Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

June 15, 2017

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Group Insurance Board: Contracts to Self-Insure for State Employee Group Health Plans

Under 2015 Act 119, the Group Insurance Board (GIB) must notify the Joint Committee on Finance if it intends to execute a contract to provide self-insured group health plans on a regional or statewide basis to state employees. Under the act, the Committee is provided 21 working days to review the proposed contract. If the Co-chairs of the Committee notify the GIB within the period of review that the Committee has scheduled a meeting for consideration of the contract, the GIB may not execute the contract without the approval of the Committee.

On May 8, 2017, in consultation with the Department of Administration's (DOA) Division of Personnel Management, the GIB notified the Committee that it intended to execute seven contracts with third-party administrators to manage self-insured group health plans offered to state employees and certain other eligible group health program participants on a regional and statewide basis. On June 1, 2017, the Committee scheduled a meeting relating to the review of the contracts. The decision before the Committee is approval or rejection of the contracts. If the Committee does not approve the contracts, the GIB may not execute them.

Self-insurance refers to a practice of managing risk by making payments for losses as they occur, rather than paying a fixed monthly amount for an insurance policy. A self-insured plan, also called a self-funded plan, assumes the full risk of paying claims. An employer that offers health benefits to its employees typically sets a monthly premium amount for employees to pay, which can be used to offset the cost of the plan to the employer. Additionally, the employer may pay fees to a third party to process claims or administer other services for the program.

Currently, the state self-insures for the following group health program benefits, which are offered to state employees, local government employers, and retirees of state and local public employers: (a) the standard plan (required under s. 40.52(1) of the statutes) and state maintenance plan (offered in counties that do not have a low-cost fully-insured plan available) under a contract

with Wisconsin Physician Services which expires in December 31, 2017; (b) pharmacy benefits; and (c) dental benefits. Most of the group health program's benefits are provided through fully-insured medical plans administered by competing health maintenance organizations (HMOs). The proposal to self-insure under the seven contracts submitted to the Committee pertains to: a new contract for the standard plan, which is already self-insured and which would continue to have statewide and nationwide provider networks; and the transfer of the risk associated with most of the program's expenses to the state. Under the proposal, six vendors would administer claims processing and other services for plans covering one of four regions in the state, which would replace the current model of 17 competing HMOs. The current 17 HMOs are listed below.

Current Fully-Insured HMO Plans

Anthem Blue Preferred Northeast
Arise Health Plan
Dean Health Insurance
Group Health Coop. of Eau Claire
Group Health Coop. of South Central WI
Gundersen Health Plan
Health Tradition Health Plan
HealthPartners Health Plan
Humana
Medical Associates Health Plans
MercyCare Health Plans
Network Health
Physicians Plus
Security Health Plan
UnitedHealthcare of Wisconsin
Unity Health Insurance
WEA Trust

BACKGROUND

Program History. The State of Wisconsin employee health benefits program was at one time administered on a self-insured basis. The state began considering changes to transition the program to an HMO-based model in the 1980s after experiencing significant year-over-year increases in program costs. State employee health benefit rates increased by 30.4% in 1982 and by 22.1% in 1983. Health benefit costs were projected to increase again by 17% annually during the 1983-85 biennium. In part, health management organizations were identified as a potential means by which health care, and use of medical services, could be more effectively managed to limit unnecessary expenses.

Premium Tiers. Under 2003 Act 33, the GIB is required to place health plans into one of three tiers based on the employee's share of premium costs. This requirement was created based on a proposal developed by a study group of the GIB. Health plans are placed into each of the three tiers according to the cost-effectiveness of the plans, which can include consideration of factors other than cost alone, such as the risk profile of participants in the plan. The employer contribution share is highest for Tier 1 plans, which are deemed most cost-effective. Currently, the state employer share for Tier 1 plans is approximately 88%, while the employee share is approximately 12%. In comparison, the state employer contribution for Tier 3 plans (which are higher-cost) is approximately 81%, while the employee share is approximately 19%. The purpose of the tiering structure is, in part, to reduce employer expenses by encouraging health plans to become more cost-effective (through lower premiums) and by encouraging state employees to choose lower-cost plans. Currently, the competing HMO plans are designated as Tier 1 plans, while the self-insured standard plan is designated as a Tier 3 plan.

Premium Increases Over Time. As a point of reference, Table 1 provides the following information for calendar years 2009 through 2017: (a) preliminary bids for premium increases submitted to the Department of Employee Trust Funds (ETF) by participating health plans for the program year; (b) annual medical cost trend figures reported by PricewaterhouseCoopers (PwC) as a point of comparison; (c) state health program reserves used to reduce program expenses; (d) savings estimated by ETF associated with negotiating with health plans to reduce preliminary bids (savings attributable to all contributions under the state program only); and (e) final premium increases. It should be noted that final premium increases are not directly comparable to preliminary bids for two reasons. First, while preliminary bids are submitted by participating health insurers, final premium increases depend not only on final amounts paid to participating health plans, but also include dental and pharmacy components which have in recent years been influenced to a great degree by the use of pharmacy reserves to reduce employer and employee expenses overall. Second, final premium increases may also be affected by transferring costs from state employers to employees through increases in deductibles, copays, and out-of-pocket maximums.

Significant plan design changes were made in 2016 to introduce or increase deductibles and increase out-of-pocket maximums members pay. As a result, the actuarial value of the plans, which was noted by Segal (the consulting actuary for the state's health insurance programs) in its March, 2015, report as unusually high compared to other employers, decreased. The actuarial value of a plan (sometimes called the "richness" of a plan) represents the percentage of health care costs that the plan covers. For example, an actuarial value of 90% would mean that, for the premium paid, approximately 90% of health care costs would be covered. In the case of the state's group health programs, the actuarial value of group health program plans in 2015 was 96% for Tier 1 plans and 93% for the Tier 3 It's Your Choice Access plan (the standard plan). Based on recent information provided by Segal, after the 2016 plan changes that shifted additional costs to members, the actuarial value of the plans decreased to 91% for Tier 1 plans and 90% for the standard plan.

TABLE 1

State Group Health Program Preliminary Bids, Reserves Utilization, Negotiation Savings, and Premium Increases, 2009 to 2017 ($ in Millions)

Calendar Year	Preliminary Bid	Medical Cost Trend (PwC)	State Program Reserves Used	Negotiation "Savings"	Final Premium Increase
2009	10.0%	9.2%	$18.5	$13.5	8.1%
2010	10.0	9.0	6.1	18.8	7.7
2011	9.5	9.0	0.2	28.0	6.3
2012	2.1	8.5	30.0	30.1	-1.5
2013	8.7	7.5	32.8	33.1	5.1
2014	8.2	6.5	20.5	45.5	3.5
2015	6.9	6.8	20.0	19.3	5.0
2016	7.7	6.5	0.0	56.4	-2.5
2017	5.4	6.5	0.0	37.9	1.6
Average	7.6%	7.7%	$14.2	$31.4	3.7%

From 2009 to 2017, preliminary bids ranged from a 2.1% increase (2012) to a 10.0% increase (2009 and 2010). On average, preliminary bids were for a 7.6% increase. Final premium increases for calendar years 2009 to 2017, which would include any cost shifts to employees or draw-downs of reserves, averaged 3.7%. The only years in this period in which significant draw-downs of reserves and cost shifts to employees did not occur were 2011 and 2017. The average preliminary bid increase for these years was 7.5%, and the average final premium increase was 4.0%. Additionally, based on information in Table 1, negotiations with participating health plans reduced estimated premium expenditures by $19 million to $56 million each year (approximately $31 million annually on average). State health program reserves were used in seven of nine years to reduce program costs.

Request for Proposal (RFP). Subsequent to the enactment of the Affordable Care Act, the GIB sought input from state consultants on a wide array of policy options, including self-insuring the group health programs. In part, the GIB wished to make changes to the state's health plans so that the state could avoid paying certain taxes and fees that were mandated under the new law. Reports were issued in October, 2012, and August, 2013, by Deloitte Consulting. The October, 2012, report was an overview of the potential financial impact of self-insuring for medical benefits. The report estimated a range from $20 million in reduced costs (savings) to $100 million or more in increased costs. With regard to assumptions made in producing the estimates, Deloitte indicated that "As many of the above potential advantages and disadvantages to self-insured plans possibly offset each other, and whose financial impacts are dependent upon numerous assumptions and variables, it would be misleading to assign estimated savings or costs to any single factor. Rather, very broad estimates in aggregate across all such factors under a range of assumptions have been developed under upside and downside scenarios." The Board then issued a request for information from participating health plans to further determine the merit of a self-insurance model. Deloitte subsequently conducted a self-insurance advisability assessment and actuarial cost-benefit analysis based on the information provided by health plans. In its executive summary of the report, which was provided to the GIB for its August, 2013, meeting Deloitte indicated that "the current fully-insured arrangement operates under a unique and complex managed competition and tiering model. This model makes use of multiple HMOs and inherently drives competition between health plans to promote cost efficiency for the State. Without adequate safeguards and controls to maintain competition, the financial benefits to the State of the current model could be lost in changing to a self-insured arrangement." The report concluded:

> 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.
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> 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.
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> Finally, it should be noted that the short term “quick-wins” of a self-insured

arrangement need to be balanced against the potential long term risks of a self-insured arrangement. The risks range from uncontrolled utilization and trend increases to catastrophic claim events which could possibly be managed through reinsurance at a cost.

Thus, any move to a self-insured arrangement needs to proceed with caution, and particular attention paid to the drivers of claims experience as the State becomes liable for unexpected variances in costs. Consideration of the impact on the Local program also needs to be evaluated as part of the process.

It is important to note that this analysis provides a high level analysis of the advisability of a self-insurance arrangement and offers directional guidance into the areas that need to be further investigated through an RFP process to definitively conclude on the advisability of any form of self-insurance.

In 2014, two contracts were awarded to Segal Consulting in 2014 to serve as: (a) the consulting actuary for health insurance programs; and (b) a health care benefits consultant for health insurance programs. In March and November, 2015, Segal Consulting issued reports relating to the group health program. The November, 2015, report made various recommendations that included improving engagement in wellness and disease management. The Board approved solicitations for wellness and disease management programs and the development of a data warehouse, for which contracts have since been executed. The Board also directed ETF to issue a request for proposal (RFP) to evaluate self-insurance and regionalization for the health insurance program. The RFP was issued several months later in July, 2016, for which vendor proposals were due in September.

The process required vendors to submit responses including information relating to:

- the vendor's experience with public and private large group accounts and with administering self-insured benefits;
- a description of any acquisitions, mergers, or other material developments in the previous five years and upcoming three years;
- two years of audited financial statements;
- staff qualifications and customer service;
- data security including compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) security requirements;
- health provider management;
- provider reimbursement;
- medical and total health management;
- data integration and technology;
- a region designation;
- provider network; and
- network pricing, administrative fees, and capitation.

