# DUEY STROEBEL

STATE SENATOR • 20TH DISTRICT

## Testimony on SB 806

*March 6, 2018*

Good morning Chairman Craig and members of the Senate Committee on Insurance, Financial Services, Constitution and Federalism. Thank you for giving SB 806 a public hearing. This legislation establishes a framework that allows small businesses to work together to self-fund their own health insurance. Under current state law, individual businesses may self-fund their own health insurance. However, because of the economies of scale needed to make self-funded insurance work, this option is often not feasible for small and medium-sized employers.

SB 806 creates new health coverage options for small businesses by allowing individual employers to join together in a self-funded health benefits project. Qualified employers will be existing members of a chamber of commerce or industry-based association that has had at least 5 member businesses for at least 5 years. There is no size limit for participating employers, but covered employees must be full-time employees.

To ensure feasibility, the bill outlines specific provisions that must be a part of the contract between employers participating in a self-funded group. Such requirements include contribution amounts from participating employers, designation of an agent for service of process, maintenance of stop-loss coverage, maintenance of a surplus fund, actuarial review of the group finances, a minimum period of participation and provisions for employers who wish to leave the group, among other things. These common-sense requirements ensure that the mechanics of self-funded insurance are financially sound. We expect that many groups will contract with a third-party administrator to handle the day-to-day operation of these entities.

Assembly Amendment 5 to the Assembly companion legislation specifically requires the state Office of the Commissioner of Insurance to examine the solvency of these self-funded entities. This important provision provides peace of mind to employees who are covered by a self-funded health benefits project. Additionally, it ensures that all employers participating in the project have full awareness of the financial solvency of the structure.

Self-funded health insurance meets federal Affordable Care Act requirements for employer-sponsored minimum health insurance for employees. Because the risk group is relatively controlled, based on who is employed by the participating employees, it is possible for employers to pursuing self-funded insurance and reduce their health insurance costs.

This does not mean that certain coverage mandates found in the Affordable Care Act do not apply to self-funded insurance. In fact, the minimum essential coverage requirements and the prohibition on discrimination against pre-existing conditions, for example, do apply to employer-

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sponsored self-funded plans. Because employers are not insurers, community rating rules, the need to derive a profit strictly on the basis of claims versus premiums, and other overhead costs are not present. This allows self-funding employers to focus on ensuring their employees get access to quality, efficient and preventive care.

Self-funded health insurance has already seen success here in Wisconsin. Some employers have chosen to self-fund entire health plans, others have chosen to self-fund only certain health benefits. SB 806 is an important step forward to allow employers of any size to embrace innovation while still providing their employees with quality health insurance. Thank you.

# SHANNON ZIMMERMAN

STATE REPRESENTATIVE • 30th ASSEMBLY DISTRICT

Chairman Craig and Committee Members,

Thank you for taking the time to hear my testimony on Senate Bill 806/ Assembly Bill 920, concerning self-funded health coverage.

Healthcare is one of the most important issues facing Americans today. Costs are rising dramatically, causing families to struggle to pay for care. Many get their health care through companies they work for and many businesses, especially small businesses, are having to contend with those same cost issues. According to the National Conference of State Legislatures, small businesses pay on average about **eight to eighteen percent more** than large firms for the same health insurance policy.

Under current law, any individual business can self-fund (meaning the business provides health benefits to its employees with its own funds). This offers businesses flexibility and cost-savings. However, smaller businesses cannot pool resources as effectively as larger businesses because of economies of scale. If the law is working for big businesses and their employees, then I believe the same advantage should be given to smaller businesses.

Senate Bill 806/ Assembly Bill 920 achieves this by allowing two or more small businesses, who are part of the same chamber of commerce or trade association, to band together to self-fund health benefits for their employees (and their dependents). This will give small businesses the same self-funding tools as big businesses. In fact, Wisconsin already allows farmers to purchase health care as a group.

An aspiring employer group must prove to the Office of the Commissioner of Insurance that 1) all matters necessary for administration and operation of benefit agreements are determined, 2) an agent has been designated for service of process, notice or demand, 3) the term 'dependent' is defined under the health care benefit arrangement, 4) an actuary has calculated what employers must contribute, administrative costs and stop-loss coverage and 5) the minimum period of participation is outlined (the bill requires a minimum of at least three years).

