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Correspondence Memorandum

Date: April 19, 2021

To: Group Insurance Board

From: Renee Walk, Lead Policy Advisor
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Office of Strategic Health Policy

Subject: Rate Setting Refresher Training

This memo is for informational purposes only. No Board action is required.

Background

The Department of Employee Trust Funds (ETF) in consultation with Segal (the Board's actuary), on behalf of the Group Insurance Board (Board), establishes premium rates for the Group Health Insurance Program (GHIP). The purpose of this memo is to provide information on the component parts of the premium rates in the GHIP and how those rates are established each year. This memo only addresses the premium rates for health, pharmacy, and uniform dental coverage; supplemental plan rates are not in the scope of this document.

Total Premium Rates

There are four components that make up the premium rates: medical, pharmacy, and dental premiums, and administrative fees.

The medical portion of the total premium is the largest and covers the cost of medical care provided through the Board's contracted health plans. The medical portion of the premium is fully insured. This means the Board pays health plans a set premium, and the health plan assumes any risk should medical services cost more than the amount of premiums paid.

The pharmacy portion of the rates cover the cost of prescription medications received outside of a hospital or other facility and administrative expenses. The pharmacy program is self-funded, so premium rates are determined by ETF in collaboration with Segal and the pharmacy benefit manager (PBM), Navitus Health Solutions. In a self-funded model, the Trust Fund is responsible for paying all claim costs and assumes the risk if pharmacy costs are higher than the premiums collected. This requires the Board to maintain reserve funds to cover unexpected costs.

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy

Eileen K Mallow Electronically Signed 4/30/21

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The third component of rates is the Uniform Dental Benefit (UDB) premium. The UDB program is also self-funded and administered by a single vendor, Delta Dental of Wisconsin (Delta). Similar to the pharmacy benefit, the Trust Fund assumes the risk of cost overruns beyond the premium amounts charged and maintains reserve funds to pay any excess charges.

The last component of premiums, administrative fees, includes three sub-components:

- ETF's Administrative Fee: Covers ETF's operational cost to administer the GHIP,
- Wellness Fee: Covers the cost of the Well Wisconsin program administered by WebMD, and
- DAISI Data Warehouse Fee: Covers the administrative cost to operate and maintain the data warehouse provided by IBM Watson Health.

Rate Structures

There are different rate structures offered within the GHIP, based upon the state or local employer risk pool, benefit plan design, subscriber type (for example regular versus graduate assistant employee) family/single enrollment, and Medicare coverage for retirees.

Employer Group or Risk Pools

The GHIP is first divided into two groups of members, sometimes referred to as pools, and premiums for these groups are rated separately. The largest group is referred to here as the state program, and includes state agencies, authorities, the University of Wisconsin (UW), and UW Hospital & Clinics (UWHC). The second group is the smaller local program and includes local units of government who have opted into coverage under the GHIP.

Benefit Plan Design

The plan design refers to the different copays, coinsurance, and deductibles (together, referred to as "cost sharing") that are included in a particular benefit package. Differences in cost sharing affect the total amount of the medical premium.

There are two different medical benefit plan designs offered to members in the state program. One plan offers lower cost sharing and higher premiums, while the other offers a higher deductible that qualifies it to be paired with a health savings account (HSA).

In the local program, there are four different medical benefit plan design options available. Two mirror the benefits offered to state employees, while two additional plans offer even lower levels of cost sharing.

Both state and local employees may select from one of nine regional health insurance carriers in Wisconsin, or for nationwide coverage can select the Access Plan or Access High Deductible Health Plan (HDHP). The Access Plan/Access HDHP offers a similar plan design for in-network benefits as all other carriers, and also offers an out-of-network benefit package. For all of the medical coverage plans, members are

automatically enrolled in the pharmacy benefit plan, which offers the same cost sharing for all plans, but coverage differs between HDHP and non-HDHP plans. In addition to the medical benefit plan designs, state employees and local employers may choose whether or not to elect the UDB to be added to their benefit plans.

