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November 12, 2018

Group Insurance Board
Attn: Michael Farrell, Board Chairman
P.O. Box 7931
Madison, WI 53707-7931.

VIA EMAIL

Re: Expiration of Long Term Care Insurance Offerings for Eligible Employees and Annuitants

Dear Chairman Farrell and Group Insurance Board Members:

Thank you for scheduling time to discuss the state's long term care ("LTC") standards during this week's Board meeting. It is critical that you and other Members fully appreciate the detrimental consequences that will result if the Board chooses not to act on this matter during this last scheduled meeting of the calendar year.

For the reasons explained below, we respectfully request that the Board delay the implementation of its new long term care standards, as they relate to LTC coverage, for one year, and authorize the extension of its current LTC agreement with Mutual of Omaha for 2019. All prerequisite actions necessary for Board extension of the current agreement have already been completed by or on behalf of Mutual of Omaha. Extending this agreement would allow the Board to remain in compliance with its statutory obligations, prevent the termination of important services to employees and annuitants provided by HealthChoice, and allow time for information to be prepared so that the Board can assess how best to move forward with LTC standards for subsequent years.

Background

Mutual of Omaha ("MoO") is currently the Board's only LTC insurance provider. MoO's contract with the Board expires at the end of this year. To the best of our knowledge, there are no approved contracts with other insurers to provide a LTC product in 2019. Our client, Equisource Corporation d/b/a HealthChoice Insurance Solutions ("HealthChoice"), is the marketer for the MoO LTC offering. Since 1994, HealthChoice has worked hand-in-hand

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with ETF staff and various insurers to create custom LTC offerings for eligible employees, and has served as the primary vendor for these plans.

As detailed in our August 21, 2018 correspondence with the Board (a copy of which is enclosed), negotiations between ETF staff and MoO have largely stalled with respect to LTC for 2019. In a nutshell, MoO has offered to continue offering LTC policies, through HealthChoice, under the same terms and conditions as have governed these offerings for the past few years. MoO has, at least to date, been unwilling to agree to all of the new terms and conditions that arose from the Alignment Strategy process approved by the Board last November. As a result, the state is poised to enter 2019 with no LTC provider. For more information about the reasons underlying MoO's position with respect to the Board's LTC standards, please carefully review the enclosed letter.

The purpose of this correspondence is not to rehash this history. Instead, we hope that the information below will provide the Board a clear understanding of significant costs and legal issues that are likely to arise if the Board allows the contract with its only LTC provider to expire at the end of this year.

GIB Statutory Obligation

As detailed in our prior letter, Wisconsin law *requires* the state, through the Board, to offer eligible employees and annuitants, and their spouses and parents, "long-term care insurance policies which have been filed with the Office of the Commissioner of Insurance and which have been approved for offering under contracts established by the [GIB]." Wis. Stat. § 40.55.

We have been advised that the ETF has taken the position that the language above, allowing the Board to "approve" the offering of LTC contracts, absolves the state and the Board from meeting this statutory obligation if the terms and conditions required of an LTC provider result in there being *no provider willing to offer these services*.

Taking this argument to its logical extreme, what if the ETF and the Board decided to require LTC providers to offer coverage at half of market rates? What if insurers were required to provide coverage for free? While we are not suggesting that these examples are realistic, they are illuminating. We should all be able to agree that they show how, at *some point*, terms and conditions imposed by the Board may rise to the level of being unreasonable. It would be difficult to successfully argue that the state and the Board are absolved of their statutory responsibility no matter how unreasonable are the terms and conditions that they impose on providers.

For purposes of your discussion on November 14th, we ask only that you acknowledge that more investigation is warranted as to the reasonableness of the new terms and conditions that are being imposed on LTC providers. If the Board is willing to extend the MoO agreement through 2019, HealthChoice would be able to work with ETF staff to survey potential future providers and gather other relevant information to help the Board to make an informed final decision with respect to these standards. HealthChoice is also eager to investigate ways that it might be allowed to take on contractual obligations to the state that are unacceptable to MoO or other potential insurers, so that this obstacle might be eliminated.

Potential Lost Benefits for Employees and Annuitants, and Their Family Members

Let there be no misunderstanding: in the absence of an extension of the MoO agreement, we will be forced to shut down the HealthChoice division of Equisource Corporation. This is all HealthChoice does; our enrollment agents do not offer any other products. In addition to necessitating the layoffs of six dedicated HealthChoice employees, the loss of HealthChoice will have significant, negative effects on services provided to current policy holders and the workload of ETF staff, as well as ending the availability of unique LTC coverage for potential new policy holders.

Impacts on Customer Service

For 24 years, HealthChoice has proven its commitment to keeping the 8,000+ existing state LTC policy holders informed, serviced, and satisfied. HealthChoice has established itself with employees, retirees, and ETF staff as dependable, proactive, and committed, without any complaint. HealthChoice is proud to have a perfect customer service record over the last 24 years and is an Accredited Business with the Better Business Bureau. ETF staff have told us and others that our customer service has been excellent and their relationship with us as an insurance provider has been a positive one for decades.

From its Madison office, HealthChoice provides dedicated customer service support to employees/annuitants starting at the time that someone makes an initial inquiry and continuing through the initiation of a claim. HealthChoice even helps those employees/annuitants who purchased LTC plans through past vendors that no longer offer insurance to the state ETF member group, even for insurance policies that HealthChoice *did not offer or enroll*. Many of these contacts have been referred to HealthChoice by ETF staff over the years. ETF staff make such referrals because the vendors are often no longer available and ETF is not equipped to research or answer in-depth questions related to these policies. We answer these inquiries as a courtesy to help ETF staff, and to be a true "one stop shop" for employees/annuitants with respect to LTC coverage. The Board should be aware

that HealthChoice is about much more than just selling insurance policies. We have truly become an important customer service partner with the state over the last quarter century.

HealthChoice also provides interested employees/annuitants with face-to-face consulting, education, and enrollment management services. Insurance of this type requires significant attention and due diligence through the enrollment process, and HealthChoice provides this attention and care. HealthCoice spends approximately $40,000 each year on member outreach, and maintains dedicated toll free phones, email, and a website exclusively for the state ETF member group. This includes CareOptions education information and a national care resources portal for all employees/annuitants and their family members to access.

In addition, HealthChoice assists enrollees with managing life insurance conversions to pay for LTC coverage. This is one of the only ways people can use the value of a life insurance policy before death, and there is often a tax advantage for the enrollee. This valuable and important customer service, which requires no assistance from ETF, would either be unavailable or would have to be provided by ETF if HealthChoice no longer services LTC plans for the state.

