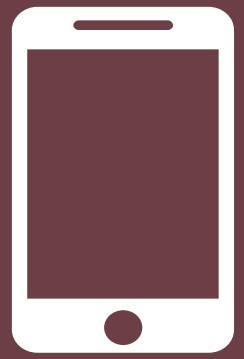
Please register your attendance by sending an email with name/organization to ETFSMBBoardFeedback@etf.wi.gov.

Meeting Materials

- Available at etf.wi.gov



Please Mute Microphones and/or Cell Phones (Using #6)

Public comments for future consideration accepted at: ETFSMBBoardFeedback@etf.wi.gov.

Welcome to the Group Insurance Board

May 12, 2021

Meeting will begin at 8:30 a.m.

Announcements

Item 1 - No Memo

Consideration of

February 17, 2021 Open and Closed Meeting Minutes
March 29, 2021 Open and Closed Meeting Minutes

Item 2A – 2D – Memo Only

Rate Setting Refresher Training

Item 3 – Group Insurance Board

Renee Walk, Lead Policy Advisor

Douglas Wendt, Health Policy Advisor

Office of Strategic Health Policy

Patrick Klein

Segal Consulting

Informational Item Only

- No Board action is required

Goals of training

- ✓Understand how the Board, ETF, and Segal determine rates and what services the premium includes
- ✓Understand tiering, qualifications, reserves, rate buy-down, surcharges, and employee share as methods for determining various aspects of rates
- ✓Understand the steps taken by ETF, Segal, and the Board to set health, dental, and pharmacy rates each year

Key terms

- **Rate/premium** = the amount of money an individual or a business pays for an insurance policy. ETF uses these words interchangeably
- **Pools** = a group of people whose individual characteristics (e.g., age, location, gender, etc.) are combined to calculate a premium
- **Plan design** = the combination of copays, coinsurance, and deductibles that insured people will pay
- **Health plan/carrier** = the company that processes claims and provides other services to members in exchange for premium
- **Subscriber** = the first person named on an insurance policy. In the Board's case, this can be the employee, the retiree, or a surviving spouse.
- **Dependent** = additional people named on an insurance policy held by a subscriber. For the Board, these are typically spouses or children of the subscriber.
- **Surcharge** = an amount charged in addition to the premium designed to cover additional costs that are anticipated due to the group's characteristics

Rates & Rate Structures

Memo pages 1 - 3

What's in a premium rate?

Medical	Pharmacy	Uniform Dental	Administrative Fees
Fully-insured	Self-insured	Self-insured	ETF costs to operate
Proposed by health plans	Developed collaboratively with PBM, ETF, Segal	Developed collaboratively with UDB vendor, ETF, Segal	Wellness program costs
Reviewed by Segal	~15% of total premium	~3% of total premium	Data warehouse fee
~80% of total premium			~2% of total premium

(Ref. GIB | 05.12.21 | 3, page 1-2)

Rate structures

Employer group or risk pools

- State: includes agencies, UW and UW Hospitals & Clinics
- Local: includes local units of government that opt into health insurance

Benefit plan design

- Three plan designs for state: HMO, PPO and HDHP
- Five plan designs for local employers: three mirror the state options, one deductible plan, one very low cost sharing plan

Subscriber & Enrollment Type

- Active employees, retirees (with & without Medicare), grad assistants, continuants
- Single or family

(Ref. GIB | 05.12.21 | 3, page 2-3)

Rate structures continued

If Medicare…

- Medicare Family All
- Medicare Family Single
- Medicare Family Some – Health Plan Medicare
- Medicare Family Some – Medicare Plus or Advantage

(Ref. GIB | 05.12.21 | 3, page 3)

Tiering

Memo Pages 4 - 5

Tier assignment

- Tiers rank plans by cost and network adequacy
- Tiers are determined separately for state and local programs
  - Plan A may be Tier 1 for state and Tier 2 for local
- Tiers in the local and state programs are the same across counties

(Ref. GIB | 05.12.21 | 3, page 4-5)

Tier assignment continued

- Tiers are based on:
  - Claims cost
  - Expected trend
  - Risk scores
  - Increase over prior year
- Tiers are NOT based on what other plans bid
  - It is possible for a Tier 2 plan to be less expensive than a Tier 1 plan

(Ref. GIB | 05.12.21 | 3, page 4-5)

Tier assignment continued

SIMPLIFIED EXAMPLE			
Criteria	Detail	Plan A	Plan B
Prelim Bid	Provided by plan	$975	1,000
Prior Year Tier 1 Premiums	Current premiums in effect	$950	$960
Risk Scores	Adjustment based on relative risk	.98	1.03
Risk-Adjusted Rate	Based on Prelim Bid x Factors	$994,90	$970.87
Allowed Increase	5% over prior year*	$997.50	$1,008.00
Tier Breakpoint	Compare to Risk-Adjusted Rate	$980.00	$980.00
Difference: breakpoint v actual		($14.90)	$9.13
Prelim. Tier		Tier 2	Tier 1

**For illustrative purposes only, not actual*

Tier assignment, continued

- In the state program, Tier 1 plans have the lowest, fixed-dollar employee share, which incentivizes the plans to be Tier 1
- In the local program, employers set their own share of premium (50% to 88%), based on the average of qualified Tier 1 plans in their county

(Ref. GIB | 05.12.21 | 3, page 4-5)

Plan Qualifications

Memo Page 5

Plan qualifications

- To be qualified in a county plans must offer a minimum number of primary care providers, hospitals, and chiropractors within certain geographic parameters
- Qualification Statuses
  - Qualified – Covered: Plan is qualified and county is in the plan's service area
  - Qualified – Not Covered: Plan is qualified but county is not in the plan's service area
  - Not Qualified – Covered: Plan is not qualified but county is in the plan's service area
  - Not Qualified – Not Covered: Plan is not qualified and county is not in service area
- If there are no qualified Tier 1 plans in a county, the State Maintenance Plan (SMP) plan will be offered as the Tier 1 plan in that county.
  - SMP is an HMO plan administered by WEA Trust

(Ref. GIB | 05.12.21 | 3, page 5)

Reserves, Buy-Down, & Surcharges

Memo Pages 5 - 6

Reserves / "Buy-down"

- The Board maintains reserve funds for the self-insured programs
  - Excess premiums vs claim costs
  - Investment returns on the reserve accounts
- ETF & Segal work with the Board to set reserve targets
  - Current fund balances are above targets
  - Board approved multi-year plan to reduce the excess funds
    - Plan reviewed annually
    - Funds above target can be used to "buy-down" premiums

(Ref. GIB | 05.12.21 | 3, page 5-6)

Reserves/"Buy-down", continued

- Multi-year plan to reduce reserves to target
  - 2018- buy-down of medical premiums
  - 2019 and after- buy down of pharmacy premiums
    - Simpler application of buy-down funds

(Ref. GIB | 05.12.21 | 3, page 5-6)

Local Program Surcharges

- Potential new, large local employers go through underwriting to assess risk
  - Large employers have 50 or more employees
- Large employers are assigned a risk category as a result of underwriting
  - Categories range from 0-4 with 0 = low/no risk to 4 = elevated risk
  - Employers in categories 1-4 are assigned a monthly premium surcharge
- Surcharges are applied based on a schedule of categories and time of year the employer joined the program
- Surcharge schedule is evaluated by Segal on an annual basis

(Ref. GIB | 05.12.21 | 3, page 6)

Employer/Employee Premium Share

Memo Page 6- 7

Employer/Employee Share of Premium

- Employers participating in GHIP are prohibited by statute from contributing more than 88% of total health premium
  - Rare exceptions for some local employers with certain bargaining agreements
- Retirees, crafts workers, and continuants pay 100% of the premium with no employer contribution

(Ref. GIB | 05.12.21 | 3, page 6-7)

Employer/Employee Share of Premium, continued

- State Program
  - The Division of Personnel Management (DPM) of DOA sets the employee share of premium
  - DPM sets three levels of employee share
    - Tier 1 applies to plans that the Board has approved per Segal's recommendations
      - Based on 88% of a weighted average of the Tier 1 plan total premiums
    - Tier 2 in addition to plans that are placed in this tier, applies to employees who are enrolled in the IYC Access Plan and who live and are assigned to work out of state
    - Tier 3 in addition to plans that are placed in this tier, applies to employees enrolled in the IYC Access Plan and who live or work in-state
  - Employees pay the same amount regardless of plan selected
  - Employers pay the difference between each plan's total premium and the employees' share

(Ref. GIB | 05.12.21 | 3, page 6-7)

Employer/Employee Share of Premium, continued

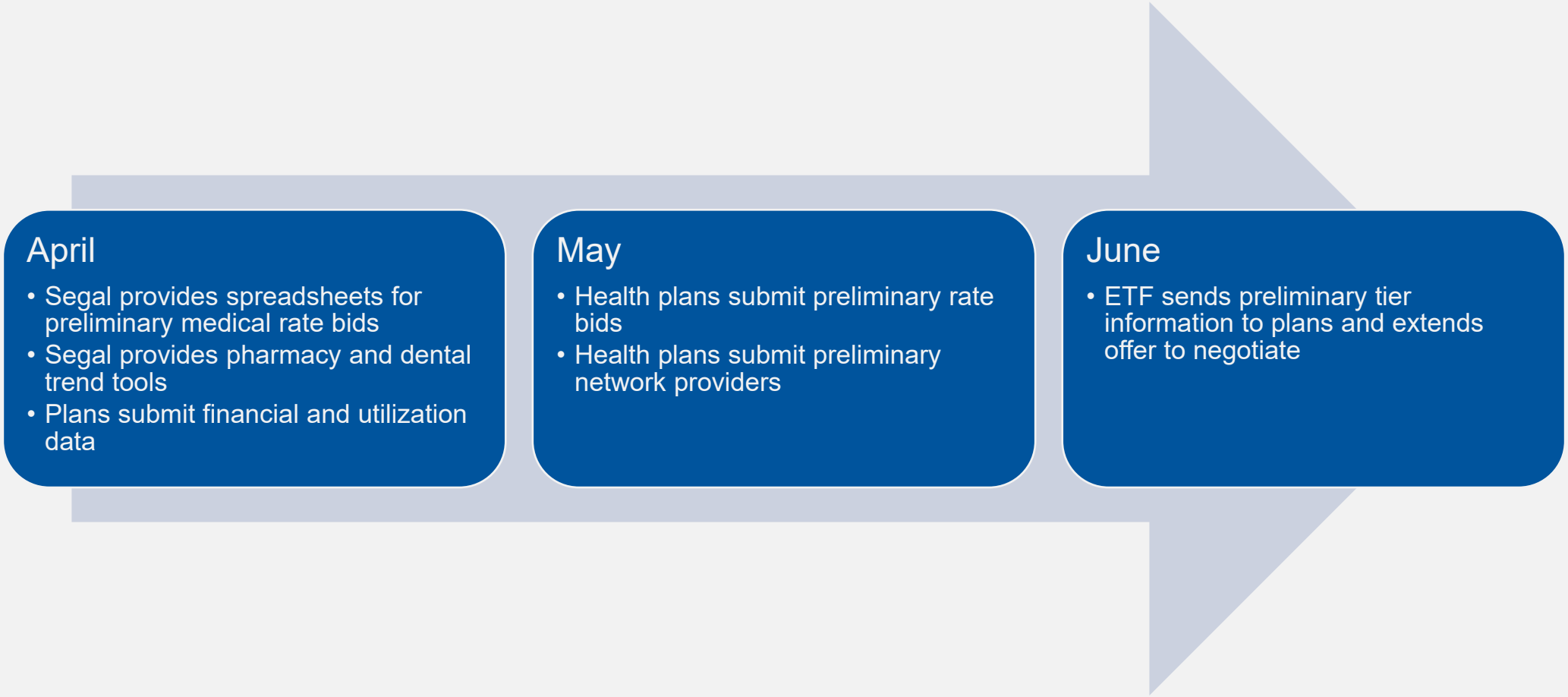
- Local Program
  - Under statute employers can pay 50-88% of total premium
    - The 88% is calculated as 88% of the average total premium of all Tier 1 plans in a county
    - The 88% calculated is done separately for each county
  - Local employers are provided 88% tables as guidance on the maximum they can contribute
    - 88% tables are created by Segal and distributed by ETF
    - ETF also provides a worksheet for employers to use if they want to contribute less than 88%
  - Employees pay the difference between the total premium of the health plan they choose and their employers contribution
    - This incentivizes employees to pick a lower cost plan

(Ref. GIB | 05.12.21 | 3, page 6-7)

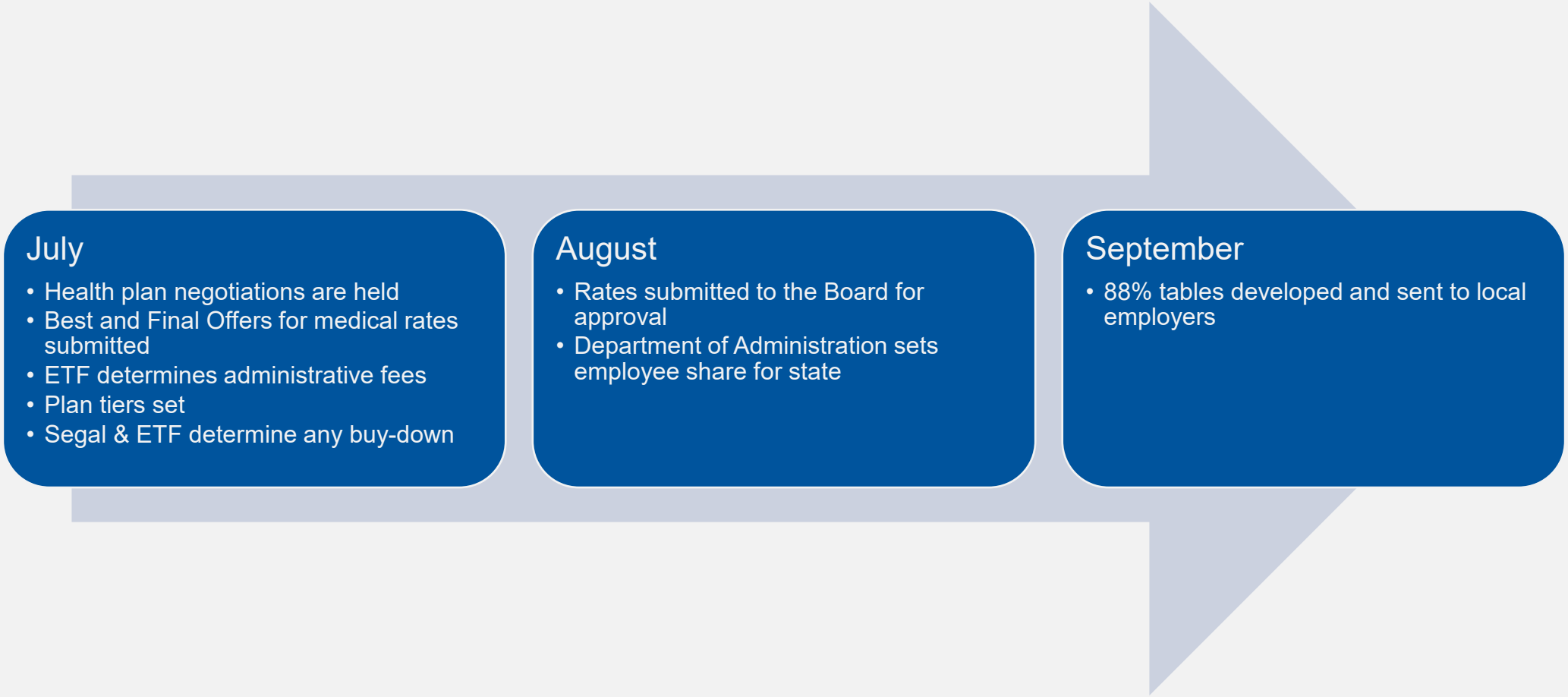
Annual Process

Review of Timeline for Rate Development

Annual process



Annual process, continued



Questions?

LAB Report Findings Implementation Update

Item 4 – Group Insurance Board

Eileen Mallow, Director

Office of Strategic Health Policy

Action Needed

- ETF requests that the Group Insurance Board approve the proposed policy on funding targets for the state and local life insurance pools.

Background

- 2018 Legislative Audit Bureau report contained 30 findings recommending improvement in administration and oversight of GHIP
- Follow up report released in February 2021 found 24 of 30 findings had been implemented
- Status of remaining recommendations
  - 3 partially implemented; no additional recommendations
  - 1 not started until 2021
  - 2 partially implemented with additional recommendations

Recommendation 1

ETF should provide the Board with additional information on the performance of program auditors

- OSHP and ETF's Office of Internal Audit (OIA) review auditor performance, preliminary reports for consistency with audit scope and generally accepted auditing standards
- ETF will make Board aware of any vendor performance issues
- ETF continues to report on status of audits-in-progress to the ETF Board Audit committee

Recommendation 2

The Board should establish a written reserve policy for the life insurance programs

- The Board receives a report annually from Securian Financial, the life insurance program administrator, that provides a valuation status
- Securian establishes reserves under the terms of the contract, but valuation status directly impacts reserves
- Board has previously determined that the valuation status should be 100% and has adjusted premiums to achieve this target
- Written policy establishes Board goal and process to regularly review status

Action Needed

- ETF requests that the Group Insurance Board approve the proposed policy on funding targets for the state and local life insurance pools.


Questions?

