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Correspondence Memorandum

Date: December 9, 2016

To: Group Insurance Board

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Subject: Group Health Insurance Program (GHIP) and Wisconsin Public Employers (WPE) Program: 2018 Program and Operational Considerations

Staff requests Group Insurance Board (Board) approval to pursue the following program changes:

1) **Wisconsin Public Employers (WPE) Program – reduce number of options available**
2) **Local Annuitant Health Program (LAHP) – combine with WPE**
3) **IYC Access Plan (Standard Plan) – consolidate into statewide contracts**
4) **Medicare – make new Medicare Advantage options available for 2019**

If approved, staff will begin to initiate these changes and will provide status updates at the 2017 Board meetings.

Background

Program structure changes currently under consideration by the Board will require and/or create the opportunity to revamp the following aspects of the health insurance program:

- Wisconsin Public Employers (WPE) Program
- Local Annuitant Health Program (LAHP)
- IYC Access Plan (formerly called the Standard Plan)
- Medicare Options

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	4B

An overview of issues and staff recommendations follows below.

Wisconsin Public Employers (WPE) Program

Starting in 2005, Wisconsin public employers (local governments) participating in the group health insurance program could select between several benefit variations (program options). Currently, four program options are available to participating employers; two options mirror the benefit plans offered to state employees. The Board's consulting actuary, Segal Consulting (Segal), has recommended offering only the program options that mirror state benefits. This would result in reduced administration by staff and vendors, but would also reduce options for WPE participants. The four WPE program options are outlined in Table 1. PO 16 and PO 17 are identical to the plans available to state employees.

Table 1. WPE Benefits Summary by Program Option (PO)
2017 Non-Medicare Medical Benefits for In-Network Providers

	PO 12 IYC Local Traditional Plan	PO 14 IYC Local Deductible Plan	PO 16 IYC Local Health Plan	PO 17 IYC Local High Deductible Health Plan (HDHP)
Deductible	No Deductible	$500 individual $1,000 family	$250 individual $500 family	$1,500 individual $3,000 family (Deductible must be met before coverage begins)
Office Visit Copayment	None	None	$15 Primary Care $25 Specialty Care	(After deductible) $15 Primary Care $25 Specialty Care
Coinsurance	20% for DME, hearing aids, and adult cochlear implants	After deductible, none except 20% for DME, hearing aids, and adult cochlear implants	After deductible, 10% except for office visits	After deductible, 10% except for office visits
Annual OOPL	Up to $500 only for DME, and adult cochlear implants, and $1,000 for adult hearing aids	After deductible none, except for $500 for DME and adult cochlear implants and $1,000 for adult hearing aids	$1,250 individual $2,500 family	$2,500 individual $5,000 family

Currently, most local employers offer either PO 12 or PO 14 to their employees; PO 16 and PO 17 were only recently made available to local employers, and have the smallest number of groups enrolled. Current WPE participation is outlined in Table 2.

Table 2. WPE Employer and Subscriber Counts by Program Option (PO)

	PO 12 IYC Local Traditional Plan	PO 14 IYC Local Deductible Plan	PO 16 IYC Local Health Plan	PO 17 IYC Local High Deductible Health Plan (HDHP)
Number of Employers	228	111	10	3
Number of Employees	4,421	1,238	585	105

ETF surveyed WPE participants in late 2016 to ask whether they would consider terminating participation in the program if ETF limited options to just PO 16 and PO 17. Most WPE employer representatives that responded indicated that they were unsure; however, those that indicated they were likely to leave currently offer the richest benefit plan, PO 12. In comments, many local employers expressed concerns about the ability to recruit and retain staff without generous benefits, given limitations on offering competitive salary levels. Comments also expressed confusion regarding the structure and rates of the PO 16 and PO 17 plans.

In summary, most local government employers:

- Offer employees the options that do not mirror the state employee plans
- Prefer to offer benefits to their employees that are more generous than the state plans
- Prefer not to be forced to change their benefits
- Are undecided as to whether they would remain in the program if the Board changes program options

It should also be noted that the larger program structure changes being considered by the Board could influence future participation in the WPE program.

Staff recommends reducing the number of plan designs available for 2018 to three: PO 12, PO 16, and PO 17. This would begin the transition of membership to plans that mirror the two state plans, while still allowing a more generous option for local governments that feel they need these benefits as a competitive recruitment tool.

Local Annuitant Health Program (LAHP)

The LAHP is required by Wis. Stat. § 40.51 (10); it serves individual annuitants from municipalities who are not otherwise eligible for program participation and who may not have an insurance offering from their former employer. This program is fully insured and offers different benefit levels than those available in other ETF-administered programs.

LAHP offers a Medicare Supplement to retirees over age 65 and a Preferred Provider Organization (PPO) for retirees under age 65. It is administered by WPS.

LAHP covers a small population of 5 annuitants under age 65 and 173 annuitants over age 65. Previous analysis exploring program consolidation indicated that these members could be folded into the WPE program without adversely impacting the program.

Combining the LAHP into the WPE program would greatly simplify administration and could also stabilize LAHP rates, which have been volatile over time. There are enrollment policies to consider with this change. Retirees in the Wisconsin Retirement System (WRS) currently may join LAHP during specified open enrollment periods when they retire or when they turn age 65 and/or first enroll in Medicare Part B. Retirees currently may also apply outside of open enrollment if they submit to individual medical underwriting. Retirees may be denied coverage based upon this underwriting. Federal law permits this process as this program is considered individual coverage for retirees.