If the Board does not extend the MoO agreement such that HealthChoice cannot maintain its services, the parent company of HealthChoice will continue to fulfill its obligations to policyholders that have been enrolled by HealthChoice over the years. However, these obligations are limited, and would primarily consist of connecting policyholders with the insurance company from whom they purchased their policy; all of the additional services that have been provided by HealthChoice as an active vendor will no longer be possible.

Impacts on LTC Options

In addition to the loss of service that would result from the elimination of HealthChoice, the MoO LTC plan contains important exclusive benefits that will be lost to future enrollees if this plan is not extended. These benefits are not available for individually purchased plans on the open market. For instance, there is a 5% premium discount under this plan, which results in an average $2,000 savings per policyholder. Also, this plan includes a guaranteed purchase option which allows policyholders to increase their benefit every two years with no additional health underwriting –a very important feature that is unique to this plan.

Furthermore, people who do not obtain their LTC coverage as annuitants under the ETF member group are also be ineligible for certain benefits. For example, annuitants who are retired public safety officers may elect to have LTC premiums deducted from their monthly WRS annuity payment and remitted directly to the annuitant's insurance provider. If

annuitants are not enrolled under a ETF-offered LTC policy, they have to pay their provider directly and may lose tax exclusion benefits.

Similarly, other annuitants are allowed to convert the cash value of their group life insurance to pay for LTC insurance. This is possible only if the conversion is to pay for premiums under ETF-approved policies. If there is no ETF-approved LTC policy offering, annuitants may forfeit cash value in their life insurance policies that they could have used for LTC coverage.

Impact to the State and ETF Staff

HealthChoice, not MoO, has been paying the state up to $20,000 per year in administrative fees to cover internal staff costs related to LTC insurance. As described above and below, HealthChoice handles most of the communications efforts with prospective and existing policyholders for ETF, and these policyholders do not utilize other administrative services such as payroll deduction and open enrollment. Therefore, it will not be a wash for the ETF budget if LTC coverage is dropped; our fees help to cover more costs than those associated strictly with LTC matters.

With the loss of HealthChoice, ETF staff will likely be called upon to field the thousands of contacts that HealthChoice currently manages, from people looking for information about enrollment or with questions about or needing help with their existing policy. In sum, this means that ETF will have a *significant increase* in work related to this insurance product, and a *decreased revenue* source to fund those efforts.

Lastly, from a fiscal perspective, the state is always in a better position if a portion of its employees/annuitants are continuously enrolling under LTC insurance policies, because this type of coverage reduces state Medicaid costs for long-term care services. The lack of a state LTC offering and educational program could, over time, have significant fiscal impacts.

Steps for Extension of the Existing Agreement

Clearly, there is a lot at stake as you decide whether to extend the MoO agreement for 2019. As you consider this, it is important to understand that extending this agreement is wholly in the Board's hands. Even with the short time remaining in this calendar year, no interruption of LTC offerings will occur and no additional administrative costs or burdens would be incurred if the Board agrees to extend the existing LTC agreement with MoO. This is because all of the following steps that are necessary for the continuation of this offering have already been completed.

First, the MoO LTC insurance plan for 2019 was already approved by ETF in February of this year. At that time, ETF indicated that they would recommended this plan for approval by the Board, contingent upon MoO agreeing to the new terms and conditions. The 2019 plan has also been approved by the state's consulting actuaries (Milliman).

Second, there is no specific open enrollment period for LTC insurance. Employees and annuitants are allowed to enroll at any time. HealthChoice and MoO will certainly see a reduction in new enrollees in 2019 because the late date of plan approval will result in lost marketing opportunities, including participation at health benefit fairs, but this does not preclude continuing this service. In addition, no change is needed to the marketing materials used for member outreach. These materials have all been approved and are currently in use.

Third, there is no concern about the timing related to processing of payroll deduction requests. In all the time that HealthChoice has been involved in LTC offerings in the state, no employee has used payroll deduction to pay for LTC premiums. This is not expected to change, because there are disadvantages to paying in this manner, including that there is no pre-tax advantage, these plans are intended to carry over into retirement, and most importantly, paying LTC premiums on a monthly basis is more costly. (These factors do not apply to retired public safety officers who pay their LTC premiums by deduction from their monthly WRS annuity payments, as mentioned above.)

Lastly, there are no changes that would be required on the ETF website if the MoO agreement is extended. The required information is already posted and is still accurate. The existing agreement, if extended, would also continue to provide all necessary rules, limitations and protections as it has in previous years.

In conclusion, HealthChoice respectfully asks that the Board delay the implementation of its new long term care standards for one year as they relate to LTC coverage, and authorize the extension of its current LTC agreement with MoO for 2019. This would allow the Board to maintain compliance with its statutory charge and avoid the termination of a range of benefits that provide significant value to the state and to eligible employees and annuitants. This would also keep the doors open on a small business that has been dedicated to being a constructive partner with the state for almost a quarter of a century. HealthChoice also commits to doing everything it can to help the Board to evaluate its long-term strategy with respect to terms and conditions applicable to LTC coverage, including potentially accepting contractual obligations with the state as the marketer and broker of future LTC plans.

Thank you in advance for your consideration. If you have questions or would like any additional information, please do not hesitate to contact us.

Very truly yours,

STAFFORD ROSENBAUM LLP

Jeffrey A. Mandell

JAM:EMK:LAK
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cc: HealthChoice
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A. John Voelker (via email)
David Nispel (via email)
Eileen Mallow (via email)
Renee Walk (via email)
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August 21, 2018

Group Insurance Board
Attn: Michael Farrell, Board Chairman
P.O. Box 7931
Madison, WI 53707-7931.

VIA EMAIL
BoardFeedback@etf.wi.gov

Re: Mutual of Omaha's 2019 Long Term Care Proposal (the "2019 Proposal")

Dear Chairman Farrell:

I write on behalf of Equisource Corporation d/b/a HealthChoice Insurance Solutions ("HealthChoice") to inform discussions regarding the Board's long-term care ("LTC") policy offerings. HealthChoice serves as the marketer for the Board's only current LTC provider, Mutual of Omaha ("MoO"). HealthChoice additionally maintains and services LTC policies formerly approved by the Board but no longer actively sold, including Bankers Life and John-Hancock/Fortis plans. HealthChoice was instrumental in working with insurers to custom design the first LTC plans offered by the Board. Since 1994 HealthChoice has been the primary vendor for all Board-offered LTC plans and has extensive knowledge about requirements for LTC plans.

Alarmingly, negotiations have stalled with respect to the 2019 Proposal for LTC coverage because the Department of Employee Trust Funds ("Department") has insisted that MoO must agree to the terms and conditions the Department recently implemented for Supplemental Insurance Plans. The Department has indicated that these terms and conditions are part of the Alignment Strategy approved by the Board in November 2017 with the goals of standardizing available benefits, reducing the number of plans offering overlapping benefits, and minimizing administrative complexity for Supplemental Insurance Plans. (*See* Attachment A.)

