, 194 (1994).]

The state plans are subject to the mandates regarding domestic abuse, emergency medical conditions, chemotherapy, cancer clinical trials, mental disorders, alcohol and other drug abuse, mammograms, HIV, lead poisoning, temporomandibular disorders, surgical dental care, autism spectrum, breast reconstruction, immunizations, hearing aids, colorectal cancer screening, and contraceptives. The mandates also apply to services from particular types of providers (such as chiropractors) and to coverage for specific persons (such as adopted children). [ss. 40.51 (3) to (5), (8), and (9) and 40.52 (1) (b), Stats.]

State law does not explicitly require compliance by state plans with certain other mandates. These include services by a nonphysician provider, services for home care or for skilled nursing care, coverage for a newborn, coverage of an adult child with an intellectual or physical disability, and coverage of maternity care, diabetes, and kidney disease. [ss. 632.87 (1) to (2m), 632.88, and 632.895 (2) to (5) and (6) and (7), Stats.]

Each of the mandates that are not explicitly required for state plans have been incorporated into the "uniform benefits" that are required by the board. Also, the board stated in its February 9, 2017, correspondence to the JFC Co-Chairs that, among its goals, it aims to

[4] A shift in applicable mandates is available at any time under the state's sovereignty, and is not due to a shift in regulatory oversight that is applicable if a private employer shifts from an insured to a self-insured plan. A private self-insured plan is not subject to state mandates that apply to policies offered by an insurance company, and the exclusion from those laws is therefore a consideration for a private employer. For a private self-insured plan, federal law preempts state law requirements, making the state laws inapplicable. However, federal law does not apply to a governmental plan, and, accordingly, that exclusion does not apply to the state or other governmental units that are considering self-insurance. [29 U.S.C. ss. 1002 (1), (3), and (32), 1003 (a) and (b) (1), and 1144 (a), of the Employee Retirement Income Security Act of 1974 (ERISA).]

reduce costs under a self-insured structure without reducing benefits. However, the board may review and revise uniform benefits in its discretion, and does so on an annual basis.

Local Public Employers

Under current law, a local public employer may offer its employees a health care coverage plan that is offered through the state program, though different eligibility standards and contribution requirements may apply. This option may, however, be limited to the state's insured plans. [s. 40.51 (7), Stats.]

The duties and powers of the board include the power to either enter a contract with insurance companies for group plans or to wholly or partially provide any group plan on a self-insured basis. The exercise of either alternative must be "on behalf of the state." [s. 40.03 (6) (a), Stats.]

In a 1987 opinion, the Attorney General examined whether the board may establish a pool of local public employers to provide health care benefits on a self-funded basis. The Attorney General concluded that the state was not permitted to establish a self-insured pool for participation by local public employers. The Attorney General stated that although local public employers may offer a state program, the board's power to offer self-insured plans was limited to being on behalf of state employees, and could not be offered by the state on behalf of local public employees. [76 OAG 311.]

The Attorney General primarily rested the opinion on the plain language given in the board's power to self-insure only "on behalf of the state."[5] Additionally, the Attorney General found that this reading avoids the potential of creating an obligation on the part of the state to pay the debt of another. The Wisconsin Constitution prohibits the credit of the state from being given or loaned in aid of another. [Art. VIII, s. 3, Wis. Const.]

If health care coverage for state employees is offered on a self-insured basis, this may in effect limit the options for local public employers to offer plans through the state program. This option will depend on whether the board offers an insured alternative, in which case some amount of participation in the state program would be available. Alternatively, although somewhat uncertain, it may be possible for ETF to manage a trust account that is self-funded by local public employers and their employees, utilizing the board's contracts for administrative services, if adequately structured as a separate account with its own claims processing and no state liability.

The board's self-insured plan does not affect other options that are available under current law, for a local public employer to itself provide health care coverage on a self-insured basis or to contract with an insurance company. A local public employer may review the options and revise its approach, in any manner it chooses. [ss. 66.0137 and 120.13 (2) (b), Stats.]

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[5] The opinion did not address the effect of the same language ("on behalf of the state") that is given in the board's power to contract with insurance companies for any group plans.

Regional Networks

Under current practice, insured health care plans often arrange a network of providers, which may be structured as an HMO or a PPP. The health plan may bid to provide uniform benefits for state employees. According to ETF's Office of Strategic Health Policy, the networks result in provider competition in some areas, but overlap in other areas where plans utilize the same network. The board's self-insured plan moves the emphasis from the insurance company's available network to a regional coverage model, as described above. [ETF, Correspondence to GIB (Nov. 22, 2016).]

ETF states that the regionalization will increase access to providers in all parts of the state, streamline program administration, simplify program information for participants, and control costs. It is possible that available providers could change under the self-insured regional structure. However, ETF states that 98%of current providers will be available under the regional structure, including certain specific providers from the current insured plans. [ETF, Frequently Asked Questions regarding GIB (Feb. 8, 2017); GIB, Correspondence to JFC Co-Chairs (Feb. 9, 2017).]