Following the submission of proposals in September, 2016, each vendor's proposal was scored: ETF staff conducted a technical evaluation accounting for 60% of the vendor's total score; and Segal conducted a financial evaluation accounting for 40% of the score. The state was divided into four regions, with pre-Medicare membership in the state totaling 206,208 overall and 3,379

members out-of-state. The regions were designated as: (a) Northern (8,123 members, 3.9%); (b) Western (21,024 members, 10.0%; (c) Eastern (63,762 members, 30.4%); and (d) Southern (113,299 members, 54.1%). A map of the four regions is shown in Attachment 1.

Self-Insurance and Regionalization Scenarios. On December 13, 2016, the GIB met to consider alternatives to the structure of the group health program and to decide what the structure of the program would be starting with the 2018 program year. In a December 8, 2016, memorandum to the GIB, staff of ETF outlined seven scenarios: (a) current program structure with up to 16 fully-insured plan vendors [Scenario 1]; (b) regionalized structure with seven to 11 fully-insured plan vendors [Scenario 2]; (c) regionalized structure with six to 10 fully-insured plan vendors [Scenario 3]; (d) regionalized structure with two self-insured plans that have statewide and nationwide networks, six to eight total vendors, and a mix of fully-insured and self-insured regions to be determined by the GIB [Scenario 4]; (e) regionalized structure with six total vendors and a mix of fully-insured and self-insured regions to be determined by the GIB, with negotiations in the Southern region limited to only two vendors [Scenario 5]; (f) regionalized structure with six self-insured vendors [Scenario 6]; and (g) a statewide self-insured structure with one to two vendors [Scenario 7]. With regard to Scenario 7, the memorandum noted that "ETF and Segal do not recommend this option."

Data Access Requirements. The December 8 memorandum specified that under all scenarios, including Scenario 1 to maintain the current program structure, non-negotiable reporting requirements would be implemented which would apply to participating health plans. Specific data submissions will be required regardless of whether the state maintains the program structure or transitions to self-insurance. Changes to 2018 program agreements with health plans, which were approved by the GIB on May 24, 2017, will require the following submissions to the data warehousing vendor: (a) data on payments made for benefits provided to ETF members, including claim payments made or denied, capitation or per-member payments, administrative payments, and payments made after coordinating responsibility with third parties; (b) data on other financial transactions associated with claims payments, including the charged amount, allowed amount, and charges to members such as copayments, coinsurance, and deductibles; (c) data on the providers of benefits; and (d) other data as specified by ETF. Data submitted would be required to meet the specifications of ETF's data warehousing vendor, which is currently under contract. Additionally, a participating plan must agree that financial penalties (up to 4% of the total administrative fee for the quarter) will be assessed if multiple submissions are called for due to unacceptable data quality. During initial implementation, two submissions would be allowed before a penalty would be charged. Once ongoing operation of the data warehouse is established, only the first submission would be free of charge; if corrective submissions were required, a charge would apply for each data file submitted. Charges would also apply due to failure to submit data or communicate to the data warehousing vendor in a timely manner.

Option to Delay Implementation. The December 8, 2016, memorandum from ETF also indicated that a decision could be made to implement one of the scenarios on a delayed schedule, such that some or all program changes would begin July 1, 2018, or January 1, 2019. The memorandum indicated that delaying implementation by six months to a year would allow "sufficient time for successful transition" including time to complete contracts, complete provider

network arrangements, and provide effective member communication. Specifically, the memorandum noted that "the Board could assume a phased-in approach and move forward with certain structural changes for 2018 (e.g. regionalization), and delay other significant changes such as self-insuring. This would provide the Board with an opportunity to evaluate the impact of a more aggressive tiering strategy, as well as other program changes already targeted for 2018 implementation." At the December meeting, the GIB announced that it would delay the decision and reconvene in January, 2017.

Letters of Intent Awarded. The Board reconvened on February 8, 2017, and announced that letters of intent would be issued to the following winning vendors under the structure outlined in Scenario 6 of the ETF memorandum: (a) Compcare Health Services, Anthem Blue Preferred (statewide/ nationwide); (b) Security Health (Northern); (c) Compcare Health Services -- Anthem Blue Priority (Eastern); (d) Network Health (Eastern); (e) Quartz (Southern); (f) Dean Health Plan (Southern); and (g) HealthPartners (Western).

The Governor's budget recommendations included an assumption that savings of $60 million GPR would be realized over the 2017-19 biennium under the GIB proposal. Funding that would have otherwise been provided to the University of Wisconsin System for health insurance expenses was reduced by $9,853,000 GPR in 2017-18 and $19,705,900 GPR in 2018-19; and a lapse from compensation reserves for other state employees was assumed in the general fund condition statement in the amount of $10,147,000 GPR in 2017-18 and $20,294,100 GPR in 2018-19. Additionally, certain provisions relating to per pupil aid increases for elementary and secondary school districts were made conditional upon the Committee's decision to approve contracts to self-insure for the state employee group health program. A more detailed discussion of the budget provisions and alternatives to the provisions are provided in a separate budget paper which may be addressed at an executive session relating to budget management and compensation reserves.

SELECTED CONTRACT PROVISIONS

The provisions of the contracts are generally uniform, with the exception of the names of the vendors and information relating to Medicare Plus coverage under the statewide vendor contract. Following are several contract provisions that may be worth noting. In considering alternatives, the Committee may choose to approve one or more contracts without approving all contracts. Additionally, the GIB requested special consideration for the statewide contract, otherwise known as the standard plan or It's Your Choice Access plan. Specifically, the GIB indicated in a May 26, 2017, letter to the Committee that "Failure to act in a timely manner jeopardizes ETF's ability to negotiate a new contract and ensure an insurance provider is available in all corners of Wisconsin and to our retirees around the country."

As noted in a subsequent section of this paper relating to benefits covered, the distinction between the standard plan and other plans would consist mainly of the provider networks that would be available under the plans. Since the GIB approved a decision to make benefits covered under the standard plan match the coverage specified in uniform benefits, covered benefits would not differ between plans except where indicated relating to Medicare Plus coverage. The regional contracts would not provide Medicare Plus coverage. This is consistent with current practice, as

Medicare Plus coverage is only offered through the It's Your Choice Access plan and not Tier 1 plans currently offered through HMOs.

Eligible Members. Although they are not explicitly identified, the GIB intends for active local government employees to be eligible employees. Therefore, if the Committee approves any of the contracts, it could specify that the contract language be amended to include active local government employees as eligible employees. [Alternative B1]

Term Length. Each of the contracts provides for a three-year initial term with three renewal options for two-year periods each. If contract renewal options were exercised, each contract could be maintained for up to nine years in total. If the Committee wishes for the contracts to be approved for three years only, it could choose to specify that the language providing three contract renewal options for two-year periods each be deleted from the approved contract or contracts. [Alternative B2]

Regions. As noted above, the state would be divided into four regions: Northern, Eastern, Southern, and Western. The regional vendors would be required to provide coverage to the entire designated region. The Department of Employee Trust Funds indicates that members would be permitted to select the vendor of their choice, which would not be limited to the region in which the individual lives or works. The contracts do not specify that a member can or cannot enroll in a plan based on their place of residence. However, the contracts do note that in some cases Medicare does not allow an enrollment due to a participant's residence in a given area. While the vendors must operate within applicable limitations determined by federal agencies, the Committee could specify that, in general, a member could choose a plan in a region in which they do not reside or work (that is, unless otherwise specified in federal law). [Alternative B3]

Premium Payments and Tiers. The contracts specify that the GIB would determine premiums for the self-insured benefit plans. Specifically, the premium would be established after reviewing claims experience, trends, and other factors in consultation with the consulting actuary (currently Segal). While the contracts indicate that state employers' contributions toward premiums for state employees would be based on a tiered structure, as outlined under s. 40.51(6) of the statutes, the contracts do not indicate which tier or tiers the proposed vendors would be placed in or the amounts that would be charged to employers or employees in calendar year 2018. The Board typically determines in which tiers specific plans should be placed later in the year, prior to open enrollment. The Department of Administration's Division of Personnel Management determines the amounts that state employers and employees will contribute, subject to an 88% maximum contribution for state employers. The maximum contribution also applies to local governments that participate in a group health program administered by ETF.

Medicare Plus Coverage. Under the statewide vendor contract, Compcare Health Services (Anthem Blue Preferred) would also provide Medicare Plus coverage. This would be a continuation of past practice, as the current statewide vendor for the standard plan also administers the Medicare Plus plan.

POINTS OF CONSIDERATION

Constitutionality. Some have raised questions regarding the constitutionality of offering self-insured health plans to local governments. This is based upon a 1987 opinion of the Wisconsin Attorney General. In response to those questions, the Legislative Council staff provided background and analysis which read, in part:

> 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.]
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> 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.]
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> 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.
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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.

In response to concerns relating to this issue, ETF prepared a legal opinion on the subject. Attorneys for ETF indicated in response to the question of whether the 1987 AG opinion prohibits GIB from establishing a self-insured program for local governments through the Wisconsin Public Employer (WPE) program:

> "No. GIB authority to establish a self-funded health insurance program for local governmental employees whose employers choose to participate in the WPE program is found in the plain language of Chapter 40 of the Wisconsin Statutes. Specifically, Wis. Stat. §40.03(6)(a)2. states that the GIB may provide any group insurance plan on a self-insured basis for insured employees. "Insured employee" is defined in state law to include eligible employees based on a local governmental employer's participation in the WPE program. Wis. Stat. §§40.02(39) & 40.02(25)(b)9.
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> With respect to the 1987 A.G. opinion requested by the Office of the Commissioner of Insurance, its analysis was incomplete in concluding: (1) the language in Wis. Stat. §40.03(6)(a)2. limits the GIB to providing a group insurance plan on a self-insured basis on behalf of the state, and the state does not include municipal employers; and (2) that such an

interpretation avoids creating the potential issue of the state taking on the obligation of paying the debt of another, which would be prohibited by article VIII, section 3 of the Wisconsin Constitution.

Regarding a potential constitutional issue, the opinion did not conclude that establishing a self-funded plan as an option to local governmental employers was unconstitutional. It only identified the issue. Based on how the Wisconsin Supreme Court has previously defined the word "debt," it appears establishing such a plan would not, in fact, raise such a concern. In particular, the Court defined the word debt for purposes of article VIII, section 3 to mean the state taking on absolute obligations to pay money or its equivalent.[1]

Under the current fully-insured model, the Department of Employee Trust Funds (ETF) maintains separate health insurance reserve accounts for state employees and local governmental employees.[2] Under a self-insured model, those two separate reserves, one for state employees and one for local governmental employees, would continue.[3] The WPE self-funded reserve would be a continuation of the already existing fully-insured reserve. Under a self-funded model, that reserve would continue to receive contributions via ongoing employer and employee premiums. As in all self-insured plans, if claims experience outpaced the continued build-up of funds in the reserve, adjusting premiums would be one of a number of considerations.[4] Based on these protections, the state would not be taking on an absolute obligation to pay money or its equivalent for a WPE self-insured plan.