The Department's attempt to subject the 2019 Proposal for LTC coverage to the Alignment Strategy and to require that MoO adhere to the Supplemental Insurance Plan terms and conditions is fundamentally flawed. LTC coverage by definition is not a Supplemental Insurance Plan. It is instead a unique and statutorily mandated coverage. The Department's Supplemental Insurance Plan Guidelines (effective January 1, 2018) define "Supplemental Insurance Plans" as having "the same meaning as 'other group insurance plans' found in Wis.

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Stat. § 40.03(6)(b)." Section 40.03(6)(b) states: "[The Board] may provide other group insurance plans for employees and their dependents and for annuitants and their dependents in addition to the group insurance plans specifically provided under this chapter." Because LTC coverage is explicitly required elsewhere in Chapter 40, it falls outside of this definition and is not a Supplemental Insurance Plan. The Department itself shares this understanding, as reflected in its November 7, 2017 Correspondence Memorandum addressing the Alignment Strategy; that memo does not list the MoO LTC policy as an offered or affected Supplemental Insurance Plan. (*See* Attachment B at page 2.)

Considering that LTC coverage is not a Supplemental Insurance Plan, the inclusion of the MoO LTC policy in the Alignment Strategy is erroneous. And it is an error with significant consequences. Specifically, because LTC coverage differs in kind from other insurance offerings that are Supplemental Insurance Plans, it is unreasonable to expect that MoO will be willing to accept a one-sided form contract designed for other industries. Indeed, as HealthChoice has repeatedly expressed to the Department, MoO will not do so. It follows that, if the Department persists in its insistence on applying the terms and conditions to LTC coverage, MoO will stop offering LTC coverage through the Department, placing the Board outside of compliance with the statutory mandate to offer LTC coverage. These consequences are addressed below.

The Board is Required to make LTC Coverage Available

As a threshold matter, Section 40.55 of the Wisconsin Statutes mandates that the Board make LTC insurance available to state employees, annuitants, their spouses, and the parents of state employees. The first subsection sets out the unambiguous mandate:

> (1) [Except with respect to eligible employees in a District Attorney's Office], the state ***shall*** offer, through the group insurance board, to eligible employees under s. 40.02 (25) (bm) and to state annuitants long-term care insurance policies which have been filed with the office of the commissioner of insurance and which have been approved for offering under contracts established by the group insurance board. The state shall also allow an eligible employee or a state annuitant to purchase those policies for his or her spouse or parent.

Wis. Stat. § 40.55(1) (emphasis added).

Wisconsin law is clear that the word "shall" is presumed mandatory when the Legislature uses it in a statute. *See, e.g., State ex rel. Dep't of Nat. Res. v. Wis. Ct. of Appeals, Dist. IV*, 2018

WI 25, ¶13 & n.7, 380 Wis. 2d 354, 909 N.W.2d 114; *Karow v. Milwaukee Cty. Civil Serv. Comm'n*, 82 Wis. 2d 565, 570, 263 N.W.2d 214 (1978). This is particularly true, where, as here, the mandatory "shall" (see subdivision (1)) and permissive "may" (see subdivisions (2) and (4)) appear in the same statutory section, such that courts "infer that the legislature was aware of the different denotations and intended the words to have their precise meanings." *Heritage Farms, Inc. v. Markel Ins. Co.*, 2012 WI 26, ¶32, 339 Wis. 2d 125, 810 N.W.2d 465 (quoting *Karow*, 82 Wis. 2d at 571). In light of these well-settled background principles, it is clear that the Board may not choose to eliminate LTC coverage, or to take actions that result in such an elimination, without violating the Legislature's express statutory mandate.

This is intertwined with the distinction drawn above between LTC coverage on the one hand and Supplemental Insurance Plans on the other. Because the Legislature expressly requires the Board to offer LTC coverage, the MoO LTC policy is not an "other group insurance plan" that falls under the umbrella term of Supplemental Insurance Plans. This is a crucial background principle that must be considered in reviewing the Department's actions with regard to HealthChoice's proposal to renew the MoO LTC policy.

LTC Coverage is Unique and Should Not be Treated the Same as Supplemental Insurance Coverage

In addition to the fundamental legal principles at issue, there are policy reasons not to treat LTC coverage like other Board-offered group insurance plans that differ in kind. LTC insurance is voluntary and, where elected, paid for entirely by the subscriber. It is also, unlike the Supplemental Insurance Plans offered by the Board, individually underwritten. Long-term care coverage offers insurance to fund a variety of services that include medical and non-medical care to people who have a chronic illness or disability. Long-term care insurance helps meet health or personal needs.

The LTC policies offered by the Board have always been bespoke policies. When the Department first established rules and guidelines for LTC policies in 1992, HealthChoice realized the LTC plan features and benefits required under the Department's rules were not met by any offering in the marketplace. HealthChoice worked closely with an insurance provider to develop and underwrite a LTC plan that met the Department's requirements. The initial plan, offered in August 1994, was the first of its kind in the United States. This plan became a national model for other insurers. Since 1995, the Board's LTC plans have paid out millions in claims, protecting Wisconsinites' assets, and saving the State of Wisconsin money by reducing reliance on Medicaid.

In the years since, HealthChoice has assisted subsequent providers to create and offer compliant coverage. Since 2011, MoO has been the Board's exclusive provider of LTC

policies. This Board has approved other LTC providers in recent years, but it has been unable to come to terms with those providers on plans that meet the Department's strictures. MoO has been the *only* company willing to provide LTC coverage that meets the Department's requirements. The MoO LTC policy arranged by HealthChoice and offered by the Board provides better benefits and services at a lower cost than LTC plans generally available to individuals. Over the past 24 years, HealthChoice has enrolled more than 10,000 total members and annuitants in LTC policies offered through the Board, and the current MoO LTC policy provides both the best rate stability and the most significant plan of benefits to date. The MoO LTC coverage includes numerous exclusive benefits that participants will lose if the Board does not continue to offer this policy.

This Board has directed the Department to implement the Alignment Strategy with a specific goal of reducing the number of the Supplemental Insurance Plan providers. That may make sense where there are multiple providers of Supplemental Insurance Plans, but it is inapposite to the Board's LTC coverage, which is offered by only one insurer that has already customized its offering to meet the Department's requirements.