Once an employer group is formed, they are responsible for 1) ensuring members offer similar health benefits to eligible employees and dependents, 2) filing an annual report on the state of the fund, 3) allow any employer who meets who agrees to meet minimum standards, such as contribution amounts, participate, 4) pay at most $50,000 in benefits, unless an actuary finds the group can pay more (the stop-loss coverage kicks in beyond this), 5) terminate employers who don't pay contributions and 6) ensure members participate for the required minimum time. Beyond this, employer groups may require employers to contribute to a surplus fund, set rules for employers to leave before the minimum time. Terminated employers must pay for their proportion of claims incurred before leaving and the required contribution amounts had they stayed in the group.

**Please note Assembly Bill 920 was amended.** Amendment 4 includes all requirements of coverage from chapters 631 and 632 of the statutes that insurance companies must meet, such as chiropractic parity, autism spectrum disorders, breast reconstruction and more. Amendment 5 includes a number of requirements, including that an employer group must have a formal governing structure and giving the Office of the Commissioner of Insurance oversight to ensure employer groups are meeting solvency requirements.

Thank you for listening. I appreciate everyone who has reached out to me on this important matter. I welcome any feedback people are willing to give, and look forward to crafting the best bill we possibly can.

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March 6, 2018

**Statement on Senate Bill 806**

Wisconsin Physicians Service Insurance Corporation, d/b/a WPS Health Solutions, offers its support for Senate Bill 806, legislation relating to employer groups for self-funded health care coverage, also known as Association Health Plans.

Over the past five years, health care costs have risen steadily for all Wisconsin employers, but perhaps most acutely impacted small employers. Senate Bill 806 seeks to address the rising costs of health care for small employers by authorizing Association Health Plans as an alternative for health care coverage.

WPS worked with the authors of this legislation to ensure the bill was sound public policy. At our suggestion, the drafters included a minimum period of participation of three years to reduce adverse selection. We also suggested reinsurance contracts be required on the basis of benefits incurred in a calendar year for each individual covered under its employee health care benefit arrangement, meaning the reinsurance is based on the date of service the individual receives care versus when the health plan pays the claim.

Association Health Plans carry a great deal of risk for associations and employers that does not exist with fully insured group health plans. An association who intends to establish an Association Health Plan under this Act should fully understand the risks and liability it will incur. An employer should exercise due diligence before purchasing an Association Health Plan in order to determine if it is the best alternative for the employer.

Additionally, the U.S. Department of Labor is in the process of issuing rules under the Employee Retirement Income Security Act of 1974 (ERISA) to allow Association Health Plans. It is not clear to what extent the provisions of SB 806 are consistent with the proposed Association Health Plan rules from the Department of Labor.

Thank you for the opportunity for us to share our perspectives on this legislation.

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# *Wisconsin Association of Health Plans*

***The Voice of Wisconsin's Community-Based Health Plans***

TO: Members, Senate Committee on Insurance, Financial Services, Constitution and Federalism
FROM: Tim Lundquist, Director of Government and Public Affairs
RE: Senate Bill 806
DATE: March 6, 2018

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Senate Bill 806 would create a new, largely unregulated arrangement for small employers to pay for some of their employees' health care costs. The bill has the potential to adversely impact consumers and destabilize the small group health insurance market. The Wisconsin Association of Health Plans urges you to oppose the bill.

The Association, which represents 11 community-based health plans, recognizes the authors' intent and interest in providing small businesses with more affordable health benefit options. Wisconsin health plans share that goal, which is why the Association consistently works in the Legislature to advance policies that provide individuals and businesses with greater access to high-quality health care coverage at lower costs.

**SB 806, while well-intentioned, could limit access to affordable, comprehensive health care coverage.**

The American Academy of Actuaries recently said, "A key to sustainability of the health insurance markets is that health plans competing to enroll the same participants must operate under the same rules." SB 806 would create a product that would largely operate outside the reach of state regulation and state consumer protection laws.

Wisconsin statutes have 258 pages of insurance laws largely designed to protect consumers, ranging from continuity of care requirements to a defined appeal process. Wisconsin law also mandates that health plans cover certain people, providers, and services. For example, Wisconsin is unique in requiring health plans to provide coverage to certain grandchildren. Similarly, Wisconsin requires health plans to cover a variety of services like mammograms, colorectal cancer screening, and autism treatment, to name a few. Products created under SB 806 would skirt these long-standing requirements and consumers may not realize these arrangements lack traditional state protections until it's too late.

Wisconsin health plans support consumer choice, but there are consequences to creating an uneven regulatory playing field. Rather than reducing costs in the small group market, SB 806 has the potential to actually raise costs for those who need health care coverage the most.