Subscriber Type & Family/Single Enrollment
Rates may also vary by the category into which the subscriber falls. There are separate rates calculated within the plan design options for:

- Active employees and retirees who are not yet enrolled in Medicare, and
- Graduate assistants (UW only).

Subscribers can choose whether they want to enroll in individual coverage only, or if they want to enroll in a family policy to cover all eligible dependents. Individual and family policies are each assigned a different rate within the above categories.

Medicare Coverage
Retirees who are age 65 or older must enroll in Medicare. The Board's programs coordinate coverage with Medicare and offer reduced rates to those enrollees. Medicare retirees also may enroll as individuals or with eligible dependents on a family policy, similar to active employees.

For the Medicare population, there are four different available rate structures:

- Medicare Family All: A Medicare rate offered by all health plans. All family members must have Medicare and be enrolled with the same health plan.
- Medicare Single: Individual coverage for a retiree who must be enrolled in Medicare.
- Medicare Family Some – Health Plan Medicare: The family includes some members with Medicare and some not on Medicare. All family members are enrolled with one of the health plans that also offer non-Medicare benefits.
- Medicare Family Some – Medicare Advantage or Medicare Plus: This was originally referred to as Medicare Splits. The family includes some Medicare members and some non-Medicare members. The Medicare members enroll in either Medicare Advantage or Medicare Plus, while the other family members enroll with one of the health plans that offer non-Medicare benefits.

In addition to the plan offerings described above, the Board also offers the Local Annuitant Health Program (LAHP) to local annuitants whose former employer does not participate in the GHIP. Starting with plan year 2021, the LAHP has its own rate structure, reflective of the population enrolled in that program, which includes all rate structures listed above.

Rate Proposals and Negotiations
Each spring, Segal provides the health plans with a set of spreadsheets to use in providing their preliminary bids for medical rates and proposed provider networks. Health plans submit their completed documents and supporting data to Segal.

Segal evaluates the supporting data and compares it to the claims data in the Data, Analytics, and InSIghts (DAISI) data warehouse to determine whether the proposed rates align with what Segal would expect premiums to be, based on the claims paid in the prior year with an average plan administrative fee. As a result of this comparison, Segal assigns a Tier (1, 2, or 3) to each health plan. Tiers are assigned separately for the state and local programs.

ETF provides health plans with a notice of its initial tier based on Segal's analysis and an invitation to negotiate rates if the plan is not in Tier 1. Health plan negotiations are usually held during the first week of July each year. This is an opportunity for the health plans to provide additional justification for their preliminary rate proposals. Following the negotiations, the health plans who wish to revise their rates for better tier placement submit a Best and Final Offer (BAFO). Health plans may also submit changes to their proposed provider networks or notify ETF and the Board if they no longer wish to participate in the program.

During this period, renewal information is also submitted for the pharmacy and dental programs. Navitus and Delta each provide information on claims costs for the prior year and expected trends. Navitus also includes information on drug rebates and federal subsidies that might impact rates.

Finally, ETF assesses potential program cost changes for the wellness program and the DAISI data warehouse, as well as ETF's administrative costs for the year to be included with the final rates once established.

Tier Assignment

Tiering is a method of ranking health plans by cost and quality. Tiers are proposed each year by ETF and Segal. Wis. Stats. §40.51(6) requires the Board to separate health plans into one of three tiers as approved by the Board. ETF and Segal set the standards for the three tiers on behalf of the Board. Tiers is determined separately for the state and local programs. The tier assignment for a health plan applies to that plan statewide. It does not vary by county.

Tiers are based on a plan's premium relative to claims costs, expected trends, risk scores, and the amount of increase requested by that plan over the prior year. Tier assignments are not done as a comparison between health plans. It is possible for a plan to be Tier 2 and have a lower premium than a Tier 1 plan due to a failure to meet any one of the criteria above.

In the state program, Tier 1 plans have the lowest, fixed-dollar employee premium contribution as established by the Department of Administration (DOA). Tier 2 and 3 plans are more expensive to the employee, which provides a strong incentive for employees to choose Tier 1 plans, and for health plans to meet Tier 1 premium requirements.

