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Correspondence Memorandum

Date: December 8, 2016

To: Group Insurance Board

From: Lisa Ellinger, Director
Office of Strategic Health Policy

Subject: Request for Proposals for the State of Wisconsin Health Benefit Program: Results and Analysis

This memo presents a variety of options for program structure changes to the State of Wisconsin Group Health Insurance Program (GHIP). The options seek to maintain benefits, contain costs, and improve quality. The Department of Employee Trust Funds (ETF) requests Group Insurance Board (Board) approval of either a preferred option or a combination of strategies from the options presented.

Background

The Request for Proposal (RFP) to evaluate the impact of self-insurance and/or regionalizing the GHIP 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 (Ref. GIB | 11.30.16 | 6).

Proposal Scoring

Proposers were required to respond to questions in three sections of the RFP: Section 6, General Questionnaire; Section 7, Technical Questionnaire; and Section 8, Cost, Data, and Network Submission Requirements. A summary of the categories covered follows in Table 1, RFP Scoring Categories. The entire RFP and questions are available at: https://etfonline.wi.gov/etf/internet/RFP/HealthBeneAdminRFP1/index.html

A total of 1,000 points were available, with general questions receiving a maximum of 200 points; technical questions receiving a maximum of 400 points; and the cost proposal receiving a maximum of 400 points. Two teams evaluated the responses, with the assistance of an IT subcommittee. Section 6 and Section 7 (with the exception of section 6.5 Data Security) were scored by a five-member evaluation committee. Section

Reviewed and approved by Lisa Ellinger, Director, Office of Strategic Health Policy
Lisa Ellinger Electronically Signed 12/9/16

Board	Mtg Date	Item #
GIB	12.13.16	4A

6.5 was scored by a subcommittee of three IT subject matter experts. These two committees were supported by ETF procurement. Section 8 was scored by the Board's consulting actuary, Segal Consulting (Segal).

Table 1. RFP Scoring Categories

RFP Section and Title	Description
Section 6 General Questionnaire	
Experience	Location, types of clients and health insurance business
Staff Qualifications	Account management and key staff
Customer Service	Policies to meet contractual requirements and increase health literacy
Implementation	Submission of implementation plan with detail and key dates
Data Security	Security of hosting environment, application architecture, account and identity management and vulnerability assessment
Section 7 Technical Questionnaire	
Provider Management	Provider steerage, engagement and feedback on initiatives such as evidence-based practices and behavioral health care
Provider Reimbursement	Experience in administering various provider reimbursement methods
Medical Management	Case and disease management (DM), including financial rewards and integration with other wellness or DM vendors
Total Health Management	Experience in administering and facilitating value-based benefit designs, shared savings initiatives and member tools
Data Integration and Technology	Integration of electronic medical records and telehealth
Section 8 Cost, Data, and Network Submission Requirements	
Region Designation	Identification of the region the vendor is bidding on
Network Access	Listing of providers and GeoAccess analysis for member disruption
Network Pricing	Submission of claim repricing files on service categories, providers, and contract types
Administrative Fees	Detailed breakdown of administrative fees
Capitation	Identification of any and all services that would be capitated
Self-Insured Projection	Estimated costs in proposed region including adjustments for utilization and allowed amounts
Data Certification	Signed certification of submission by actuary, CFO or CEO

RFP Results
Results and analysis from the RFP were presented to the Board at its November 30, 2016 meeting. Segal also modeled a variety of scenarios based on the vendor proposals, which included potential cost savings estimates. The meeting was an opportunity for the Board to ask questions about the RFP results and provide feedback on the development of recommendations for the December 13, 2016 Board meeting.

The RFP was informative on several fronts: It provided the Board with an indication of the number of vendors, and which vendors, would participate in a restructured program. This aspect of the analysis revealed that there are multiple vendors available in every region and at the statewide level that provide broad access to providers. The RFP also indicated that vendors with a history of demonstrated quality in the GHIP would be available in a new program structure.

The cost analysis also indicated that there is the potential for significant savings in a new program structure. This memo outlines various options for achieving equivalent future costs under different program structures.

Considerations
A “decision matrix” was used to outline priority criteria to consider in deliberating potential changes to the program structure (see Table 2).