May COVID-19 Update

Item 5 – Group Insurance Board

Renee Walk, Lead Policy Advisor

Molly Heisterkamp, Wellness & Disease Management Program Manager

Office of Strategic Health Policy

Informational item only

- No Board action is required

(Ref. GIB | 5.12.21 | 5, Page 1)

Legislative updates

ARP Act of 2021	• Relief funds for pandemic • COBRA continuation subsidy (GIB Item 6) • FSA and dependent account flexibility (GIB Item 10B)
CMS Guidance re: coverage of testing and vaccines	• Clarifies/reiterates that patients should not be charged during the public health emergency
HHS extends public health emergency	• New period continues through July 20, 2021

(Ref. GIB | 5.12.21 | 5, Pages 1-2)

Legislative updates

New state legislation allows dentists to provide vaccines

- Not expected to be used frequently for GHIP members

State Supreme Court strikes down public health restrictions

- Statewide mask mandate
- Bar and restaurant capacity

(Ref. GIB | 5.12.21 | 5, Pages 1-2)

Benefits coverage

- Some health plans begin to revoke voluntary cost sharing waivers
- ETF clarified guidance for members on Medicare seeking vaccines
  - Claims may process without additional member coordination at a clinic versus pharmacy
  - However, members should go wherever they're able to book appointments

(Ref. GIB | 5.12.21 | 5, Page 2)

Vaccine updates

Johnson & Johnson vaccine now cleared for use with warning about rare blood clots

Relative risk of clots from vaccine is extremely low

- 6 cases in 7M recipients in the US
- According to BMJ study, COVID-19 patients are 10 times as likely to suffer a similar blood clot due to the disease itself
- Blood clots from oral birth control = between 6 and 10 in 10,000
- Blood clots from long flights = between 2 and 10 in 100

(Ref. GIB | 5.12.21 | 5, Page 3)

Employer onsite COVID vaccine clinics

- ETF has begun working with DOA, DHS, DOC, and UW to scope out onsite COVID vaccine clinics
- DHS has notified ETF of mobile vaccine teams, staffed by WI National Guard teams, that may be able to support without impact to GHIP costs
- DOA released an all-staff interest survey on April 26
- ETF will continue to support efforts to provide onsite opportunities for both state and local employers

(Ref. GIB | 5.12.21 | 5, Pages 3-4)

Vaccine Messaging & Outreach

Continuing to push information on vaccine benefits availability and care access

- Forthcoming WRS News articles
- Updated website info

Working with UW-Madison student cohort on messaging for vaccine hesitant people

- Trust, lack of resources, and limited comfort with new technology play major role
- Communications should focus on facts and education versus persuasion
- Physicians are best messengers to convince people to get vaccinated

(Ref. GIB | 5.12.21 | 5, Page 4)

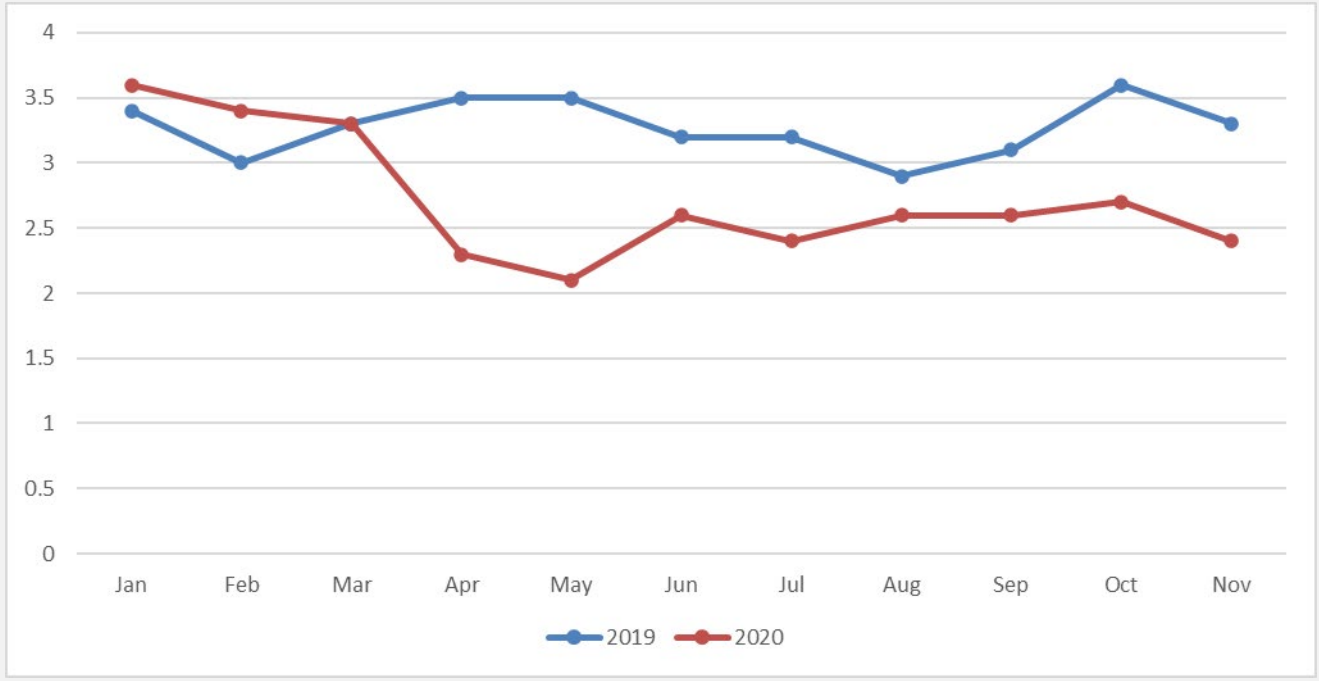
COVID-19 vaccines and Well Wisconsin

- Board inquired about including vaccine as an activity option for earning the $150 Well Wisconsin incentive
- As of end of April 2021, 11.5K members have earned their incentive compared to 4.5K in 2020
- While WebMD can include vaccine as an activity option, ETF has concerns with this approach
- May be better to focus on comprehensive communications and working with employers on ways to support employees getting vaccinated

(Ref. GIB | 5.12.21 | 5, Pages 4-5)

Health impacts

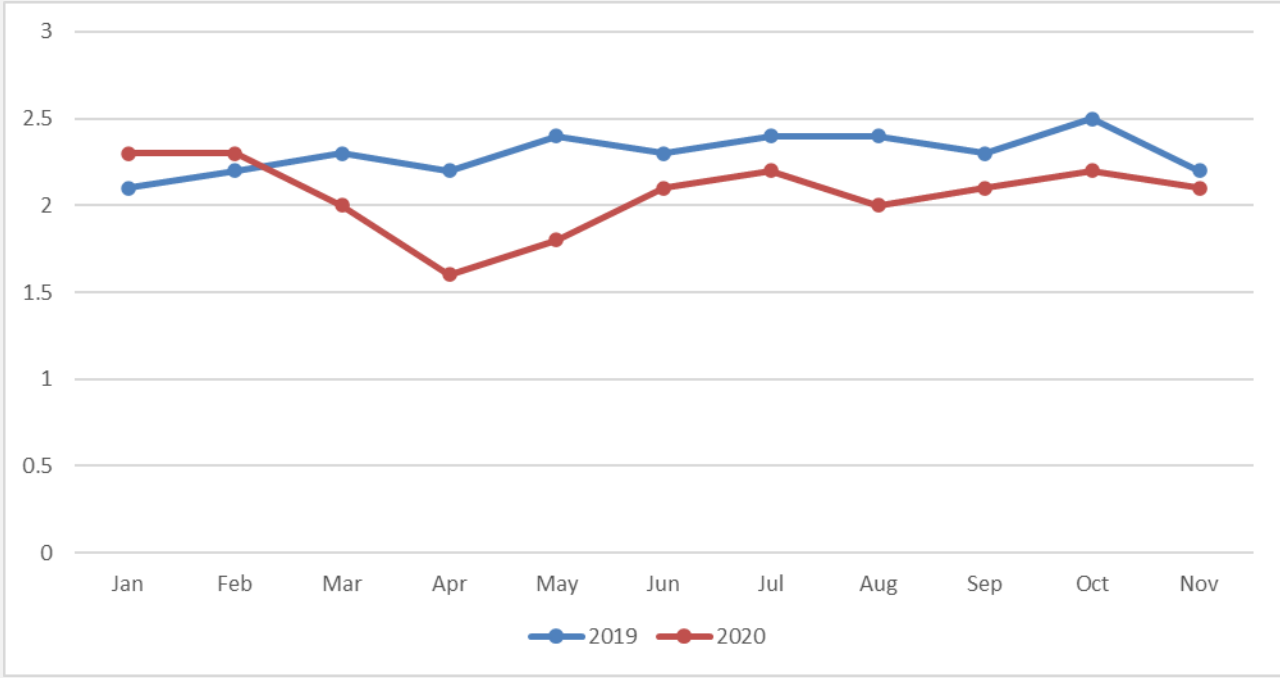
- Vaccines & GHIP as of 4/19 = ~32,000 members with at least one dose
- Concerning utilization patterns for asthma patients



(Ref. GIB | 5.12.21 | 5, Pages 5-6)

Health impacts continued

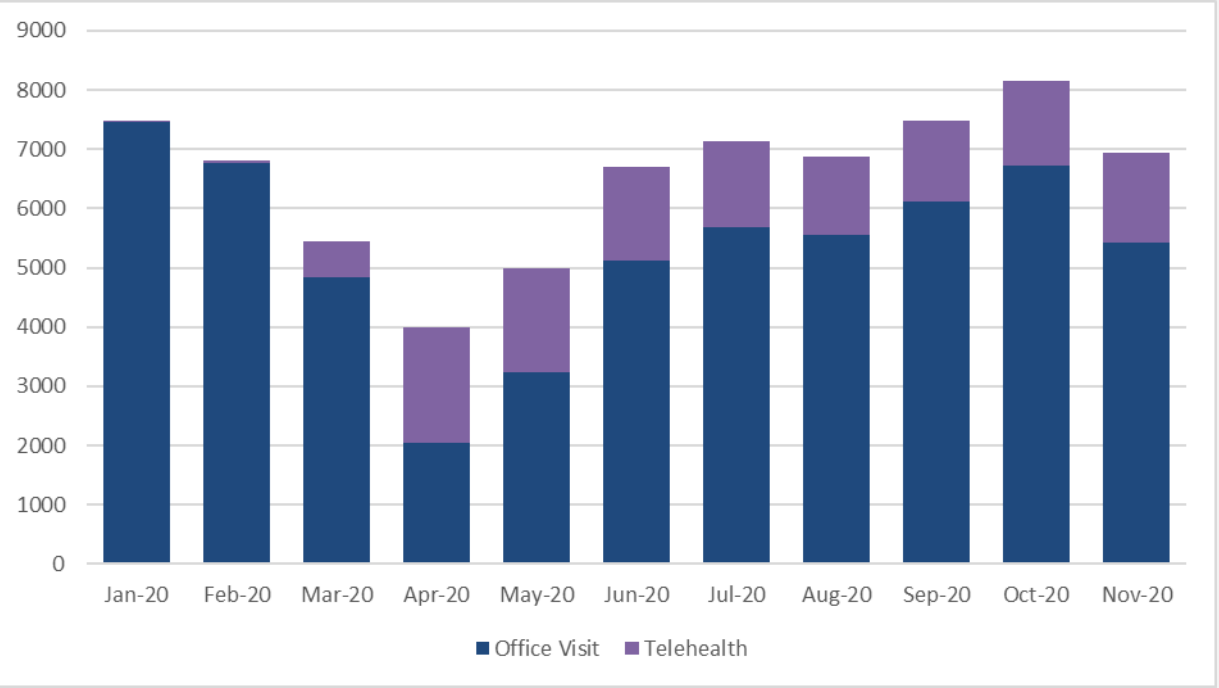
- Mental Health & Substance Use Disorder claims down slightly



(Ref. GIB | 5.12.21 | 5, Pages 5-6)

Quality impacts

- Telehealth continues to fill care gaps



(Ref. GIB | 5.12.21 | 5, Pages 7-8)

Quality impacts continued

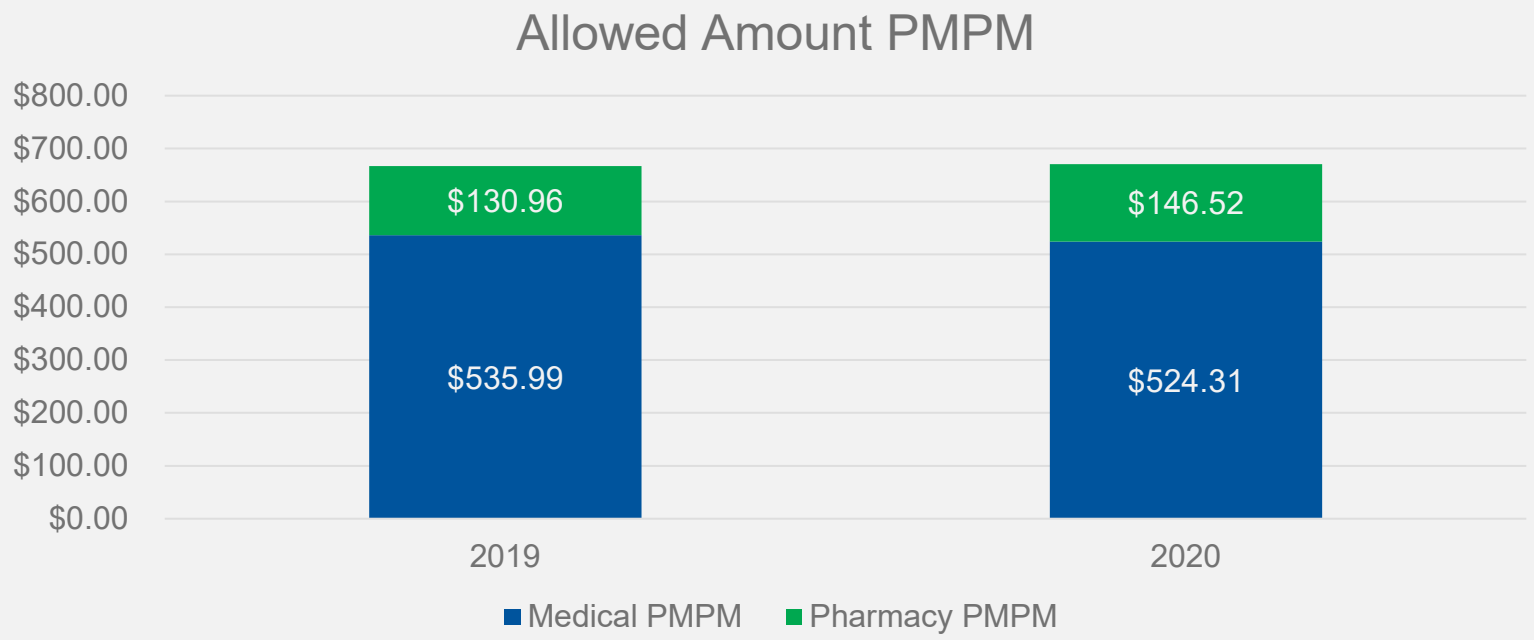
- Dental care use increases, may imply greater confidence

YTD = through 4/12 of reported year	YTD 2021	YTD 2020	YTD 2019
Claims in Actual $	$17,090,589	$13,912,090	$16,114,169
Number of Claims	121,225	100,010	117,385

(Ref. GIB | 5.12.21 | 5, Pages 7-8)

Cost impacts

- Allowed amounts throughout 2020 were similar despite utilization decrease.



(Ref. GIB | 5.12.21 | 5, Pages 9-10, chart updated)

Cost impacts continued

- Life insurance claims slow, continue to impact retirees more than actives
  - Claims as of 4/13/2021

Class	Number of Deaths	Claims in Dollars
Active	16	$2,760,000
Retiree	251	$3,990,250
Spouse/Dependent	12	$215,000
Total	279	$6,965,250

(Ref. GIB | 5.12.21 | 5, Pages 9-10)


Questions?

