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Correspondence Memorandum

Date: January 21, 2021

To: Group Insurance Board

From: Arlene Larson, Manager Federal Health Programs & Policy
Brian Stamm, Deputy Director
Office of Strategic Health Policy

Subject: Board Strategic Initiative Update on the Wisconsin Public Employers Group Health Insurance Program

This memo is for informational purposes to facilitate discussion. No Board action is required.

Background

At the November 13, 2019, Group Insurance Board (Board) meeting, the Board approved exploring an initiative that could lead to improvements in the Wisconsin Public Employers (WPE) Group Health Insurance Program (GHIP) (Ref. GIB | 11.13.19 | 6). A cross functional team consisting of Office of Strategic Health Policy and the Employer and Contact Services Bureau staff examined the strengths and weaknesses of the WPE GHIP. The team also explored opportunities currently used by other state and municipal GHIPs; opportunities resulting from analysis of our data warehouse; and opportunities suggested by Segal, the Board's actuarial consultant.

This memo provides a summary of the topics explored to date, the findings, and initial recommendations for development. The Department of Employee Trust Funds (ETF) seeks the Board's feedback on the opportunities described in this memo. Board input will assist developing an action timeline.

Current State

The WPE GHIP has experienced decreases in subscriber enrollment since 2016, while simultaneously increasing the number of employer groups who participate. Employer participation in this program is voluntary. There are 1,476 WPE groups in the Wisconsin Retirement System (WRS) that are eligible to participate in the GHIP. Table 1 illustrates changes in enrollment from 2016 through 2020.

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy
Eileen K Mallow Electronically Signed 2/4/21

Board	Mtg Date	Item #
GIB	2.17.21	6C

Table 1

Enrollment Changes	2016	2017	2018	2019	2020	2021
Employer Groups	363	356	357	369	378	394
Subscribers	16,325	14,658	14,398	13,149	13,559	12,864
Members	42,699	38,068	37,007	33,474	34,284	32,380
Mean/Average Members per Group	119	107	103	92	90	82
Median/Middle value of Members	24	21	22	21	21	19

ETF is conducting ongoing outreach to employers, as described at the end of this memo. In the past, ETF surveyed employers (Ref. GIB | 8.21.19 | 4) and identified alignment between survey responses and previously received employer feedback. The key findings include:

1. Appreciate program stability
2. Like choices of benefits and provider networks
3. Are concerned about premium cost
4. Want renewal rates sooner in the year than after the August Board meeting
5. Experience difficulty in explaining the reasoning behind a change in tiering where a lower cost plan is not tier 1

To gain more information about the market, ETF first met with Segal. Segal feels the WPE GHIP is a program that is performing favorably but would benefit from membership growth. The program's premiums are lower than some other states, when adjusted for benefit differences. Segal recommend some changes be made, such as enhanced education and outreach. An overhaul of the program was not recommended by Segal, as significant changes may prompt some health plans to exit the program.

In addition, staff interviewed policy analysts and program managers from 10 states that offer voluntary municipal GHIPs to gather insight into what works for their programs. The states interviewed were Alabama, Connecticut, Kansas, Kentucky, Maine, Minnesota, Oregon, South Carolina, Tennessee, and Washington. While the WPE GHIP has a number of similarities to other programs, noteworthy differences appear in the Discussion of Opportunities section.

Some health plans have expressed concerns about perceived WPE GHIP problems. On January 12, 2021, staff met with participating health plans, Navitus Health Solutions, and StayWell/WebMD, the wellness vendor, at ETF's Council on Health Program Improvement (CHPI). Vendors discussed perceived opportunities and barriers to participating in the WPE GHIP, including tiering, benefit design, and marketing. Feedback is included in the pertinent sections within the Discussion of Opportunities below.

Discussion of Opportunities:
In exploring opportunities for change, ETF considered the following Triple Aim goals:

- Provide participants with plan choices that positively impact their health
- Provide offerings that have low monthly premium costs
- Offer health plans that deliver high-quality, high-value services

Communication
Segal and administrators of local GHIPs from other states noted that improved communication about the program often leads to growth. This can include:

- Website layouts that provide quick access to areas of frequent interest to help employers gain confidence with programs
- Webinars for prospective and existing employers
- Attendance at conferences held by trade associations of counties, municipalities, and school districts

Employers are interested in the ability to quickly access answers to their questions on-line. Therefore, ETF is working to improve ETF's employer site, with an initial focus on marketing to prospective and new employers. Making commonly asked questions more readily available will allow us to focus on complex questions and high-level customer service.