Also, it is significant to note that the GIB already provides self-insured coverage to local governmental employees through the Its Your Choice Access Health Plan and State Maintenance Plan, a pharmacy benefit program, and the uniform dental benefit program.

In addition to failing to fully analyze the plain language of Chapter 40, Wisconsin Supreme Court precedent, and note that the local employer plan is separately funded, the 1987 opinion did not distinguish between the statutory language related to the GIB authority to establish fully-insured plans and the GIB authority to establish a self-insured plan. Both reference the GIB as "acting on behalf of the state." While the A.G. opinion uses that language to support its conclusion that the GIB cannot establish a self-insured plan for local governmental employers, the opinion does not address how that same language does not restrict the GIB from establishing fully-insured plans for local governmental employers as well.[5]"

[Footnoted citations omitted.]

Some have also raised questions regarding the possibility of exhausting program reserves if costs exceed anticipated expenditures and funding set aside for such purposes. With regard to this possibility, staff of ETF indicate that health program reserves are established at a level intended to prevent the depletion of funding and that ETF and Segal would track incoming claims, incoming premium equivalents, and outgoing expenditures throughout the year. Staff further indicate that if trends in expenditures indicated that the reserves and incoming premium were insufficient and required emergency action, the means to address the imbalance would likely be a mid-year premium increase. This could apply to a situation that could arise for either the local program or the state program, to prevent a deficit and to prevent transfers from other fund sources. However, the financial management of the state and local programs would be accounted for separately.

Required Benefits for Self-Insured Plans. In reviewing differences in providing health care coverage for state employees under a self-insured versus fully-insured plan, Legislative Council

staff indicated that if the state self-insures for employee group health plans, coverage of certain benefits that health insurance companies are required to cover under state statute would not be required of the state's plans. Specifically, compliance with the following insurance mandates would not be required.

- treatment by a non-physician provider or an optometrist if the service is covered when performed by other covered providers [s. 632.87(1) to (2m)]
- coverage for an adult child with an intellectual or physical disability [s. 632.88]
- coverage for home care [s. 632.895(2)]
- coverage for skilled nursing care provided in a licensed skilled nursing care facility [s. 632.895(3)]
- inpatient and outpatient treatment for kidney disease [s. 632.895(4)]
- coverage for a newborn infant [s. 632.895(6)]
- treatment for and management of diabetes [s. 632.895(6)]
- maternity coverage [s. 632.895(7)]

Changes to Standard Plan (Access Plan). In a December 9, 2016, memorandum to the GIB for consideration at its December 13 meeting, ETF staff recommended pursuing a strategy to modify the It's Your Choice Access plan (the standard plan) to reduce the premiums charged to members and employers by aligning benefits covered with uniform benefits that apply to other plans and by implementing "a meaningful differential between in-network versus out-of-network out-of-pocket costs in order to steer care in-network." The memorandum indicated that this approach could allow the GIB to offer a plan with a statewide and nationwide provider network that would be cost-effective and which could be placed in Tier 1. The Board approved the pursuit of the program change for 2018 at its February 8, 2017, meeting.

Benefits Covered. In addition, at the GIB's May 24, 2017, meeting several changes were approved relating to 2018 health benefit program agreements, which were outlined in a May 17 memorandum from ETF staff to the GIB. Several changes would be prospective and would only apply if the state self-insures. Other changes would be made to the program regardless of the structure of the program. The modifications to uniform benefits that would be made only if the state self-insures are: to remove a limitation on the number of organ transplants an individual may receive per organ (currently, each participant has a lifetime limit of one transplant per organ); remove an exclusion relating to "retransplantation or other costs related to a failed transplant that is otherwise covered under the global fee;" and specify that, in accordance with federal law, third-party administrators (vendors) would be required to use a federal external review process rather than the independent review organization process specified under s. 632.835 of the statutes. Changes to uniform benefits that would not depend on a decision to self-insure include: to specify that re-enrollment options may be limited under the GIB's authority (replacing language that states a change to plan choice is available during the open enrollment period); to delete language requiring participant-requested biometric screening provided annually at no cost to the participant (ETF indicates that this would be covered by other preventive service coverage language and that biometric screenings provided by on-site events are "only available through sole-source vendor"); various changes to "clarify information for members and align benefits with 2017 contract;" and to clarify the definitions of "dependent" to specify a permanent legal ward and "subscriber" to include annuitants (not just employees).

2018 Benefits. At its May 24, 2017, meeting the GIB approved uniform benefits for 2018 as recommended by ETF staff. Those benefits are essentially the same benefits that are provided to employees in 2017. It should be noted that the GIB has, by statute, discretion over the determination of uniform benefits covered by the health program. Under s. 40.03(6)(c) of the statutes, the GIB may modify or expand benefits under any group insurance plan if "the modification or expansion is required by law or would maintain or reduce premium costs for the state or its employees in the current or any future year." Thus, although uniform benefits for 2018 were approved by the GIB at its May 24, 2017, meeting, benefits for 2018 could be modified by the GIB after the program year starts on January 1, 2018. For example, under this authority, the GIB amended uniform benefits for the 2017 program year on December 30, 2016, to exclude certain benefits from coverage. This authority would continue to apply under both a fully-insured or self-insured program.

DISRUPTION ANALYSES

Analyses Conducted. Segal's financial evaluation of the vendor proposals included several disruption analyses. The purpose of a disruption analysis is to identify the extent to which individual members and providers might be affected by changes to provider networks to which members would have access. For example, if a member has a primary care doctor that he or she sees regularly, and the doctor would not be available in any of the proposed networks, it is assumed the member would need to select a different doctor and would, therefore, experience a degree of disruption in medical care. It should be noted, however, that the analyses performed by Segal include all types of providers, including specialists and ancillary providers such as labs and physical therapists. A summary of the analyses is provided for the Committee's reference.

Table 2 provides estimates of the percentage of members, claims, dollar amounts of claims, and providers that would be disrupted by the change in provider networks that members would have access to under the proposal. The analysis is provider-based and based on 12 months of actual claims data; if a member was seen by a provider during the 12-month period and the provider would no longer be in one of the available networks, the visit to the provider would be counted, as would the member, the number of claims, and the dollar amount associated with the claim. As shown in Table 2, most providers (97.9%) would be available in the proposed networks. The claims data analyzed by Segal show that approximately 3.7% of members could experience disruption associated with the 2.1% of providers that would not be available.

TABLE 2

Self-Insurance Disruption Analysis
Prepared by Segal -- All Vendors

Region	% of Members	% of Claims	% of Claim $s	% of Providers
Eastern	4.6%	1.1%	0.6%	3.7%
Northern	1.7	0.8	0.6	2.2
Southern	4.1	1.1	0.4	2.3
Western	0.3	0.1	0.0	0.3
Total	3.7%	1.0%	0.4%	2.1%

In response to concerns regarding the potential premium price to employees for choosing the statewide network, which is unknown at this time (as are the prices of other vendors), an additional analysis was performed to illustrate the degree of disruption that might be experienced if the statewide vendor and its provider network were removed. As shown in Table 3, if providers in the statewide vendor network were not available, approximately 19.2% of members could experience disruption.

TABLE 3

Self-Insurance Disruption Analysis
Prepared by Segal -- Without Statewide Vendor

Region	% of Members	% of Claims	% of Claim $s	% of Providers
Eastern	30.9%	15.6%	10.7%	24.8%
Northern	12.1	4.9	2.5	9.7
Southern	15.0	5.9	3.7	9.7
Western	11.7	5.8	2.0	8.6
Total	19.2%	8.9%	5.8%	13.5%

Attachment 2 to this paper provides a third disruption analysis conducted by Segal that shows a provider-based listing, by county, of the number of providers, members, and unique claims (such as for a provider visit or diagnostic test) that are estimated to be disrupted under the proposal.

HEALTH PROGRAM RESERVES

Reserves Policy. The Group Insurance Board approved a program reserves policy in August, 2011, recommended by the state's health program actuary at the time, Deloitte Consulting, to maintain a fund balance that equals 15% to 25% of the sum of: (a) 100% of annual self-funded medical claims; and (b) 20% of annual fully-insured medical claims. The policy has not been modified since its adoption in 2011.

Reserves Under Current Structure. Table 4 provides the actual amounts of year-end reserves (2016 figures are unaudited) for the past five calendar years and the estimated amount of year-end reserves that would correspond to the GIB reserve policy based on actual or estimated medical claims expenses for the same years. Amounts are shown separately for state plans and local plans, for which revenues and expenses are maintained separately. As shown in the table, as of the end of calendar year 2016, program reserves for state plans were 28.6% of the claims benchmark, which exceeds the maximum reserve policy of 25%. The local program, in comparison, ended 2016 with approximately 19.8% of the claims benchmark, between the recommendation of 15% and 25%.

TABLE 4

Health Program Reserves for State and Local Group Health Programs, Calendar Years 2012 to 2016 ($ in Millions)

	Calendar Year				
	2012	2013	2014	2015	2016
State Program					
Claims Benchmark*	$430.8	$449.0	$481.6	$502.2	$504.0
Year-End Reserves	140.8	129.8	100.1	81.5	144.4
Reserves as % of Claims	32.7%	28.9%	20.8%	16.2%	28.6%
Local Program					
Claims Benchmark*	$70.8	$72.2	$77.9	$81.4	$76.5
Year-End Reserves	18.8	21.1	16.3	9.0	15.2
Reserves as % of Claims	26.6%	29.3%	20.9%	11.1%	19.8%

*Benchmark established in August, 2011, is 100% of actual self-insured claims and 20% of estimated fully insured claims.

Planned Reserves for Self-Insurance. The state's consulting actuary for health programs, Segal, recommended that the GIB not utilize program reserves to reduce state health program costs in calendar year 2016 and calendar year 2017. In developing 2016 state rates, Segal projected that program reserves at the end of calendar year 2015 would be approximately 18%, which would be closer to the minimum reserve policy of 15%. Table 4 shows that actual year-end program reserves for the state in 2015 were approximately 16%. On August 16, 2016, Segal again recommended to the GIB that program reserves not be used to reduce state health program costs for calendar year 2017. However, in contrast to the prior year, Segal projected that year-end state health program reserves in 2016 would be "approximately 29% of claims and outside of the 15-25% corridor." In its August, 2016, presentation Segal further noted that:

> Given this is a year of good experience for the overall program, particularly with the low renewals on the medical side, we recommend not implementing a buy-down this year and maintaining the cash for future years. With the potential move to self-insurance in 2018, this will also provide a solid starting reserve.