As HealthChoice has conveyed to the Department, MoO is unwilling to sign the terms and conditions the Department has generated in furtherance of the Alignment Strategy. There are several reasons for this. One is that the terms and conditions were drafted for Supplemental Insurance Plans. LTC coverage is, as established above, not a Supplemental Insurance Plan. It is, therefore unsurprising that significant portions of the terms and conditions the Department drafted to govern such plans are inapposite to MoO's LTC coverage. Additionally, even where the provisions are arguably applicable to LTC coverage, the Department is demanding adherence to a set of terms and conditions that are extremely one-sided. For example:

- Section 12.0 of the terms and conditions contains a liquidated damages provision in favor of the Department but does not spell out the amount of damages. This creates risk and uncertainty for the insurance carrier.
- Section 13.0 of the terms and conditions mandates an extensive alternative dispute resolution which limits the carrier's ability to select the most prompt and efficient method for addressing issues. In contrast, in Section 18.0 the Department reserves for itself any remedy available under Wisconsin law.
- Section 15.0 provides the Department the unilateral ability to terminate the Contract at its discretion, creating significant business risk for the carrier.
- Section 23.0 requires the carrier to indemnify the Department, but this obligation is not reciprocal.

- The Department's Materials state that "Exceptions to the contract language will not be considered." (Paragraph 1 of the Insurer Acknowledgement on page 39 of 59).

These provisions in the MoO proposed contract are identical to those in the Supplemental Insurance Plan contracts. LTC coverage is different from the Department's Supplemental Insurance Plan contracts in that it is statutorily mandated, entirely subscriber paid, and already a bespoke policy created to comply with Department requirements.

Neither, with respect to LTC coverage, can these provisions be understood as necessary to protect the public. The proposed MoO insurance plan meets all requirements set out by the Office of the Commissioner of Insurance ("OCI") and the Interstate Insurance Product Regulation Commission ("IIPRC"); indeed not only did OCI and IIPRC approve the MoO LTC13-WIAG LTC offering, but the Department and its chosen consultants (Milliman) also recommended, after their own thorough reviews, continuing the plan for the 2019 contract year. Nor are these one-sided provisos necessary to protect public funds or keep rates low. LTC insurance is voluntary and, where elected, paid for entirely by the subscriber. If anything the Department's unilateral insistence on the terms and conditions will likely raise rates by requiring MoO to take on significant new financial uncertainty.

Furthermore, it is worth noting that HealthChoice has been paying up to $20,000 in annual costs for mostly minor administrative tasks incurred by Department staff. HealthChoice also provides a dedicated service department exclusively for Department member employees and annuitants so that the Department does not have to serve as the intermediary between policyholders and their LTC insurer. The Department incurs no direct administrative costs and no costs for payroll deduction.

MoO will not agree to the terms and conditions that the Department seeks to impose. Thus, if the Board insists on the Department's terms and conditions, it will lose its only LTC provider, failing to meet its statutory obligation to provide coverage under Wis. Stat. § 40.55 and sacrificing the significant benefits that HealthChoice provides, at no cost to the Department, to LTC policyholders.

* * *

In conclusion, HealthChoice asks you to clarify that MoO is not, as a condition of continuing to offer its LTC policy through the Board, required to accept the terms and conditions developed for Supplemental Insurance Plans. At minimum, we ask that the Board exempt MoO from such a condition for the 2019 Proposal so that HealthChoice, MoO, and the Board can together continue meeting the statutory mandate to offer LTC coverage while continuing to address this issue going forward.

Thank you in advance for your consideration. If you have questions or would be assisted by additional information, please do not hesitate to let me know.

Very truly yours,

STAFFORD ROSENBAUM LLP

Jeffrey A. Mandell

JAM:EMK
Enclosure
cc: HealthChoice
Robert J. Conlin (via email)
A. John Voelker (via email)
David Nispel (via email)
Eileen Mallow (via email)

Attachments:

A. May 25 Email from Joanne Klaas to Bob Pearson.
B. Correspondence Memorandum to Board dated November 7, 2017

Attachment A

From:	Klaas, Joanne L - ETF
To:	bob@healthchoice.com
Cc:	Adam.Walling@mutualofomaha.com; Walk, Renee - ETF
Subject:	[ETFnoPII] LTC Insc. Contract
Date:	Friday, May 25, 2018 12:36:04 PM
Attachments:	image001.png image002.png image003.png image004.png Long-Term Care Insurance Contract.docx

Good Afternoon,

In an April 23 email from Adam, it was requested that we use our 2016 contract for 2019. We are unable to do that because we are aligning the supplemental plans and modifying the administrative documents that govern them in order to reduce duplication of services and improve program administration under the Alignment Strategy that was approved by the Group Insurance Board last November 2017. To that end we require a contract with Mutual of Omaha that includes the Department Terms and Conditions, the Standards for LTC (ET-7423), and the Agreement we've used with the other Supplemental Plans for 2019 with some adjustments so that it applies to the long-term care insurance plan. We have also included the General Agent Agreement and Confidential and Privacy Agreement between Mutual and Health Choice from the 2016 contract.

The Department Terms and Conditions in this contract are identical to those sent to you in a March 14, 2018 email from me. As I mentioned then, we are very reticent to make changes to the DTCs as consistency among contracts is a priority. I would like to highlight Section 6.6 of the Agreement which states if a section of the DTCs in not applicable, it will not apply. And if there is disagreement between the parties on applicability, Section 13 of the DTCs would prevent one party from unilaterally invoking a section the other finds inapplicable. We would go through the contract dispute resolution procedure outlined in Section 13.

If a teleconference would facilitate the negotiation of this contract please propose a few days and times and we will discuss.

Joanne Klaas | Contracts Specialist
Budget, Contract Administration & Procurement
Wisconsin Department of Employee Trust Funds | etf.wi.gov
608 261-7247 | 877 533-5020

We've moved! Our new address is: 4822 Madison Yards Way, Madison, WI 53705-9100. Please continue returning forms and correspondence to: ETF, P.O. Box 7931, Madison, WI 53707-7931.

Attachment B

State of Wisconsin
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: November 7, 2017

To: Group Insurance Board

From: Shayna Schomber, Optional Plans & Uniform Dental Benefits Manager
Renee Walk, Strategic Health Policy Advisor
Office of Strategic Health Policy

Subject: Supplemental Plans Alignment

ETF recommends the Group Insurance Board (Board) approve an overall alignment strategy for supplemental insurance plans and modifications to the administrative documents that govern supplemental plans, in order to reduce duplication of services and improve program administration.

Background

The Board oversees the provision of several supplemental plans, including supplemental dental, long term care (LTC), accidental death and dismemberment (AD&D), and vision. These products are offered to employees with no employer contribution; supplemental benefits are only available to State employees and retirees. Note: ETF has updated the program name from "Optional Plans" to "Supplemental Plans" moving forward, based upon feedback and support from employers, staff, and members.