Outreach and education can be done via webinars, as well as at conferences of trade associations for counties, school districts, and municipalities. A varied outreach approach will not only provide information about the program to prospective employers, but also connect these employers to ETF staff, not an insurance broker, for follow-up questions. ETF is investigating opportunities for the future.

States have taken various approaches to educating eligible municipalities about their GHIPs. In Minnesota, for example, a law was passed that requires all school districts to obtain a quote from the GHIP every other year. There is no requirement to join the program. Minnesota has seen significant growth following passage of this law, as employers learned about the program's administrative and health benefits and rate stability. Initially the growth was seen with school districts, but now it has expanded to other eligible employers as word has spread. If the Board is interested in a similar approach, ETF could explore the possibility of a statutory change.

After analysis, ETF recommends enhanced communication to help grow the WPE GHIP and thus support its long-term sustainability. Following discussion with the Board, a timeline will be developed for review.

Program Policy Considerations
ETF researched policy alternatives to current practice and discussed them with Segal throughout the investigation. The topics discussed below are to inform the Board of current policy, options for change, and reaction from Segal and ETF. Only 4.b. of the 11 presented alternatives is recommended at this time. Additional recommendations may

be presented after employer input is received. We are interested in the Board's feedback on any or all possibilities listed.

1. Tiering of plans by county and employer contribution

Employers contribute up to 88% of the average tier 1 premium in their county. For the past several years in some rural parts of the state, a few plans with the lowest premium were not tier 1 for the WPE GHIP and thus their premiums were not used in the calculation for employer contribution. Employees and retirees frequently choose the lowest-cost plan.

WPE tiering is established using a complex criteria (Ref. GIB | 8.19.20 | 7) in addition to items shown in Table 2, that is, limitations on increases over current rates and the relative cost of the WPE rate to the State rate. After overall program tiering is established, including quality credits and other rate limitations, a plan's WPE renewal increase is reviewed to determine its WPE tier.

Table 2

2021 WPE Tiering Limitations

Tier	Rate Increase	% of State Rate
1	6%	110%
2	10%	120%
3	15%	130%

In 2021, six of 16 plans that could be tier 1 chose to be tier 2 or 3 (Ref. GIB | 8.19.20 | 7 and GIB | 11.30.16 | 6). In 2021, the WPE tier 2 or 3 plans are HealthPartners, Robin with Health Partners, Medical Associates, Quartz – Community, WEA Trust West – Mayo Clinic and WEA Trust West – Chippewa Valley.

ETF received a few complaints from employers who were seeking an explanation in circumstances where tiering results in the employer paying more for a popular plan than in the past year. In Lafayette County for 2021, as shown in Table 3, Dean is the only tier 1 plan and it has higher premiums than Medical Associates, a plan popular with employees in part due to its longstanding low premium cost and provider network. The employer contribution for employees who select Medical Associates is 13.6% higher than in 2020. In 2020, Medical Associates was a tier 1 plan and the employer's maximum contribution was $1,459.09 based upon the 88% calculation.

Table 3

Program Option: P12 Traditional No Dental		88% of Tier 1 Qualified Plan Average Premium			
			Family Premium		
County	**Tier**	**Carrier**	**Maximum Employer Share**	**Minimum Employee Share**	**Total Premium**
Lafayette					
	1	*Dean Health Insurance*	*$1,689.83*	*$230.43*	*$1,920.26*
	*	GHC of South Central Wisconsin	$1,689.83	$161.03	$1,850.86
	2	*Medical Associates Health Plans*	*$1,689.83*	*$77.79*	*$1,767.62*
	2	Quartz - Community	$1,689.83	$629.29	$2,319.12
	3	Local IYC Access Plan	$1,689.83	$1,245.83	$2,935.66

* Tier = Not in calculation - Plan not qualified in county

ETF asked other states about their renewal processes. Most offer only one or two plans, so tiering is not necessary. However, the state of Minnesota is self-insured and utilizes a similarly complex model that tiers medical providers and not plans. This model requires direct contracts with providers.