Reserves Under Proposal. Table 5 provides an estimated claims benchmark for the state and local programs using Segal's midpoint medical claims expense estimate (which does not include members covered by Medicare), actual calendar year 2016 pharmacy and dental claims, assumed growth in claims costs of 1.6% in 2017 (overall premium increase) and 7% in 2018 (the sum of Segal's midpoint estimates for medical trend and medical CPI), and corresponding figures for 15% to 25% reserves under the assumption that the state would self-insure for all group health plans. The claims benchmark is significantly higher than under the current program structure, shown in Table 4, due to the increase from reserving based on 20% of fully-insured medical claims to reserving based on 100% of self-insured medical claims. It should be noted that claims could be higher than shown, given that claims for members covered by Medicare were not included in the self-insured medical claims estimates. Claims expenses could also be higher or lower due to other

variations from assumptions used here and in Segal's analysis. [The analysis conducted by Segal is described in more detail in a later section of this paper and summarized in Table 7.]

Based on the estimates shown in Table 5 relative to year-end reserves in 2016, the state program would need an additional $47.2 million in reserves to reach the 15% reserve policy for 2018 program expenses. The local program would need more than twice the year-end 2016 reserve to reach 15% of estimated program expenses, an increase of approximately $17 million.

TABLE 5

Group Health Programs, Estimated Reserves Needed to Self-Insure Based on GIB Policy ($ in Millions)

State Program				
Claims Benchmark*		2016 Reserve	15% Reserve	25% Reserve
Medical**	$986.4			
Pharmacy	233.2			
Dental	57.7			
Total Claims	$1,277.4	$144.4	$191.6	$319.4
Local Program				
Claims Benchmark*				
Medical**	$174.1			
Pharmacy	38.9			
Dental	1.2			
Total Claims	$214.2	$15.2	$32.1	$53.6

*Benchmark equal to 100% of estimated claims. Segal's midpoint medical claims estimate of $1,160.5 million is allocated to the state program (85%) and local program (15%). Pharmacy and dental are based on 2016 claims, assuming 1.6% growth in 2017 (final premium increase) and 7% growth in 2018 (the sum of Segal's midpoint estimates for medical trend and medical CPI). ** Medical claims based on Segal's midpoint estimates do not include members covered by Medicare.

MARKET ANALYSIS

Regionalization. The Group Insurance Board has not made a final determination regarding its course of action if the Committee does not approve the contracts to self-insure. Instead, the GIB directed ETF staff at its May 24, 2017, meeting to proceed with soliciting bids from health plans under the current program model as well as requesting bids to administer fully-insured health plans on a regional basis (as outlined in the proposal to self-insure). However, the GIB has indicated that it would seriously consider pursuing regionalization on a fully-insured basis and may consolidate health insurance purchases with fewer insurers, to realize cost efficiencies from lower premiums. Several members of the GIB have cited, as a reason for pursuing consolidation with fewer lower-cost health plans, the tendency of health plans to be placed in Tier 1 regardless of the premium paid by employers. Tier 1 is the lowest-cost tier of three tiers designated in statute for employees' share of health insurance premium contributions. However, the Board's concern is that premiums within Tier 1 vary widely. In 2017, single coverage for the state program ranges from $652 to $880

per month (including both employer and employee contributions), while family coverage ranges from $1,606 to $2,175 per month. Additionally, the GIB argues that by reducing the number of vendors, the state could realize savings associated with: (a) lower provider prices negotiated by vendors using leverage gained by higher volumes of state group health program members; and (b) lower administrative expenses paid to vendors on a per-member basis.

Effect of Competition on Price. Two main concerns have been raised regarding the pursuit of consolidation: (a) the policy could reduce member choices and potentially disrupt the continuity of health care services that employees and their families receive; and (b) consolidation of the state's programs with fewer insurers could reduce competition through increased market share for the insurers remaining in the program. [A third concern not specific to consolidation, and which relates to a self-insured model only, could be raised regarding the effect that the transfer of risk from insurers and providers to the state could have on incentives to manage and contain health care usage and other cost increases. This issue is addressed in a subsequent section.]

Some have observed that among the lowest-cost, high quality health plans that currently participate are smaller local insurers that would not be able to cover an entire region. Transitioning to a regionalized model with fewer and larger insurers could ultimately lead to restructuring of the insurance market in the state and higher prices being eventually charged to state employers, other public and private employers, and individuals. When market competition is reduced, prices can be increased independent of actual costs to the companies. Economists, business analysts, and the U.S. Department of Justice (U.S. DOJ) have observed that if consumers have fewer options available, producers can charge more for products and services. Other consequences could include reductions in service availability or quality. If the state adopts the self-insurance proposal or the proposed alternative to consolidate the state's business with fewer health insurers, the policy change could increase the market share of the participating vendors within the state's boundaries. This could, in turn, result in increased health insurance prices in the state.

While a projection of the potential long-term impact on prices resulting from state employee group health program policies is beyond the scope of this paper, the following analysis compares the health insurance market of Wisconsin to other states with respect to competition between insurers (as of 2015, the most recent year of data available).

Measuring Competition. There are a variety of methods for measuring the level of competition in a given market. This analysis utilizes a measure described by the Horizontal Merger Guidelines published by the U.S. DOJ and Federal Trade Commission (FTC) in 2010, the Herfindahl-Hirschman Index (described below). The publication documents "the principal analytical techniques, practices, and the enforcement policy" of the agencies in enforcing federal antitrust laws and evaluating proposed horizontal mergers (mergers and acquisitions involving actual or potential competitors). The guideline cautions that "merger analysis does not consist of uniform application of a single methodology." The analysis provided here, likewise, is only one of several analytical methods.

It is important to note that the contracts to self-insure that are under consideration by the Committee do not constitute a merger or acquisition of businesses. However, a review of the

comparability of the health insurance market in Wisconsin to health insurance markets in other states, particularly regarding market competition may be merited. This analysis is intended to serve as a comparison of the level of market competition in this state relative to other states.

Market Comparison of States. Using medical loss ratio data submitted by health insurers to the federal Centers for Medicare and Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight to estimate market share for insurers in each state, the Herfindahl-Hirschman Index (HHI) formula can be applied to approximate a measure of market concentration. This is one of the indicators outlined in the merger guidelines noted above. The index is calculated by summing the squared market shares of individual firms in a market. For example, if a market consists of only two firms, each with 50 percent, the resulting index value would be the sum of 2,500 and 2,500 (5,000). As a result, the index ranges from values approaching zero (close to perfect competition, small percentages squared and summed) to 10,000 (a pure monopoly with 100 percent market share). In comparing state health insurance markets using CMS data, a number of reported figures could be used to estimate insurer market share. This analysis utilizes the following two measures: (a) the percentage of covered lives by insurer as a share of total lives covered in the state; and (b) the percentage of direct written premiums by insurer as a share of total direct written premiums in the state. A brief summary of the analysis conducted is provided in Table 6. As shown in the table, Wisconsin would be considered most competitive (least market concentration) of the 50 states based on both measures: the distribution of covered lives and direct written premiums for the year. Attachment 3 identifies the calculated HHI measures for all states.

TABLE 6

Comparison of Top Five and Bottom Five State Health Insurance Market Competition Levels, Calendar Year 2015

Index by Covered Lives			Index by Direct Written Premiums		
Rank	State	HHI Total*	Rank	State	HHI Total*
1	Wisconsin	563	1	Wisconsin	584
2	Pennsylvania	599	2	New York	643
3	New York	619	3	Pennsylvania	827
4	Georgia	690	4	Georgia	1,111
5	Florida	692	5	Florida	1,123
45	Arkansas	4,067	45	North Dakota	4,853
46	Alabama	4,177	46	North Carolina	4,897
47	Iowa	4,233	47	Montana	4,906
48	North Dakota	4,245	48	Vermont	5,329
49	Idaho	4,448	49	Alaska	5,335
50	Vermont	4,960	50	Alabama	7,985
Average (50 States)		1,957	Average (50 States)		2,948

*Calculated based on CMS data and percentage shares of state totals for each insurer.

Other States that Self-Insure. The administration and the GIB have cited research conducted by the National Conference of State Legislatures (NCSL) regarding the number of states that self-insure for all or part of their state employee health benefit programs. In its February and May, 2017, letters to the Committee relating to the self-insurance contracts, the GIB referenced the study, indicating that 46 states fully or partially self-insure their employee health benefit programs. Attachment 4 to this paper provides a list of the states reported in the document published by NCSL, which was a report of programs as of 2010. As shown in the attachment, Wisconsin is one of the 46 states listed. Currently, the state self-insures for the standard plan, state maintenance plan, pharmacy benefits, and dental benefits. The four states not listed are: (a) Iowa; (b) Maine; (c) New York; and (d) North Dakota. An attempt was made to provide an updated report of fully and partially self-funded states. However, states provide varying benefit offerings to different groups of state employees, such as law enforcement, corrections officers, and university staff. Due to challenges in completeness and availability of information, an updated list is not provided.

RISK ANALYSIS

Risk Premium. In its May 8, 2017, letter to the Committee, GIB indicated an estimate of 1% to 2% of program costs may be associated with risk premium. While attention has been directed to the expense associated with insurers assuming risk for the state, the state's actuary has indicated the primary sources of savings under the proposal would be medical claims (approximately $49.5 million per year for the entire program) and administration (approximately $35.7 million per year for the entire program). Risk premium would not be considered a medical expense. Therefore, it could be assumed that the administrative savings would include the elimination of a risk premium.

Stop-Loss Insurance. Some members of the Committee have expressed an interest in the cost to the state to purchase a stop-loss insurance policy if the state does self-insure for the purpose of limiting the risk of large, unexpected claims. In its May 8, 2017, letter to the Committee, the GIB indicated that Segal had estimated such coverage could cost as much as $4 million per calendar year corresponding to a $1 million attachment point. [In the context of stop-loss insurance, an attachment point is the point at which an excess insurance or reinsurance limit would apply. If an annual attachment point of $1 million applied to aggregate claims per individual, the stop-loss policy would cover annual losses over $1 million associated with each specific individual.] In the letter, GIB indicates that Segal "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." Further, the letter indicates that "more precise estimates would require a formal bid process with stop loss insurance carriers."

Administrative Fees. Based on information provided by ETF and Segal, under the contracts, administrative fees would be determined based on a per member per month fixed amount that would vary by vendor. As a result, actual enrollment figures would affect final determination of administrative fees. The amounts that would be paid to the vendors for administrative fees were redacted from the contracts which were presented to the Committee for competitive negotiation purposes. The calculations and estimates of vendor fees were not made available for review and, therefore, could not be evaluated.

Medical Costs. Segal provided a description of the basis for self-insured claims cost estimates. Actual medical claims data for group health program members that corresponded to a 12-month period (April, 2015, to March, 2016) was submitted by participating health plans, excluding HealthPartners (which cited Minnesota law in declining to provide the data). The claims data included line item detail, such as the number of specific procedures performed by each provider. The claims lines were then "repriced" using pricing and discount data that proposed vendors provided in response to the RFP. Since the pricing and discounts submitted are considered proprietary and confidential, they cannot be disclosed or shared. [Therefore, an evaluation of the calculations and estimates for claims expenses cannot be provided.]

