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State of Wisconsin Group Health Insurance Benefit Program: Results and Analysis of 2016 Request for Proposals

Executive Summary

Overview

The Group Insurance Board (Board) is considering changes to the program structure of the State of Wisconsin Group Health Insurance Program (GHIP), including self-insuring and/or regionalizing the program. A Department of Employee Trust Funds memo to the Board, Request for Proposals for the State of Wisconsin Health Benefit Program: Results and Analysis, describes options that seek to maintain benefits, contain costs, and improve quality.

At its Dec. 13, 2016 meeting, the Board deliberated seven different change options (scenarios) ranging from fully-insured to self-insured and further defined by varying levels of regionalization and degrees of program change (from minimal to major). These options are briefly outlined beginning on page three of this document. The Board will reconvene in January to approve a future program structure that could be implemented as early as 2018.

The Board has considered self-insuring the medical portion of the GHIP periodically over the past five years, as outlined in the February 2016 memo, Self-Insuring Medical Claims – Request for Proposals.

In February 2016 the Board directed ETF to issue a Request for Proposals (RFP) to evaluate both self-insuring and regionalizing the GHIP, with possible implementation in 2018.

Process

Due to the large population insured by the GHIP, ETF's long-term partnerships with 18 different health plans, and interest among other stakeholders, the Board and ETF wanted to ensure a transparent process as well as provide opportunities to collect feedback throughout this process. Therefore, a Request for Comments was issued on May 14, 2016. ETF staff addressed certain concerns before issuing a draft of the RFP, released to the public in the form of a Request for Information on June 13, 2016. ETF responded to additional questions and concerns as appropriate.

The RFP to evaluate the effects of self-insurance on the program and/or regionalizing the program was issued July 22, 2016. Nine vendors submitted proposals by the due date, September 19, 2016. Vendors could choose to participate in any or all of the regions, as well as the statewide/nationwide service area. Detailed information about

the motivation for this evaluation is outlined in the November 22, 2016 Board memo, State of Wisconsin Group Health Insurance Program — Current State & Overview.

Proposal Scoring
Proposers were required to respond to questions in three sections of the RFP.

Sections and points were allocated as follows:

General Questions	200 Maximum Points
Technical Questions	400 Maximum Points
Cost Proposal	400 Maximum Points
Total	1,000 Maximum Points

Proposals were reviewed and scored by two evaluation teams. One team, comprised of ETF and external subject matter experts, evaluated the general and technical questionnaires and consulted with information technology and finance specialists as needed. The other team was comprised of Segal experts who evaluated the cost, data and network access portions of the proposals.

RFP Results
RFP results and analysis were presented to the Board at its November 30, 2016 meeting, along with a variety of scenarios outlining potential cost savings. The cost analysis indicates there is the potential for significant savings in a new program structure. All options presented to the Board on December 13, 2016 achieve comparable future cost savings under different program structures.

Considerations
Initial Board feedback directed ETF to present options that meet the following objectives:
- Achieve program cost savings
- Meet access standards
- Maintain/improve quality options
- Minimize disruption
- Maintain benefit levels
- Understand capacity concerns
- Highlight vendor proposal scores
- Delineate risks
- Consider the timing of other ongoing Board initiatives
- Highlight prior experience with vendors
- Maximize use of tools currently available to the Board
- Maintain competition

Scenarios
Based on Board priorities and the RFP results, the following scenarios were developed for the Board's consideration. All scenarios produce equivalent future costs, allowing the Board to focus equally on the non-financial merits and concerns of each scenario. The

scenarios are listed from those that represent the least change to current structure (Option 1) to those that are the most transformative (Option 7).

Scenario	Funding Structure*	Level of Program Change
Scenario 1: Current Program Structure Up to 16 Vendors	Fully-Insured	Minimal
Scenario 2: Regionalized 7-11 Total Vendors	Fully-Insured	Moderate
Scenario 3: Regionalized 6-10 Total Vendors	Fully-Insured	Moderate
Scenario 4: Regionalized 6-8 Total Vendors	Hybrid	Significant
Scenario 5: Regionalized 6 Total Vendors	Hybrid	Significant
Scenario 6: Regionalized 6 Total Vendors	Self-Insured	Major
Scenario 7: Statewide 1-2 Total Vendors	Self-Insured	Major

**IYC Access Plan (formerly Standard Plan) remains self-insured in all options.*

Scenarios: Risks and Benefits
The following is a brief description of each scenario, along with key considerations for the Board.