If LAHP were combined with the local group health insurance program, individual medical underwriting of late applicants would no longer be permitted. In order to limit adverse risk, ETF recommends that new enrollees be limited to applying for coverage only during the established open enrollment periods.

ETF recommends administering the LAHP within the WPE program structure.

<u>IYC Access Plan (formerly called the Standard Plan)</u>
In the Request for Proposal (RFP) for self-insurance and regionalization, vendors that submitted a proposal for the statewide/nationwide region were asked to incorporate certain services currently provided by the administrator of the Standard Plan (which is how the program is referenced in statute). Statute currently requires the plan to be offered alongside another plan, and that the benefits of the two plans be substantially equivalent.

The IYC Access Plan is currently a self-insured, Tier 3 PPO that is available nationwide. It is attractive to out-of-state members and those who prefer greater freedom of choice of providers. This structure could continue within the new model. The plan is currently administered through WPS, with a contract end date of December 31, 2017.

The plan has been decreasing in membership for many years, as noted in the Table 3 summary.

Table 3. Membership in IYC Access Plan (2012 – 2016)

Year	State membership	Change from prior year	Local membership	Change from prior year
2016	1,540	-3%	18	-25%
2015	1,588	-15%	24	-20%
2014	1,870	-3.6%	30	-25%
2013	1,940	-13.8%	40	+48%
2012	2,250	-14%	27	-20.6%

As noted above, the statutes stipulate that the Board provide at least two health care coverage plans that offer substantially equivalent benefits. The IYC Access Plan contains a few noteworthy benefit variations from Uniform Benefits.

Table 4. Benefit Comparison

Benefit	IYC Access Plan	Uniform Benefits
Bariatric Surgery	Covered	Excluded
Adult hearing aids and adult cochlear implants	Excluded	Covered
Transplants	Covers bone marrow, musculoskeletal, corneal, and kidney	Covers bone marrow, musculoskeletal, corneal, kidney, parathyroid, heart, liver, kidney with pancreas, heart with lung, and lung
Oral Surgery	Covers 23 procedures	Covers 11 procedures
In/Out-of-Network	In- and Out-of-Network coverage available	In-Network coverage only

Less significant benefit variations include coverage for cardiac rehabilitation, clinical trials, genetic tests, midwife services and smoking cessation.

ETF recommends pursuing a strategy that would establish a Tier 1 statewide/ nationwide plan to replace the IYC Access Plan to ensure that it is a competitive offering.

ETF recommends the following strategies to achieve this objective:

- Adjust benefits to align with Uniform Benefits
- Implement a meaningful differential between in-network versus out-of-network out-of-pocket costs in order to steer care in-network
- Investigate any statutory changes necessary to implement this program change

Medicare Options

Currently, Medicare-eligible annuitants have several options available for coverage under the GHIP: the It's Your Choice (IYC) Health Plan; the IYC Medicare Advantage (MA) plan; and the IYC Medicare Plus supplement.

The IYC Health Plan includes comprehensive coverage, with cost-sharing and rates that reflect Medicare coverage, with plans coordinating claims with Medicare. The IYC Medicare Advantage plan is administered by Humana and meets all the requirements of a Medicare Advantage plan and the Uniform Benefit requirements for Medicare-eligible members, and includes Medicare-covered services. The IYC Medicare Plus supplement plan is a self-insured health plan administered by WPS, which meets all requirements for a Medicare supplement plan, and wraps around Medicare fee-for-service benefits. The contract with WPS to administer the IYC Medicare Plus supplement expires on December 31, 2017.

The rates available under these plans are highly variable across the options. Because annuitants are fully responsible for the cost of their premium, these members tend to be price sensitive in their plan selections.

Segal has recommended that the Board consider offering more Medicare Advantage plan choices to state and WPE annuitants. Based on its experience in other states, the federal subsidies available for these programs, and the programs' focus on rewarding quality, Segal believes that Medicare-eligible annuitants could see reductions in premiums if more Medicare Advantage plans were available.

Options for consideration include, from least to most disruptive compared to the current system:

1. Current Medicare Program structure. A replacement for the current IYC Medicare Plus carrier is necessary, and staff recommends negotiating with the selected statewide/nationwide carrier(s) to administer this contract.
2. Medicare offerings from existing providers, and consider continuing to offer Humana's MA plan if new statewide vendor does not have a suitable replacement.
3. Allow all IYC vendors to propose Medicare offering and pricing each year.
4. Similar to 3, but limit number of vendors and self-insure the non-MA plans.
5. Similar to 4, but lock into 3-year Medicare contracts as well. This will limit MA expansion.

6. Issue an MA RFP, with an implementation date of July 1, 2018 or January 1, 2019 (due to the timing issues noted below, as well as the time necessary to develop and issue an RFP). Still allow Medicare supplemental plans with other insurers.

The Board should also be aware that insurers offering a Medicare Advantage plan must submit an application to the federal government each year and the process for 2018 started November 14, 2016. Final submissions are due February 15, 2017.

Staff recommends option 1 for 2018, and option 6 longer term, from the list above.

Staff will be at the Board meeting to answer any questions.