American Rescue Plan Act COBRA Subsidy

Item 6 – Group Insurance Board

Renee Walk, Lead Policy Advisor

Office of Strategic Health Policy

Informational item only

- No Board action is required

American Rescue Plan Act (ARP)

Signed on March 11, 2021

Broad-reaching stimulus plan

Provides a subsidy for COBRA premiums

- 100% of premiums
- Eligibility for the subsidy begins April 1, 2021 and ends September 30, 2021

Applies to all benefits with COBRA option

- Includes supplemental plans

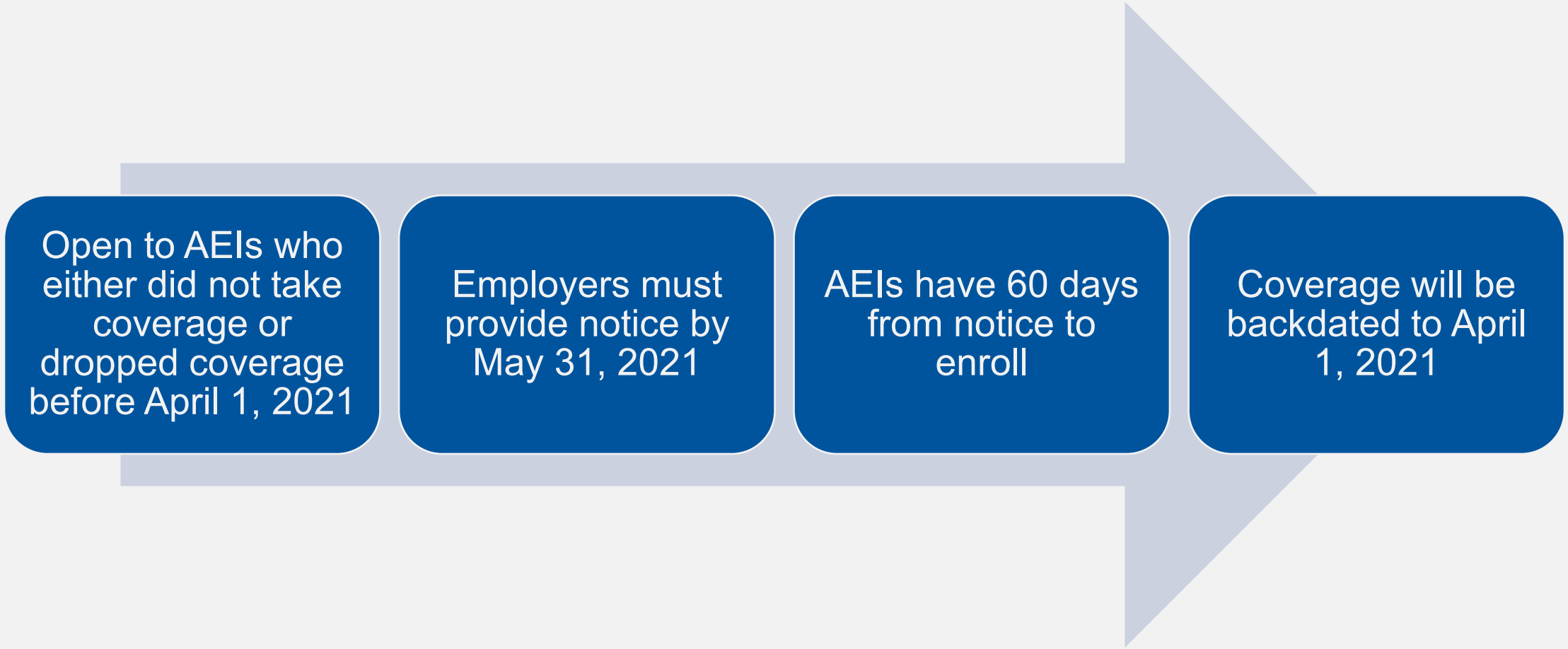
(Ref. GIB | 05.12.21 | 6, page 1)

Determining AEIs

- An Assistance Eligible Individual (AEI) is a COBRA-qualified beneficiary who became COBRA eligible due to involuntary loss of employment or reduction in hours and:
  - Is enrolled in COBRA as of April 1, 2021, or
  - Became eligible for COBRA between April 1, 2021 and September 30, 2021, or
  - Would have still been eligible for COBRA on April 1, 2021, but either did not elect coverage or dropped coverage.
- Some AEIs may have lost coverage as early as November 2019

(Ref. GIB | 05.12.21 | 6, page 1 - 2)

Extended Enrollment Period



(Ref. GIB | 05.12.21 | 6, page 2)

End of Eligibility

Eligibility for the subsidy ends when the earlier of the following happens:

- When the AEI's COBRA period ends,
- When the AEI becomes eligible for another group health plan,
- When the AEI becomes Medicare eligible, or
- September 30, 2021

(Ref. GIB | 05.12.21 | 6, page 2)

AEIs Must Notify Employers of Other Eligibility

- Subsidy ends when an AEI becomes *eligible* for another plan, regardless of enrollment
- AEIs must notify employers immediately of other eligibility
- Failure to notify will result in fines of up to 110% of the premium assistance provided after eligibility should have ended

(Ref. GIB | 05.12.21 | 6, page 2)

Implementation

- Employer News released on April 28, 2021
  - Created form ET-2314 to help employers record employee attestations of eligibility
- Forms should be returned to employers, who will process eligibility and forward to ETF
- AEIs will be enrolled like other COBRA members
- AEIs will be billed by plans and will then submit bills to employers for payment

(Ref. GIB | 05.12.21 | 6, page 2 - 3)


Questions?

Break

10 minutes

(Please turn cameras off and mute microphones/phones using #6)

Nurseline Usage Statistics

Item 7A – Memo Only

Rachel Carabell, Senior Health Policy Advisor

Molly Heisterkamp, Wellness and Disease Management Program Manager

Tom Rasmussen, Life Insurance and Dental Program Manager

Office of Strategic Health Policy

Wisconsin Public Employers Advisory Council Information

Item 7B – Group Insurance Board

Arlene Larson, Manager Federal Health Programs & Policy

Korbey White, Health Program Manager

Office of Strategic Health Policy

Information Item

Informational purposes only. No Board action is required.

Overview

Goal: Improve Local Government Employers GHIP Experience

- 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)

Memo Reference: Page 1

Activities

- Employer Advisory Council creation
- ETF selected Employers
- Hosted Meetings
- Present to the GIB
- ETF Implementation Strategy

Memo Reference: Pages 1

Three Meeting Structure

First meeting: Focus – Benefits

Second meeting: Focus – Rates, Wellness and Communication

Third meeting: Focus – (ICI), Open Market and Future State

First meeting – Benefits

Current Wisconsin public Employers Group (WPE) Benefits (Program Options)

Strengths and weaknesses of the GHIP

How could ETF improve members' GHIP experiences?

Memo Reference: Page 1-2

First meeting – Employer Responses

GHIP exceeds employer expectations with rates offered for benefits and administrative services received.

Employers request ETF to offer multiple program options

One large employer wants ETF to explore a four-tier premium rate system

Memo Reference: Page 2

Second meeting – Rates, Wellness and Communication

Timing of renewal rates

Thoughts on the wellness program

Preferred method of communication

Memo Reference: Page 2-3

Second meeting – Employer Responses

Employers would like to have the renewal rates in August.

Education on the wellness program is welcomed. Employers want assistance to reinforce materials sent from Well Wisconsin.

Employers like the Employer News sent out by ETF and the Decision Guides and Employers find the Employer Manual very helpful

Memo Reference: Page 2-3

Third meeting – (ICI), Open Market and Future Meeting

Overview of ICI Program (with Q & A)

Employer impressions of the commercial market

Health Insurance Plans being offered by employers over the next two to five years.

Memo Reference: Page 3

Third Meeting – Employer Responses

Non-participating employers interested to join the ICI Program

Four-tier structure makes commercial market attractive

If ETF would offer more supplemental benefits, employers would participate more in WPE.

Memo Reference: Page 3

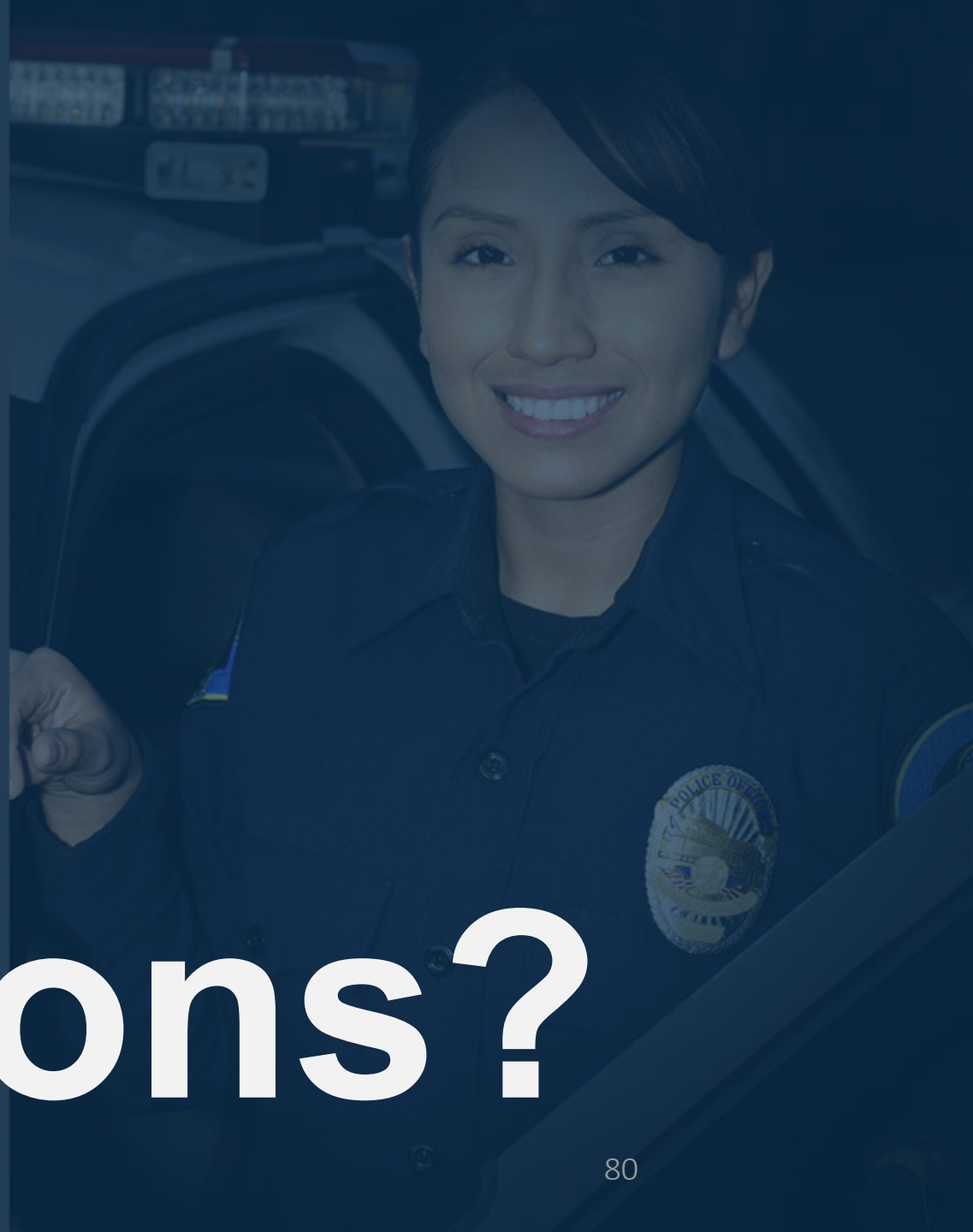
Next Steps – ETF Action

ETF staff work daily to improve communications with employers.

ETF anticipates providing preliminary health plan and pharmacy benefit increases prior to negotiations in mid- to late-June.

Due to changes in family demographics, ETF will be discussing a four-tier structure with Segal.

ETF expects to issue a local employer survey using the information gathered from these meetings as its foundation.



Questions?

2022 Local Annuitant Health Program Renewal Information

Item 7C – Group Insurance Board

Arlene Larson, Manager Federal Health Programs & Policy

Office of Strategic Health Policy

Informational Item Only

- No Board action is required

Local Annuitant Health Program

LAHP is a retiree-only group

- Subscribers have retired from local employers that do not participate in the group health insurance program.

LAHP Enrollment & Loss Ratio

Table 1 Group Name	Average Members year of 2019	Average Members Jan-Nov 2020	2019 MLR	2020 MLR
LAHP Overall	263	455	127.6%	160.2%
LAHP non-Medicare only	109	278	110.6%	159.2%
LAHP Medicare only	154	177	161.3%	165.0%

LAHP Comparison to Marketplace Gold Plans

Table 4 Marketplace City	Individual Deductible	Coinsurance	Individual OOPL	Retiree's Monthly Premium*
Green Bay	$1,200	80% / 20%	$7,900	$274.93
Waukesha	$1,500	100% but Copays	$7,900	$87.95
Madison	$1,500	70% / 30%	$8,550	$6.45
Milwaukee	$1,800	80% / 20%	$6,500	$301.68
Sheboygan	$1,500	80% / 20%	$5,100	$195.18
Fond du Lac	$1,500	80% / 20%	$5,100	$63.53

***Amount due from retiree.**

LAHP pre-Medicare	Individual Deductible	Coinsurance	Individual OOPL	Dean* Individual Premium
Green Bay	$250	90% / 10%	$1,250	$959.98
***Most popular plan for non-Medicare LAHP subscribers**				

Memo Pages 2 and 3

LAHP to Marketplace Benefits

Marketplace Subsidies

- Make those plans more attractive

LAHP

- Higher utilizers of care often choose richer benefits
- LAHP's current benefits are richer than plans on the Healthcare Marketplace

Example of 30% Rate Change

Health Plan	2021 Individual Premium	30% increase	2022 Individual Premium Prior to renewal increase
Dean	$959.98	1.3	$1,247.97
Dean Prevea 360	$964.32	1.3	$1,253.62
Network	$1,100.42	1.3	$1,430.55
Quartz UW	$873.50	1.3	$1,135.55
WEA East	$1,133.14	1.3	$1,473.08

Memo Pages 3 and 4

Questions?

Wisconsin Health Market: Review and Update

Item 8A – Group Insurance Board

Rachel Carabell, Senior Health Policy Advisor

Office of Strategic Health Policy

Informational Item Only

- No Board action is required

Wisconsin Health Market Background

The memo identifies new acquisitions and mergers and new provider facilities in 2020 and 2021.

Wisconsin's health insurance market is very competitive.

- 19 health insurers operating in the large group market in 2020 with more than 5,000 lives.
- In 2015, *Modern Healthcare* reported that 32% of Wisconsin's insurance market was controlled by provider-owned insurance plans.

Healthcare provider market has been consolidated for years and continues to consolidate.

- In 2020, the Kaiser Family Foundation reported that a wide body of research has found that provider consolidation leads to higher health care prices.

Vendor Mergers, Acquisitions and Other Partnership

New Owners/Partnerships

- Costco and Navitus
- WebMD and StayWell
- Optum Financial and ConnectYourCare
- Advocate Aurora and Quartz

Provider Mergers and Acquisitions

Divine Savior Hospital and Clinics joined Aspirus Health System

- Aspirus providers are not currently in-network with:
  - Dean
  - Quartz Community
  - WEA Trust East

Provider Mergers and Acquisitions

St. Clare's Hospital and Flambeau Hospital sold to Marshfield Clinic Health System

- St. Clare's Hospital (Weston) and Flambeau Hospital (Park Falls) previously part of the Ascension Wisconsin system.
- Marshfield providers are not in-network for Network Health Plan.

Provider Mergers and Acquisitions

Seven hospitals and 21 clinics transferring ownership from Ascension Wisconsin to Aspirus Health System:

- Eagle River Hospital (Vilas County)
- Good Samaritan Hospital (Lincoln County)
- Howard Young Medical Center (Oneida County)
- Our Lady of Victory Hospital (Clark County)
- Sacred Heart Hospital (Lincoln County)
- St. Mary's Hospital (Oneida County)
- St. Michael's Hospital (Portage County)
- Network Health Plan currently offers Ascension providers in-network but not Aspirus providers.

Provider Mergers and Acquisitions

Holy Family Memorial Medical Center joining Froedtert Health and Medical College network

- Froedtert and the Medical College providers are not currently in-network with:
  - WEA Trust East
  - Dean Prevea360

Provider Network Changes

Beaver Dam Community Hospital

- Acquired by Marshfield Clinic Health System in 2019
- Renamed Marshfield Medical Center – Beaver Dam

Marshfield Medical Center – Beaver Dam

- No longer available in-network with Dean Health Plan effective March 1, 2021
- Existing Dean patients are currently transitioning to a new Dean Medical Group clinic which recently opened in Beaver Dam.

New Provider Facilities

- Rogers Behavioral Health clinic and living space (Sheboygan County)
- Ascension clinic in Mount Pleasant (Racine County)
- Advocate Aurora Medical Center – Mount Pleasant (Racine County)
- Ascension Obstetrics Emergency Room in Milwaukee
- Froedtert Health and the Medical College micro-hospitals in New Berlin and Pewaukee (Waukesha County)

New Provider Facilities

- Dean Clinic – Beaver Dam (Dodge County)
- Sixteenth Street Behavioral Health Clinic (Milwaukee)
- Aspirus Hospital Stevens Point (Portage County)
- Marshfield Clinic Stevens Point Hospital (Portage County)
- ProHealth Waterford Clinic (Racine County) and Mukwonago Hospital (Waukesha County)
- Miramont Behavior Health Psychiatric Hospital in Middleton (Dane County)


Questions?

Medicare Member Survey

Item 8B – Group Insurance Board

Rachel Carabell, Senior Health Policy Advisor
Arlene Larson, Manager Federal Health Programs & Policy
Office of Strategic Health Policy

Informational Item Only

- No Board action is required

Background

- At its November 2020 meeting, the Board extended UnitedHealthcare's (UHC) contract to provide a Medicare Advantage plan to Medicare members enrolled in the Group Health Insurance Program (GHIP) through 2023.
- As part of that discussion, the Department of Employee Trust Funds (ETF) indicated that UHC would conduct a survey of its GHIP members and ETF would conduct a similar survey of other Medicare members.
- The purpose of the survey was to determine member satisfaction with UHC's Medicare Advantage plan compared with other plan options available to Medicare members.

Survey Development

- Two surveys (UHC and ETF) asked the same questions with the exception that UHC's survey asked about members' experiences using out-of-network providers.
- UHC sent their survey by e-mail to members with an e-mail on file, or *via* US Postal Service to those members without an e-mail address on record.
- ETF sent our survey *via* e-mail to members who had previously provided an e-mail address to ETF.