In order to participate as a supplemental plan in the Board's program, insurers must submit a proposal annually according to the Guidelines for Offering Optional Insurance Plans (ET-7422) and/or Standards for Proposing and Offering Long-term Care Insurance to State Employees (ET-7423) documents. The Department of Employee Trust Funds (ETF) staff review these proposals and consult with the Board's actuarial firm, Milliman, to make approval recommendations to the Board annually.

There are currently five insurers offering ten different supplemental plan products to eligible members; there are six different supplemental plan options for dental alone. Employers have indicated these benefits are too complicated for members to compare, and are difficult to communicate effectively.

Reviewed and approved by Lisa Ellinger, Director, Office of Strategic Health Policy
Lisa Ellinger Electronically Signed 11/8/17

Board	Mtg Date	Item #
GIB	11.15.17	7A

For reference, enrollment in each of the supplemental benefit plans as of March 31, 2017, is below:

	Contracts	Members
EPIC Benefits+	19,013	37,232
Optional Vision[1]	*5,377*	*11,831*
Dental Wisconsin PPO	4,173	7,692
Dental Wisconsin Select	6,059	11,893
Anthem DentalBlue[2]	8,962	18,121
VSP	25,023	48,993
Zurich	5,676	Not Provided

[1] Enrollment in Optional Vision requires enrollment in EPIC Benefits+
[2] Anthem DentalBlue enrollment counts include three different plans: Dentacare HMO, Preferred PPO, and Anthem Supplemental

There is a significant administrative burden on employers, payroll centers, and ETF staff in managing the annual changes and the ongoing maintenance of these plans. In addition, the supplemental plan benefits often duplicate or overlap one another and the Uniform Dental Benefits that they are intended to support.

In February of 2017, staff presented a preliminary plan for alignment to the Board. This memo provides greater detail of the multi-year goals for supplemental plan alignment, as well as modifications to the Guidelines and Standards that support the alignment initiative.

Alignment Strategy
Historical program strategy has emphasized member choice in supplemental benefit products. While staff still promote member choice in supplemental benefits, the current slate of benefits is redundant in terms of benefits provided. The following is a summary of the alignment strategy proposal, broken down by calendar year.

2017: Update Guidelines and Standards Criteria
Staff propose initiating an alignment strategy with the revision of the Guidelines and the Standards. These documents have been modified to include basic benefit plan design criteria that should be included in a qualified proposal, and include changes designed to simplify program administration as well as the contract negotiation and proposal submission processes.

2018: Reduce Vendors and Improve Plan Options
If the Board approves the changes to the Guidelines and Standards, ETF will use the new criteria to improve the value of these plan options for employees and employers. The proposal submission process will be simplified and insurers will be required to submit additional information that will aid in a thoughtful review of the proposals. For example, plans will submit the actuarial value of each proposed plan to more easily compare plans. In addition to benefits requirements, the new criteria also include

requests for explicit service level agreements. These criteria will ensure that service, performance, and administrative requirements are clearly defined and agreed upon by the proposing insurer.

ETF also seeks to reduce complexity of the plan offerings by limiting the number of insurers offering the same services. The considerable number of plans currently offered causes confusion among employees and employers and can lead to members unknowingly purchasing duplicate coverage. The new criteria include an amended provision that plan proposals will be considered in the greater context of other plans and services being covered, and will limit the number of insurers and plans approved to participate.

2019: Consider Integrating Supplemental Plans with Other Contracts
Several of the Board's other programs, such as Life and Dental, will require either a procurement effort or contract extension in 2019. Based on direction from the Board, ETF will consider whether it would make administrative and fiscal sense to incorporate any of the services currently offered as supplemental plans into other contracts. ETF will present any such additional information to the Board in May of 2018 with the negotiated contracts.

Guidelines and Standards Modifications
In order to execute the strategy described above, ETF is proposing substantial changes to the Guidelines and Standards documents. The following is a summary of these changes:

- Simplified proposal template for submission
- Simplifying the titles of each document
- Adjust key proposal dates (e.g., January 31 proposal submission due date)
- Require contract terms and conditions signed and included with initial proposal
- Require a signed acknowledgment of insurer requirements and responsibilities as defined in the Guidelines and/or Standards
- Require a fully-negotiated, and signed contract before May Board meeting
- Limit number of eligible insurers per product type
- Identify specific criteria for references submitted in the proposal

In addition, ETF is proposing the following changes to the Guidelines only:

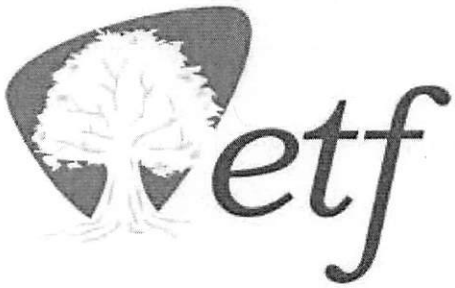
- Change the program name from "Optional Plans" to "Supplemental Plans"
- Restrict the amount of any annual premium increase
- Require itemization of premium rates and forecasted loss ratios for any bundled plan proposals to easily identify and compare plan costs
- Add penalty for failure to meet minimum loss ratio
- Add service guarantee for reporting timeliness
- Include an outline of covered services to avoid duplication of coverage

The revised Standards and Guidelines are attached for the Board's reference. Staff will be available at the Board meeting to answer questions.

Attachment A: Supplemental Plan Guidelines (ET-7422)
Attachment B: Long-Term Care Standards (ET-7423)

Attachment A

Supplemental Insurance Plan Guidelines



Department of Employee Trust Funds
Group Insurance Board
801 West Badger Road
Madison, Wisconsin 53702

Effective as of January 1, 2018

Table of Contents **Page**

1. Purpose

This document, "Supplemental Insurance Plan Guidelines," serves as a resource for insurers interested in offering state employees supplemental insurance plans. It sets forth the requirements insurers must meet to offer these plans, provides the instructions insurers must follow for submitting a proposal, and outlines the criteria the Group Insurance Board (Board) uses in approving or denying an insurer's proposal.

2. Definitions

A. Group Insurance Board (Board): Eleven (11) member board that sets policy and oversees administration of the group health, life insurance, and income continuation insurance plans for state employees, retirees and the local employers who choose to offer them. The Board also can provide other insurance plans, if employees pay the entire premium. The Board's authority is governed by Wis. Stat. § 40.03 (6). For more information on the Board visit: http://www.etf.wi.gov/boards/board_gib.htm

B. Group Master Contract: Contract between an insurer and the Board related to the offering of an Supplemental Insurance Plan(s) to state employees.