The status of being the lowest cost plan in a county can change, year over year, in the WPE GHIP. When a plan's cost, relative to others, materially impacts an employee's contribution, we typically see movement in enrollment to the lower cost option. This can create an incentive for plans to bid at the tier 1 level in the following year. Therefore, Segal and ETF do not recommend a change to the WPE tiering process. To date it has been effective at controlling overall costs and ETF has been able to address employer questions to assist them in communication with their boards and employees.

2. SMP designated in counties with no other Tier 1 plan

Another area of questions and potential concern arises when there is no tier 1 plan available in a county. In this situation the State Maintenance Plan (SMP) is designated by the Board to be the tier 1 plan. WEA Trust (WEA) is the current vendor that offers SMP.

SMP counties can vary widely year after year. For example, in:

- 2018 SMP counties were Florence, Forest, Iron, Price and Rusk.
- 2019 SMP counties were Buffalo, Florence, Forest, Marinette, Pepin, Pierce, Polk, Rusk, Shawano, St. Croix, Waupaca, Waushara, and Wood.
- 2020 SMP counties were Florence, Forest, Pepin, Pierce, and Rusk.

- 2021 SMP counties are Buffalo, Crawford, Florence, Jackson, La Crosse, Monroe, Pepin, Pierce, Polk, Rusk, St. Croix, and Trempealeau.

These network fluctuations, which are determined after final best bids are provided to Segal and ETF, can make it difficult for WEA to manage the program and its network. SMP's rates are agreed upon before WEA learns what counties SMP will be offered in. Therefore, the premiums do not accurately reflect the claims risk from year to year. However, as shown in Table 5, enrollment in SMP is typically very small compared to WEA's other offerings, so the risk is not prohibitive for WEA. The 2021 growth in SMP was primarily due to movement from Quartz-Community and WEA Mayo.

Table 5

WEA WPE Program Member Enrollment	2018	2019	2020	2021
SMP	1	10	4	1,102
Access Plan	2	21	19	270
WEA East	1,163	1,168	1,412	1,710
WEA Chippewa Valley	14	18	17	20
WEA Mayo	32	53	105	46

SMP placement can significantly impact employer contributions from year to year. For example, for 2021 in La Crosse County, SMP became the tier 1 plan. WEA chose to use their existing Mayo Clinic network to support SMP and this qualified the plan in many new counties. Since the employee's contribution for SMP is significantly lower than any other offering as shown in Table 6, enrollment has increased in SMP following open enrollment. This may result in an adverse medical loss ratio for SMP in 2021, however, the network could change substantially in 2022 if other plans make the decision to be tier 1.

Table 6

Program Option: P12 Traditional Plan No Dental		**88% of Tier 1 Qualified Plan Average Premium**			
			Family Premium		
County	**Tier**	**Carrier**	**Maximum Employer Share**	**Minimum Employee Share**	**Total Premium**
La Crosse					
	3	HealthPartners Health Plan	$1,753.98	$687.64	$2,441.62
	2	Quartz - Community	$1,753.98	$565.14	$2,319.12
	1	*Local SMP*	*$1,753.98*	*$239.18*	*$1,993.16*
	2	*WEA Trust – West Mayo Clinic Health System*	*$1,753.98*	*$870.18*	*$2,624.16*
	3	Local IYC Access Plan	$1,753.98	$1,181.68	$2,935.66

Due to the small size of SMP and ETFs ability to explain to employers and members the rationale behind shifts, staff does not recommend policy changes to the determination of SMP counties.

3. Underwriting and surcharges for new employers with 50 or more employees

Beginning in 2005 the WPE GHIP began a policy of underwriting prospective new groups and assigning surcharges if the employer group was determined to have a claims risk that could adversely impact the pool. Surcharge dollars are passed on to the health plans and prescription drug plan to cover anticipated claims.

The Board's actuary administers the underwriting process including the assessment of surcharges. Underwriting determines whether the large group may join the GHIP at current rates or whether the group must pay an additional per contract per month surcharge in addition to the published rates for an average of 24 months.

Currently, surcharges are assessed to large groups with 50 or more employees in rate bands as described in Table 7. Small groups with 49 or fewer employees join the program at current rates.