Because association health plans would be exempt from state benefit and certain rating requirements, these plans could "cherry pick" healthy groups by designing coverage options and rates that disadvantage groups with high health care needs. This, in turn, would make the state-regulated market more expensive, as groups with significant health needs are attracted to products that are required to provide more comprehensive coverage.

**Wisconsin health plans recognize and support efforts to provide greater access to health care at lower costs,** but SB 806 does not address health care costs, and may actually cause premiums for comprehensive health care coverage to increase for small groups.

We respectfully request your opposition to SB 806.

**ALLIANCE OF HEALTH INSURERS, U.A.**
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Anthem Blue Cross and Blue Shield in Wisconsin
Children's Community Health Plan
Delta Dental of Wisconsin, Inc.
MHS Health Wisconsin.
Molina Healthcare of Wisconsin
UnitedHealthcare of Wisconsin
WPS Health Insurance

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|---|---|
| To: | Chairperson David Craig<br>Members, Senate Committee on Insurance, Financial Services, Constitution and Federalism |
| From: | R.J. Pirlot, Executive Director |
| Subject: | **SB 806, employer groups for self-funded coverage**<br>**For Information Only** |
| Date: | March 6, 2018 |

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Senate Bill 806 (SB 806), authored by Sen. Stroebel and Rep. Zimmerman, would allow two or more employers who are members of the same chamber of commerce or industry-based association to form an employer group to jointly provide health care benefits on a self-funded basis to the employers' employees and their dependents.

**First, a cautionary note: the expansion of association health plans (AHPs) is currently the subject of federal Department of Labor rulemaking.**

Comments on this federal rulemaking are due March 6, 2018, and the *earliest* we anticipate the rule to be finalized is June 6, 2018. Enacting SB 806 *prior* to final promulgation of this rule, the specifics of which are still uncertain, could lead to uncertainty and confusion in the marketplace.

The anticipated Department of Labor AHP rule is expected to be extensive and potentially address some of the very issues that are the subject of SB 806.

Enactment of SB 806 prior to final promulgation of the Department of Labor rule raises a serious, substantial risk of conflict between Wisconsin law and the federal rule. Any provisions of the Department of Labor rule that are stricter than those in SB 806 would prevail over state law. Conflict between a state law and a federal rule would likely result in uncertainty and confusion in the marketplace.

**Second, SB 806 lacks basic solvency requirements necessary to protect consumers.**

SB 806 requires employer groups to submit annual reports to the Commissioner of Insurance describing the group's "stability and finances," without going into specifics, but does not give the Commissioner authority to *act* on the information in the annual report. Moreover, SB 806 frequently refers to actuarial "recommendations" or "confirmations," but does not clearly state the *requirements* for those recommendations.

A lack of meaningful solvency requirements raises the danger an employer group could have insufficient funding and inadequate reserves, leaving consumers unable to pay medical bills and providers forced to finance uncompensated care. A lack of meaningful solvency requirements creates an unlevel playing field with commercial health plans, who must meet such requirements.

**Suggested Changes to the Proposed Legislation to Ensure Solvency**

- Require that an employer group establish a surplus fund with the required funding level determined by the analysis and certification of an independent actuary.

- Require that actuarial analyses and certifications be based on sound actuarial principles and conducted by an actuary in good standing with the Academy of Actuaries who has the skills and knowledge necessary to perform the analysis and provide the certification.

- Require an employer group be subject Wisconsin regulations that require the group to establish and maintain specific levels of capital, surplus, and reserves and require quarterly financial reports from the arrangement and allow the Office of the Commissioner of Insurance to regulate the arrangements for solvency, just as it does for health insurers.

The state Assembly, when considering AB 920, the Assembly companion bill to SB 806, adopted Assembly Amendment 5 to help address these concerns. We respectfully urge you to similarly amend SB 806.

Wisconsin Medical Society
Insurance & Financial Services, Inc.