C. Supplemental Insurance Plan(s): This term has the same meaning as, "Other group insurance plans" as provided in Wis. Stat. § 40.03 (6). It includes insurance plans is approved by the Board as voluntary group plan offerings for state employees with 100% of the premium paid by employees through payroll deduction. Examples of insurance plans falling under this definition include: accidental death & dismemberment (AD&D), supplemental vision and supplemental dental plans. Note that group health insurance, life insurance, income continuation insurance and long-term care insurance are part of different programs.

3. Statutory and Administrative Authority

A. The Board is given the following statutory and administrative authority related to Supplemental Insurance Plans:

1. The Board is given authority under Wis. Stat. § 40.03 (6) (b) to provide group insurance plans in addition to plans provided for in Wis. Stats. Chapter 40 to annuitants, employees and their dependents.
2. The Board is charged by Wis. Stat. § 20.921 (1) (a) (3) and Wis. Admin. Code § ETF 10.20 to approve or disapprove group insurance plans for which payment of premium is made through payroll deductions
3. Fees for program administration are authorized under Wis. Stat. § 40.04 (2)

4. Supplemental Insurance Plan Requirements

In order to be considered for approval, each proposed plan must:

A. Be approved as an Accident & Health insurance policy by Wisconsin OCI.

B. Be a group insurance plan; not individual policies marketed as a group plan.

1. For rating purposes, the "group" consists of all eligible employees, their spouses and other dependents, and retiring members within limits proposed by the insurer.

C. Meet all applicable requirements listed in the attachments.

5. Insurer Responsibilities

Insurers interested in offering a Supplemental Insurance Plan must meet and agree to the requirements as listed below.

A. General

1. The insurer must hold a license from the State of Wisconsin Office of the Commissioner of Insurance (OCI) to conduct the business of insurance in this state.
2. The insurer must have at least two years of operating experience in the state of Wisconsin.
3. The insurer must satisfy payment of the annual fee which ETF will assess for administration of the plan(s).

B. Plan Administration

1. Each plan must maintain a minimum annual claim/premium loss ratio of 75%.
2. Each plan's premium increase may not exceed 5% annually.
3. Each plan must offer an open enrollment opportunity every two years, at a minimum.
4. Newly-eligible employees must be allowed to enroll, provided an application is submitted within 30 days of eligibility.
5. The insurer will work directly with ETF staff and assist payroll centers and employers with technical implementation and ongoing maintenance of each plan.
6. Eligible employees and his/her eligible dependents must be allowed to enroll without restrictions or benefit limitations due to a HIPAA qualifying event, such as loss of other comparable coverage, marriage, birth or adoption.
7. Annuitants must be allowed to enroll in the plan unless the proposal can demonstrate negative impacts on premium rates, or substantial constraints for continuing to administer the plan if annuitants are included. This must be approved by the Board.
8. Submit data regarding enrollment, provider networks, utilization, service level statistics and performance standards must be reported on a quarterly basis, including an aggregate data submission annually.

C. Marketing, Materials and Member Resources

1. A Group Master Contract with the Group Insurance Board must be in place prior to any marketing activity or distribution of materials to State of Wisconsin members.
2. All marketing and informational materials provided to State of Wisconsin members must have prior approval by ETF, including materials distributed plan-wide. Approval of marketing materials by OCI is not a substitute for ETF approval.
3. The insurer must provide customized webpages and materials specific to State of Wisconsin members with ETF approval.
4. The insurer must provide hard copies of brochures, applications, and reporting forms to State of Wisconsin employers, agencies, or payroll centers upon request.
5. The insurer must provide a of State of Wisconsin Employer Group-specific website available to members prior to the annual open enrollment period. This website must

include the following at a minimum:

a. Information summarizing benefits and exclusions,
b. Provider directory or provider search function,
c. Links or access to plan forms without requiring login,
d. Access to online processes for enrollment,
e. Information on continuation coverage and how to report status changes,
f. Customer service phone number and email address for members, and
g. Resources for members to file a grievance or appeal.

D. Member Complaints and Grievances
The insurer agrees to provide the following to members:

1. A method whereby the insured who filed the grievance, or the insured's authorized representative, has the right to appear in person before the grievance panel to present written or oral information.
2. A written notification to the insured of the time and place of the grievance meeting at least 7 calendar days before the meeting.
3. A written acknowledgement to the insured or the insured's authorized representative confirming receipt of the grievance within 5 business days of receipt of a grievance.
4. Detailed complaint and grievance process in the policyholder certificate. The ETF Insurance Complaint Form details the ETF process.

6. Board Responsibilities

A. In accordance with Wis. Admin. Code § ETF 10.20 (1) (a), the Board will determine whether a vendor qualifies to offer a particular program through consideration of, but not limited to, the following factors:

1. Number of employees affected
2. Amount and variation in premiums
3. Adequacy of other approved coverage providing the same or similar protection
4. History, performance, and acceptance of the plan by the employees
5. Reference checks

B. The Board will limit the number of approved vendors to one plan for each plan type.

C. The Board reserves the right to deny an insurer and/or plan proposal for up to three (3) years if the minimum loss ratio is not met in the previous plan year.

D. The Board may withdraw its approval if insurers and the Supplemental Insurance Plans they offer fail to meet requirements detailed in the Guidelines or its attachments, or the Group Master Contract.

7. Submitting a Proposal

The process for submitting a proposal is as follows:

A. Insurer reviews this document and all attachments thoroughly to understand all requirements and expectations.

B. Insurer should contact Department of Employee Trust Funds (ETF) with any questions about the insurer responsibilities and requirements prior to submitting the signed proposal.

C. Insurer submits a complete proposal to ETF including all attachments with applicable signatures.

D. Submit a completed "Proposal Submission Checklist (Attachment A).

E. All proposals are due January 31st of each year and will be considered at the following May Group Insurance Board meeting for the next plan year.

8. Review & Approval Process

A. ETF notifies an insurer within ten (10) business days that the submission has been received and whether it is deemed complete.

1. If ETF does not receive a complete proposal within five (5) business days of notification to the insurer, the proposal may not be recommended to the Board for approval

B. ETF reviews the proposal.

1. Review by the Board's consulting actuary may be necessary and will range from brief to extensive, based on the features of the plan and clarity of the proposal submitted.
2. The review process may include discussions between the insurer and ETF, an advisory committee of employer representatives, and/or the consulting actuary.
3. Any modifications to the proposal must be received electronically by ETF no later than six (6) weeks prior to the scheduled Board meeting where the proposal will be discussed
4. ETF will contact all references provided in the proposal on behalf of the Board.