Savings Projected. The consulting actuary estimated savings under three sets of assumptions: (a) medical trend of 6%, medical loss ratio of 92%, and medical inflation of 2.5% ["high" savings]; (b) medical trend of 5%, medical loss ratio of 93%, and medical inflation of 2.0% ["midpoint" savings]; and (c) medical trend of 4%, medical loss ratio of 94%, and medical inflation of 1.5%. Table 7 shows the actuary's estimates of savings based on the source of anticipated cost reduction: claims expenses, administrative expenses, and a "regional" adjustment that is primarily attributable to claims expenses. Segal's baseline estimates under a fully insured model, shown in Table 7, were made available for review, while the estimates for expenditures under the self-insured proposal were not.

TABLE 7

Savings Estimates and Assumptions under Self-Insurance Proposal for State and Local Programs, All Payors ($ in Millions)

	"High" Estimate			"Midpoint" Estimate		
Expense Type	Fully Insured	Self-Insured	Difference	Fully Insured	Self-Insured	Difference
Claims	$1,222.5	$1,168.9	-$53.6	$1,196.9	$1,160.5	-$36.4
Administration	104.6	55.2	-49.4	89.3	53.6	-35.7
"Regional" Adjustment*	26.1	13.0	-13.1	26.1	13.0	-13.1
Total	$1,353.2	$1,237.1	-$116.1	$1,312.3	$1,227.1	-$85.2

	"Low" Estimate		
Expense Type	Fully Insured	Self-Insured	Difference
Claims	$1,171.3	$1,152.2	-$19.1
Administration	73.9	52.4	-21.5
"Regional" Adjustment*	26.1	13.0	-13.1
Total	$1,271.3	$1,217.6	-$53.7

Cost Assumptions	High	Midpoint	Low
Medical Trend	6%	5%	4%
Medical Loss Ratio	92	93	94
Consumer Price Index	2.50	2	1.50

Estimates shown were prepared by Segal, GIB's consulting actuary.
*Regional adjustment refers to lower expenses anticipated due to higher discount rates submitted by Quartz for counties in the LaCrosse area.

Table 7 shows that the share of Segal's estimated savings associated with claims versus administration varies depending on the assumptions. Additionally, overall savings under each set of assumptions as a percentage of total baseline expenses are: 8.6% (high); 6.5% (midpoint); and 4.2% (low). These figures would correspond to assumptions that the state would self-insure and assume full risk for medical claims that are assumed to comprise: 92% of program costs ("high" savings assumption); 93% of program costs ("midpoint" savings assumption); and 94% of program costs ("low" savings assumption).

Recent Health Plan Submissions. As indicated by Segal in a presentation to the GIB at the Board's May 24, 2017, meeting, health plans participating in the state's group health program have been operating at an unusually efficient level. First, reports by plans of actual medical claims expenses in calendar year 2016 were lower than previously expected. Second, the plans report currently operating at an overall medical loss ratio of 96.5%, meaning that only 3.5% of premium expenses paid by the group health program is associated with administrative costs including profit. The actuary indicates that this ratio is much higher than the industry standard, and that the GIB should expect the ratio to return to 93% (7% administrative expenses). In part, this is the reasoning for Segal's projection of higher than usual premium increases.

The information presented relating to recent health plan performance and financial management, however, could be interpreted in other ways. For example, lower medical claims costs could be the result of effective health care coordination and management of risk by insurers. Likewise, a high medical loss ratio may represent administrative efficiency.

Incentives and Risk Transfer. Under the current program model, health insurers assume the risk for medical claims. If the percentage of medical claims expenses in an average year is approximately 93% of the premium paid by the state, fully-insured health plans are currently managing the risks associated with a substantial share of total program costs. Currently, the incentive for health plans to contain medical costs is proportionate to the cost to the plans if medical costs increase. Additionally, health insurance premiums for the plans are determined prior to the start of a year. The amount the program pays does not change during the year if prices or usage of medical services exceed estimates. The administration and the GIB have argued that this is a weakness in the program: if costs are higher than expected, insurers will make up the loss the next year through increased rates; if costs are lower than expected, insurers retain the difference.

On the other hand, participating health plans are currently required to submit very detailed data regarding actual medical claims expenses and administrative expenses each year, prior to the start of negotiations. Based on this information, the consulting actuary works with ETF staff to determine which demands are reasonable or credible, and which are not. Second, the participation of as many as 17 plans ensures that the state can maintain a firm position on price when appropriate, as other options exist. If the state transitions to a structure with fewer insurers that cover larger service areas, the state's ability to deny unreasonable cost increases could be reduced, as there would be fewer insurers with sufficient capacity to be selected as an alternative. Under the current program structure, health insurers are highly motivated to lower costs and manage the provision of health care services efficiently for two reasons: (a) they bear the entire risk associated with medical costs, which Segal estimates are 93% of program costs; and (b) as noted above, they operate in one of the most competitive health insurance markets in the country.

Additionally, the outcome of final fully-insured premium increases depends on health plan preliminary bids, negotiations, and the management and use of reserves as the GIB generally deems appropriate. While the final increases that the state would pay if the program is not restructured are not known at this time, ETF staff has a demonstrated record of conducting effective negotiations. A review of actual premium increases over the past nine years (provided in Table 1) shows that program management has contained cost increases at rates below the health insurance market nationally.

Fees at Risk, Discount Guarantees, and Gain Sharing. The administration indicates that incentives for vendors to contain costs and meet performance measurements are provided in the self-insurance contracts through fees at risk and gain sharing provisions.

First, regarding discount guarantees, Exhibit B of each self-insurance contract sets a 2018 "discount target" that is calculated by vendors based upon enrollment and regional assumptions. The contracts indicate that "Upon open enrollment, these will be re-based accordingly." The contracts also indicate that actual performance relative to discount targets would be calculated six months after the end of the calendar year. The consequence to a vendor of not meeting its discount target would be to reduce up to 10% of the vendor's total administrative fees. Based on Segal's cost estimates shown in Table 7, administrative fees that would be paid to vendors are estimated to total between $52 million and $55 million per calendar year. At most, fees at risk would total $5.5 million based on these estimates (10% of $55 million). In comparison, estimates for medical claims, also shown in the table, are estimated to total $1.15 billion to $1.17 billion. If medical claims expenses in a given year exceeded the actuary's estimates by 5% (under low savings assumptions) to 10% or more (under high savings assumptions), the proposal could ultimately increase rather than decrease program costs. If increases of 15% or more were to occur, the level of reserves may not be sufficient to manage costs without a mid-year correction. As shown in Table 5, this could potentially be a significant challenge for the local program.

Second, the outline of a gain sharing model is provided in Exhibit B of the contracts. The gain sharing model provides an additional incentive for financial performance where the vendor is rewarded with a percentage of savings that depends on the "target PMPM" (per member per month rate). The target PMPM would be set by March 1 each year and would be based on prior year incurred claims with "current year enrollment, adjustment for network pricing, completion factors and trend." No savings would be shared if the PMPM were improved (reduced) by less than 3%. If the percentage PMPM below the target were between 3% and 6%, the vendor would receive 5% of savings. If the PMPM reduction were over 6%, 10% of savings would be shared.

SUMMARY

The Group Insurance Board argues that the contracts to self-insure for group health plans would: (a) lower administrative and medical claims costs; (b) maintain access to most providers currently available to employees and retirees; (c) maintain benefits covered by the program; and (d) minimize cost increases to state employees. Therefore, the Committee could approve any or all of the contracts to self-insure. [Alternatives A1 through A7] Attachment 5 to this paper includes a

listing provided by ETF of the major health providers, such as hospitals and clinics, that potentially would be available under each of the seven vendors.

The Committee could additionally consider several modifications to the contracts, such as specifying that active employees of local governments would be eligible members to participate [Alternative B1]; deleting three contract renewal options for two-year periods each [Alternative B2]; and specifying that a member may select a vendor in a region in which they do not reside or work, unless otherwise specified in federal law [Alternative B3].

On the other hand, while administrative and medical claims costs could be reduced under a self-insured program, costs could also be increased. If the state self-insures under the proposed model or, alternatively, consolidates the state's business with fewer health insurers, the policy change could increase the market share of the participating vendors within the state's boundaries. The most significant risk to self-insuring the state health program is the potential for reducing health plan vendor and provider incentives to contain cost. If the state assumes the program's financial risk for medical claims, which in 2017 comprise approximately 96.5% of total program costs, the likelihood that current incentives could be reduced as a result may be a cause for concern. Because insurers keep savings when generated (potentially all savings, not up to 10%) and because insurers incur financial losses when costs exceed estimates (potentially all losses, not limited to 10% of administrative fees, which are estimated at 7% of program costs), it could be argued that the most effective incentive structure for administration of health care is through competitive negotiations with fully-insured plans.

In addition, although uniform benefits for 2018 were approved by the GIB at its May 24, 2017, meeting with few modifications to 2017 benefits, the GIB has sole discretion over the determination of uniform benefits covered by the health program, which it may choose to modify if it would maintain or reduce premium costs for the state or its employees in the current or any future year. As noted previously, certain requirements in state law to cover benefits that apply to insurers would not apply to the state's plans if it self-insured. Further, staff to GIB has indicated that if health program reserves are depleted, the means by which an imbalance might be addressed would be to increase premiums charged to employees. Therefore, the Committee could deny the request. [Alternative C1]

The decision before the Committee is approval or rejection of the contracts with third-party administrator vendors to self-insure for group health plans on a statewide and regional basis. The Committee may approve one or more contracts without approving all contracts. Additionally, the Committee may specify that approval is conditional upon one or more modifications to the contracts. If the Committee does not approve the contracts, the GIB may not execute them.

As noted previously, the GIB has not made a final determination regarding its course of action if the Committee does not approve the contracts to self-insure. The Board directed ETF staff at its May 24, 2017, meeting to proceed with soliciting bids from health plans under the current program model as well as requesting bids to administer fully-insured health plans on a regional basis. The Board has the authority to pursue regionalization if done on a fully-insured basis.

ALTERNATIVES

A. Contract Approval

Approve any of the following contract(s) to self-insure for group health plans:

Statewide/Nationwide
1. Compcare Health Services -- Anthem Blue Preferred

Northern
2. Security Health

Eastern
3. Compcare Health Services -- Anthem Blue Priority
4. Network Health

Southern
5. Quartz
6. Dean Health Plan

Western
7. HealthPartners

B. Contract Modifications

Specify that approval of the contract(s) selected under Alternative A above be conditional upon the following modifications to the contract(s):

1. Amend to include active local government employees as eligible members with regard to participation in the group health program.