Table 7

Large Groups (50 + employees) Risk Category	**Needed Premium as % of Premium Rates**	**Surcharge % Amount**	**2021 Surcharge Individual $ Amount[1]**
N/A	< 110%	0%	$0
1	110-119%	10%	$80
2	120-129%	20%	$160
3	130-139%	30%	$240
4	>140%	40%	$320

[1] Surcharge amount shown is for single and Medicare Some contracts. The surcharge amount for family contracts is 2.5 times the single surcharge. Medicare single and Medicare All family contracts are not applied a surcharge.

Growth in the WPE GHIP for the past several years has been slow and primarily made up of very small groups. Table 8 illustrates the surcharge and total premium dollars in the WPE GHIP. In 2019 a large group of 105 subscribers joined. In 2018 a group of 55 joined. During CHPI, one plan expressed concern about the risk of small groups who are entering without underwriting or surcharges. However, due to the size of the pool in comparison to the impact of new small groups, Segal is comfortable with the current policy on surcharge assessments. Staff is continuing to talk to the plan about options, as the plan is concerned that while the entire pool is large, their smaller pool could be impacted by the risk of new groups.

Table 8 Year	Surcharges Paid	Total Premium
2019	$250,712	$149,423,268
2018	$29,652	$161,057,486
2017	$8,204	$159,604,741
2016	$4,704	$184,714,641

There are other methods of controlling for risk with new groups. Half of the states that were interviewed use underwriting to differing effect to control risk. A summary follows.

- Connecticut will deny enrollment to groups that are expected to have a claims cost higher than 7.5% of the current rate.
- Minnesota requires new groups to be underwritten and have an individualized rate applied. If the group has more than 100 employees, the group's prior claims and enrollment is underwritten to develop the rate. For groups with less than 100 employees, demographics are used to determine the rate. Typically, after a year the group is put into one of approximately 15 rate bands.
- Oregon underwrites groups with 100 or more employees by reviewing claims and enrollment experience. Groups with under 100 employees join the program at the standard rate.
- South Carolina may permit the new local to pay the same premiums as state agencies following underwriting, but rates can be adjusted up by an experience rate factor. Employers are grouped by size into one of three categories, 1-99 employees; 100-500; and 501 or more.
- Washington's actuary may apply a surcharge to new group rates for the next year following underwriting. Groups must provide a census and large groups must include claims experience.

After analysis, staff and Segal feel that the current underwriting with surcharge policies is working well to protect the GHIP from adverse selection. No changes are recommended at this time.

4. Timing of renewal rate information

Some employers express concern regarding the timing of renewal rates due to a mismatch between this process and their budget cycles. A number of employers have requested that rates, or at a minimum an estimated increase, be provided in summer.

The timeline for GHIP rate development begins in earnest in March, with discussion of possible changes to benefits, cost changes for programs like StayWell/WebMD and DAISI and other potential changes for the next year. There are more than 140 activities identified in the annual rate development project plan. Detail about the claims experience used in the annual renewal process appears in section c., below.

There are alternatives to our current premium information sharing to be considered, as follows.

a. Perform a preliminary renewal estimate early in the year prior to a second, final renewal.
   Two renewals are done in a few other states. The state of Oregon announces a Not to Exceed (NTE) increase in late winter to be effective January of the following year. Then, when its board later determines final rates, if self-insured claims cost are expected to surpass the NTE amount, reserves are used to cover the difference. Segal and ETF have concerns about this option for the WPE GHIP, as the use of reserves to buy down individual plan increases to tier 1 could be argued as a reward for plans who fall into tier 2 or 3.

   Connecticut performs two renewals a year in order to give employers a preliminary number. There are barriers to doing a second renewal with the GHIP. Such an effort would nearly double rate renewal activities in the project plan. An analysis of resource needs including additional costs from Segal would have to be considered. In addition, ETF is focusing on a number of Board strategic initiatives (Ref. GIB | 2.5.20 | 5) and adding a preliminary calculation of premiums would likely result in other projects being delayed.

b. Instead of two renewals, ETF is considering other options, such as gathering information from participating health plans about average book of business renewal increases, or trends, for next year's claim costs in the late spring or early summer of the year. Staff could then compile that information and share it with employers as an estimate. Staff began discussions with the plans at CHPI to learn if and how this could be done. Segal stated it could provide information on national trends, but those are not the best predictor of the Wisconsin market.