C. ETF finalizes the review and prepares a recommendation for the Board.

1. ETF will provide advance notification of the recommendation to the insurer.

D. The Board will determine whether to approve the proposal at a publicly noticed Board meeting.

1. A spokesperson for the insurer should be present at the Board meeting.
2. The agenda and documents for Board meetings are posted to etf.wi.gov prior to each meeting.

E. If the Board approves a proposal, ETF will provide the final version of the Group Master Contact to the Board Chair for signature.

9. Additional Information

A. Please send questions related to the Supplemental Plan approval process to: ETFSMBInsuranceSubmit@etf.wi.gov

B. The attachments to these Guidelines are:

a. Attachment A: Proposal Submission Checklist
b. Attachment B: Benefit Design Proposals
c. Attachment C: Insurer Acknowledgement
d. Appendix I: Reporting and Performance Standards
e. Appendix II: Department Terms and Conditions

Attachment B

Long-Term Care Insurance Standards

Department of Employee Trust Funds
Group Insurance Board
801 West Badger Road
Madison, Wisconsin 53702

Effective as of: January 1, 2018

Table of Contents **Page**

1. Purpose

This document, "Long-Term Care Insurance Standards," serves as a resource for Insurers interested in offering state employees and retirees Long-Term Care (LTC) insurance. It sets forth the requirements Insurers must meet to offer these plans, provides the instructions Insurers must follow for submitting a proposal, and outlines the criteria the Group Insurance Board (Board) uses in approving or denying an Insurer's proposal.

2. Definitions

A. Agent: For purposes of this document, the Agent refers to any individual or organization that markets, solicits, or sells insurance policies underwritten by the Insurer for compensation. This includes, but is not limited to: brokers, marketing agents, selling agents, managing general agents, and any other intermediary.

B. Group Insurance Board (Board): Eleven (11) member board that sets policy and oversees administration of the group health, life insurance, and income continuation insurance plans for state employees, retirees and the local employers who choose to offer them. The Board also can provide other insurance plans, if employees pay the entire premium. The Board's authority is governed by Wis. Stat. § 40.03 (6). For more information on the Board visit: http://www.etf.wi.gov/boards/board_gib.htm

C. Group Master Contract: Contract between an Insurer and the Board related to the offering of Long-Term Care insurance to state employees.

D. Insurer: For purposes of this document, the Insurer refers to the company offering and underwriting the Long-Term Care insurance policy. The Insurer assumes the risk for the long-term care insurance policies.

E. Long-Term Care insurance (LTCi): Board-approved LTCi plans as defined under Wisconsin Administrative Rule Ins 3.46 available to state employees. The Board is required to offer plans to eligible employees and annuitants, and to their spouses and parents. The LTCi plan may be made available based on underwriting to establish each subscriber's initial eligibility and premium levels. The State does not contribute to LTCi plan premiums; subscribers pay 100% of the premium, and may do so through payroll deduction.

3. Statutory and Administrative Authority

A. The Board is given the following statutory and administrative authority related to LTC insurance plans:

1. Wis. Stat. § 40.03 (6) (a) (1) and Wis. Stat. § 40.55 direct the Board to offer Long-Term Care insurance to eligible employees and state annuitants, as well as define eligible dependents.

2. Wis. Stat § 40.05(4m) authorizes approval of plan premiums to be paid through payroll or annuity deduction.

4. Long-Term Care Insurance (LTCi) Plan Requirements

In order to be considered for approval, each proposed plan must:

A. Be approved by the Wisconsin Office of the Commissioner of Insurance (OCI) prior to submitting a proposal.

B. Be a group insurance plan; not individual policies marketed as a group plan.

1. For rating purposes, the "group" consists of all eligible employees, their spouses and other dependents, and retiring members within limits proposed by the Insurer.

C. Meet all applicable requirements listed in the Standards and all listed attachments and appendices.

5. Insurer Responsibilities

Insurers interested in offering or marketing a LTCi plan must meet and agree to the requirements as listed below.

A. General

1. Hold a license to sell Long-Term Care insurance from the State of Wisconsin Office of the Commissioner of Insurance (OCI), and be in good standing, including compliance with duties outlined in Wis. Admin. Rule Ins 42.05.

2. Comply with all applicable state and federal laws (including without limitation regulations) concerning the confidentiality, privacy, or security of personally identifiable information created, received, or otherwise accessed by the Insurer.

3. Demonstrate ability to manage premiums through automated systems for payroll deduction that interface with State payroll systems for employees and annuitants.

4. The Insurer must satisfy payment of the annual fee for administration of the proposed plan.
    a. ETF will prepare an annual invoice reflecting the anticipated administrative costs by the Board and its agents (ETF) in administering the LTCi plan for members and employers.
    b. Administrative costs for the first year may be higher based on implementation complexity.
5. Ensure that intermediaries and Agents, including a managing general agent licensed under Wis. Stat. § 628.04, comply with the terms of these Standards and with terms of a contract between the Board and the Insurer.
6. Only sell long LTCi plans to state employees and/or retirees which have been approved by the Board. The introduction or sale of any other insurance plan or product, where Insurer access to referral was gained through marketing an approved LTC plan, is prohibited without prior Board approval.
7. The Board reserves the right to withdraw its approval if Insurers and the LTCi plans they offer fail to meet requirements detailed in the Standards or its attachments, or the Group Master Contract

B. Plan Administration

1. Plan must be filed with OCI, and meet all statutory requirements including those related to benefit design, inflation protection, the WI Partnership Program, and premium increases. (Examples: Wis. Admin. Code § Ins. 3.45; Wis. Admin Code § Ins. 3.455; Wis. Admin. Code § Ins. 3.465; Wis. Admin. Code § Ins. 3.46).
2. Plan must meet additional requirements for minimum daily benefit and lifetime maximum benefit, as outlined in Attachment I.

3. Demonstrate a history of performance and acceptance by eligible participants and/or a record of positive assessment by other large group entities that make the same or similar plan available to their employees
4. The Insurer will work directly with ETF staff and assist payroll centers and employers with technical implementation and ongoing maintenance of the plan
    a. Utilize *Authorization to Deduct Monthly Premium for LTC Insurance* form (ET-2364) or *Retired Public Safety Officer Insurance Premium Deduction - Authorization* form (ET-4330) for all new enrollees and for changes to premiums.
5. Enrollment may begin not less than eight weeks after Board approval, with payroll or annuity deduction for premiums effective no sooner than January 1 of the year following the year the proposed plan was approved by the Board.