2. Delete language providing three contract renewal options for two-year periods each.

3. Amend to provide that a member may select a vendor in a region in which they do not reside or work, unless otherwise specified in federal law.

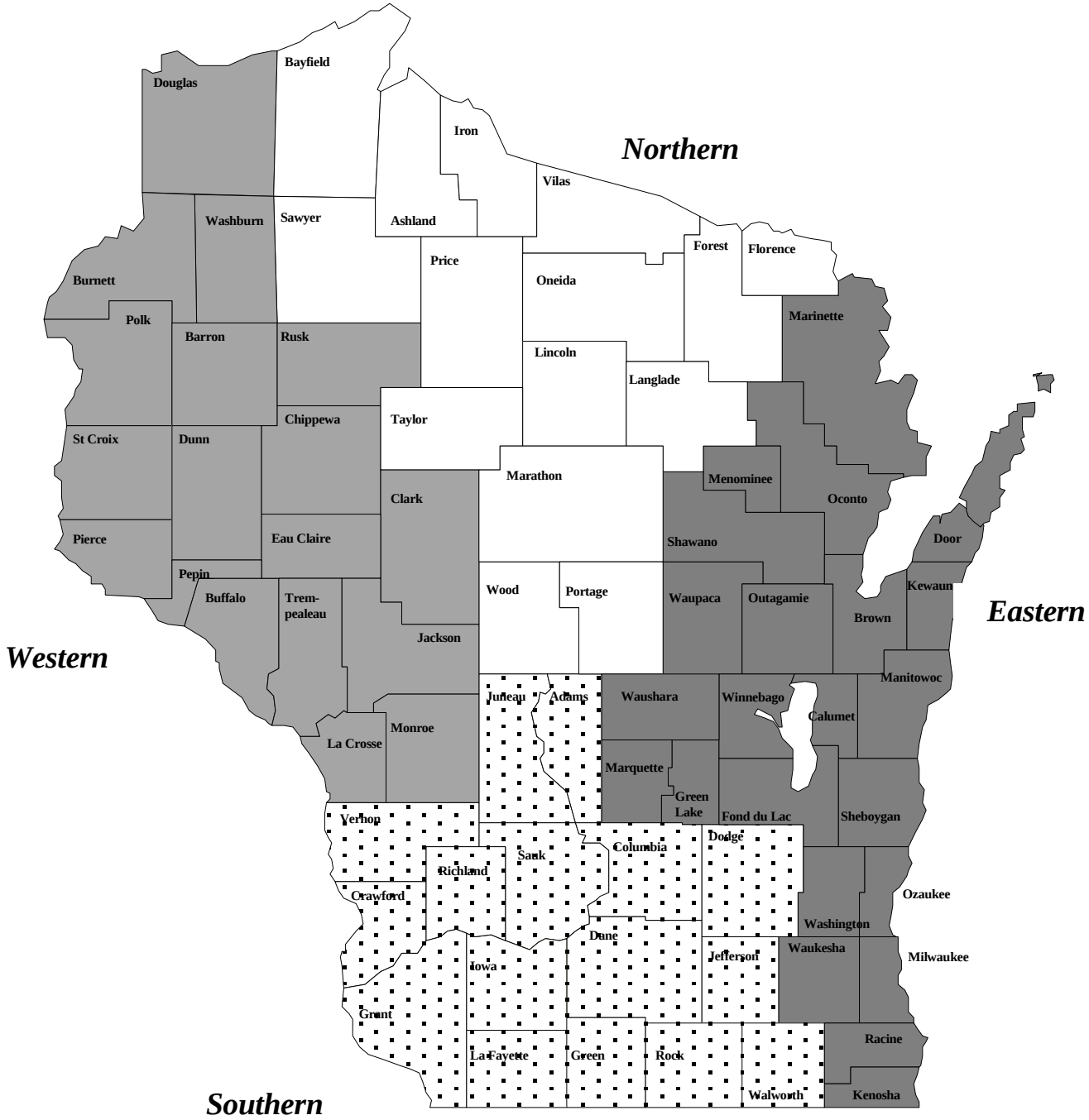
C. Maintain Program Structure

1. Deny the request.

Prepared by: Rachel Janke
Attachment

ATTACHMENT 1

Employee Trust Funds Regional Map



ATTACHMENT 2

Provider-Based Disruption Analysis by County
Prepared by Segal Consulting

		Providers			Members			Unique Claims		
County	Region	Total	Disrupted	%	Total	Disrupted	%	Total	Disrupted	%
Adams	Southern	50	2	4.0%	455	4	0.9%	1,881	5	0.3%
Ashland	Northern	126	5	4.0	228	19	8.3	3,020	33	1.1
Barron	Western	198	0	0.0	412	1	0.2	4,511	-	0.0
Bayfield	Northern	28	5	17.9	228	3	1.3	450	32	7.1
Brown	Eastern	1,993	43	2.2	3,855	192	5.0	63,145	631	1.0
Buffalo	Western	22	0	0.0	223	-	0.0	349	-	0.0
Burnett	Western	26	0	0.0	98	-	0.0	231	-	0.0
Calumet	Eastern	49	1	2.0	275	7	2.5	1,489	13	0.9
Chippewa	Western	212	2	0.9	1,918	8	0.4	12,961	21	0.2
Clark	Western	65	0	0.0	422	1	0.2	1,107	-	0.0
Columbia	Southern	432	12	2.8	4,501	222	4.9	24,024	364	1.5
Crawford	Southern	80	4	5.0	825	101	12.2	5,587	107	1.9
Dane	Southern	9,738	183	1.9	81,523	3,999	4.9	1,145,195	13,127	1.1
Dodge	Southern	698	15	2.1	3,992	63	1.6	42,043	220	0.5
Door	Eastern	131	9	6.9	264	28	10.6	2,973	73	2.5
Douglas	Western	158	1	0.6	913	1	0.1	5,345	2	0.0
Dunn	Western	111	0	0.0	1,979	-	0.0	15,331	-	0.0
Eau Claire	Western	978	3	0.3	4,527	6	0.1	77,286	11	0.0
Florence	Northern	5	0	0.0	28	-	0.0	20	-	0.0
Fond Du Lac	Eastern	899	24	2.7	4,859	74	1.5	53,531	273	0.5
Forest	Northern	22	2	9.1	64	3	4.7	337	6	1.8
Grant	Southern	456	10	2.2	3,628	73	2.0	29,440	170	0.6
Green	Southern	338	4	1.2	2,760	45	1.6	15,171	210	1.4
Green Lake	Eastern	21	2	9.5	516	12	2.3	995	26	2.6
Iowa	Southern	161	5	3.1	1,766	11	0.6	12,292	12	0.1
Iron	Northern	8	0	0.0	55	-	0.0	101	-	0.0
Jackson	Western	65	0	0.0	721	-	0.0	5,856	-	0.0
Jefferson	Eastern	559	11	2.0	5,027	18	0.4	41,129	55	0.1
Juneau	Southern	110	3	2.7	2,086	6	0.3	11,102	6	0.1
Kenosha	Eastern	679	24	3.5	1,422	62	4.4	20,076	132	0.7
Kewaunee	Eastern	69	1	1.4	420	1	0.2	1,343	2	0.1
La Crosse	Western	1,486	6	0.4	4,007	55	1.4	87,604	169	0.2
Lafayette	Southern	70	2	2.9	1,459	3	0.2	4,004	3	0.1
Langlade	Northern	100	5	5.0	134	12	9.0	2,050	33	1.6
Lincoln	Northern	121	4	3.3	766	15	2.0	5,993	40	0.7
Manitowoc	Eastern	327	5	1.5	474	10	2.1	5,838	61	1.0
Marathon	Northern	883	11	1.2	1,313	68	5.2	29,086	528	1.8
Marinette	Eastern	242	4	1.7	589	4	0.7	4,087	13	0.3
Marquette	Eastern	12	0	0.0	887	-	0.0	267	-	0.0
Menominee	Eastern	7	0	0.0	4	-	0.0	32	-	0.0

County	Region	Providers			Members			Unique Claims		
		Total	Disrupted	%	Total	Disrupted	%	Total	Disrupted	%
Milwaukee	Eastern	6,213	242	3.9%	13,181	1,029	7.8%	298,325	3,142	1.1%
Monroe	Western	133	0	0.0	1,256	-	0.0	8,809	-	0.0
Oconto	Eastern	105	0	0.0	479	-	0.0	2,094	-	0.0
Oneida	Northern	307	6	2.0	675	21	3.1	12,568	86	0.7
Outagamie	Eastern	1,070	34	3.2	3,800	82	2.2	67,778	338	0.5
Ozaukee	Eastern	590	27	4.6	1,700	411	24.2	19,764	689	3.5
Pepin	Western	22	0	0.0	263	-	0.0	1,008	-	0.0
Pierce	Western	97	0	0.0	1,114	-	0.0	2,606	-	0.0
Polk	Western	95	0	0.0	178	-	0.0	1,073	-	0.0
Portage	Northern	424	17	4.0	2,922	54	1.8	37,011	186	0.5
Price	Northern	37	0	0.0	170	-	0.0	1,248	-	0.0
Racine	Eastern	745	56	7.5	4,457	141	3.2	33,336	776	2.3
Richland	Southern	148	3	2.0	1,219	22	1.8	8,870	70	0.8
Rock	Southern	1,382	34	2.5	4,865	260	5.3	61,586	907	1.5
Rusk	Western	37	0	0.0	153	-	0.0	1,091	-	0.0
Sauk	Southern	696	12	1.7	3,605	202	5.6	40,156	594	1.5
Sawyer	Northern	75	2	2.7	125	16	12.8	1,318	78	5.9
Shawano	Eastern	152	5	3.3	609	7	1.1	3,925	35	0.9
Sheboygan	Eastern	480	12	2.5	997	18	1.8	8,416	95	1.1
St. Croix	Western	188	0	0.0	795	-	0.0	3,897	-	0.0
Taylor	Northern	87	1	1.1	157	1	0.6	1,811	1	0.1
Trempealeau	Western	58	0	0.0	1,521	-	0.0	5,808	-	0.0
Vernon	Southern	134	6	4.5	615	35	5.7	6,182	109	1.8
Vilas	Northern	135	1	0.7	355	1	0.3	2,435	1	0.0
Walworth	Eastern	325	12	3.7	2,446	52	2.1	17,746	89	0.5
Washburn	Western	58	0	0.0	524	-	0.0	2,787	-	0.0
Washington	Eastern	439	21	4.8	1,687	26	1.5	10,545	226	2.1
Waukesha	Eastern	3,248	112	3.4	5,731	216	3.8	94,332	1,269	1.3
Waupaca	Eastern	227	7	3.1	2,005	19	0.9	27,171	64	0.2
Waushara	Eastern	239	57	23.8	1,174	213	18.1	9,570	347	3.6
Winnebago	Eastern	1,090	31	2.8	6,908	362	5.2	119,819	854	0.7
Wood	Northern	898	10	1.1	931	35	3.8	48,759	182	0.4
Total		41,669	1,116	2.7%	206,240	8,350	4.0%	2,699,126	26,516	1.0%

Segal notes that because figures are specific to providers and provider counties, it is possible that some numbers in the table are counted more than once.