# Association Health Plan – Design Options

**Select up to six of the eight plan options to offer employees in your organization.**

| Plan Designs | $500 80% | $1500 80% | $3000 80% | $1500 80% | $1500 100% | $3000 80% | $3000 100% | $6550 100% |
|---|---|---|---|---|---|---|---|---|
| **Deductible** | | | | | | | | |
| In Network | | | | | | | | |
| Single | $500 | $1,500 | $3,000 | $1,500 | $1,500 | $3,000 | $3,000 | $6,550 |
| Family | $1,000 | $3,000 | $6,000 | $3,000 | $3,000 | $6,000 | $6,000 | $13,100 |
| Out of Network | | | | | | | | |
| Single | $1,000 | $3,000 | $6,000 | $3,000 | $3,000 | $3,000 | $3,000 | $13,100 |
| Family | $2,000 | $6,000 | $12,000 | $6,000 | $6,000 | $6,000 | $6,000 | $26,200 |
| **Coinsurance** | | | | | | | | |
| In Network | 80% | 80% | 80% | 80% | 100% | 80% | 100% | 100% |
| Out of Network | 60% | 60% | 60% | 60% | 70% | 60% | 70% | 70% |
| **Max Out of Pocket** | | | | | | | | |
| In Network | | | | | | | | |
| Single | $3,500 | $4,500 | $6,000 | $4,500 | $1,500 | $6,000 | $3,000 | $6,550 |
| Family | $7,000 | $9,000 | $12,000 | $9,000 | $3,000 | $12,000 | $6,000 | $13,100 |
| Out of Network | | | | | | | | |
| Single | $7,000 | $9,000 | $12,000 | $7,500 | $6,000 | $9,000 | $7,500 | $17,600 |
| Family | $14,000 | $18,000 | $24,000 | $15,000 | $12,000 | $18,000 | $15,000 | $35,200 |
| **Primary Care Visit** | $25 | $25 | $25 | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins |
| **Specialist Visit** | $50 | $50 | $50 | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins |
| **Emergency Room** | $300 | $300 | $300 | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins |
| **Prescription Drugs** | | | | | | | | |
| Generic | $10 | $10 | $10 | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins |
| Preferred Brand | $35 | $35 | $35 | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins |
| Non-Preferred Brand | $60 | $60 | $60 | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins |
| Specialty | 25% to $250 | 25% to $250 | 25% to $250 | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins | Ded./ Coins |

*Max out of Pocket doesn't include copays; Copays accumulate in network to $7,350 and $14,700

1205017

Anthem. BlueCross BlueShield

Anthem Blue Cross and Blue Shield
N17 W24340 Riverwood Drive
Waukesha, WI 53188

To: Chairperson David Craig
Members, Senate Committee on Insurance, Financial Services, Constitution and Federalism
Fr: Ted Osthelder, Senior Government Relations Director
RE: SB 806, employer groups for self-funded coverage, for information only
Da: March 6, 2018

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Anthem Blue Cross and Blue Shield provides coverage to over 20,000 consumers in Wisconsin's small group market, and we are supportive of the development of options that help address the demand for affordability. As it relates to Association Health Plans, Anthem is presently engaged in discussions with policymakers at the federal and state level, and our comments in this testimony are limited to the Wisconsin SB 806 being discussed here today.

Anthem has decades of experience in the marketplace and experience with forms of Association Health Plans and other alternative funding arrangements, and history has shown that it is critically important to achieve the right balance of market flexibility while also ensuring consumers are not exposed to potential fraud and the failures of entities in providing coverage. There are many examples going back to the early 1990s to as recently as last year when entities offered coverage and then were not able to pay claims due to failure. With that in mind, we are supportive of states ensuring there are basic consumer protections in place. Unless amended, we are concerned that SB 806 (self-funded coverage for employer groups) has the potential to destabilize the health insurance market and create an opportunity for fraud, resulting in consumers being left with unpaid medical bills. We do not believe that SB 806 in its current form would provide sufficient state oversight of these new health care benefit arrangements, and has the potential to harm Wisconsin consumers. Our recommendations to improve SB 806 are as follows:

<u>Enhance State Oversight of Health Care Benefit Arrangements</u>

First and foremost, Anthem is concerned that this bill does not require sufficient state regulation and oversight of health care benefit arrangements. The bill would require the Wisconsin insurance commissioner only to initially qualify the arrangement, but would not provide ongoing oversight of



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essential financial and governance components of the arrangement such as solvency and a formal governance structure. In the absence of state regulation, the federal Department of Labor (DOL) would primarily regulate and enforce these arrangements under ERISA. The history of self-funded multiple employer welfare arrangements (MEWAs), which include these proposed health care benefit arrangements, has shown over the past 40 years the need for stricter state regulation of self-funded MEWAs in order to protect consumers from the financial catastrophe of unpaid medical bills due to scammers who set up fraudulent health benefits arrangements.