C. Marketing, Materials and Member Resources

1. A Group Master Contract with the Group Insurance Board must be in place prior to any marketing activity or distribution of materials to State of Wisconsin members. This contract must be signed by the Insurer and relevant Agent.
2. All marketing and informational materials provided to State of Wisconsin members must have prior approval by ETF, including materials distributed plan-wide. Approval of marketing materials by OCI is not a substitute for ETF approval.
3. The Insurer must provide hard copies of brochures, applications, and reporting forms to State of Wisconsin employers, agencies, or payroll centers upon request.
4. A Board-approved LTCi plan may be marketed to State employees, who are defined by Wis. Stat. § 40.02 (25) (bm) as:
    a) Any employee of the state who received a salary or wages in the previous calendar year.
    b) State annuitants under Wis. Stat. § 40.02 (54m).
    c) Any participant who was formerly employed by the State who received a lump sum if paid as an annuity.
    d) Any employee who is a resident of Wisconsin and has filed an application for an immediate annuity, regardless of whether final administration has been taken.
5. ETF will facilitate Insurer and/or Agent outreach to members by:
    a) Providing the Insurer or its Agent with a list showing contact information for each state payroll center by request,
    b) Providing and annual review, approval, and distribution of informational or outreach messaging provided by the Insurer or its Agent.
    c) Annually preparing census list for direct marketing, if requested by the I nsurer or Agent.

D. Member Complaints and Grievances

The Insurer agrees to provide the following to members:

1. A method whereby the insured who filed the grievance, or the insured's authorized representative, has the right to appear in person before the grievance panel to present written or oral information.

2. A written notification to the insured of the time and place of the grievance meeting at least 7 calendar days before the meeting.
3. A written acknowledgement to the insured or the insured's authorized representative confirming receipt of the grievance within 5 business days of receipt of a grievance.
4. Detailed complaint and grievance process in the policyholder certificate. The ETF Insurance Complaint Form details the ETF process.

E. Reporting

Insurers must annually report to ETF for compilation and review by Board, data to include, at a minimum:

1. Number of member inquiries
2. Number of member inquiries that did not meet the suitability standard, as described in Wis. Admin. § Ins. 3.46 (16)
3. Number of policies sold
4. Age ranges at time of purchase
5. Employers, if active employees purchased policies
6. Number of employee/retiree/family
7. Premiums total
8. Average premium by gender
9. Age ranges at time of initial claim
10. Number of claims
11. Amount of claims paid
12. Setting of subscribers in claim status (home, assisted living, skilled nursing facility)
13. Number of policies lapsed
14. Number of complaints and grievances in previous 3 years, and how resolved
15. Other data elements as requested

F. Inflation Protection

1. Refer to Attachment II for a comparison of inflation protection requirements against those required understate insurance law.
2. Policies must include inflation protection as follows:
    a. **Under Age 65**: Automatic annual *compounded* inflation protection must be included:
        1) Level premiums, with benefits increasing at a rate of at least 3%, and
            a) Guaranteed annual opportunity to adjust the compound inflation rate at minimum 0.5% intervals up or down (within the range of 3% to 5%), and
            b) with premium rates for higher amounts based on age at purchase, and
            c) available until 20 years after purchase, or age 76, whichever is earlier;

OR

2) Level premiums with benefits increasing at a rate based on CPI changes;

OR

3) Level premiums with benefits increasing at a rate of 5% for 20 years, or until age 76, whichever is earlier.

b. **At least age 65, but less than 76**: Automatic annual *compounded* inflation protection described above. Additional options include:

1) Level premiums with at least 3% annual *simple* inflation protection until subscriber attains age 76, and

2) Guaranteed bi-annual purchase option of the difference between current value and 5%, for the earlier of 10 years, or until age 76, or subscriber rejects two *non-consecutive* offers.

c. **At least age 76**: Must offer same as above, but inflation protection is not required.

G. Premium Increases

1. Standards for premium increase by class.

a. The proposed plan must follow provisions in Ins 3.46(19), which outlines what constitutes a substantial premium increase allowing a non-forfeiture opportunity for the policy-holder.

b. In addition, the proposed plan must show procedures to notify the Department of Employee Trust Funds (ETF), as the agent of the Board, at least 60 days before a class rate increase is scheduled to take effect.

c. ETF should have notice no later than the date notices are mailed or posted to subscribers.

6. Submitting a Proposal

The process for submitting a proposal is as follows:

A. Insurer reviews this document and all attachments thoroughly to understand all requirements and expectations.

B. Insurer should contact Department of Employee Trust Funds (ETF) with any questions about the Insurer responsibilities and requirements prior to submitting the signed proposal.

C. Insurer submits a complete proposal to ETF including all attachments with applicable signatures.

D. Submit a completed "Proposal Submission Checklist (Attachment A).

E. All proposals are due January 31st of each year and will be considered at the following May Group Insurance Board meeting for the next plan year.

F. Proposals must be electronically submitted to the following e-mail address: *ETFSMBInsuranceSubmit@etf.wi.gov*

7. Review & Approval Process

A. ETF notifies an Insurer within ten (10) business days that the submission has been received and whether it is deemed complete.

1. If ETF does not receive a complete proposal within five (5) business days of notification to the Insurer, the proposal may not be recommended to the Board for approval

B. ETF reviews the proposal.

1. Review by the Board's consulting actuary may be necessary and will range from brief to extensive, based on the features of the plan and clarity of the proposal submitted. The fee for this review will be billed directly to the Insurer by the Board's consulting actuarial firm.

i) *Note*: If the actuarial review fee will be paid by an Agency different than the Insurer, ETF will provide an additional written agreement at the time of notification. This document is required to be signed by both the Agency responsible for the fee and the Insurer.

2. The review process may include discussions between the Insurer, Agent, and ETF, an advisory committee of employer representatives, and/or the consulting actuary.

3. Any modifications to the proposal must be received electronically by ETF no later than six (6) weeks prior to the scheduled Board meeting where the proposal will be discussed

4. ETF will contact all references provided in the proposal on behalf of the Board.

C. ETF finalizes the review and prepares a recommendation for the Board.

1. Note: ETF will not present a recommendation for Board approval without a signed Group Master Contract.

D. The Board will determine whether to approve the proposal at a publicly noticed Board meeting.

1. A spokesperson for the Insurer should be present at the Board meeting.

2. The agenda and documents for Board meetings are posted to etf.wi.gov prior to each meeting.

E. If the Board approves a proposal, ETF will provide the final version of the Group Master Contact to the Board Chair for signature.

8. Additional Information

A. Please send questions related to the Long-Term Care insurance approval process to: ETFSMBInsuranceSubmit@etf.wi.gov

B. The attachments to these Standards are:

a. Attachment A: Proposal Submission Checklist

b. Attachment B: Insurer Acknowledgement

c. Appendix I: Comparison of Benefit Standards for Long Term Care Insurance (LTCi)

d. Appendix II: Department Terms and Conditions