ATTACHMENT 3

Comparison of State Health Insurance Market Competition Levels, Calendar Year 2015

Index by Insurer Market Share of Covered Lives

Rank	State	HHI Total*
1	Wisconsin	563
2	Pennsylvania	599
3	New York	619
4	Georgia	690
5	Florida	692
6	Michigan	780
7	California	808
8	Oregon	854
9	Washington	892
10	Massachusetts	924
11	Maryland	958
12	Missouri	976
13	Ohio	998
14	Louisiana	1,076
15	Colorado	1,106
16	Minnesota	1,143
17	Arizona	1,259
18	Texas	1,263
19	New Jersey	1,326
20	Mississippi	1,351
21	Virginia	1,396
22	Utah	1,497
23	New Hampshire	1,532
24	Nevada	1,538
25	Connecticut	1,600
26	West Virginia	1,670
27	Nebraska	1,737
28	South Dakota	1,749
29	New Mexico	1,753
30	North Carolina	1,897
31	Delaware	1,944
32	Tennessee	1,974
33	Kentucky	2,041
34	Wyoming	2,137
35	Maine	2,142

Index by Insurer Market Share of Direct Written Premiums

Rank	State	HHI Total*
1	Wisconsin	584
2	New York	643
3	Pennsylvania	827
4	Georgia	1,111
5	Florida	1,123
6	Massachusetts	1,143
7	Washington	1,212
8	Michigan	1,288
9	Virginia	1,462
10	Maryland	1,512
11	Connecticut	1,547
12	Minnesota	1,568
13	Oregon	1,591
14	Ohio	1,595
15	Missouri	1,668
16	Colorado	1,715
17	California	1,820
18	Arizona	1,986
19	Texas	2,120
20	New Hampshire	2,148
21	New Jersey	2,266
22	Kansas	2,451
23	Louisiana	2,522
24	Nevada	2,607
25	Utah	2,688
26	New Mexico	2,866
27	Mississippi	3,077
28	Tennessee	3,104
29	Maine	3,182
30	South Dakota	3,266
31	South Carolina	3,310
32	Kentucky	3,426
33	Rhode Island	3,890
34	Oklahoma	3,943
35	Wyoming	3,959

Index by Insurer Market Share of Covered Lives			Index by Insurer Market Share of Direct Written Premiums		
Rank	State	HHI Total*	Rank	State	HHI Total*
36	Oklahoma	2,451	36	Nebraska	3,966
37	Kansas	2,474	37	Indiana	3,971
38	South Carolina	2,568	38	Hawaii	4,109
39	Rhode Island	2,692	39	West Virginia	4,299
40	Alaska	2,792	40	Illinois	4,342
41	Illinois	2,798	41	Idaho	4,443
42	Indiana	3,120	42	Delaware	4,528
43	Montana	3,466	43	Iowa	4,540
44	Hawaii	3,887	44	Arkansas	4,667
45	Arkansas	4,067	45	North Dakota	4,853
46	Alabama	4,177	46	North Carolina	4,897
47	Iowa	4,233	47	Montana	4,906
48	North Dakota	4,245	48	Vermont	5,329
49	Idaho	4,448	49	Alaska	5,335
50	Vermont	4,960	50	Alabama	7,985

*Herfindahl-Hirschman Index equals sum of squared market share of each insurer. US DOJ and FTC standard: unconcentrated markets, less than 1,500; moderately concentrated markets, between 1,500 and 2,500; highly concentrated markets, greater than 2,500.

Data source: Medical loss ratio data submitted to the Centers for Medicare and Medicaid Services' Center for Consumer Information and Insurance Oversight.

ATTACHMENT 4

States that Fully or Partially Self-Funded State Employee Health Programs in 2010, National Conference of State Legislatures (NCSL)

Fully Self-Funded States	Partially Self-Funded States
Alabama	Arizona
Alaska	California
Arkansas	Colorado
Delaware	Connecticut
Idaho	Florida
Kentucky	Georgia
Minnesota	Hawaii
Mississippi	Illinois
Montana	Indiana
New Hampshire	Kansas
New Mexico	Louisiana
North Carolina	Maryland
Oklahoma	Massachusetts
Pennsylvania	Michigan
Rhode Island	Missouri
South Dakota	Nebraska
Tennessee	Nevada
Vermont	New Jersey
West Virginia	Ohio
Wyoming	Oregon
	South Carolina
	Texas
	Utah
	Virginia
	Washington
	Wisconsin

ATTACHMENT 5

Major Providers Available Under Self-Insured Contracts, Listed by Region and Vendor

Statewide

Provider or Health System	City	State
Anthem Blue Preferred		
Affinity Health - Ascension	Appleton, Chilton, Oshkosh	WI
Agnesian Healthcare	Fond du Lac, Ripon, Waupun	WI
Aspirus Health Network	Antigo, Medford, Wausau, Wisconsin Rapids	WI
Aurora Health Care	Various Locations	WI, IL
Bay Area Medical Center	Marienette	WI
Bay Care Clinic	Green Bay, Marinette	WI
Beaver Dam Community Hospital Children's Hospital of Wisconsin	Beaver Dam	WI
Bellin Health	Green Bay, Oconto	WI
Beloit Health System	Beloit	WI
Children's Hospital of Wisconsin	Neenah, Milwaukee	WI
Columbia St Mary's - Ascension	Milwaukee	WI
Divine Savior Healthcare	Portage	WI
Essentia Health	Superior	WI
Fort Healthcare	Fort Atkinson	WI
Franciscan Skemp Healthcare-Mayo Health System	LaCrossse, Arcadia, Sparta	WI
Froedtert & Community Health	Milwaukee	WI
Gundersen Lutheran Health System	LaCrosse	WI
Holy Family Memorial	Manitowoc	WI
Luther/Midelfort-Mayo Health System	Various Locations	WI
Marshfield Clinic	Various Locations	WI
Medical College of Wisconsin	Various Locations	WI
Mercy Health System	Harvard, Janesville, Lake Geneva	IL, WI
Meriter Hospitals and Clinics	Madison	WI
Ministry Health Care - Ascension (Hospitals and Medical Group)	Various Locations	WI
Prevea Health	Green Bay	WI
Prohealth Care	Oconomowoc	WI
Sacred Heart Hospital - Prevea Health	Eau Claire	WI
SSM Health Care and Dean Clinics	Madison	WI
The Monroe Clinic	Monroe	WI
ThedaCare	Various Locations	WI
United Hospital and Medical Center	Kenosha	WI
UW Hospitals and Clinics	Madison	WI
Watertown Regional Medical Center	Watertown	WI
Wheaton Franciscan Healthcare-Ascension	Racine, Brookfield, Milwaukee, Wauwatosa	WI

Northern

Provider or Health System	City	State
Security Health		
Ascensin - Sacred Heart Hospital	Tomahawk	WI
Ascensino - Our Lady of Victory Hospital	Stanley	WI
Ascension - Eagle River Memorial Hospital	Eagle River	WI
Ascension - Good Samaritan Health Center	Merrill	WI
Ascension - Howard Young Medical Center	Woodruff	WI
Ascension - Ministry Health Care	Various	WI
Ascension - St. Clare's Hospital of Weston	Weston	WI
Ascension - St. Mary's Hospital	Rhinelander	WI
Ascension - St. Michael's Hospital	Stevens Point	WI
Aspirus	Various	WI
Aspirus Grand View Hospital	Ironwood	MI
Aspirus Iron River Hospitals and Clinics	Iron River	MI
Aspirus Langlade Hospital	Antigo	WI
Aspirus Medford Hospital	Medford	WI
Aspirus Riverview Hospital	Wisconsin Rapids	WI
Aspirus Wausau Hospital	Wausau	WI
Bellin Health	Various	WI
Bellin Health Oconto Hospital	Oconto	WI
Bellin Memorial Hospital	Green Bay	WI
Diagnostic and Treatment Center	Weston	WI
Dickinson County Healthcare System	Various	MI, WI
Dickinson County Memorial Hospital	Iron Mountain	MI
Essentia Health	Various	MN, WI
Essentia Health St. Mary's Hospital Duluth	Duluth	MN
Essentia Health St. Mary's Hospital Superior	Superior	WI
Flambeau Hospital	Park Falls	WI
Hayward Area Memorial Hospital	Hayward	WI
HSHS Sacred Heart Hospital	Eau Claire	WI
HSHS St. Joseph's Hospital	Chippewa Falls	WI
Lakeview Medical Center	Rice Lake	WI
Marshfield Clinic	Various	WI
Memorial Medical Center - Ashland	Ashland	WI
Memorial Medical Center and Hospital - Neillsville	Neillsville	WI
Oakleaf	Various	WI
Oakleaf Surgical Hospital	Altoona	WI
Prevea Clinic - West	Eau Claire	WI
Rusk County Memorial Hospital	Ladysmith	WI
St. Luke's Healthcare System and Hospital	Duluth and Various	MN, WI
ThedaCare	Various	WI
Thedacare Medical Center	Shawano, Waupaca, Wild Rose, Berlin, New London	WI
ThedaCare Regional Medical Center	Appleton	WI

Eastern

Provider or Health System	City	State
Anthem Blue Priority		
Aspirus Health Network	Antigo, Medford, Wausau, Wisconsin Rapids	WI
Aurora Health Care	Various Locations	WI
Bay Area Medical Center	Marienette	WI
Bellin Health	Green Bay, Oconto	WI
Berlin Memorial	Berlin	WI
Children's Hospital of Wisconsin	Neenah, Milwaukee	WI
Fort Healthcare	Fort Atkinson	WI
Gundersen Lutheran Health System	LaCrosse	WI
Langlade Hospital	Antigo	WI
Meriter Hospitals and Clinics	Madison	WI
Oconomowoc Memorial	Oconomowoc	WI
Prevea Health	Green Bay	WI
ProHealth Care	Oconomowoc	WI
St Joseph's Health Services Inc	Hillsboro	WI
ThedaCare	Various Locations	WI
Tri-County Memorial Hospital	Whitehall	WI
UW Hospitals and Clinics	Madison	WI
Vernon Memorial Hospital	Viroqua	WI
Watertown Regional Medical Center	Watertown	WI
Waukesha Memorial Hospital	Waukesha	WI
Network Health		
Affinity Health System	Appleton	WI
Ministry Health Care	Stevens Point	WI
Bellin Health Care	Green Bay	WI
Prevea Health System	Green Bay	WI
Agnesian Health Care	Fond du Lac	WI
Door County Memorial	Sturgeon Bay	WI
Holy Family Memorial	Manitowoc	WI
Physician Health Network	Sheboygan	WI
Wheaton Franciscan Healthcare	Various	WI
Columbia St. Mary's	Various	WI
Froedtert Health System	Various	WI
Medical College of Wisconsin	Various	WI
Children's Hospital and Health System	Milwaukee & Neenah	WI
United Hospital System	Kenosha	WI