Based on these priorities, scenarios for the Board to consider were built, with the following objectives in mind:

- 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

Table 2. Decision Matrix

Consideration	Description
Cost	How do claims and administrative costs under the scenario compare with the projections under the current model?
Access	Do members have sufficient access to primary and specialty care as well as facilities?
Quality	How do the vendors in the scenario currently perform on quality measures and what is the potential to improve performance over time?
Disruption/ Capacity	How does access to primary and specialty care providers and facilities compare to the access members have today? Is there sufficient capacity in the available network(s) to absorb the disruption?
RFP Score	Does the scenario include only the top scoring vendors?
Risk	How significant/likely are the risks associated with the scenario and do they outweigh the potential improvements?
Timing	What is the appropriate implementation timeline, given other ongoing Board priorities?
Tools	Does the Board have other mechanisms available to effectively achieve the same goal in more efficient manner?
Partnerships	Have the vendors included in the scenario demonstrated that they understand Board/ETF program needs well and are poised to be strong partners with the Board/ETF?
Competition	Are there sufficient vendors available to provide negotiation leverage/options?
Program Control	Does the scenario maintain control of the program with the Board or give the Legislature's Joint Committee on Finance an opportunity to determine next steps?
Opportunity to Try Different Models	Does the scenario give the Board/ETF the opportunity to try different models: fully-insured vs. self-insured, narrow vs. broad networks?
Impact on Markets	Does the scenario include the maximum number of vendors participating to minimize disruption in the Wisconsin insurance market? Does it reflect provider systems' service areas and their referral patterns?

Based on the Board priorities and RFP results, the scenarios listed in Table 3 were developed for the Board's consideration. All scenarios were developed to produce equivalent future costs, in order to allow 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 from current structure (Option 1), to those that are the most transformative (Option 7).

Table 3. Program Structure Scenarios

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.

Scenario 1: Current Program Structure, Up to 16 Vendors
The "Current Program Structure" scenario does not represent the status quo, but includes 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.

Scenario 1 would allow all existing health plans to continue to participate in the program under the conditions specified above. The most controversial of the changes is the final bullet point – fixed premium rates. This would reverse the current dynamic, wherein health plans submit preliminary bids and negotiate with ETF to reach the desired Tier 1 premium threshold. In this scenario, ETF would establish fully insured premium levels 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. Premium levels would be established to match estimated program costs under a restructured program.

The Board could direct ETF to initially pursue a fully insured strategy, but also authorize ETF to move to a self-insured approach if premium negotiations on a fully insured basis do not progress toward signed contracts within a reasonable time frame.

A significant unknown in this scenario is whether all health plans would continue to participate under the established premium structure, given the requirements noted above. An additional unknown is the future of fees associated with the Affordable Care Act (ACA). In the event that ACA fees remain, a fully insured model would include additional costs related to the ACA.

This scenario would also select a new self-insured statewide/nationwide vendor to administer the IYC Access Plan (formerly Standard Plan), as the current self-insured statewide/nationwide vendor contract ends December 31, 2017.

Table 4. Scenario 1: Current Program Structure, Up to 16 Vendors

Program Structure:	
Self-Insured Plan	**Fully-Insured Plans**
• *Statewide/Nationwide*: One Plan	• Up to 16 current plans willing to meet program requirements; plans define service area

Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Insurer financial responsibility for claims costs • Insurer incentive to focus on medical management and utilization • Maintain competitive insurer environment • Legislative approval required for statewide vendor only • Public/member positive perception • Ability to administer with current ETF staff capacity	• Missed opportunity to eliminate lower quality vendors • Complex administration	• Which health plans will continue to participate -- impacts access and provider disruption

Scenario 2: Regionalized, 7 to 11 Total Vendors

This scenario would adopt the regional structure outlined in the RFP, establishing regional service areas in the North, South, East and West. Table 5 provides a breakdown of group health insurance program members for each region. The majority of members reside in the South and East regions.

Table 5. ETF Regional Membership

Region	NORTH	SOUTH	EAST	WEST
% of membership	**4%**	**54%**	**30%**	**10%**

This scenario maintains a fully insured program structure, with the exception of the statewide/nationwide vendor, which will be self-insured (as noted in Scenario 1). The requirements noted in Scenario 1 would apply in this scenario as well, including the fixed premium approach.

Participating insurers in Scenario 2 would be required to provide coverage to the entire region where they participate. This is a reversal from current practice, wherein health plans determine the service area on a county-by-county basis. In addition to moving toward a regional structure, 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.

The only exception to the regionalization approach outlined above 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.

Table 6. Scenario 2: Regionalized, 7–11 Total Vendors

Program Structure:	
Self-Insured Plan	**Fully-Insured Plans**
• *Statewide/Nationwide*: One Plan	• *North*: Multiple Plans • *East*: Multiple Plans • *West*: Multiple Plans • *South*: Current plans willing to meet program requirements; plans define service area

Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Insurer financial responsibility for claims costs • Insurer incentive to focus on medical management and utilization • Maintain competitive insurer environment, but with fewer insurers • Legislative approval required for statewide vendor only • Public/member positive perception • Ability to administer with current ETF staff capacity	• Missed opportunity to eliminate lower quality vendors • Complex administration	• Which health plans will continue to participate -- impacts access and provider disruption

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.