Survey Development

- The survey asked questions on the following topics:
  - How likely would members recommend their plan to others
  - Why did the member select her/his particular plan?
  - What's the member's overall satisfaction with the plan?
  - How well does the member understand the benefits available in the plan?
  - What's the member's experience with the plan's call center or website? What about materials mailed to the member at home? Is the member satisfied with in-network providers?
- UHC & ETF sent the surveys on January 12, 2021. Members had until March 14, 2021 to respond.
- All survey responses were anonymous.

Survey Responses

- The table below shows statistics on the surveys sent

Survey Method	Medicare Members	Members Sent a Survey	Survey Responses	Response Rate
ETF Survey	24,057	12,840	3,084	24.0%
UHC Email Survey	5,195	5,195	1,515	29.2%
UHC Paper Survey	4,472	4,472	2,062	46.1%
Total	33,724	22,507	7,106	33.8%

Survey Responses

- Survey responses were converted to numerical scores along a scale of 0 to 100.
- The numerical scores are shown separately for the top four health plans based on share of Medicare enrollment. Scores for the remaining plans are combined on a weighted average to balance the impact on the smaller plans, which received fewer responses.

Responses – Overall Performance

- The table below shows an overall satisfaction score based on net promoter score, net satisfaction score, and net provider score.

Medicare Plan Vendor	Score Out of 100	% of Medicare Members
UHC Medicare Advantage	84.52	29%
WEA Trust	80.01	27%
Quartz	73.98	21%
Dean	74.62	15%
All Other Plans	72.78	8%

Responses – Call Center

- On average, 50% of members called their plan's customer call center.

Medicare Plan Vendor	Score out of 100	% of Medicare Members
UHC Medicare Advantage	83.74	29%
WEA Trust	80.53	27%
Quartz	70.66	21%
Dean	76.52	15%
All Other Plans	78.35	8%

Responses – Web Experience

- On average, 68% of members reported they did *not* visit their plan's website.

Medicare Plan Vendor	Score out of 100	% of Medicare Members
UHC Medicare Advantage	51.50	29%
WEA Trust	44.17	27%
Quartz	38.47	21%
Dean	38.74	15%
All Other Plans	46.05	8%

Materials Effectiveness

- We asked members about materials the plan sent to them at home.

Medicare Plan Vendor	Score Out of 100	% of Medicare Members
UHC Medicare Advantage	84.14	29%
WEA Trust	84.25	27%
Quartz	73.37	21%
Dean	77.98	15%
All Other Plans	82.45	8%

Analysis

- The higher scores for UHC and WEA Trust may be attributed to the following factors:
  - UHC receives federal subsidies to invest in customer satisfaction, it offers nationwide coverage, and it is the lowest cost plan.
  - WEA invests in its Medicare Plus plan to attract members, it offers nationwide coverage, and it is the second-lowest cost plan.
  - Members of regional plans most likely transitioned into their plan automatically when they became Medicare eligible.

Next Steps

- ETF will share aggregate response data with appropriate health plans and will work with health plans to improve service to our members.
- ETF will consider survey responses when we draft the upcoming Medicare Advantage Request for Proposal.


Questions?

New Health Plan Proposal for Aspirus Health Plan

Item 8C – Group Insurance Board

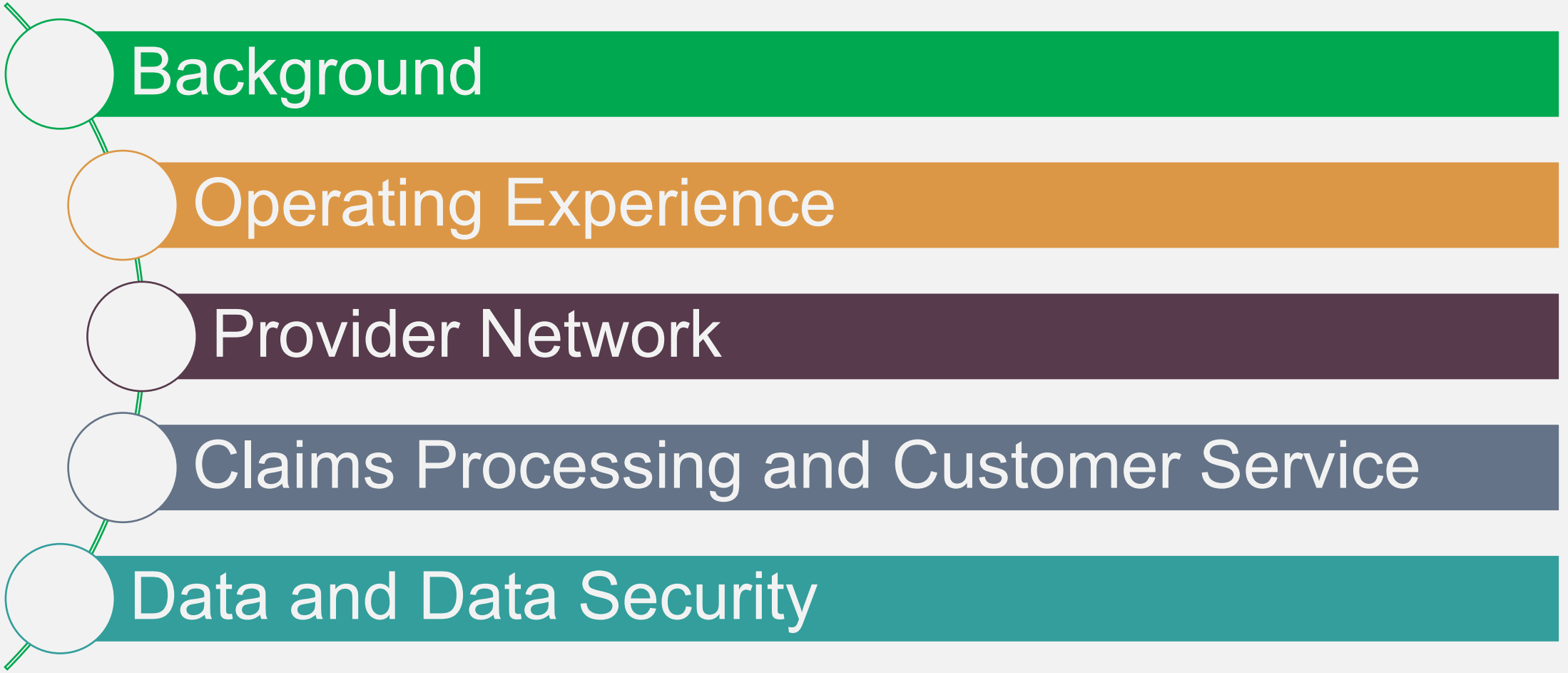
Korbey White, Health Plan Policy Advisor

Office of Strategic Health Policy

Action Needed

- **The Department of Employee Trust Funds (ETF) recommends the Group Insurance Board (Board) accept the application from Aspirus Health Plan (Aspirus) to provide health insurance services within the Group Health Insurance Program (GHIP) contingent upon successful negotiations of premiums.**

Evaluation Overview



Memo Reference: Pages 1-4

Background

Initial Communication

- January 7, 2021 ETF and Aspirus meeting
- February 2, 2021 Aspirus notified GIB of intent to join GHIP

Application to join GHIP

- April 14, 2021 ETF received completed application from Aspirus to join GHIP

ETF Application Review

- General information about the organization, growth projections, information about the organization's contracted vendors, financial documentation, information about the organization's health care provider network, documentation of how health plan services are performed, customer service data, data integration and utilization documentation, and data security measures

Evaluation and recommendation

- Review team evaluated the topics on the upcoming slides and developed board recommendation

Memo Reference: Pages 1

Operating Experience

- Aspirus Arise Health Plan of Wisconsin, Inc., a subsidiary of Aspirus Health Ventures, was formally created in 2016 with membership first enrolling for January 1, 2017.
- Rebranded (Aspirus Health Plan)
- January 1, 2021 PreferredOne became administrator
- PreferredOne has 36 years of health plan experience, beginning in 1984

Memo Reference: Pages 2

Sales Support	**Underwriting**	**ASO**
Risk Adjustment Support	**Product Development**	**Plan Product and Market Research**
Medical Management	**Provider Contracting and Maintenance**	**Account and Membership Administration**
QHP and Marketplace Required Services	**Claims Processing**	**Accounting and Finance**
Corporate and Regulatory Services	**Marketing and Communications**	**Telehealth Integration**
Actuarial	**Reporting and Analytics**	

Memo Reference: Pages 2

Provider Network

Provider Network

- Aspirus' largest provider network agreement is with the Aspirus Network, Inc. (ANI),

Providers and Facilities

- Ascension, Aurora, Bellin Health, Gundersen, UW Health, and ThedaCare.

Central Wisconsin HMO Offering

- Adams, Clark, Columbia, Florence, Forest, Iron, Juneau, Langlade, Lincoln, Marathon, Marquette, Oneida, Portage, Price, Sauk, Shawano, Taylor, Vilas, Waushara, and Wood

Memo Reference: Pages 3

Claims Processing and Customer Service

All Met or Exceeded

- Claims Processing Accuracy
- Claims Processing Time
- Written Inquiry Response
- Open Call Resolution Turn-Around Time
- Call Abandonment Rate
- Call Answer Timeliness

Memo Reference: Pages 3

Data and Data Security

All data transmission, sharing, and security requirements

Consumer Assessment of Health Care Providers (CAHPS), and Health Care Effectiveness Data and Information Set (HEDIS)

SOC 2 Type 2 Requirement

Memo Reference: Page 4

Action Needed

- **The Department of Employee Trust Funds (ETF) recommends the Group Insurance Board (Board) accept the application from Aspirus Health Plan (Aspirus) to provide health insurance services within the Group Health Insurance Program (GHIP) contingent upon successful negotiations of premiums.**

Questions?

2020 Health Plan Performance Statistics Annual Report

Item 8D – Group Insurance Board

Korbey White, Health Plan Policy Advisor

Office of Strategic Health Policy

Informational Item

- No Board action is required

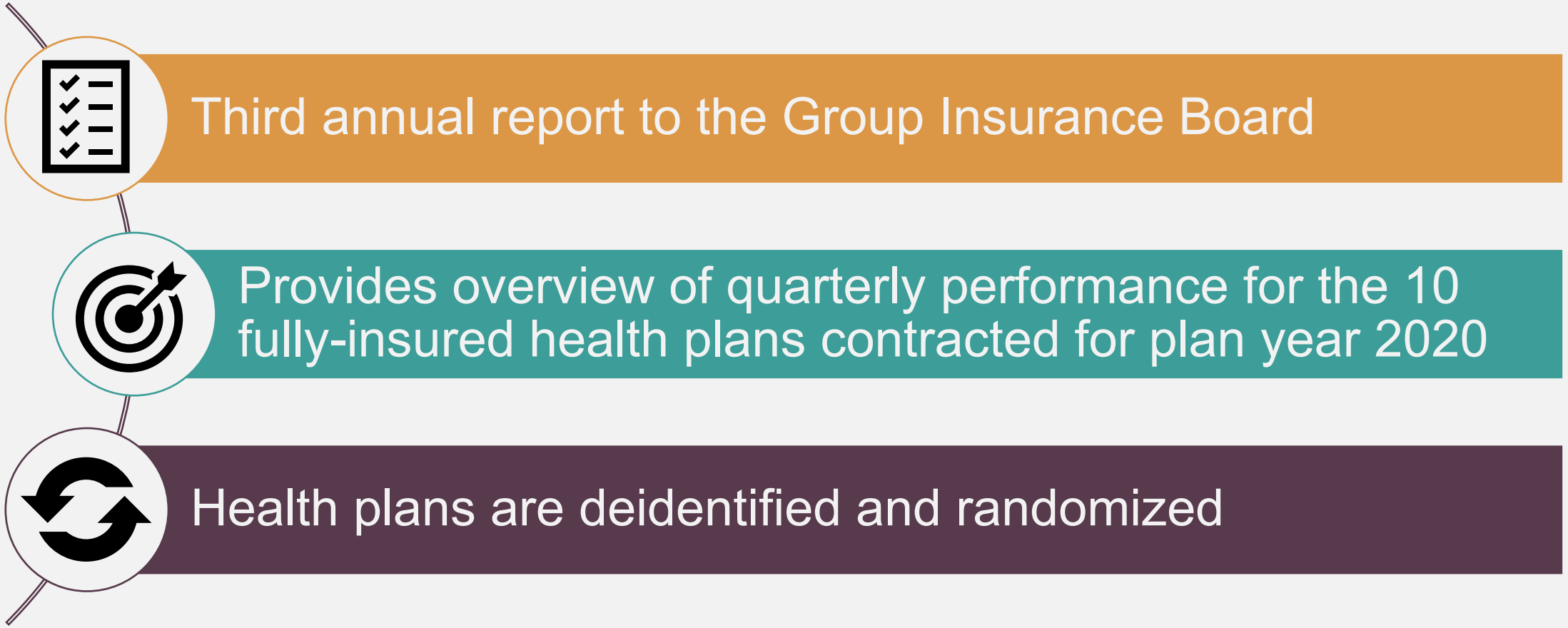
Overview

- Background
- Claims Processing
- Customer Service
- Additional Key Performance Measures

Background

2020 Health Plan Performance Report

2020 Performance Report



Background

2018	Exceeded performance standards in four of the six categories
2019	Improved performance standards in all six categories
2020	Exceeded Performance Standards in all six categories Change to quarterly penalty assessment from monthly

2020 Performance Summary

- Health plans met or exceeded most measurement targets on a regular basis
- Health plans consistently submitted quarterly performance reports
- Health plans provided sufficient details in the event of a performance exception

2020 Performance Summary

All Met or Exceeded

- Claims Processing Accuracy
- Claims Processing Time
- Written Inquiry Response
- Open Call Resolution Turn-Around Time
- Call Abandonment Rate
- Call Answer Timeliness

Claims Processing

2020 Health Plan Performance Report

Claims Processing Accuracy

Performance Target	2020 Average Performance	2020 Average Variance
97%	99.3%	2.3% ↑

- All health plans met or exceeded claims processing targets for accuracy
- This key performance measurement held true in every quarter

Claims Processing Time

Performance Target	2020 Average Performance	2020 Average Variance
95% processed within 30 days	99.2%	4.2% ↑

- All health plans exceeded the 95% performance target each quarter

Customer Service

2020 Health Plan Performance Report

Call Answer Timeliness

Performance Target	2020 Average Performance	2020 Average Variance
80% ≤ 30 seconds	90.3%	10.3% ↑

- 1 out of 10 health plans failed to meet 80% target in Q4, largely due to member transitions stemming from exiting health plans

Call Abandonment Rate

Performance Target	2020 Average Performance	2020 Average Variance
< 3% of calls abandoned	1.0%	-2.0%

- 1 out of 10 health plans failed to meet target in Q4
  - ETF assessed penalties for this measure in Q4
- All 10 health plans met or exceeded average performance target

Open Call Resolution Turn-Around Time

Performance Target	2020 Average Performance	2020 Average Variance
90% resolved within 2 days	96.5%	6.5% ⬆

- All 9 measured health plans met or exceeded target each quarter
- 1 health plan is granted reporting exemption due to system limitations, provided a written summary instead – no issues identified for 2020

Electronic Written Inquiry Response

Performance Target	2020 Average Performance	2020 Average Variance
98% response within 2 days	99.6%	1.6% ↑

- All 10 health plans met or exceeded the performance target each quarter

Additional Key Performance Measures

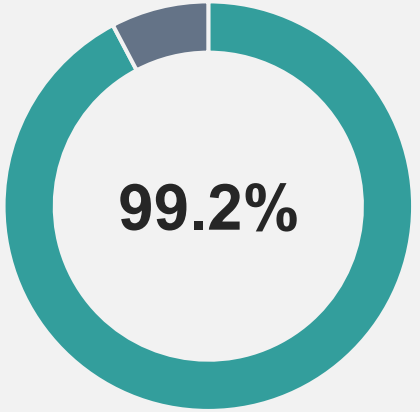
2020 Health Plan Performance Report

Additional Key Performance Measures - Enrollment

of daily 834 files accepted and processed

of database discrepancies resolved within 1 day of notification

of exception report corrections completed within 5 days of notification



of identification cards issued within 5 days

Questions?