In the local program, employers each set their own share of premium for employees, based upon a formula described in state statute. Often, local employee premium share is a percentage of the average cost of qualified Tier 1 plans available in a county. In cases where there are Tier 2 plans with lower premiums than the Tier 1 plans in a county, local employees may select the Tier 2 plan because a greater portion of their premium costs would be paid by their employer.

Plan Qualifications

Segal also reviews the provider data sent in by health plans to verify that they meet minimum requirements to be offered in a county. The minimum requirements are set in the Program Agreement, which is signed by all participating health plans. Plans must offer a minimum number of primary care providers, hospitals, and chiropractors within certain geographic parameters in order to qualify to be offered in a county. In their data submissions, plans also indicate which counties they wish to cover or be offered in.

Based on those requirements and the data provided, Segal assigns one of the following qualification statuses for each plan by county:

- Qualified – Covered: The health plan has sufficient provider access in the county and the county is within the health plan's stated service area.
- Qualified – Not Covered: The health plan has sufficient provider access in the county, but the county is not in the health plan's stated service area.
- Not Qualified – Covered: The health plan does not have sufficient provider access in the county, but the county is in the plan's stated service area.
- Not Qualified – Not Covered: The health plan does not have sufficient provider access in the county, and the county is not in their stated service area.

Program Reserves and Premium "Buy-down"

The Board maintains reserve funds for the self-insured programs. These reserve funds are a combination of excess premiums paid in years where the self-insured programs have lower claims experience than expected, as well as investment returns on the reserve accounts themselves. Segal and ETF work with the Board to set target amounts for the reserve funds. When the reserves exceed the target amounts, the Board can opt to use the extra funds to reduce or "buy-down" premium rates for members.

In mid-July, ETF submits the prior year and current year (through June) reserve account balance to Segal. Segal uses this information to recommend any change in rates necessary to maintain the reserve account, including increases or, in the case of recent years, premium buy-downs. The GHIP currently has reserve funds that are larger than the targeted amount for the program. There is a multi-year plan approved by the Board to reduce those excess funds.

The first year of buy-down was plan year 2018. That year, the buy-down was applied to the medical portion of the premiums. This was due, in part, to the elimination of all self-insured medical plans in the GHIP as required under the law. The employers/members were charged a lower medical premium than what was paid to the health plans with the

difference being made up from reserve funds. Applying buy-down to the medical portion of the premium is complicated because the full medical premium has to be paid to each health plan while collecting a lower amount from employers and retirees.

Starting with the 2019 plan year, the buy-downs have been applied to the pharmacy portion of the premium. This has been a simpler solution since pharmacy is self-funded and provided by a single vendor. Under this approach, the pharmacy premiums are set to be less than the expected program costs, with the difference paid from the reserve balance.

Board Approval
At the August Board meeting, Segal presents the proposed premium rates, reserve balance information, and proposed buy-down to the Board for approval. This information is presented as aggregate totals with percentage changes from the prior year. The Board is asked for its approval of the proposed rates and any buy-down at this meeting.

Rate Validation
Once proposed rates and any possible buy-down are set, Segal creates a workbook, or multi-tab spreadsheet, that contains all of the different variations of the rates. The main worksheet includes all of the rates and rate components for each of the program options and rate structures described previously. It is currently comprised of 54 rate tables. The workbook also includes other versions of the rate tables that are formatted for various uses and audiences. ETF does quality assurance checks on the tables to ensure that all of the rates are complete and accurate. The various versions of the tables are distributed to the intended audiences once the final rates are approved by the Board.

Local Surcharges
When new large employers apply to join the local employer program, they are required to go through underwriting to assess risk. An employer is classified as a large employer if they have 50 or more employees. If the large employer is found to have higher risk than the group or risk pool, the employer is assigned a risk category ranging from 1 to 4, with 1 as lower risk and 4 as elevated risk. Those determined to have a risk are then assessed a premium surcharge that lasts from 18 to 27 months, depending on what point in the year they join the program as set by a surcharge schedule. The schedule is set that employers will pay the same overall amount of surcharge, so there is no financial incentive to join the program at any given quarter. The surcharge schedule is evaluated by Segal on an annual basis.