Again, 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.

Table 7. Scenario 3: Regionalized, 6–10 Total Vendors

Program Structure:		
Self-Insured Plans	**Fully-Insured Plans**	
• *Statewide/Nationwide*: Two Plans	• *North*: Fewer Plans • *East*: Fewer Plans • *West*: Fewer Plans • *South*: Current plans willing to meet program requirements; plans define service area	
Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Insurer financial responsibility for claims costs • Insurer incentive to focus on medical management and utilization • Maintain competitive insurer environment, but with fewer insurers • Legislative approval required for statewide vendors only • Public/member positive perception • Ability to administer with current ETF staff capacity • Improved ease of administration	• Missed opportunity to eliminate lower quality vendors	• Which health plans will continue to participate -- impacts access, disruption

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 saving 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.

The only exception to the regionalization approach 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.

Table 8. Scenario 4: Regionalized, 6–8 Total Vendors

Program Structure:	
Self-Insured Plans	**Fully-Insured Plans**
• *Statewide/Nationwide*: Two Plans • *Regions selected by Board*	• *Regions selected by Board* • *South*: Current plans willing to meet program requirements; plans define service area

Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Maintain competitive insurer environment, but with fewer insurers • Steer membership toward highest quality insurers • Improved ease of administration	• Legislative approval required • Shared financial responsibility for claims costs • Public/member perception	• Which health plans will continue to participate -- impacts access, disruption

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

Table 9. Scenario 5: Regionalized, 6 Total Vendors

Program Structure:	
Self-Insured Plans	**Fully-Insured Plans**
• *Statewide/Nationwide*: Two Plans • *Regions selected by Board*	• *Regions selected by Board* • *South*: Two Plans

Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Maintain competitive insurer environment, but with fewer insurers • Steer membership toward highest quality insurers • Improved ease of administration	• Legislative approval required • Public/member perception • Health plan capacity • Shared financial responsibility for claims costs	• Which health plans will continue to participate -- impacts access, disruption

Scenario 6: Regionalized, 6 Total Vendors

This scenario is very similar to Scenario 5, with one key change:

- Self-insure the entire program

Table 10. Scenario 6: Self-Insured/Regionalized, 6 Total Vendors

Program Structure:		
Self-Insured Plans	**Fully-Insured Plans**	
• *Statewide/Nationwide*: Two Plans • *Regions*	• None	
Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Maintain competitive insurer environment, but with fewer insurers • Steer membership toward highest quality insurers • Improved ease of administration	• Legislative approval required • Public/member perception • Health plan capacity • Shared financial responsibility for claims costs plan capacity	• Which health plans will continue to participate -- impacts access, disruption

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. The Board should note that this scenario does not achieve the same level of cost containment available in the previous scenarios. ETF and Segal do not recommend this option.

Table 11. Scenario 7: Self-Insured, 1–2 Total Vendors

Program Structure:		
Self-Insured Plan(s)	**Fully-Insured Plans**	
• *Statewide/Nationwide*: One - Two Plans	• None	
Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Improved ease of administration	• Missed opportunity for cost savings • Legislative approval required • Public/member perception • Health plan capacity • Full financial responsibility for claims costs	

All options presented in this memo are summarized in Table 12.

Table 12. All Scenarios

Scenario	Self-Insured	Fully-Insured
Scenario 1: Current Program Structure Up to 16 Vendors	• *Statewide:* 1 plan	• *Maintain current structure* • *Up to 16 plans* • *Plans define service area*
Scenario 2: Regionalized 7-11 Total Vendors	• *Statewide:* 1 plan	• *East:* Multiple plans • *West:* Multiple plans • *North:* Multiple plans • *South:* Current plans that define service area
Scenario 3: Regionalized 6-10 Total Vendors	• *Statewide:* 2 plans	• *East:* Fewer plans • *West:* Fewer plans • *North:* Fewer plans • *South:* Current plans that define service area
Scenario 4: Regionalized 6-8 Total Vendors	• *Statewide:* 2 plans • *Regions selected by Board*	• *Regions selected by Board* • *South:* Current plans that define service area
Scenario 5: Regionalized 6 Total Vendors	• *Statewide:* 2 plans • *Regions selected by Board*	• *Regions selected by Board* • *South:* 2 plans
Scenario 6: Regionalized 6 Total Vendors	• *Statewide:* 2 plans • *Regions selected by the Board*	• *None*
Scenario 7: Statewide 1-2 Total Vendors	• *Statewide:* 1-2 plans	• *None*

Delayed/Phased Implementation
The Board could delay or phase-in the implementation of self-insuring and/or regionalizing to allow adequate transition time for contracting and member communication. The public discussion around implementation has generally focused on January 1, 2018; however, the Board could opt for a mid-2018 implementation (which would align the GHIP with the state budget cycle) or aim for 2019 or beyond.