2022 Health Program Agreement Changes

Item 8E – Group Insurance Board

Renee Walk, Lead Policy Advisor

Korbey White, Health Program Manager

Office of Strategic Health Policy

Action Needed

ETF requests the Board to approve the following changes to the Health Program Agreement:

- Clarify and reiterate information security protocols
- Add Consolidated Appropriations Act (CAA) supporting language
- Clarify language regarding out-of-network care if in-network providers are not available
- Add language to support coverage of testing and vaccines during the COVID-19 pandemic

- ETF also requests the Board to approve changes in the Employer Manuals permitting subscribers to switch health plans upon new legal guardianship or custody changes

Background

February: Initial concepts brought to the Board

March – April: reviewed by Segal and Health Plans

May: Final review and request for Board approval

(Ref. GIB | 05.12.21 | 8E, page 1)

Agreement Restructuring

- New outline provided (Attachment A to memo)
- Original intent largely preserved
- New organization intended to be more intuitive
- Includes Certificate of Coverage to be more member-focused

(Ref. GIB | 05.12.21 | 8E, page 2)

Agreement Changes

Supporting compliance with CAA

- Mental Health Parity transparency
- Price transparency

Information Security Reviews

Language clarifications:

- Supporting COVID test & vaccine coverage
- Clarifying when a plan will pay for out-of-network care
- Other documentation requirements

(Ref. GIB | 05.12.21 | 8E, page 2 - 3)

Employer Guidelines Change

- Prior guidelines did not allow change of health plan for employees who added a new legal ward or court ordered placement
- Situations happen infrequently, older policy is challenging to administer
- ETF recommends allowing a 30-day window to change for any new dependent, including cases above

(Ref. GIB | 05.12.21 | 8E, page 4)

Action Needed

ETF requests the Board approve the following changes to the Health Program Agreement:

- Clarify and reiterate information security protocols
- Add Consolidated Appropriations Act (CAA) supporting language
- Clarify language regarding out-of-network care if in-network providers are not available
- Add language to support coverage of testing and vaccines during the COVID-19 pandemic

- ETF also requests the Board to approve changes in the Employer Manuals permitting subscribers to switch health plans upon new legal guardianship or custody changes

2022 Health, Pharmacy and Dental Benefit Changes

Item 8F – Group Insurance Board

Renee Walk, Lead Policy Advisor

Tricia Sieg, Pharmacy Program Manager

Tom Rasmussen, Life Insurance/Dental Programs Manager

Office of Strategic Health Policy

Action Needed

ETF requests the Board to approve changes to the health, pharmacy, and Uniform Dental benefits as described in Memo 8F, and consideration of options for medical and/or pharmacy benefits coverage of continuous glucose monitors (CGMs)

Health Benefit Changes

Memo Pages 2 - 4

Orthognathic Surgery

Increase coverage to include medically necessary cases

- Health Impact: High for treated individuals
- Quality Impact: Moderate due to increased industry consistency
- Cost Impact: Minimal due to limited utilization

(Ref. GIB | 05.12.21 | 8F, page 2)

Changes to Maximum Out of Pocket (MOOP)

Update MOOP to match federal values

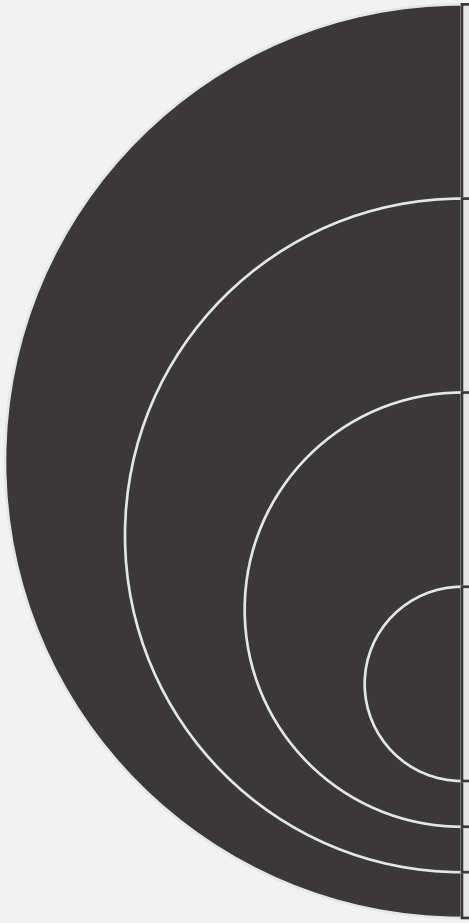
- Health Impact: Minimal, few members exceed lower out of pocket limits, much less reach MOOP
- Quality Impact: Moderate due to greater consistency in benefit communication
- Cost Impact: Minimal, due to the small number of people who reach the MOOP

Apply all covered benefits to MOOP

- Health Impact: Minimal, due to low utilization
- Quality Impact: Minimal, due to minor simplification of benefit
- Cost impact: Minimal, due to low utilization, does not change benefit maximums

(Ref. GIB | 05.12.21 | 8F, pages 2 - 3)

Remove Acupuncture Exclusion



Allows flexibility in coverage under Alternate Care Provision

Does not add coverage across the board

ETF will review acupuncture pilots and available literature to determine future coverage

Health Impact: Undetermined
Quality Impact: Moderate due to clarification of benefit language
Cost impact: Minimal due to low use and low provider availability

(Ref. GIB | 05.12.21 | 8F, pages 3)

Remove timeframe for dental repairs due to accident

Current language may conflict with pre-existing condition requirements

Removing limit not likely to change use

- Health Impact: Minimal, care use not likely to change
- Quality Impact: Moderate, improves member experience and reduces barriers to care
- Cost Impact: Minimal, utilization not expected to change

(Ref. GIB | 05.12.21 | 8F, pages 3 - 4)

Telemedicine Coverage

- Increased requests for clarity resulting from telehealth expansion during pandemic
- New guidance includes better definitions of types of care
- Cost sharing clarified
- Language will be added to Certificates of Coverage

(Ref. GIB | 05.12.21 | 8F, page 4 and Attachment B)

Telemedicine Coverage

Cost Sharing by Service Type		
Service Category	Non-HDHP Plans (PO1, PO 6/16)	HDHP Plans (PO1 and PO 7/17)
E-Visit	$0	Deductible, then $0
Telehealth	$15 or $25, depending upon provider specialty	Deductible, then $15 or $25, depending upon provider specialty
Telephone Visit	$15 or $25, depending upon provider specialty	Deductible, then $15 or $25, depending upon provider specialty
Remote Patient Monitoring	$15 for each 30-day period of monitoring	Deductible, then $15 for each 30-day period of monitoring

(Ref. GIB | 05.12.21 | 8F, Attachment B)

Pharmacy Program & Benefit Changes

Memo Pages 4 - 8

Recommended Pharmacy Benefit Changes

Remove Level 4 Out of Pocket Limits

- No member has met the OOPL in past three years
- Segal projects change to be cost neutral
- Removal will cut down on member confusion with Level 1, 2, & 3 OOPLs

(Ref. GIB | 05.12.21 | 8F, pages 4-5)

Pharmacy Benefit Change for Board Discussion

CGM Coverage Changes

- Currently a wide range of CGMs covered under Medical Insurance
- Pharmacy formulary would cover three types of CGMs
- Segal found moving CGMs to pharmacy would move $0.5 million from medical to pharmacy benefit

(Ref. GIB | 05.12.21 | 8F, pages 5-6)

Option 1

Move all CGM coverage to Pharmacy Benefit

Pros	Cons
• May cut down on member and health insurance vendor confusion • CGM rebates through the pharmacy benefit will be passed back to the Board	• All CGMs currently covered will not all be covered, leading to member confusion and complaints • Change would require members to pick up CGMs from pharmacy and bring to providers office for insertion • Members could have higher coinsurance and OOPL under pharmacy benefit than they have under the medical benefit

(Ref. GIB | 05.12.21 | 8F, pages 6)

Option 2

Allow CGM coverage under both Medical and Pharmacy Benefit

Pros	Cons
• CGM rebates through the pharmacy benefit will be passed back to the Board • Allows members to stay with current CGM brand • ETF's data warehouse will see more data on CGM brands through pharmacy benefit right away • Provides data warehouse team more time to work with health insurance vendors to be able to obtain better CGM medical claims data	• Could create member and vendor confusion • Would create overlapping coverage on two CGM brands

(Ref. GIB | 05.12.21 | 8F, pages 7)

Option 3

Keep CGMs covered under Medical Benefit (status quo)

Pros	Cons
• Allows members to stay with current CGM brand • No increase to coinsurance or OOPL • Provides data warehouse team more time to work with health insurance vendors to be able to obtain better CGM medical claims data • Staff continues to monitor market and could come back to Board with new changes in the future	• ETF would be an outlier in GHIP's health insurance vendors book of business creating vendor issues and member confusion • The Board would continue to not realize any rebates on CGMs

(Ref. GIB | 05.12.21 | 8F, pages 6)

Changes Not Recommended

- Removing Individual OOPLs for level 1 and 2 drugs
- Implementing Navitus’ Copay-Max program
- Enacting Navitus’ Copay True program
- Beginning Navitus’ Medication Therapy Management program
- Enrollment into Pharmacogenomics program
- Blanket enrollment into Navitus' texting program

(Ref. GIB | 05.12.21 | 8F, pages 7-8)

Uniform Dental Benefit Changes

Memo Pages 8-10

Recommended Uniform Dental Benefit Change

ETF recommends changing the coverage for dental fillings to allow coverage for composite/resin fillings for both anterior and posterior teeth for plan year 2022.

(Ref. GIB | 05.12.21 | 8F, pages 8)

Filling Material

Amalgam

- Mixture of metals consisting of liquid mercury and powdered alloy composed of silver, tin and copper

Composite/Resin

- Ceramic and plastic compound

(Ref. GIB | 05.12.21 | 8F, pages 9)

Current Benefit

Amalgam (silver) fillings are covered at 100% for back teeth

Composite/resin fillings are covered at 100% for front teeth only

Member is responsible for the difference in cost

Typical cost difference is $40-$60 per filling

(Ref. GIB | 05.12.21 | 8F, pages 8-9)

Composite/Resin

Advantages

- Looks more like a healthy tooth
- Requires less drilling and fewer follow up appointments
- Bonds to the tooth structure better providing more support
- Increased member request

Disadvantages

- Less durable
- The process is more involved, more time at the dentist office
- More expensive – increase of 4.5%

(Ref. GIB | 05.12.21 | 8F, pages 9)

Amalgam

Advantages

- More durable
- Less time at dentist office
- Less expensive

Disadvantages

- Potential complications to a high-risk individual's health
- Requires more drilling of the tooth
- Doesn't create a strong bond to the tooth
- Not as natural looking
- Fewer dentists offering

(Ref. GIB | 05.12.21 | 8F, pages 9)

Potential Health Risks Associated with Amalgam Fillings

FDA updated recommendations

- Issued in September 2020
- Noted potential risk to a high-risk individual's overall health associated with fillings containing mercury
- Recommended that individuals in high-risk category avoid getting amalgam fillings whenever possible

(Ref. GIB | 05.12.21 | 8F, pages 9)

Wis. Stats. §40.03(6)(c)

- The Board is usually limited under Wisconsin State Statute §40.03(6)(c) from changing benefits in a way that causes an increase to overall program costs
- The information provided to ETF as part of the UDB Request for Proposal (RFP) and updated by the Food and Drug Administration (FDA) safety guidance creates a situation where the existing benefit is effectively no longer accessible
- The Board intended the UDB to provide for filling coverage. Modifying the benefit to allow full coverage of resin fillings would be consistent with that intent.

(Ref. GIB | 05.12.21 | 8F, pages 9-10)

Action Needed

ETF requests the Board to approve changes to the health, pharmacy, and Uniform Dental benefits as described in Memo 8F, and consideration of options for medical and/or pharmacy benefits coverage of continuous glucose monitors (CGMs)

Questions?

Health Plan Reserves

Item 8G – Group Insurance Board

Ken Vieira, Senior Vice President

Patrick Klein, Vice President

Segal Consulting

Reserve Update

State of Wisconsin Group Insurance Board
Department of Employee Trust Funds

May 12, 2021

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Segal

Agenda

- Highlights
- Review of Approved Multi-year Reserve Strategy
- Comparison of Projected & Preliminary 2020 EOY Balance
  - State
  - Local
- Questions

Highlights

- State 2020 YE fund balance $203.9M versus the $195.6M projected at August GIB - $8.3M Gain
  - Much lower than last year's gain of almost $28M
  - Once again driven by investment return exceeding the 7% assumption
  - Expense projections nearly exact
- Local 2020 YE fund balance $14.5M versus the $15.9M projected at August GIB - $1.4M Loss
  - Driven by higher claims and lower Rx rebates
- Market has realized higher returns YTD compared to assumption (as of 4/13/21), so additional gains are likely anticipated.
- The gains and losses above lack the size needed to materially alter planned upon buy downs and increases. This continues to be highly dependent on investment returns.

Board Approved Multi-Year Reserve Draw Strategy – Option 3

- This is the approved strategy which targets a similar rate increase (**2.7%**) using various draws over the next three year—reaching new policy target in 2023 (State). Local draw amount spread out over the three years as well.

State Reserve Multi-year Strategy

	Balance[1]	Target[2]	% of Claims/ FI Premium	Surplus[3]	Draw
2021	~~$195.6~~ **$203.9**	$78.2	5.2%	$117.3	$10.5
2022	$198.0	$82.2	5.2%	$115.9	$43.5
2023	$165.3	$86.3	5.2%	$79.1	$79.1

Projected Balance

Updated Balance

Local Reserve Multi-year Strategy

	Balance[1]	Target[2]	% of Claims/ FI Premium	Surplus[3]	Draw
2021	~~$15.9~~ **$14.6**	$11.5	5.1%	$4.4	$1.7
2022	$15.3	$12.1	5.1%	$3.2	$1.7
2023	$14.5	$12.7	5.1%	$1.8	$1.8

1 Assumes 7% investment return and no additional gains or losses that would impact the fund balance.
2 Reserve Policy assumed to increase at 5% per year.
3 The Surplus refers to the money in the fund that exceeds the Midpoint Target Reserve at beginning of year.

Fund Balance – Projected
State, as of 6/30/2020

- Using ETF transactional data through 6/30/2020, Segal projected the December ending fund balance.

State Health Reserve (in millions)

	Medical	Pharmacy	Dental	Total
Balance 1/1/2020	73.5	132.4	5.5	211.4
Revenue				
Premiums	1,169.5	180.4	61.0	1,410.9
EGWP Subsidy		51.9		51.9
Investment Income	5.2	7.7	0.9	13.8
Total Revenue	**1,174.7**	**240.0**	**61.9**	**1,476.5**
Expenses				
Paid Claims	1,150.9	335.2	45.8	1,531.9
Admin Costs	17.6	8.4	1.3	27.3
Rebates		(66.9)		(66.9)
Total Expenses	**1,168.5**	**276.8**	**47.1**	**1,492.3**
Net Income /(Deficit)	6.2	(36.8)	14.8	(15.8)
Balance 12/31/2020	**79.6**	**95.6**	**20.4**	**195.6**

Fund Balance – Preliminary
State, through 12/31/2020

- Below are the preliminary State health insurance plan results for the period ending December 31, 2020.

State Health Reserve (in millions)

	Medical	Pharmacy	Dental	Total
Balance 1/1/2020	73.5	132.4	5.5	211.4
Revenue				
Premiums	1,168.6	167.8	59.3	1,395.7
EGWP Subsidy		48.8		48.8
Investment Income	9.6	18.6	0.7	28.9
Total Revenue	**1,178.2**	**235.2**	**60.0**	**1,473.4**
Expenses				
Paid Claims	1,148.3	343.4	44.8	1,536.5
Admin Costs	18.7	8.8	1.2	28.7
Rebates		(71.4)		(71.4)
Total Expenses	**1,167.0**	**280.8**	**46.0**	**1,493.8**
Net Income /(Deficit)	11.2	(32.9)	14.0	(7.7)
Balance 12/31/2020	**84.8**	**99.6**	**19.6**	**203.9**

Fund Balance – Gain/Loss
State

- Below is the Gain/Loss for State health insurance plan for the period ended December 31, 2020.

State Health Reserve (in millions)

	Medical	Pharmacy	Dental	Total
Revenue				
Premiums	(0.9)	0.1	(1.7)	(2.4)
EGWP Subsidy		(3.1)		(3.1)
Investment Income	4.4	10.9	(0.2)	15.2
Total Revenue	**3.6**	**7.9**	**(1.8)**	**9.7**
Expenses				
Paid Claims	2.7	(8.2)	1.0	(4.5)
Admin Costs	(1.1)	(0.4)	0.1	(1.4)
Rebates		4.5		4.5
Total Expenses	**1.6**	**(4.1)**	**1.1**	**(1.4)**
Gain/(Loss)	**5.2**	**3.9**	**(0.7)**	**8.3**

- Overall – 2020 gains driven by investment income

Fund Balance – Projected
Local, as of 6/30/2020

- Using ETF transactional data through 6/30/2020, Segal projected the December ending fund balance.

Local Health Reserve (in millions)

	Medical	Pharmacy	Dental	Total
Balance 1/1/2020	(2.0)	21.0	(0.2)	18.9
Revenue				
Premiums	175.2	26.2	1.8	203.3
EGWP Subsidy	0.0	3.1	0.0	3.1
Investment Income	(0.1)	1.3	0.0	1.2
Total Revenue	**175.0**	**30.6**	**1.8**	**207.5**
Expenses				
Paid Claims	172.7	45.4	1.5	219.6
Admin Costs	2.2	1.0	0.0	3.2
Rebates	0.0	(12.3)	0.0	(12.3)
Total Expenses	**174.9**	**34.1**	**1.5**	**210.5**
Net Income /(Deficit)	0.1	(3.4)	0.3	(2.9)
Balance 12/31/2020	**(1.8)**	**17.6**	**0.2**	**15.9**

Fund Balance – Preliminary
Local, through 12/31/2020

- Below are the preliminary Local health insurance plan results for the period ending December 31, 2020.

Local Health Reserve (in millions)

	Medical	Pharmacy	Dental	Total
Balance 1/1/2020	(2.0)	21.0	(0.2)	18.8
Revenue				
Premiums	176.0	26.4	1.8	204.2
EGWP Subsidy		2.8		2.8
Investment Income	(0.4)	2.9	0.0	2.5
Total Revenue	**175.6**	**32.1**	**1.8**	**209.5**
Expenses				
Paid Claims	173.5	46.2	1.5	221.2
Admin Costs	2.4	0.8	0.0	3.2
Rebates		(10.6)		(10.6)
Total Expenses	**175.9**	**36.4**	**1.5**	**213.8**
Net Income /(Deficit)	(0.3)	(4.3)	0.3	(4.3)
Balance 12/31/2020	**(2.3)**	**16.7**	**0.1**	**14.5**

Fund Balance – Gain/Loss
Local

- Below is the Gain/Loss for Local health insurance plan for the period ended December 31, 2020.