Southern

Quartz		
Access Community Health Centers	Madison	WI
Agnesian Healthcare Services	Fond du Lac	WI
Associated Physicians, LLP	Madison	WI
Beaver Dam Community Hospital & Clinics	Various	WI
Beloit Health System	Various	WI, IL
Black River Memorial Hospital	Black River Falls	WI
Columbus Community Hospital	Columbus	WI
Crossing Rivers Health Medical Center	Prairie du Chien	WI
Delton Family Medical Center	Lake Delton	WI
Divine Savior Healthcare, Inc	Portage	WI
Edgerton Hospital and Health Services	Edgerton	WI

Provider or Health System	City	State
Quartz (continued)		
Family Health of Lafayette County	Darlington	WI
Fort Memorial Hospital & Clinics	Various	WI
Grant Regional Health Center & Clinics	Lancaster	WI
Group Health Cooperative - SC	Madison	WI
Gundersen Boscobel Hospital and Clinics	Boscobel	WI
Gundersen Lutheran Medical Center & Clinics	Various	WI
Gundersen St. Joseph's Hospital and Clinics	Hillsboro	WI
Gundersen Tri-County Hospital and Clinics	Various	WI
Hirsch Clinic	Viroqua	WI
Journey Mental Health Center	Madison	WI
Kickapoo Valley Medical Clinic	Soldiers Grove	WI
Krohn Clinic, Ltd.	Black River Falls	WI
Madison Women's Health, LLP	Madison	WI
Meade Medical Clinic	Watertown	WI
Memorial Hospital of Lafayette County	Darlington	WI
Mile Bluff Medical Center, Inc.	Various	WI
Monroe Clinics & Hospital	Various	WI
Moundview Memorial Hospital & Clinics	Friendship	WI
Prairie Clinic, SC	Sauk City	WI
Prairie Ridge Health Clinic - Beaver Dam	Beaver Dam	WI
ProHealth Medical Group	Various	WI
Reedsburg Area Medical Center, Inc.	Reedsburg	WI
Richland Medical Center, Ltd.	Richland Center	WI
Rogers Memorial Hospital	Oconomowoc	WI
Sauk Prairie Memorial Hospital, Inc.	Prairie du Sac	WI
Southwest Health Center & Clinic	Platteville	WI
Stoughton Hospital	Stoughton	WI
SwedishAmerican Hospital & Clinics	Rockford	WI
Tomah Memorial Hospital	Tomah	WI
UnityPoint Health - Meriter Hospital	Madison	WI
Upland Hills Health	Dodgeville	WI
UW Cancer Center at ProHealth Care	Waukesha	WI
UW Cancer Center Johnson Creek	Johnson Creek	WI
UW Health at The American Center	Madison	WI
UW Health Clinic	Various	WI
UW Health Regional Services Specialty	Various	WI
UW Health Rehabilitation Hospital	Madison	WI
UW Health Specialty Clinic	Various	WI
UW Health-American Family Children's Hospital	Madison	WI
UW Health-University Hospital	Madison	WI
Vernon Memorial Hospital	Viroqua	WI
Watertown Regional Medical Center	Watertown	WI
Dean Health Plan		
Agnesian HealthCare	Markesan, Waupun	WI
Agnesian HealthCare (Hospital and Clinics)	Brandon, Brownsville, Campbellsport, Fond du Lac, Fox Lake, Mayville, Mt. Calvary, Ripon	WI
Beaver Dam Community Hospital, Inc. Medical Clinics	Beaver Dam, Horicon, Juneau	WI
Beloit Health System - Beloit Hospital & Clinics	Beloit, Clinton, Darien, Roscoe	IL, WI
Columbus Community Hospital	Columbus	WI
Divine Savior Healthcare	Oxford, Pardeeville, Portage	WI
Edgerton Hospital & Health Services	Edgerton, Milton	WI
Finley Hospital	Dubuque	IA
Fort HealthCare, Inc.	Cambridge, Fort Atkinson, Jefferson, Johnson Creek, Lake Mills, Whitewater	WI

Provider or Health System	City	State
Dean Health Plan (continued)		
Fresenius Medical Care	Baraboo, Dodgeville, Janesville, Madison	WI
Grant Regional Health Center	Lancaster	WI
Gundersen Boscobel Area Health Care	Boscobel, Fennimore, Muscoda	WI
Gundersen St. Joseph's Hospital & Clinics	Elroy, Hillsboro, Wonewoc	WI
Home Health United	All cities	WI
LSM Chiropractic Clinic	Cottage Grove, Fitchburg, Fort Atkinson, Madison, Middleton, New Glarus, Oregon, Sauk City, Sun Prairie, Verona, Whitewater	WI
Memorial Hospital of Lafayette County	Darlington	WI
Monroe Clinic	Blanchardville, Durand, Freeport, Lena	IL, WI
Monroe Clinic Hospital and Clinics	Albany, Brodhead, Monroe, New Glarus	WI
Moundview Memorial Hospital & Clinics	Friendship, Westfield	WI
Prairie Ridge Health Clinic	Beaver Dam, Columbus, Marshall	WI
Primary Care Clinics	Argyle, Darlington, Shullsburg	WI
ProHealth Care Oconomowoc Memorial Hospital	Oconomowoc	WI
ProHealth Care Waukesha Memorial Hospital	Waukesha	WI
ProHealth Solutions, LLC - ProHealth Care	Brookfield, Delafield, Hartland, Mukwanago, Muskego, New Berlin, Oconomowoc, Pewaukee, Sussex, Watertown, Waukesha	WI
Reedsburg Area Medical Center	Reedsburg	WI
Richland Hospital	Richland Center	WI
Richland Medical Center	Muscoda, Richland Center	WI
Rogers Memorial Hospital	Brown Deer, Kenosha, Madison, Oconomowoc, West Allis	WI
Sauk Prairie Memorial Hospital & Clinics	Lodi, Mazomanie, Prairie du Sac, Plain, Spring Green	WI
Southwest Health Hospital & Clinics	Cuba City, Platteville	WI
SSM Health - Dean Medical Group	Baraboo, Barneveld, Beaver Dam, Columbus, Deerfield, Delevan, Dodgeville, Edgerton, Evansville, Fort Atkinson, Janesville, Lake Delton, Madison, Mineral Point, Oregon, Portage, Prairie du Sac, Stoughton, Sun Prairie, Waterloo, Waunakee, Whitewater, Wisconsin Dells	WI
SSM Health Davis Duehr Dean Eye Care	Baraboo, Dodgeville, Fort Atkinson, Janesville, Madison, Portage, Prairie du Sac, Reedsburg, Stoughton, Sun Prairie, Waunakee, Whitewater	WI
SSM Health St. Clare Hospital	Baraboo	WI
SSM Health St. Mary's Hospital - Janesville	Janesville	WI
SSM Health St. Mary's Hospital - Madison	Madison	WI
Stoughton Hospital	Stoughton	WI
Tri-State Independent Physicians Association	Boscobel, Cuba City, Dubuque, Lafayette, Lancaster, Platteville	IA, WI
Turville Bay MRI & Radiation Oncology Center	Madison	WI
Upland Hills Health	Dodgeville, Highland, Montfort, Mt. Horeb, Spring Green	WI
Watertown Network	Oconomowoc, Watertown	WI
Watertown Regional Medical Center	Ixonia, Johnson Creek, Juneau, Lake Mills, Oconomowoc, Waterloo, Watertown	WI

Western

Provider or Health System	City	State
HealthPartners		
Advanced Medical Clinic	Saint Paul	MN
AALFA Family Clinic, PA	White Bear Lake	MN
Allina Health System	Various	WI/MN
Amery Regional Medical Center	Various	MN
Apple Valley Medical Clinic	Apple Valley	WI
Aspirus	Various	WI
Baldwin Area Medical Center	Various	WI
Black River Memorial Hospital	Black River Falls	WI
Burnett Medical Center	Grantsburg	WI
Burnsville Family Physicians	Burnsville	MN
Center for Reproductive Medicine	Various	MN
CentraCare	Monticello	MN
Children's Health Care	Various	WI, MN
Children's Health Network	Various	WI, MN
Chippewa Valley Hospital & Oakview Care Center	Durand	WI
Community Memorial Hospital	Cloquet	MN
Cumberland Memorial Hospital	Various	WI
Dunn County Department of Human Services	Menomonie	WI
Essentia Health	Various	WI, MN
Fairview	Various	MN
Family HealthServices	Various	MN
Family Innovations	Various	WI, MN
Flambeau Hospital	Park Falls	WI
Gillette Childrens	Various	MN
Gundersen Lutheran	Various	WI, MN
Hayward Area Memorial Hospital	Hayward	WI
HealthEast	Various	WI, MN
HealthPartners	Various	WI, MN
Hudson Hospital	Hudson	WI
Hudson Physicians	Various	WI
Indianhead Medical Center	Various	WI
Infinity Healthcare Physicians	Various	WI
Integrity Health Network	Various	WI, MN
Kanabec County	Various	MN
Ladd Memorial Hospital	Various	WI, MN
Lake Superior Community Health	Various	WI, MN
Lakeview Clinic	Various	MN
Lakeview Medical Center	Rice Lake	WI
Marshfield Clinic	Various	WI
Mayo Clinic Health System	Various	WI, MN
Memorial Hospital	Neillsville	WI
Memorial Medical Center	Ashland	WI
Ministry Medical Group	Various	WI, MN
Mooselake Community Hospital	Moose Lake	MN
OakLeaf Medical	Various	WI, MN
OakLeaf Surgical Hospital	Altoona	WI
Oakview Care Center & Chippewa Valley Hospital	Durand	WI
Olmsted Medical Center	Various	WI
Osceola Medical Center	Osceola	WI
Northfield Hospital	Various	MN
Park Nicollet	Various	MN
Ridgeview Clinics	Various	MN

Provider or Health System	City	State
HealthPartners (continued)		
Rusk County Memorial Hospital	Ladysmith	WI
Sacred Heart Hospital	Various	WI
Spooner Health System	Spooner	WI
St. Croix County Health & Human Services	New Richmond	WI
St. Croix Regional Medical Center	Various	WI, MN
St. Joseph's Hospital	Chippewa Falls	WI
St. Luke's	Various	WI, MN
Stillwater Medical Group	Various	WI, MN
Twin Cities Orthopedics	Various	WI, MN
University of Minnesota	Various	WI, MN
Western Wisconsin Medical Associates	Various	WI
Westfields Hospital	New Richmond	WI
Willow Creek Woman's Clinic	Eau Claire	WI
Winona Health	Winona	MN