Regionalization may have benefits or concerns in its effects on administration, market leverage, market competition, and provider groups. [ETF, Correspondence to GIB (Nov. 22, 2016).]

Anticipated Savings

The board states that anticipated savings of $60 million over the 2017-19 Biennium under the self-insured structure are expected from: (1) reduced administrative fees; (2) reduced insurer risk fees; and (3) improved discounts. The estimate applies only to aspects of the program that use general purpose revenue (GPR) appropriations. The board also states that an additional $30 million per year could potentially be saved in taxes under the ACA, though it states that the future of that Act is unknown. [GIB, Correspondence to JFC Co-Chairs (Feb. 9, 2017).]

The following discussion is based on information provided in the *Second Report – Observations and Recommendations for 2017 and Beyond*, by Segal Consulting, pages 67 to 74 and 119 to 129. The report was presented to the board at its meeting on November 17, 2015. Additional information was likely presented to the board at its closed meeting sessions on December 13, 2016, and February 8, 2017, at which it assessed and deliberated on the results of the request for proposals.

Because the dollar amounts listed in the report and cited below do not equal the total amounts given in the correspondence to the JFC Co-Chairs, it appears that the figures were revised based on an evaluation of the responses to the request for proposals. Also, the figures in the report are annual, while, if a self-insured program begins on January 1, 2018, in the first fiscal year of the fiscal biennium the program would be self-insured for only half of the year.

Administrative Costs

According to the Segal Consulting report, administrative cost savings could be $11.2 million annually. Administrative costs include claims processing, member services, network contracting and maintenance, reporting, wellness management, and the administration of HSAs and health reimbursement arrangements.

The Segal Consulting report compared a current net administrative cost per subscriber per month rate with the same rate from other sources. In making the final comparison, the report used the highest rate from a sampling of 15 other states' health plans, finding that those other states were, in general, more similar in size and composition than other surveyed plans.

Insurer Risk Fees

According to the Segal Consulting report, a reduction in insurer profit margin and risk charges could provide savings of $11 million annually.

The report states the profit and risk load reported by the state's plans are approximately 1.2% of the plans' costs, in the aggregate. The report states that the profit margin and risk charge that are included in insurance premiums will be immediately eliminated under a self-insured structure.

The report states that a profit for vendors under a self-insured structure would be included in a vendor's administrative services fee. It appears this would be addressed and included in the anticipated administrative costs.

Discounts

According to the Segal Consulting report, provider discounts could be improved by an estimated total of $57.5 million annually.

The report described provider discounts as effective discounts after discounts from billed charges, which should account for value-based, shared risk, or other provider payment methods such as capitated programs, accountable care organizations, patient medical homes, bundled payments, quality bonus payments, and others.

The report presumes that pricing discounts would be improved by a midpoint range of 3 to 5% over initial discount data, under a more consolidated contracting approach. Initial data was collected in response to an August 2015 request for information. In that data collection, 15 out of 23 current and prospective vendors provided discount data on three categories of service. The categories of service included inpatient facility services, outpatient facility services, and professional services. Data was requested for each vendor's total book of business and was not limited to state employee claims or utilization patterns.

The discount analysis was included in the request for proposals as "market pricing" data and may be subject to a designation as confidential and proprietary information.

ACA

According to the Segal Consulting report, elimination of the market share fees assessed under the ACA on premiums for insured plans could provide savings of $18.3 million annually. The board's correspondence to the JFC Co-Chairs updated that figure to $30 million annually.

The ACA market share fee is based on an insurance company's net written premiums. An insurance company may incorporate the cost of the fee in its premiums. The fee is based on the ratio of the insurance company's net written premiums to the total net premiums for all such providers, excluding the company's first $25 million in premiums and excluding half of premiums between $25 and $50 million. The fee due in 2017 from 2016 premiums is suspended. [P.L. 111-48 s. 9010; P.L. 114-113 Div. P, s. 201; 26 C.F.R. ss. 57.1 to 57.6302-1; IRS Bulletin 2013-51.]

Provisions of the ACA are currently under consideration in the U.S. Congress.

SUMMARY

In summary, the board is currently in negotiations to provide state employees' health care coverage on a self-insured basis, to begin January 1, 2018. The board has general authority to provide plans either through insurance contracts or on a self-insured basis, but must present a plan to provide a regional or statewide self-insured health care coverage plan to JFC for review.

The proposal that is currently subject to contract negotiations revises the plan structure to provide a more limited number of plan administrators over larger regions of the state than the current structure of multiple insurance coverage plans. The board estimates that providing coverage on a self-insured basis and utilizing vendors to administer the plans will save $60 million in GPR over the 2017-19 Biennium from reduced administrative fees, reduced insurer risk fees, and improved discounts. The board also estimates that an additional $30 million per year could potentially be saved in fees under the ACA.

As briefly described above, there are a number of potential differences in the management of a self-insured health care plan from the current approach that is primarily offered through insurance contracts. These include, among others: the terminology for "premiums," applicable mandates, local public employers, regional networks, and anticipated savings.

If you have any questions, please feel free to contact me directly at the Legislative Council staff offices.

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