Local Health Reserve (in millions)

	Medical	Pharmacy	Dental	Total
Revenue				
Premiums	0.8	0.2	0.0	1.0
EGWP Subsidy		(0.3)		(0.3)
Investment Income	(0.3)	1.6	(0.0)	1.3
Total Revenue	**0.5**	**1.5**	**0.0**	**2.0**
Expenses				
Paid Claims	(0.8)	(0.8)	0.0	(1.7)
Admin Costs	(0.2)	0.2	(0.0)	0.1
Rebates		(1.7)		(1.7)
Total Expenses	**(1.0)**	**(2.3)**	**0.0**	**(3.3)**
Gain/(Loss)	**(0.5)**	**(0.8)**	**(0.1)**	**(1.4)**

- Overall – 2020 loss driven by slightly lower rebates and higher claims.

You

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CLOSED SESSION

*9 - The Board may meet in closed session pursuant to the exemption contained in Wis. Stats. §19.85 (1) (e) to deliberate or negotiate the investing of public funds or to conduct other specified public business, whenever competitive or bargaining reasons require a closed session.

*10 - The Board may meet in closed session pursuant to the exemptions contained in Wis. Stats. §19.85 (1) (g) to confer with legal counsel for the governmental body concerning potential litigation regarding health insurance benefits and HHS nondiscrimination regulations. The Board may vote to reconvene in open session following the closed sessions.

Item 9 & 10 – Group Insurance Board

Announcement of Business Deliberated During Closed Session

Item 11 – Verbal Only

Herschel Day, Board Chair

Supplemental Dental Plan Proposals for Plan Year 2022

Item 12A – Group Insurance Board

Tom Rasmussen, Life Insurance/Dental Program Manager

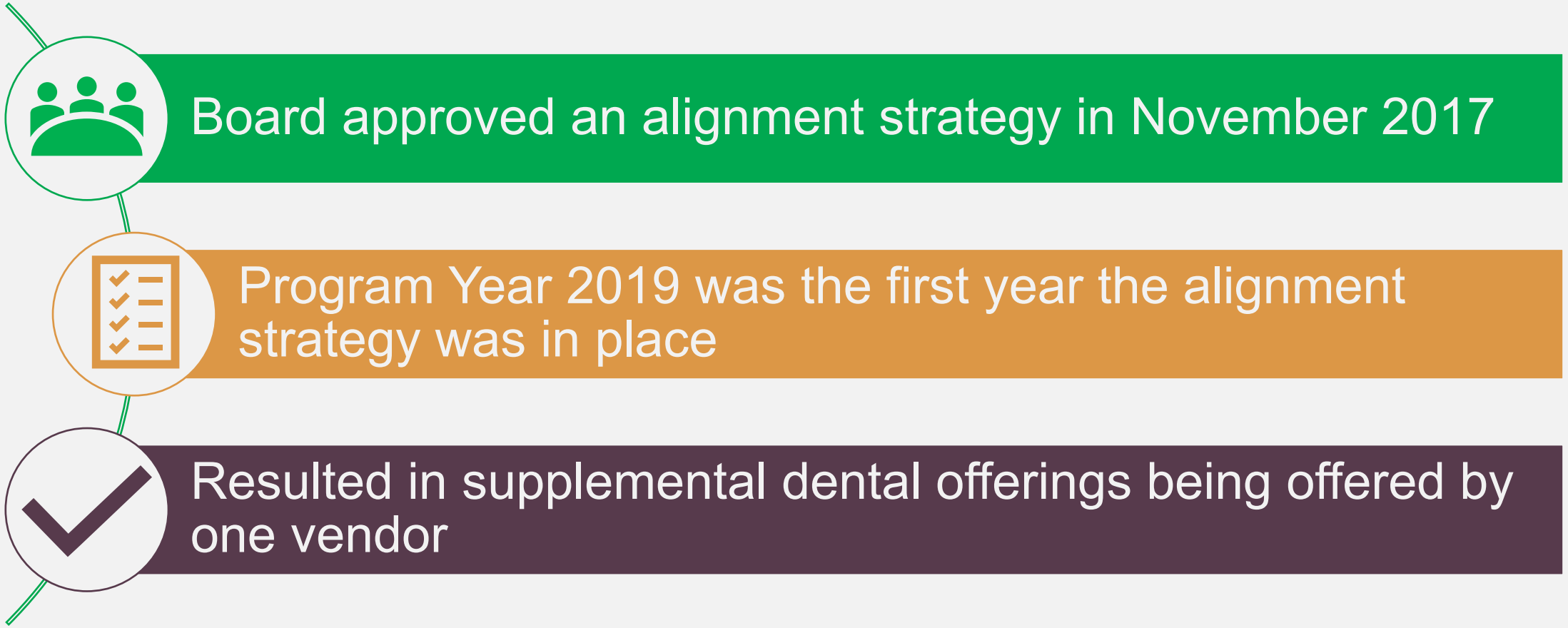
Office of Strategic Health Policy

Action Needed

Based on the recommendation of the evaluation committee, the Department of Employee Trust Funds (ETF) recommends the Group Insurance Board (Board) contract with Delta Dental of Wisconsin to administer the three Supplemental Dental Plans, which are available to Active State and Local Employees, State and Local Retirees, State Continuants, and Dependents beginning January 1, 2022, through December 31, 2023. This includes the enhanced benefit of composite/resin fillings of posterior teeth.

(Ref. GIB | 5.19.21 |12A Page 1)

Background



(Ref. GIB | 5.19.21 |12A Page 1)

Alignment Strategy Goals

Reduce the complexity of plan offerings by limiting the number of vendors offering the same services

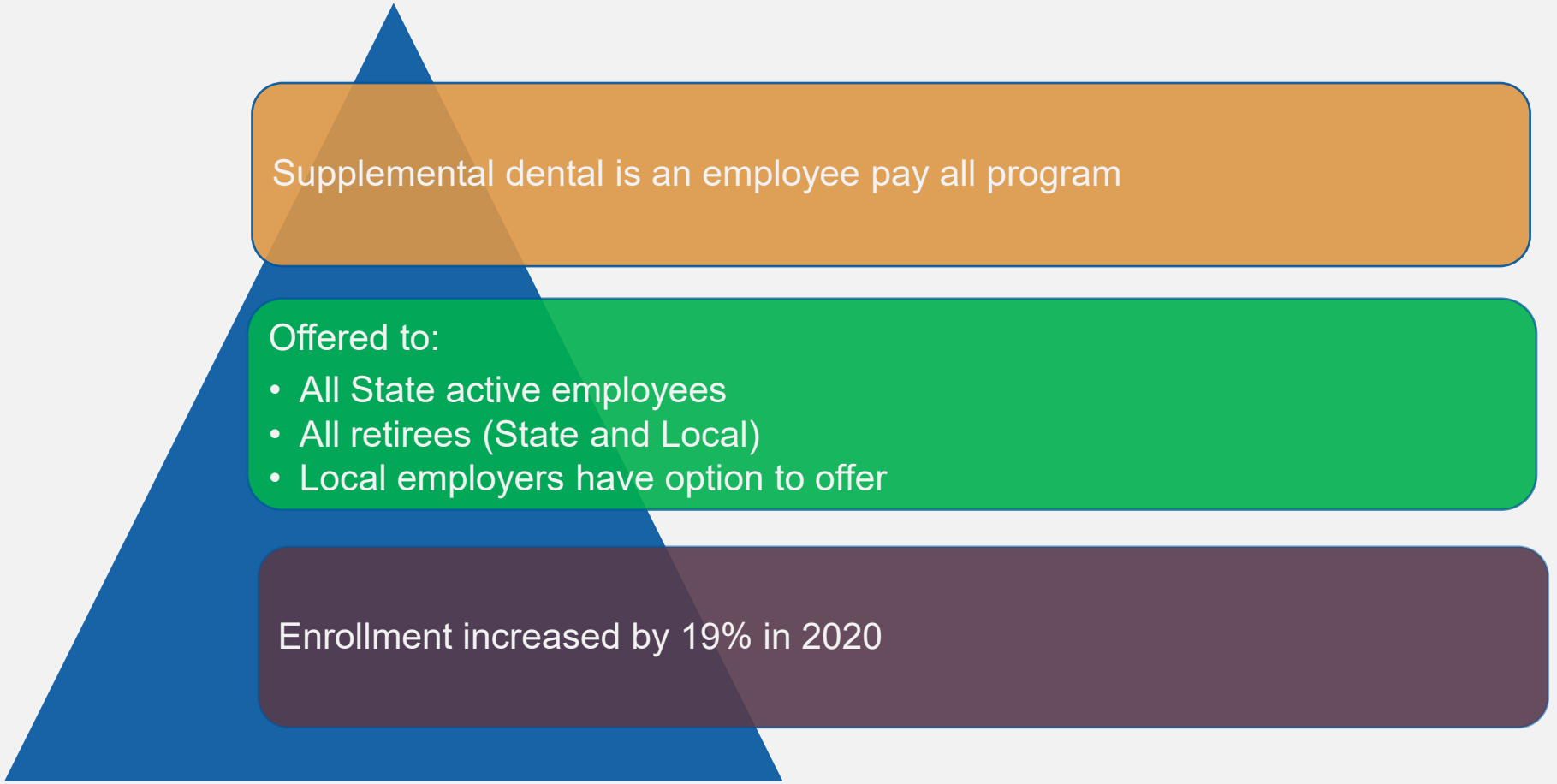
Reduce member confusion/members unknowingly purchasing duplicate coverage

Reduce the administrative burden on employers, payroll centers and ETF in managing ongoing changes and maintenance

Reduce plan duplication and overlap of one another and the UDB benefits they are intended to support

(Ref. GIB | 5.19.21 |12A Page 1)

Plan Overview



(Ref. GIB | 5.19.21 |12A Page 1-2)

Plan Designs

Benefit	Preventive Plan	Select Plan	Select Plus Plan
Annual deductible	None	$100/person	$25/person
Annual benefit maximum	$1,000/person	$1,000/person	$2,500/person
Waiting period	None	None	None
Routine evaluations ,cleanings, sealants, bitewing and panoramic x-rays, fluoride treatments, pulp vitality tests	100%	No coverage	No coverage
Fillings (Amalgam)	100%	No coverage	No coverage
Anesthesia (general)	80%	50%	80%
Emergency pain relief	80%	No coverage	No coverage
Periodontal maintenance	100%	No coverage	No coverage
Crowns, bridges, dentures, implants	No coverage	50%	80%
Surgical extractions, root canals, periodontics, oral surgery	No coverage	50%	80%
Non-surgical extractions	90%	No coverage	No coverage
Orthodontics coverage	50% (Under age 19)	No coverage	50% (Any age)
Orthodontics lifetime maximum	$1,500	No coverage	$1,500

(Ref. GIB | 5.19.21 |12A Page 2)

Proposal Process

Original invitation sent on November 24, 2020

- List of dental carriers same as UDB plus one additional carrier

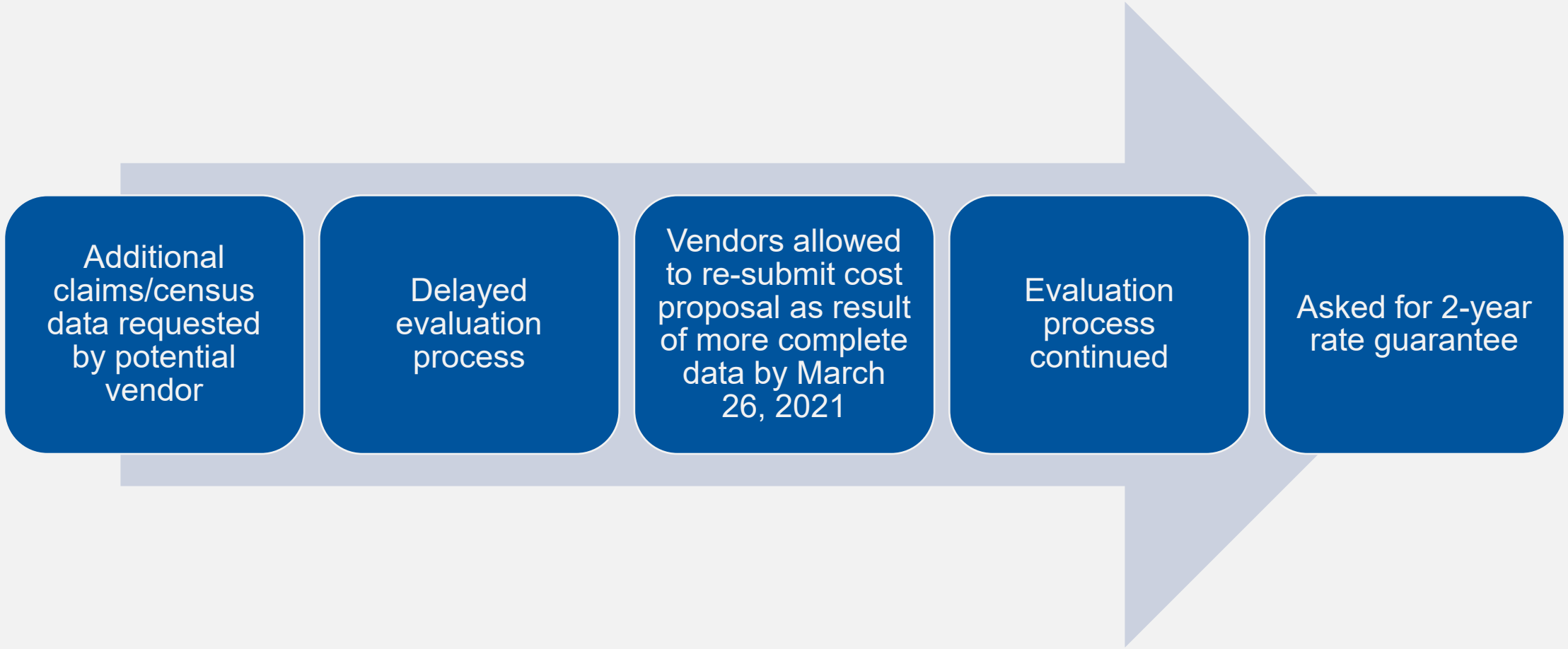
Proposals must meet the requirements outlined in the Board approved supplemental Insurance Plan Guidelines

Supplemental Benefit Plan Administrative Manual (ET-1158) also attached

January 31, 2021 was the deadline for receipt

(Ref. GIB | 5.19.21 |12A Pages 2-3)

Proposal Process



(Ref. GIB | 5.19.21 |12A Page 3)

Proposals Received

Three vendor proposals received

(Ref. GIB | 5.19.21 |12A Page 3)

Evaluation Committee

4-member Evaluation Committee

- 3 ETF Staff
- A representative from the UW System
- A representative from ETF Bureau of Budget, Contract Administration and Procurement (non-voting member)

(Ref. GIB | 5.19.21 |12A Page 4)

Evaluation Process

Reviewed and evaluated each proposal independently

Met collectively to discuss

Virtually met on four separate occasions

(Ref. GIB | 5.19.21 |12A Page 4)

Evaluation Process

- Plan administration
- Reporting and performance standards
- Claims
- Member resources
- Provider network
- References

(Ref. GIB | 5.19.21 |12A Page 4)

Evaluation

Third party actuarial review

All three vendors demonstrated ability to administer the program

Committee unanimously selected Delta

(Ref. GIB | 5.19.21 |12A Pages 4-5)

Evaluation

Why Delta

- Dedicated customer service and call center located in Stevens Point
- Dedicated web site
- Dedicated local Account Manager
- Larger network
- Lowest overall cost

(Ref. GIB | 5.19.21 |12A Pages 4-5)

Network

- Delta contracted with more providers in Wisconsin and Nationwide
- Delta has more than 90% of Wisconsin providers

Wisconsin Providers

Anthem	4,884
Delta	5,712
MetLife	3,326

Nationwide Providers

Anthem	133,000
Delta	259,962
MetLife	159,333

(Ref. GIB | 5.19.21 |12A Page 5)

Premium Consideration

MetLife's proposed premiums were lowest for Preventive and Select Plan

- Not including an additional $.08 PMPM charge for ID cards

Delta an Anthem had lowest rates for Select Plus Pan depending on tier

MetLife and Delta provided 24-month rate guarantee

Anthem capped 2nd year increase at 5%

(Ref. GIB | 5.19.21 |12A Page 6)

Total Monthly Premium

Delta has the lowest total aggregate monthly premium

Majority of membership enrolled in Select Plus Plan

	MetLife	Delta	Anthem
Monthly Premium	$1,567,114	$1,503,367	$1,507,450

(Ref. GIB | 5.19.21 |12A Page 6)

Contract Negotiations

A contract will be completed as soon as possible following the Board approval.

(Ref. GIB | 5.19.21 |12A Page 6)

Action Needed

Based on the recommendation of the evaluation committee, the Department of Employee Trust Funds (ETF) recommends the Group Insurance Board (Board) contract with Delta Dental of Wisconsin to administer the three Supplemental Dental Plans, which are available to Active State and Local Employees, State and Local Retirees, State Continuants, and Dependents beginning January 1, 2022, through December 31, 2023. This includes the enhanced benefit of composite/resin fillings of posterior teeth.

(Ref. GIB | 5.19.21 |12A Page 1)


Questions?