   After further discussion, Segal recommends using preliminary bid information from the plans and renewal information from Navitus Health Solutions, the pharmacy benefit manager. This preliminary plan renewal information could be shared with employers in mid-June. It would provide an NTE increase. Typically, preliminary increases are reduced during negotiations.

   Staff continues to work with the health plans and intends to present Segal's recommendation to our employer advisory group for its feedback.

c. Issue all final rates earlier than mid-September.
   Some employers have asked for all rates to be provided immediately after the Board meeting in August. Staff have significant concerns that errors could be published if not enough time is given to review all formulas and rates. Segal and staff discussed alternatives. After the Board meeting an overall increase could be provided to locals, but that would not give them an idea of what to expect in their county, which is based upon the average cost of tier 1 plans in it.

d. Issue the January renewal rates earlier in the year.
At the CHPI meeting, health plans remarked that they also hear from employers asking for rates earlier. They suggested that the WPE renewal be done earlier than the state. ETF's concern is that this would reduce efficiency in the renewal process where currently, Segal and staff develop rates for the entire GHIP simultaneously.

Some states issue their January rates in the spring or early summer to address budget issues. The state of South Carolina provides January renewal rates to locals in March to address July fiscal year concerns. Oregon and Kansas provide final renewal rates between April and June. In Kansas, the employer begins to pay the new premiums in July, but employees don't see a change in their contribution until January when the benefit year begins.

Segal and staff do not recommend providing the renewal rates earlier than current practice, as such a change means that costs will be further estimated, since more trend, or projected claim cost, must be applied to calculate premiums needed for the next year. The current timing uses claims experience ending the month of March with renewal bids due the middle of May for the following year.

e. Change the GHIP renewal date and benefit year to July 1.
The State of Wisconsin and many school districts have fiscal years that begin July 1. The states of Connecticut, Maine and one-third of Minnesota's local GHIPs renew as of July 1 every year. During the Board's investigation of self-insuring the entire GHIP in 2017, it was proposed that the renewal be changed to July. At that time, it was not pursued, due to resource limitations in IT at ETF, the employers, and the vendors.

Further investigation found that Flexible Spending Accounts and Health Savings Accounts are tied to a calendar year; moving the benefit year to July would complicate employee calculations on how many dollars to set aside across part of two calendar years.

If the Board is interested in pursuing changing to a July renewal date, discussions could begin to gather feedback from stakeholders. This change may make the program more attractive to school districts. The WPE GHIP currently insures 6 of 421 school districts and 1 of 12 Cooperative Educational Service Agencies (CESAs). We plan to discuss this with employers at our advisory group meetings.

5. Benefit Design

a. At times, large local employers have requested the opportunity to permit employees a choice between the current High Deductible Health Plan (HDHP) and another benefit design, as is offered to eligible State members. Segal feels that due to the range of relative actuarial values for each of the four currently

offered local benefit design alternatives (called program options), there would not be a noticeable adverse selection bias if this opportunity was available. At CHPI, a health plan commented that this is desirable to groups and the plan offers such choices in the commercial market.

ETF is limited by its current insurance administration system and such a change would require a significant time commitment for a relatively small group of employers, since most participating employers have few employees. When ETF changes its system with its modernization efforts, this option may become more viable.

b. Many employers outside of the GHIP offer HDHPs with greater Out-Of-Pocket (OOP) costs. Staff plans to contact employers in our advisory group and utilize a survey to learn of interest in such a plan design.

c. Plans commented that the HDHP offered in the GHIP is unusual in that it includes both deductibles and copays. Plans have recommended that this be changed to offer one or the other as having both is difficult for members to understand. Staff is investigating this with other potential changes for 2022 (Ref. GIB | 2.17.21 | 7D).

6. After a group leaves the GHIP, they cannot rejoin for three years

When an employer group leaves the WPE GHIP, current policy states that it cannot rejoin for three years. When the employer applies to rejoin, it is subject to underwriting and a possible surcharge. We could change the duration. It is uncommon for groups that leave the GHIP to rejoin. Of the groups shown in Table 9, only one has returned to date.

Table 9 **Year**	**# Employers Who Left the GHIP**	**Average Group Size Employees**
2019	7	191
2018	8	44
2017	16	100
2016	16	20

Of the states who offered this information during interviews, most use a three-year threshold. However, Tennessee requires groups leaving the program to stay out for two years. Oregon permits an employer group that leaves the program to return after 18 months. However, if the group returns sooner than three years have elapsed following their exit, they must pay a 15% rate penalty for 12 months.