Employer/Employee Share of Premium
Since the passage of Act 10 in 2011, GHIP participating employers are prohibited from contributing more than 88% of the total health insurance premium cost under Wis. Stats. § 40.05(4)(ag)1 and §40.51(7). The exception to this is local program employers with certain collective bargaining agreements, which are now rare.

In the state program, the employee share is calculated by the Division of Personnel Management (DPM) of DOA under authority granted in Wisconsin Stat. § 40.05(4)(ah), based on the rate tables provided by ETF. For Tier 1 plans, the employee share is calculated based on a weighted average of all health plan premiums that have been approved by the Board as Tier 1 and is the same amount regardless of which plan an employee chooses. This incentivizes plans to be Tier 1 and reduces price sensitivity for state employees who might otherwise seek a different plan to lower cost.

DPM sets three levels of employee share:

- Tier 1 applies to plans that the Board has approved per Segal's recommendations,
- Tier 2 applies to plans that are placed in this tier and employees who are enrolled in the IYC Access Plan, and who reside and are assigned to work out of state, and
- Tier 3 applies to plans that are placed in this tier and employees who are enrolled in the IYC Access Plan and work or live in-state.

The contribution amounts for local program employers and employees are a little more complicated. The maximum employer share is calculated separately by county as 88% of the average premium of the Tier 1 plans in that county.

For example, in 2021, Columbia County has four available health plans, as well as the Access Plan. Three of those plans are Tier 1. The local Traditional + Dental plan individual rates for those Tier 1 health plans are $785.34, $813.10, and $984.80. The average of those three premiums is $851.08. 88% of that average is $748.95. That is the maximum that participating employers in Columbia County can contribute to an employee's individual policy premium. The same calculation is done with the family rates. This is illustrated in the figure below. The rates highlighted yellow are the Tier 1 total premiums, and the calculated maximum employer share that applies to all plans is highlighted in blue.

Figure 1. Excerpt of 2021 Local Program Rates

Program Option: P02 WPE Traditional +Dental			88% of Tier 1 Qualified Plans' Average Premium					
2021 Rates	* = Not in calculation - Plan not qualified in county		Single			Family		
County	Tier	Carrier	Maximum Employer Share	Minimum Employee Share	Total Premium	Maximum Employer Share	Minimum Employee Share	Total Premium
Columbia								
	1	Dean Health Insurance	$748.95	$64.15	$813.10	$1,839.83	$155.93	$1,995.76
	1	GHC of South Central Wisconsin	$748.95	$36.39	$785.34	$1,839.83	$86.53	$1,926.36
	2	Quartz - Community	$748.95	$223.69	$972.64	$1,839.83	$554.79	$2,394.62
	1	WEA Trust - East	$748.95	$205.85	$954.80	$1,839.83	$510.19	$2,350.02
	3	Local IYC Access Plan	$748.95	$470.31	$1,219.26	$1,839.83	$1,171.33	$3,011.16

Employees pay the difference between the premium for the health plan they choose and the maximum employee share. If an employer located in Columbia County pays the maximum 88% of premium in the example above, an employee that picks the $813.10 plan will pay $27.76 more per month than an employee that chooses the $785.34 plan.

This results in more price sensitivity among local employees. They are more likely to pick the least expensive plan and to change plans from one year to the next if their plan is no longer the lowest cost plan.

Local program employers can contribute anywhere from 50% – 88% of the average Tier 1 plan premium under current state statutes for full time employees. Due to the more complex nature of the 88% calculation, Segal produces tables that provide the rate elements shown in Figure 1 for each county.

Triple Aim

Under the Program Affordability dimension of the Triple Aim and in accordance with the Board's fiduciary duty, it is important to manage premium rates. The goal of the annual rate setting process is to provide the most affordable health insurance premiums for employers and employees without negative impacts on the other two dimensions of the Triple Aim, Quality and Health.

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