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Correspondence Memorandum

Date: January 24, 2017

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 options for program structure changes to the State of Wisconsin Group Health Insurance Program (GHIP). All options seek to maintain benefits, contain costs, and improve quality. The Department of Employee Trust Funds (ETF) requests the Group Insurance Board (Board) approve 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. 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). ETF also presented additional information about proposal scoring and the risks and benefits associated with various restructuring scenarios at the December 13, 2016 Board meeting in the memo, Request for Proposals for the State of Wisconsin Health Benefit Program: Results and Analysis (Ref. GIB | 12.13.16 | 4A). All scenarios were structured to achieve comparable cost savings, maintain broad access to providers, and designed to be beneficial to both employers and employees. The scenarios presented at the December Board meeting are listed in Table 1. All scenarios presented included the following program improvements to achieve competitive premium rates and improve quality:

- Non-negotiable data warehousing requirements
- Increased member incentives for wellness participation
- Improved quality through performance measurement benchmarks/thresholds
- Minimal cost shift to members / minimal reduction in benefits
- Multi-year (3-year) contracts with health plans

Reviewed and approved by Lisa Ellinger, Director, Office of Strategic Health Policy

Lisa Ellinger

Electronically Signed 1/30/17

Board	Mtg Date	Item #
GIB	2.8.17	5A

Table 1. 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.*

At its December 13, 2016 meeting, the Board requested additional information pertaining to scenarios 3, 5 and 6 and decided to reconvene in early 2017 to take action on program structure changes. Specifically, the Board wanted to better understand the likelihood of potential risks and benefits, the probability of achieving projected cost savings, whether the scenarios would cause provider disruption for members, and the timeline for contract negotiations, program implementation and member outreach and communication. ETF staff and the Board's consulting actuary, Segal Consulting (Segal), have conducted additional analysis on these issues, and will be briefing the Board on these topics in closed session at the February 8, 2017 meeting.

Scenario Summaries
The following is a brief description of each scenario, along with key considerations for the Board. This memo maintains the scenario numbering from the previous Board presentation to avoid confusion.

Scenario 3: Regionalized, 6 to 10 Vendors
This scenario would adopt the regional structure outlined in the RFP, establishing regional service areas in the North, South, East and West, and also contract for a statewide/nationwide offering.

This scenario maintains a fully insured program structure for the regional vendors, with the exception of the statewide/nationwide vendors, which will be self-insured.

Participating insurers in Scenario 3 would be required to provide coverage to the entire region in which they participate. 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.

Scenario 5: Regionalized, 6 Vendors
This scenario is very similar to Scenario 3, with two key changes:

- Self-insure regions where the greatest cost saving are anticipated
- Limit negotiations to top two vendors in the Southern region

Scenario 6: Regionalized, 6 Vendors
This scenario is very similar to Scenario 5, with one key change:

- Self-insure the entire program

All options presented in this memo are summarized in Table 2.

Table 2. All Scenarios

Scenario	Self-Insured	Fully-Insured
Scenario 3: 6-10 Vendors	• *Statewide*	• *East:* Fewer plans • *West:* Fewer plans • *North:* Fewer plans • *South:* Current plans define the service area
Scenario 5: 6 Vendors	• *Statewide* • *Regions selected by Board*	• *Regions selected by Board* • *South:* 2 plans
Scenario 6: 6 Vendors	• *Statewide* • *Regions selected by the Board*	• *None*

Timeline
The public discussion around program restructuring has generally focused on a January 1, 2018 implementation; however, the Board could opt for a mid-2018 implementation (which would align the GHIP with the state budget cycle) or aim for 2019.

The following timeline highlights key deliverables and desired target dates required to implement program changes for January 1, 2018:

- February 8, 2017: Board approval and Issuance of Letter(s) of Intent to Award Contract(s)
- February 8, 2017: Board approval of 2018 benefit and contract changes
- February 9 – March 31, 2017: Contract negotiations

- May 1, 2017: Joint Committee on Finance (JCF) review process complete

The February Board approval for restructuring changes is necessary to allow sufficient time for contract negotiations and the development of a communication strategy for employers and members. Likewise, the Board approval for 2018 benefit and contract changes (which usually comes to the Board at the May meeting), is needed to ensure benefit changes are incorporated into the contracts being negotiated for 2018.

Targeting late March for the completion of contract negotiations is not only crucial to the progress of the employer and member communications strategy, but also allows ETF staff sufficient time to operationalize the changes through changes to ETF eligibility, enrollment and invoicing systems.

JCF review completion is desired early in the process to allow time to develop an alternative strategy for 2018 if restructuring changes are rejected. ETF will coordinate the submittal of the JCF proposal with the Department of Administration Division of Personnel Management, as required by state statute.

As presented at the December 13 Board meeting, the Board could delay the implementation of self-insuring and/or regionalizing until 2019 to allow adequate transition time for contracting and member communication.

After additional internal ETF discussion, it has been determined that a July 1, 2018 implementation is not advisable due to the complexity and significant risk created with a mid-year implementation within and between ETF's IT systems.

Staff and Segal will be at the Board meeting to answer questions and model the cost and member impacts of the scenarios outlined above.