Likewise 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.

The Board has also expressed an interest in coordinating long-term program strategies with the Board initiatives already underway, particularly the activities of the new wellness and disease management vendor and new data warehousing vendor. Attachment A provides a timeline of these initiatives for the Board's reference.

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 communication
- 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

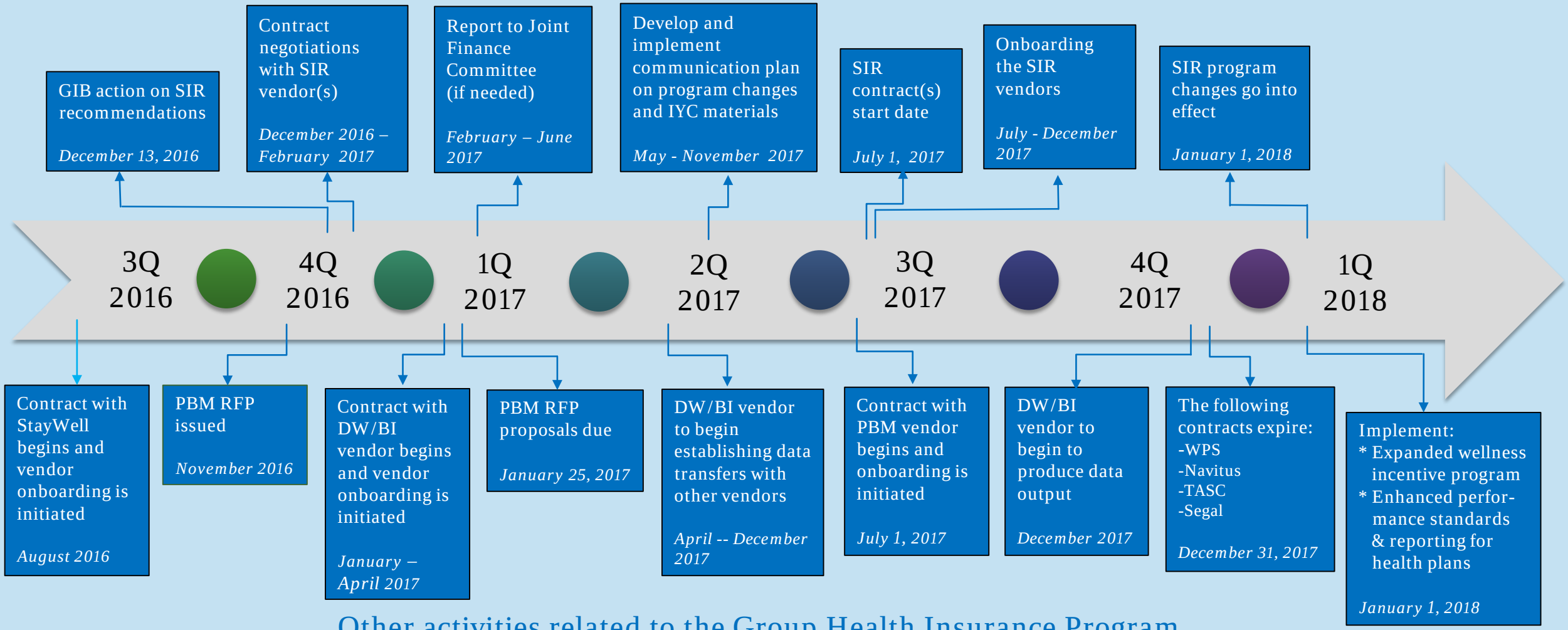
Staff and Segal will be at the Board meeting to answer any questions, and model the cost and member impacts of the scenarios outlined above. In closed session, staff and Segal will further detail the scenarios, including the number of vendors and which vendors would be included in each option.

Attachment A: Group Insurance Board Initiatives Timeline

Attachment A

Group Insurance Board Initiatives Timeline

Activities related to the self-insurance and/or regionalization (SIR) RFP



Other activities related to the Group Health Insurance Program