Long-Term Care Plan Proposals for Plan Year 2022

Item 12B – Group Insurance Board

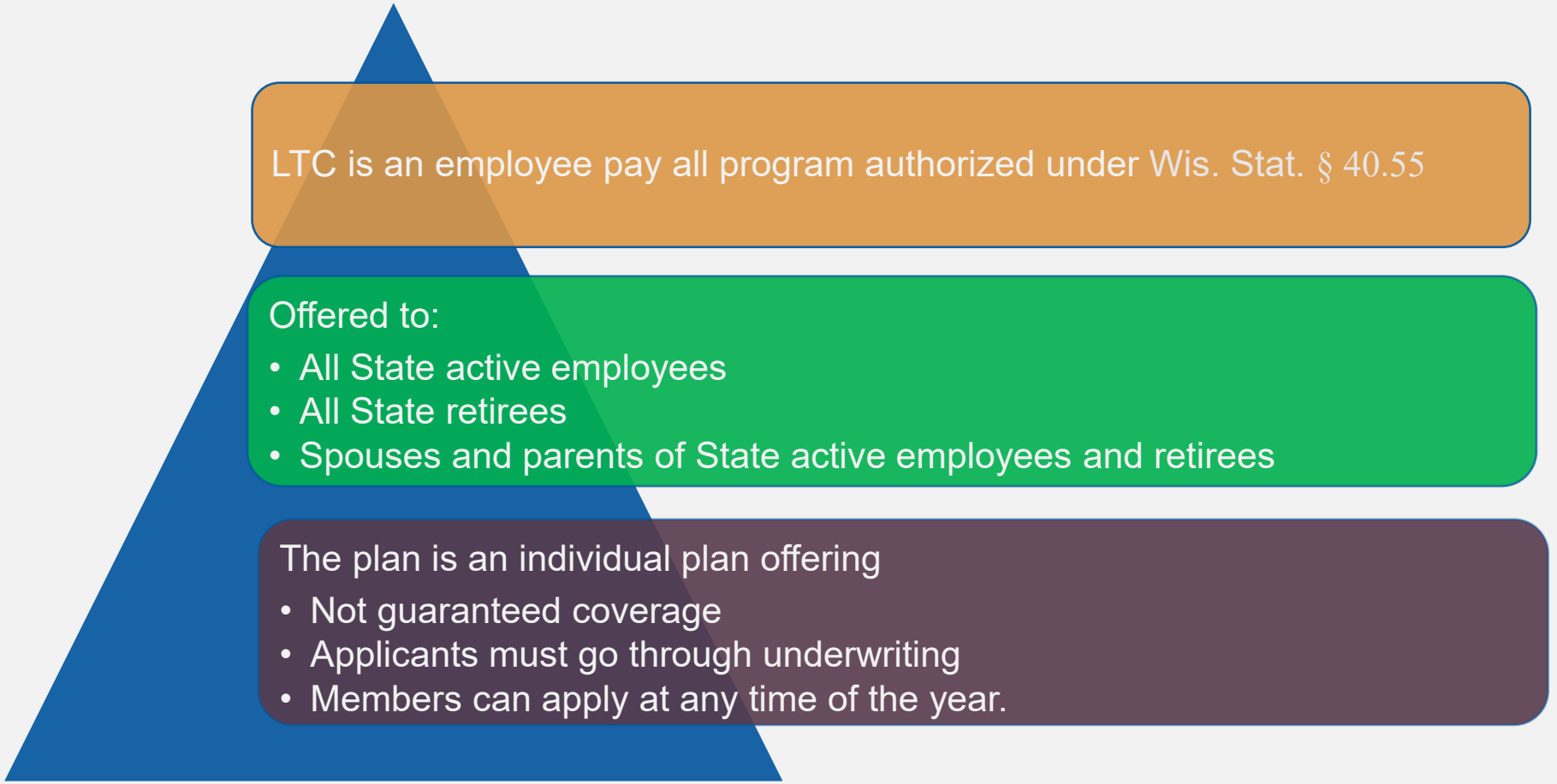
Douglas Wendt, Supplemental Plans Program Manager

Office of Strategic Health Policy

Action Needed

Based on the recommendation of the evaluation committee, the Department of Employee Trust Funds (ETF) recommends the Group Insurance Board (Board) contract with HealthChoice and Mutual of Omaha to administer the Long-Term Care (LTC) insurance plan, which is available to State Active Employees and State Retirees, their spouses, and parents beginning January 1, 2022, through December 31, 2022.

Plan Overview



(Ref. GIB | 5.12.21| 12B | Page 1)

Proposal Process

Invitation sent on November 30, 2020

- Sent to representatives of 16 OCI approved plan vendors

Proposals must meet the requirements outlined in the Board approved long-term care insurance standards

Deadline for receipt was January 31, 2021

(Ref. GIB | 5.12.21| 12B | Page 2)

Proposals Received

Three vendor proposals were received

- ACSIA Partners – broker offering National Guardian Life
- Legacy Services – broker offering Thrivent
- HealthChoice with Mutual of Omaha – Broker with Insurer

(Ref. GIB | 5.12.21| 12B | Page 2)

Evaluation Committee

4-member Evaluation Committee

- 3 ETF Staff
- UW System Representative
- Representative from ETF Bureau of Budget, Contract Administration and Procurement (Non- voting member)

(Ref. GIB | 5.12.21| 12B | Page 2)

Evaluation

- Services offered to members
- Ability to administer the published plan standards
- Vendor references
- Committee unanimously selected HealthChoice/Mutual of Omaha

(Ref. GIB | 5.12.21| 12B | Pages 2-3)

Evaluation

Why HealthChoice and Mutual of Omaha

- Offers in-person consultations
- Able to fulfill all plan standards, including required discount
- References

(Ref. GIB | 5.12.21| 12B | Page 2)

Action Needed

Based on the recommendation of the evaluation committee, the Department of Employee Trust Funds (ETF) recommends the Group Insurance Board (Board) contract with HealthChoice and Mutual of Omaha to administer the Long-Term Care (LTC) insurance plan, which is available to State Active Employees and State Retirees, their spouses, and parents beginning January 1, 2022, through December 31, 2022.


Questions?

Pre-Tax Savings Account Changes

Item 12C – Group Insurance Board

Xiong Vang, HSA & ERA Accounts Program Manager

Office of Strategic Health Policy

Action Needed

The Department of Employee Trust Funds (ETF) requests the Group Insurance Board (Board) approve the following changes related to Flexible Spending Account (FSA) programs and Dependent Day Care Account Program (DCAP) for the 2021 plan year:

1. Increase the Health Care FSA and Limited Purpose FSA annual carryover limit to $1,000.

2. Approve a DCAP annual carryover limit of $2,500 retroactively from plan year 2020 into 2021.

3. Adopt a provision allowing dependents under the age of 14 to be covered for eligible dependent care expense.

(Ref. GIB | 5.12.21 | 12C, Page 1)

Action Needed

(continued)

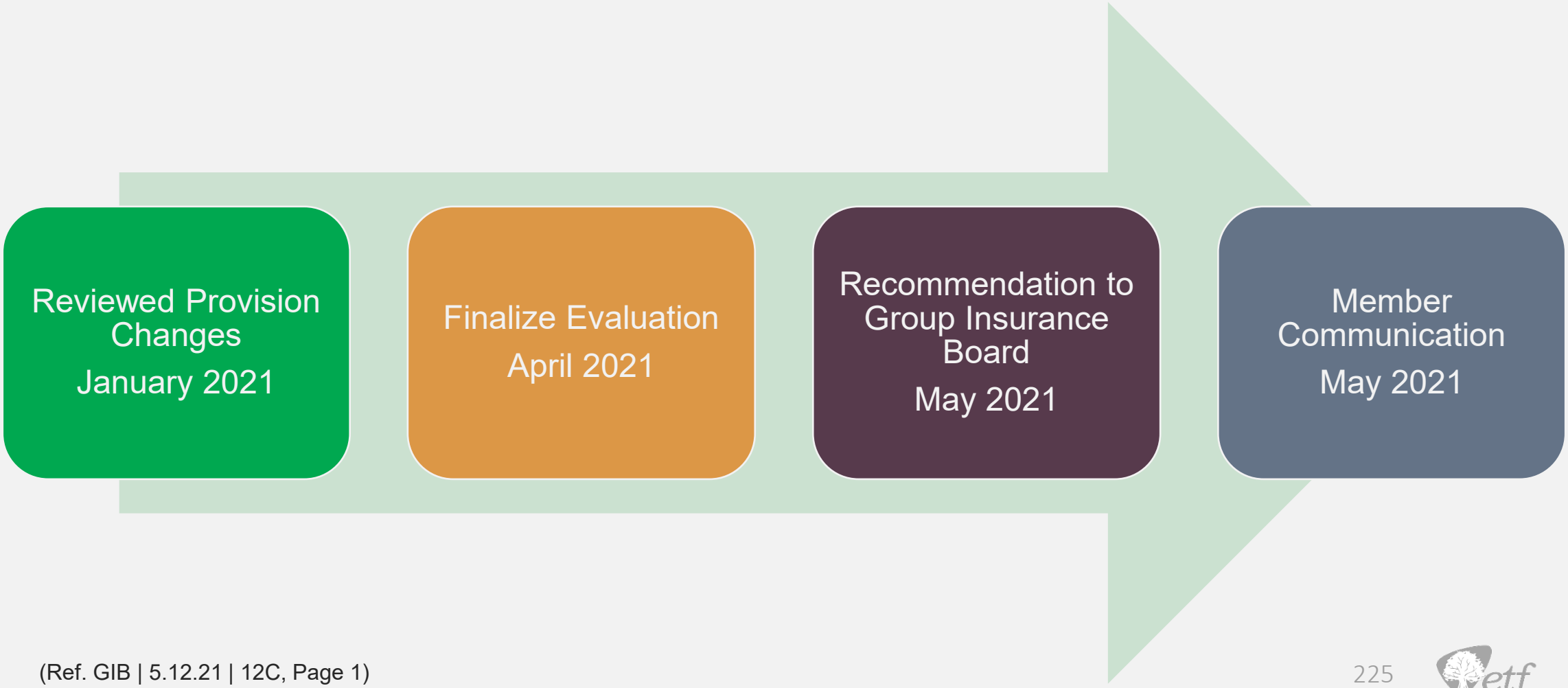
4. Increase the DCAP contribution limit from $5,250 to $10,500 for individuals or married couples filing jointly and from $2,500 to $5,250 for married individuals filing separately for plan year 2021.

5. Allow a one-time mid-year election to increase only for current DCAP elections between June 1, 2021, and June 30, 2021.

6. Approve Personal Protective Equipment (PPE), such as masks, hand sanitizer, and sanitizing wipes, as eligible expenses for the Health Care FSA and the Health Savings Account (HSA) under Section 213(d).

(Ref. GIB | 5.12.21 | 12C, Page 1)

Background



(Ref. GIB | 5.12.21 | 12C, Page 1)

Background

- **Consolidated Appropriations Act (CAA) of 2021** was signed into law on December 27, 2020 that allows an employer to adopt provision changes related to the Health Care Flexible Spending Account (FSA), Limited Purpose FSA, and Dependent Day Care Account Program (DCAP)
- **American Rescue Plan (ARP) Act** was signed into law on March 11, 2021 with addition provisions related to DCAP contribution limit and COBRA subsidy
- **IRS Announcement 2021-7** released on March 26, 2021 allows for protective equipment such as masks, hand sanitizer, and sanitizing wipes that are purchased “for the primary purpose of preventing the spread of COVID-19”

(Ref. GIB | 5.12.21 | 12C, Page 2)

Consolidated Appropriations Act (CAA)

Expanded Carryovers

- Unused funds from FSA and DCAP plan years ending in 2020 and 2021 may be carried over into the next plan year.

Spend-Down FSA

- Allow FSA participants who cease participation in a 2020 or 2021 plan to receive reimbursements from unused contributions through the end of the plan year.

DCAP Age Extension

- For a DCAP plan year that had an election period ending on or before January 31, 2020, participants may claim expenses for dependents who turned 13 during the applicable plan year and any extension to that plan year

(Ref. GIB | 5.12.21 | 12C, Page 2)

Consolidated Appropriations Act (CAA)

Extend Grace Period

- For FSA plan years ending in 2020 or 2021, the grace period may be extended up to 12 months after the end of plan year

Temporary Change in Election

- For FSA and DCAP plans ending in 2021, participants may change their election amount for any reason

(Ref. GIB | 5.12.21 | 12C, Page 2)

American Rescue Plan (ARP) Act

DCAP Contribution Limit

- For 2021 only, the DCAP contribution limit for qualifying dependent care expenses is increased from $5,250 to $10,500 for individuals or married couples filing jointly and from $2,500 to $5,250 for married individuals filing separately

IRS Announcement 2021-7

- Adopt protective equipment such as masks, hand sanitizer, and sanitizing wipes as eligible expenses for reimbursements

(Ref. GIB | 5.12.21 | 12C, Page 2)

Forfeitures

- ETF uses forfeitures to offset any negative balances of members whose contributions are less than their reimbursed claims when they terminate employment
- The forfeiture balance is also factored into the annual employer administrative rate calculation and works to put downward pressure on the rates
- At the end of each year, ETF sets the rate for the employers in the coming new year to pay based on the number of Group Health Insurance contracts they have each month

(Ref. GIB | 5.12.21 | 12C, Page 3)

FSA Carryover Limit

2016-2019

$500

2020

$550

(Ref. GIB | 5.12.21 | 12C, Page 3)

DCAP Carryover Limit

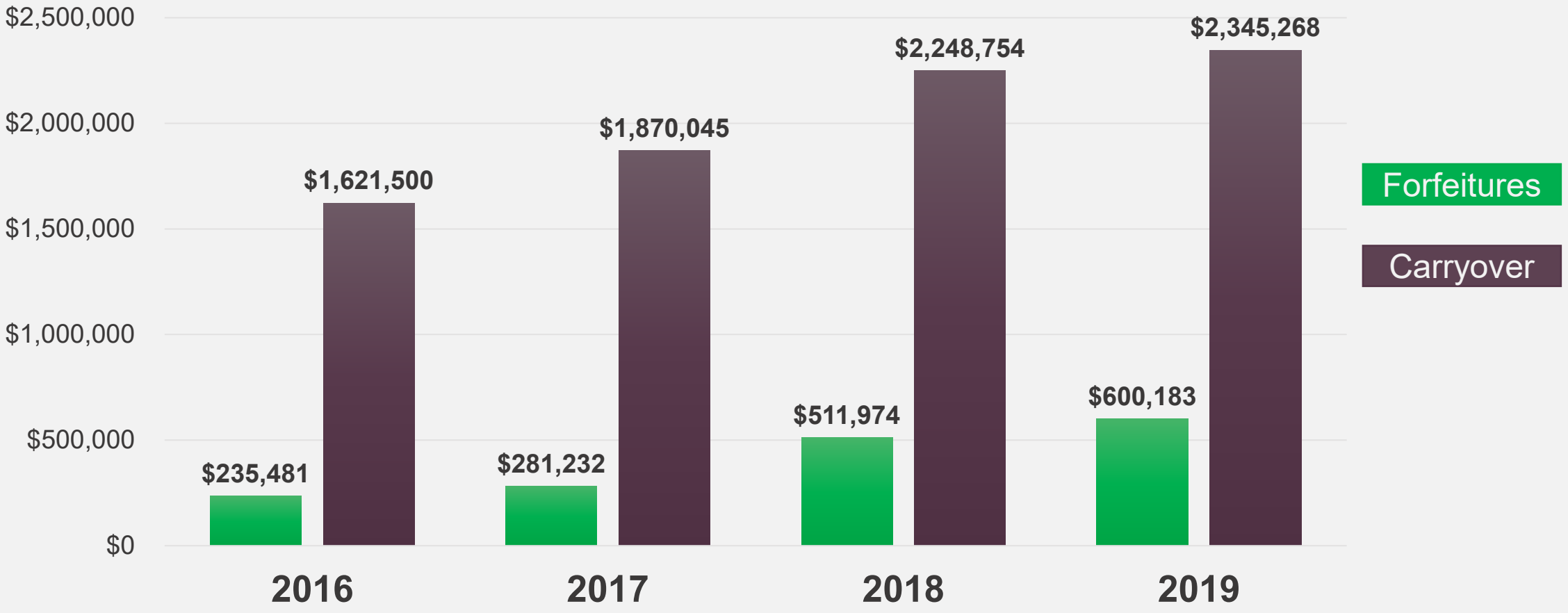
- DCAP does not have any carryover provision
- Any funds that are not used by the end of the runout period for DCAP are forfeited