Since ERISA was amended in 1983 to permit states to regulate self-funded MEWAs, states have enacted laws and issued rules to monitor self-funded MEWAs, some more stringently than others.[1] Where states have chosen to loosely regulate MEWAs, there have been examples of entities setting up fraudulent arrangements that defraud employers and employees by taking contribution payments, but delivering little or no benefits, despite oversight by the Department of Labor.[2]

Fraudulent activity in MEWAs persists to this day, with catastrophic impact to those consumers who believe they have health coverage under the MEWA. As recently as December 21, 2017, an Illinois MEWA was dissolved; the DOL had ordered it to cease and desist marketing just the month before.[3] However, before the DOL's cease and desist order was issued, the originators of the MEWA absconded with $26 million of contributions offshored to Bermuda. This fraudulent activity resulted in the nonpayment of claims in 2016 and 2017 for almost 14,000 participants and beneficiaries with more than 560 employers and located in 36 states.

Anthem believes that more stringent state regulatory oversight will protect consumers and discourage bad actors from engaging in fraudulent behavior with these arrangements. We recommend taking a stronger regulatory approach to mitigate fraud and consequent consumer harm. The SB 806 should require these arrangements to establish and maintain specific levels of capital, surplus, and reserves and require quarterly financial reports, and the insurance commissioner's office will regulate these arrangements for solvency, just as it does for health insurers.

[1] Wisconsin currently has a regulation, Wis. Admin. Code §6.62, which requires a few filing requirements for MEWAs.
[2] https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mewa-enforcement.pdf
[3] http://www.receivermgmt.com/AEUBenefitPlan.htm

These arrangements should be required to establish a surplus fund, with the funding level determined by the analysis and certification of an independent actuary skilled in health benefits. Actuarial analyses and certifications of the arrangement must be based on sound actuarial principles and conducted by an actuary in good standing with the Academy of Actuaries who has the skills and knowledge necessary to perform the analysis, form the opinion, and satisfy the results. These arrangements should be required to have bylaws and a formal governance structure, with direct representation of employer groups on the arrangement's board of directors, since increased employer group engagement tends to further inhibit fraud.

Finally, it should be noted that the Department of Labor's proposed Association Health Plan regulation[4] may be finalized with stricter requirements that Wisconsin-based arrangements would have to meet. The final rule is not expected to be complete until June of this year at the earliest, more likely in the fall.

Eligible Persons – Sole Proprietors should not be eligible

Anthem is concerned that sole proprietors and other business owners are eligible to join health care benefit arrangements. The "employer group" formed under the bill would determine whether individuals were sole proprietors without any verification or auditing. This provision would tend to foster fraud and abuse, since individuals could falsely hold themselves out to be sole proprietors in order to obtain cheaper health benefits.

Additionally, making business owners eligible for coverage under the arrangement would tend to increase adverse selection. Healthier business owners would tend to leave the Affordable Care Act (ACA) small group insured market and join these health care benefit arrangements, destabilizing and driving up premiums for the remaining small employers left in the insured small group market.

Anthem thus recommends that the bill be amended to prohibit sole proprietors and other business owners from participating in health care arrangements. However, if this provision remains, it should be limited to sole proprietors, and employer groups should be required to verify that the sole proprietor has been in existence for at least five years, and obtain proof of the legal existence of the sole proprietorship, such as state registration forms and/or federal income tax forms evidencing tax paid as a business.

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[4] U.S. Department of Labor, Proposed Rule: Definition of ''Employer'' Under Section 3(5) of ERISA—Association Health Plans (RIN 1210–AB85)(83 Fed. Reg. 614, January 5, 2018).

Risk Pool Stability – Reduce opportunity for exceptions to minimum participation period

Anthem is concerned that, although the bill would require an employer to stay in an employer group for a 3 year period ("minimum participation period"), an employer group could set special circumstances for exemptions that would essentially nullify this requirement. The minimum participation period by itself is beneficial in contributing to market stability by inhibiting employers from annually jumping back and forth from the insurance market to the self-funded health care benefit arrangement. However, the bill gives too much latitude to the employer group to create exemptions to the minimum participation period and should be tightened to avoid the exceptions swallowing the rule.

Conclusion

While we are supportive of affordable vehicles for healthcare coverage, there must be a balance between market flexibility and threshold consumer protections, and policymakers must ensure that consumers have the adequate financial protections afforded by a solvent, well-governed, and well-capitalized health care benefits arrangement. Effective state oversight of coverage arrangements—as we have outlined--will help ensure coverage exists when consumers need it the most.

##