The “Current Program Structure” scenario (Scenario 1) does not represent the status quo; it incorporates program improvements to achieve competitive premium rates and improve quality. Many of these changes are related to Board initiatives already underway that pertain to wellness and data warehousing:
• Non-negotiable data warehousing requirements
• Increased member incentives for wellness participation
• Improved quality through performance measurement benchmarks/thresholds

Other proposed changes are new concepts and are intended to ease program administration, contain costs and maintain employee benefits:
• Minimize cost shift to members / minimize reduction in benefits
• 3-year contracts with health plans
• Fully insured premium rates established/capped in order to achieve program costs comparable to other program restructure options

All of the scenarios presented in this memo assume implementation of these provisions as well as the selection of a new self-insured statewide/nationwide vendor to administer the IYC Access Plan, as the current self-insured statewide/nationwide vendor contract ends December 31, 2017.

Scenario 1: Current Vendors That Meet New Requirements
Scenario 1 allows all existing health plans to participate in the program under the conditions specified above. Premium levels would be established for each of the three program tiers and health plans would opt in at the selected premium rate and tier level where they choose to participate.

Scenario 2: Regionalized, 7 to 11 Total Vendors
This scenario adopts the regional structure outlined in the RFP, establishing regional service areas in the North, South, East and West; it also maintains a fully-insured structure. The majority of covered members reside in the South and East regions.

Participating insurers in the North, East and West regions would be required to provide coverage to the entire region where they participate. The Board may allow additional insurers/approaches in the Southern region, where the majority of the membership is located.

ETF would limit Tier 1 status to the most efficient and highest-quality health plans in each region. These structural changes would likely reduce the number of health plans participating in the GHIP.

Scenario 3: Regionalized, 6 to 10 Total Vendors
This scenario is very similar to Scenario 2, with two key changes:
• Addition of a second statewide/nationwide vendor
• Contracting with fewer insurers in each region

The addition of a second statewide vendor adds competition to the IYC Access Plan administration, which could result in lower negotiated administrative fees and the ability to compare cost and performance across vendors. This model also ensures additional member options in every region. Moving to fewer regional insurers steers more members to the most efficient and highest-quality health plans, provides those plans with additional market leverage and eases program administration.

The only exception to the regionalization approach outlined in Scenario 3 is in the Southern region, where the Board may determine that it is in the program’s best interest to allow additional insurers to compete.

Scenario 4: Regionalized, 6 to 8 Total Vendors
This scenario is very similar to Scenario 3, with one key change:
• Self-insuring regions where the greatest cost savings are anticipated

In the RFP regional bidders submitted varying administrative fees and reported different levels of discounts. In this scenario, ETF would attempt to negotiate comparable net program costs, or tier insurers accordingly if negotiations do not result in lower projected program costs. Same exception in the Southern region applies.

Scenario 5: Regionalized, 6 Total Vendors
This scenario is very similar to Scenario 4, with one key change:
• Only negotiate with the top two vendors in the Southern region

Scenario 6: Regionalized, 6 Total Vendors
This scenario is very similar to Scenario 5, with one key change:
• Self-insure the entire program

Scenario 7: Self-Insured, 1-2 Total Vendors
This scenario is very similar to Scenario 6, but would only contract with one or two statewide vendors. This scenario does not achieve the same level of cost containment available in the previous scenarios. ETF and Segal do not recommend this option.

Delayed/Phased Implementation
Other options available to help ensure a successful transition include delaying or incrementally phasing in any major program changes. A delay would allow for adequate transition time for contracting and more fully developed member and employer communications plans. Other options include July 1, 2018, January 1, 2019, or beyond.

A phased-in approach, such as implementation of regionalization, but delay of other significant changes such as self-insuring could 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. Examples include the new wellness and disease management vendor and new data warehousing vendor.

Attachment A provides a timeline of these initiatives. Key benefits and risks associated with these options include:

Benefits
• Allow sufficient time for successful transition
• Allow sufficient time to complete contracting and provider network arrangements
• Allow sufficient time for member and employer communications
• Allow for implementation of the data warehousing vendor and improved access to program data
• Allow for the evaluation of incremental strategies

Risks
• Potential missed opportunity to reduce costs in the short term

Attachment A: Group Insurance Board Initiatives Timeline