Alabama is unique in that when an employer leaves the program, it is not permitted to be insured by the same Third-Party Administrator (TPA) used by the state for three years. Blue Cross Blue Shield is Alabama's TPA and it is the most popular vendor in the

state. ETF does not recommend setting a limit on choice of vendors for employers that exit the program. A limitation on future vendors to be used by the employer appears punitive and if adopted, would result in complaints.

ETF does not recommend shortening the amount of time an employer must remain out of the program before returning. It should be noted that it is relatively common in the commercial market for groups to get two-year rate guarantees. Following that period, a larger increase for the third year may be assessed if initial premiums were underpriced in order that the vendor could get their business.

We could explore alternatives to add rate penalties in addition to underwriting surcharges for employers that want to return after two years. Penalties would not apply after three years have elapsed. It should be noted that this would impact very few groups.

7. Multi-year rates to provide predictability to locals

Renewal rates could contain a Not to Exceed (NTE) provision for two or three years. Segal does not recommend this and commented that this process typically results in more conservative pricing because claim cost trends must be estimated for a longer period of time. ETF has concerns about what would happen after the end of the multi-year period. If the NTE caps resulted in plans losing money, the fourth-year renewal could result in significantly higher premiums.

ETF and Segal recommend the current annual, aggressive pricing.

8. Gain sharing with health plans

If a plan's annual claims experience when compared to premium (loss ratio) shows a significant profit by the plan, the excess profit beyond a calculated percentage could be shared between the plan and ETF. The reverse could also occur if the loss ratio is high, showing that the plan lost a significant amount. In this case, the loss could be shared with the Trust Fund.

A variant on this gain sharing model is currently in place with WEA for the Access Plan, SMP and Medicare Plus. It began in 2018 as the plan changed from self-insurance to being fully insured. At that time there was also a benefit change so that the in-network benefit of the Access Plan matched Uniform Benefits. This left uncertainty on how premiums should have been established for the plan. WEA and the Board agreed to an arrangement where half of the premium excesses, less an administrative expense, are refunded to the Trust Fund. Premium deficiencies are not refunded from the Trust Fund to the plan; rather, they may be used to offset premium excess refunds in the future. To date, refunds have been used to offset future premium increases in the program which is illustrated in Table 10. Note that in 2019, the rates for the Access Plan were also lowered 7%. Without that change, the refund would have been greater. The 2020 gain sharing calculation will be complete in June of 2021.

Table 10 Gain Sharing Year	Members	WEA Refund to ETF
2018	11,542	$2,385,025
2019	9,530	$1,560,765

If gainsharing were adopted for the GHIP overall, the calculation with plans that have capitated payment agreements with providers, such as Quartz with UW Health, would be difficult to determine. Capitation allows a provider to group a set amount of dollars that are used to pay all claims. This payment arrangement incentivizes the provider to control costs. However, it uses retroactive adjustments that can obscure actual costs to the extent that gain sharing would likely not result in payments back to the trust fund.

9. Subdivide WPE pool

ETF staff investigated – but does not recommend -- the following options due to concerns that smaller subgroups would have more volatile claims costs that would result in premium rate swings.

a. Regionalize offerings: We investigated if multiple plans could compete against each other in defined regions of the state. Such a change would be a reversal of current practice, where plans develop their provider networks with hospitals, clinics, and independent physicians. Plan networks currently follow distinctions between provider groups and can result in provider competition in some areas, or significant overlap where many plans offer the same provider systems.

   It should be noted that in 2016 and 2017, the Board investigated many options for change to the state and local GHIP including self-insurance and regionalization (Ref. GIB | 2.8.17 | 5A). Ultimately, these changes were not adopted. Around this time a few large local employer groups exited the program due to the uncertainty about the future.

   ETF examined regionalization used by the Department of Health Services (DHS) for Wisconsin's Medicaid program. DHS divides the state into five regions where vendors must offer adequate access to providers across the region. When analyzed with the lens of the GHIP's participating plans, we found that smaller plans in rural areas and their provider networks would not completely fill a region's defined area. Therefore, such a change would likely result in a loss of those plans. Larger plans would likely be able to expand their networks to fill the region, and possibly have more leverage over provider reimbursement due to the increased market share available to the plan. This change could also result in fewer provider network changes for our members year over year.

   Additionally, analysis of Medical Loss Ratios (MLRs) from 2014 through 2019 at the county level, DHS region level, and by health plan resulted in no substantial results that would warrant a regionalization effort. It does not appear that

grouping counties into regions would significantly reduce MLR variation and therefore would have minimal effect on rates in the future.

For decades, the GHIP has leveraged its competitive health insurance model to maintain reasonable premium increases and offer choice to members. If there are fewer health insurers to compete for our population, it could negatively impact ETF's ability to negotiate reasonable premium increases. As such, ETF does not recommend this change.

b. Group WPEs by size into several stratum: Other states offer other structures that could be considered.

    - Minnesota has 15 rate bands that are based upon claims experience. All groups in a band get the same rate. If a group changes rate bands with its renewal, then it gets the overall program increase and the adjustment from its previous band to the new band. This could be a positive or negative adjustment.

    - South Carolina offers rate bands in three categories based upon group size. Adjustments are applied for larger groups based upon their individual claim experience.

ETF does not recommend a change however, due to the small size of the WPE GHIP in many of the 17 available plan offerings. The concern is that subdivision of the risk pools within the plans may reduce claim stabilization.

<u>10. Develop an RFP to offer only one or two vendors to the local pool</u>
Potential vendors should provide a nationwide provider network for eligible employees and retirees. That criteria would likely narrow the choice of potential vendors to large nationals or vendors that offer PPOs like WEA. HMOs in our program may have access to nationwide networks, but the administrative burden of use for the relatively small number of members, especially since most out-of-state members are retirees, could result in non-competitive premiums to the extent that the HMO would not submit a bid.

Vendors would be selected to insure the pool for a number of years. This may result in more competitive rates early on, but there is a concern that with the reduction of competition, rates would rise more quickly than in the current model with many competing plans.

However, the state of Kentucky changed its program from a competitive model with numerous smaller plans to one statewide plan in 2005. Following an RFP, Kentucky hired one TPA. Staff report they are satisfied with the result and feel it has resulted in stable rates and less administration but note that many of the small health plans they used to contract with are no longer doing business.

11. Combine the State and WPE risk pools

In 1987, Wis. Stat. 40.51 (7) created the opportunity for locals to participate in a group health insurance program offered by the Board. It was established as a separate risk pool with separate reserves to avoid cross subsidization. If action was taken to combine the pools, due to the overlapping location of Wisconsin state and local employees, over time, one or the other pool would likely subsidize the other. If combined, there may be issues during the state's biennial budget process. Further, it should be noted that combining the pools may result in a constitutional question. The Wisconsin constitution reads in part: "… the credit of the state shall never be given, or loaned, in aid of any individual, association or corporation." While courts have typically rejected challenges to various state actions, based on this clause, the Wisconsin Supreme Court has held that it was intended to prohibit the state from acting as surety or guarantor of collateral obligation of another party. This would include a municipality. Thus, such a change could be challenged on constitutional grounds.

Other states like Connecticut and Kansas combine their pools. Connecticut has a distinct geographical difference between state employees who live near Hartford, and local employees who live nearer New York. Due to this, Connecticut is able to apply region factors that are used to develop separate premium rates for state versus local employees. Kansas has opted to provide the same premium rates to both state and local employees as they are not concerned about cross subsidization.

ETF does not recommend investigating this option further.

Next Steps

ETF will meet with an advisory group of local employers to gain up-to-date views on the strengths and weaknesses of the GHIP compared to the commercial market and how employers would like to see the GHIP changed. The group consists of both employers that participate in the WPE GHIP and eligible, non-participating employers. The focus of the discussion will center on premium rate setting, benefits, and communication. Employers will be asked to identify where they would like to see their health insurance in two to five years. The information gathered in the advisory group is expected be used in the development of a survey for more employers.

Recommendation

ETF finds increased and improved communication with employers may result in growth and long-term stability of the WPE GHIP.

In addition to acting on input from the Board, staff will develop a phased timeline for improved communication with employers. We will also report to the Board on the outcome of the advisory group and the subsequent survey of eligible employers.

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