2016-2020

$0

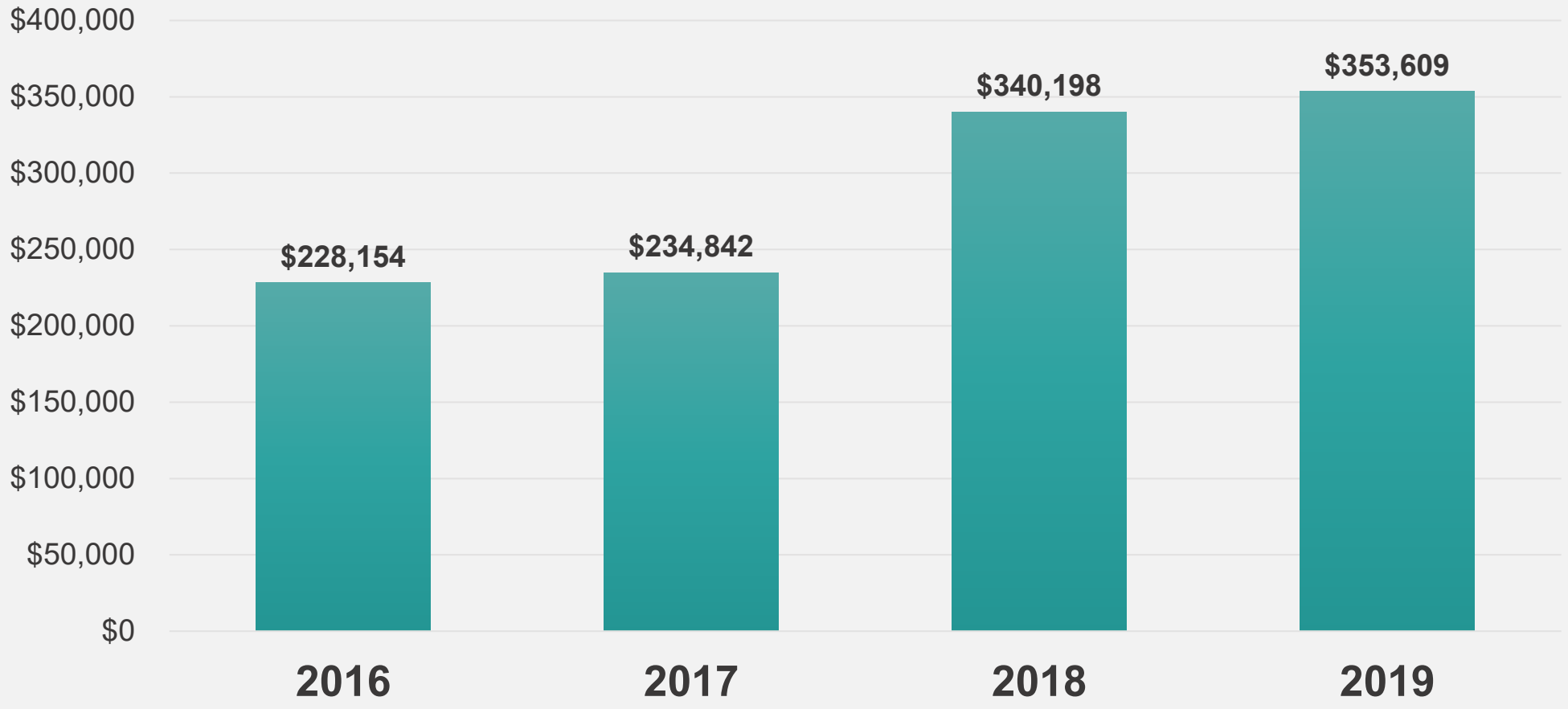
(Ref. GIB | 5.12.21 | 12C, Page 3)

FSA Forfeitures and Carryovers



(Ref. GIB | 5.12.21 | 12C, Page 3)

DCAP Forfeitures



(Ref. GIB | 5.12.21 | 12C, Page 3)

2020 FSA/DCAP Estimated Forfeiture and Carryover

	Up to $550	Up to $1,000	Up to $1,500	Up to $2,500
FSAs				
Forfeiture	$1,398,077.96	**$897,889.87**	$663,301.46	N/A *
Carryover	$3,168,728.01	**$3,668,916.10**	$3,903,504.51	N/A *
DCAP				
Forfeiture	$1,488,370.44	$1,233,281.70	$1,007,025.94	**$678,978.33**
Carryover	$453,797.65	$708,886.39	$935,142.15	**$1,263,189.76**

** Did not estimate since FSA contribution limit was $2,750 for the plan year*

(Ref. GIB | 5.12.21 | 12C, Page 3)

Proposed FSA and DCAP Changes

1

Expanded Carryovers (FSA)

- Increase the Health Care FSA and Limited Purpose FSA annual carryover limit $550 to $1,000 from plan years 2020 to 2021

Evaluation

- The Board approved a $50 carryover limit increase for plan year 2020
- Additional funds greater than the current contribution limit up to $550 can be made retroactively available to members

(Ref. GIB | 5.12.21 | 12C, Page 4)

Proposed FSA and DCAP Changes

2

Expanded Carryovers (DCAP)

- Approve an annual carryover limit of $2,500 for the DCAP retroactively from plan year 2020 into 2021

Evaluation

- Members in the DCAP have asked to be able to carry over their 2020 funds into 2021
- If approved, the carryover allowance for this program will be the first time ever for the program

(Ref. GIB | 5.12.21 | 12C, Page 4)

Proposed FSA and DCAP Changes

3

DCAP Age Extension

- Adopt the provision allowing dependents under the age of 14 to be covered for dependent care expenses (i.e., turning age 13 during the 2020-2021 plan year would qualify as dependent day care expenses)

Evaluation

- Does not require any employer system changes
- Allow members to continue using funds to pay out on dependent care expenses

(Ref. GIB | 5.12.21 | 12C, Page 4)

Proposed FSA and DCAP Changes

4

DCAP Contribution Limit

- Increase the DCAP contribution limit up to $10,500 for 2021 plan year. Married individuals filing separately can contribute up to $5,250

Evaluation

- Members frequently request a higher contribution for the DCAP account
- CYC confirmed it will not be an issue to increase the contribution limit

(Ref. GIB | 5.12.21 | 12C, Page 4)

Proposed FSA and DCAP Changes

5

Temporary Change in Election

- Allow a one-time mid-year election increase to current 2021 DCAP elections, without a qualifying event, between June 1, 2021, and June 30, 2021

Evaluation

- Allow the DCAP to be non-discriminatory for members who have already been enrolled
- Employers believe this change has minimum impact due to the low participant enrollment

(Ref. GIB | 5.12.21 | 12C, Page 5)

Proposed FSA and DCAP Changes

6

Personal Protective Equipment

- Adopt masks, hand sanitizer, and sanitizing wipes as newly eligible expenses for the Health Care FSA and HSA in accordance with Section 213(d)

Evaluation

- Merchants are in the process of updating their point-of-sale systems to recognize PPE as a qualified eligible expense
- Participants should expect some inconsistency in point-of-sale purchases when using their payment card

(Ref. GIB | 5.12.21 | 12C, Page 5)

Next Steps

- CYC is prepared to communicate with employers on the strategy plan in preparation for internal outreach and system changes
- Employers will be ready to make necessary system changes
- CYC will provide direct communication to participants who are eligible for the FSA/DCAP changes

(Ref. GIB | 5.12.21 | 12C, Page 5)

Action Needed

The Department of Employee Trust Funds (ETF) requests the Group Insurance Board (Board) approve the following changes related to Flexible Spending Account (FSA) programs and Dependent Day Care Account Program (DCAP) for the 2021 plan year:

1. Increase the Health Care FSA and Limited Purpose FSA annual carryover limit to $1,000.

2. Approve a DCAP annual carryover limit of $2,500 retroactively from plan year 2020 into 2021.

3. Adopt a provision allowing dependents under the age of 14 to be covered for eligible dependent care expense.

(Ref. GIB | 5.12.21 | 12C, Page 1)

Action Needed

(continued)

4. Increase the DCAP contribution limit from $5,250 to $10,500 for individuals or married couples filing jointly and from $2,500 to $5,250 for married individuals filing separately for plan year 2021.

5. Allow a one-time mid-year election to increase only for current DCAP elections between June 1, 2021, and June 30, 2021.

6. Approve Personal Protective Equipment (PPE), such as masks, hand sanitizer, and sanitizing wipes, as eligible expenses for the Health Care FSA and the Health Savings Account (HSA) under Section 213(d).

(Ref. GIB | 5.12.21 | 12C, Page 1)

Questions?

Acceptance of State and Local ICI Actuarial Valuations

Item 13 – Group Insurance Board

Jim Guidry, Director,

Benefit Services Bureau

Paul Correia, Consulting Actuary

Dan Skwire, Consulting Actuary

Milliman, Inc

Action Items

- **ETF recommends the Board approve the State ICI Actuarial Valuation as of December 31, 2020 and adopt Scenario 2 which would result in a 50% premium decrease for the 2022 plan year**
- **ETF recommends the Board approve the Local ICI Actuarial Valuation as of December 31, 2020 and the baseline scenario to continue the local ICI plan premium holiday for the 2022 plan year.**

State ICI Program Reserves

- 2019 Fund Balance – 100.2% of liabilities
  - Fund balance - $90.3 million
  - Liabilities - $90 million
- 2020 Fund Balance - 134% of liabilities
  - Fund balance - $120 million
  - Liabilities - $89.5 million
- Board approved 20% premium rate increases for 2016-2020 plan years
  - Goal 100% fund balance/liability ratio
  - No premium increase in 2021
- Board adopted reserve target policy – November 2019
  - Established reserve target of 135% of actuarial liabilities

Local ICI Program Reserves

- 2019 Fund Balance - 663% of liabilities
  - Fund balance - $39.6 million
  - Liabilities - $5.9 million
- 2020 Fund Balance - 612% of liabilities
  - Fund balance - $41.6 million
  - Liabilities - $6.8 million
- Local ICI program premium holiday in effect since 2012
- Board adopted reserve target policy – November 2019
  - Established reserve target of 150% of actuarial liabilities

State ICI Valuation
Estimated Liabilities as of December 31, 2020

Liability Component	Standard Benefit	Supplemental Benefit	$75 Add-On	Total Liability
Open Claims	$77,470,025	$2,350,343	$280,011	$80,100,379
IBNR Claims	$4,204,274	$127,552	$15,196	$4,347,022
Loss Adjustment Expense	$4,906,852	$148,868	$17,736	$5,073,456
Total	**$86,581,151**	**$2,626,763**	**$312,943**	**$89,520,857**

- **Open Claims**: Members disabled prior to December 31, 2020 whose claims were reported on or before that date.
- **Incurred but not Reported (IBNR) Claims**: Members disabled on or prior to December 31, 2020 whose claims had not yet been reported as of that date.
- **Loss Adjustment Expenses**: Future expenses related to the ongoing management and payment of ICI claims.

State ICI Valuation
Comparison to Prior Year

Liability Component	December 31, 2019	December 31, 2020
Open Claims	$81,180,573	$80,100,379
IBNR Claims	$4,832,244	$4,347,022
Loss Adjustment Expense	$4,079,139	$5,073,456
Total	**$90,091,957**	**$89,520,857**

- The total liability decreased by 0.6% from $90.1 million on December 31, 2019 to $89.5 million as of December 31, 2020.
- The number of open claims decreased by 2.1% from 1,140 as of December 31, 2019 to 1,116 as of December 31, 2020.
- The average net benefit amount increased by 1.9% from $1,420 as of December 31, 2019 to $1,446 as of December 31, 2020.

State ICI Valuation
Retrospective Adequacy Test

Claim Duration	Estimated Annual Margin
1 – 12 months	1.1%
13 – 24 months	10.1%
25 – 36 months	3.6%
37 – 48 months	2.7%
49 – 60 months	1.2%
61 + months	2.3%
Total	**2.5%**

- Study period: 2016 through 2020
- Positive margin of 2.5% indicates the liability is adequate to cover the runout of open disability claims during the study period

State ICI Valuation
Historical Reserve Balances

	December 31, 2018	December 31, 2019	December 31, 2020
Reserve Balance	$71,493,483	$90,324,627	$120,036,016
Actuarial Liability	$90,549,241	$90,091,957	$89,520,857
Surplus / (Deficit)	($19,055,758)	$232,670	$30,515,159

- The State ICI reserve increased by $29.7 million between December 31, 2019 and December 31, 2020.
  - Strong investment income in 2020
  - Premium contributions exceeded claims and expenses in 2020
- In 2019, the Board approved a fund reserve target of 135% of the actuarial liability for the State ICI plan.
- The December 31, 2020 reserve balance is equal to 134% of the actuarial liability.

Local ICI Valuation
Estimated Liabilities as of December 31, 2020

Liability Component	Standard Benefit	Supplemental Benefit	$75 Add-On	Total Liability
Open Claims	$5,769,134	$214,808	$35,925	$6,019,867
IBNR Claims	$373,361	$13,902	$2,325	$389,587
Loss Adjustment Expense	$372,339	$13,864	$2,319	$388,521
Total	**$6,514,833**	**$242,573**	**$40,568**	**$6,797,975**

- **Open Claims**: Members disabled prior to December 31, 2020 whose claims were reported on or before that date.
- **Incurred but not Reported (IBNR) Claims**: Members disabled on or prior to December 31, 2020 whose claims had not yet been reported as of that date.
- **Loss Adjustment Expenses**: Future expenses related to the ongoing management and payment of ICI claims.

Local ICI Valuation
Comparison to Prior Year

Liability Component	December 31, 2019	December 31, 2020
Open Claims	$5,312,948	$6,019,867
IBNR Claims	$312,651	$389,587
Loss Adjustment Expense	$345,111	$388,521
Total	**$5,970,710**	**$6,797,975**

- The total liability increased by 13.9% from $6.0 million as of December 31, 2019 to $6.8 million as of December 31, 2020.
- The number of open claims increased by 6.7% from 90 as of December 31, 2019 to 96 as of December 31, 2020.
- The average net benefit amount increased by 2.9% from $1,667 as of December 31, 2019 to $1,716 as of December 31, 2020..

Local ICI Valuation
Historical Reserve Balances

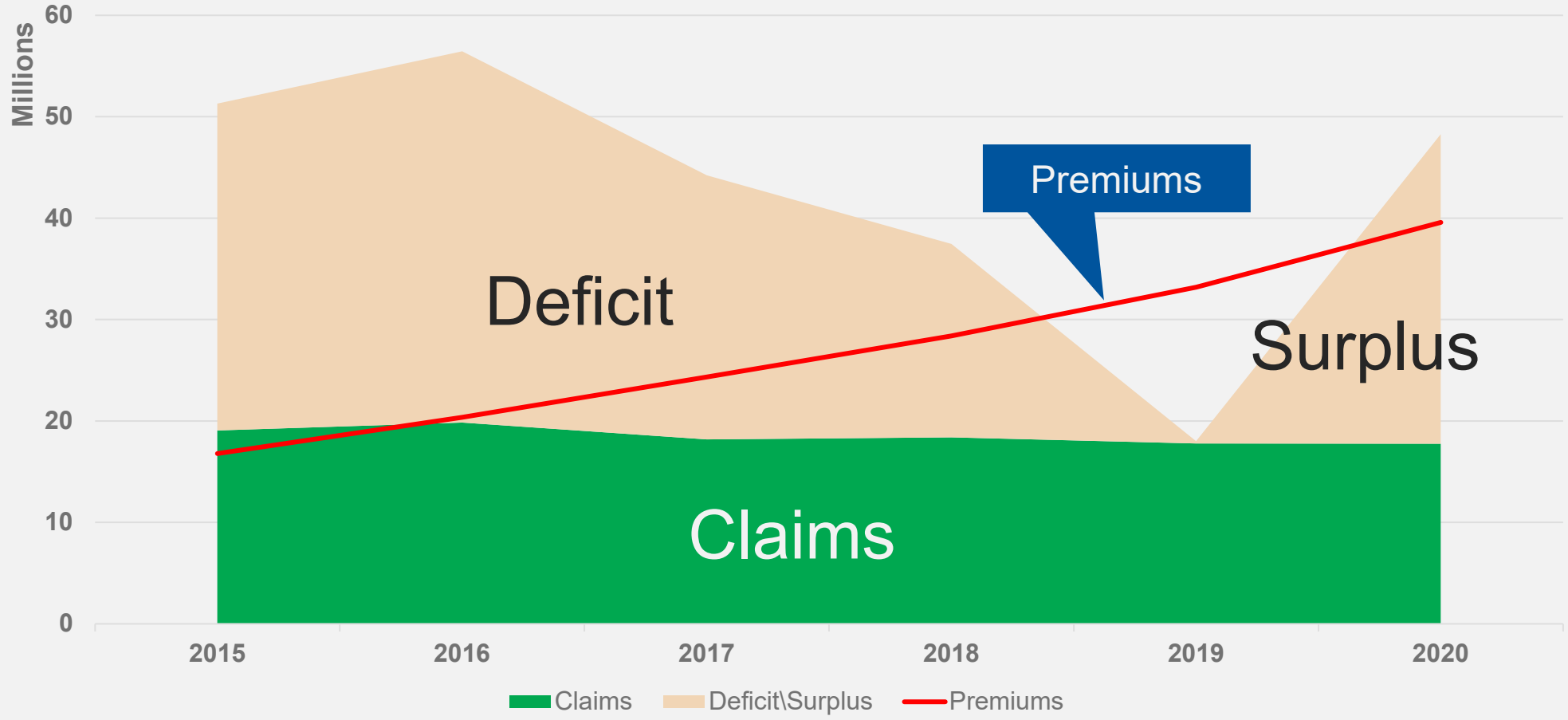
	December 31, 2018	December 31, 2019	December 31, 2020
Reserve Balance	$38,914,553	39,603,652	41,601,274
Actuarial Liability	$5,966,337	5,970,710	6,797,975
Surplus / (Deficit)	$32,948,215	$33,632,942	$34,803,299

- The Local ICI plan has run a large surplus for many years.
- Premium contributions have been waived since 2012.
- Funding analysis indicates premium waiver can be continued for the near future.
- In 2019, the Board approved a fund reserve target of 150% of the actuarial liability for the State ICI plan.
- The December 31, 2020 reserve balance is equal to 612% of the actuarial liability.

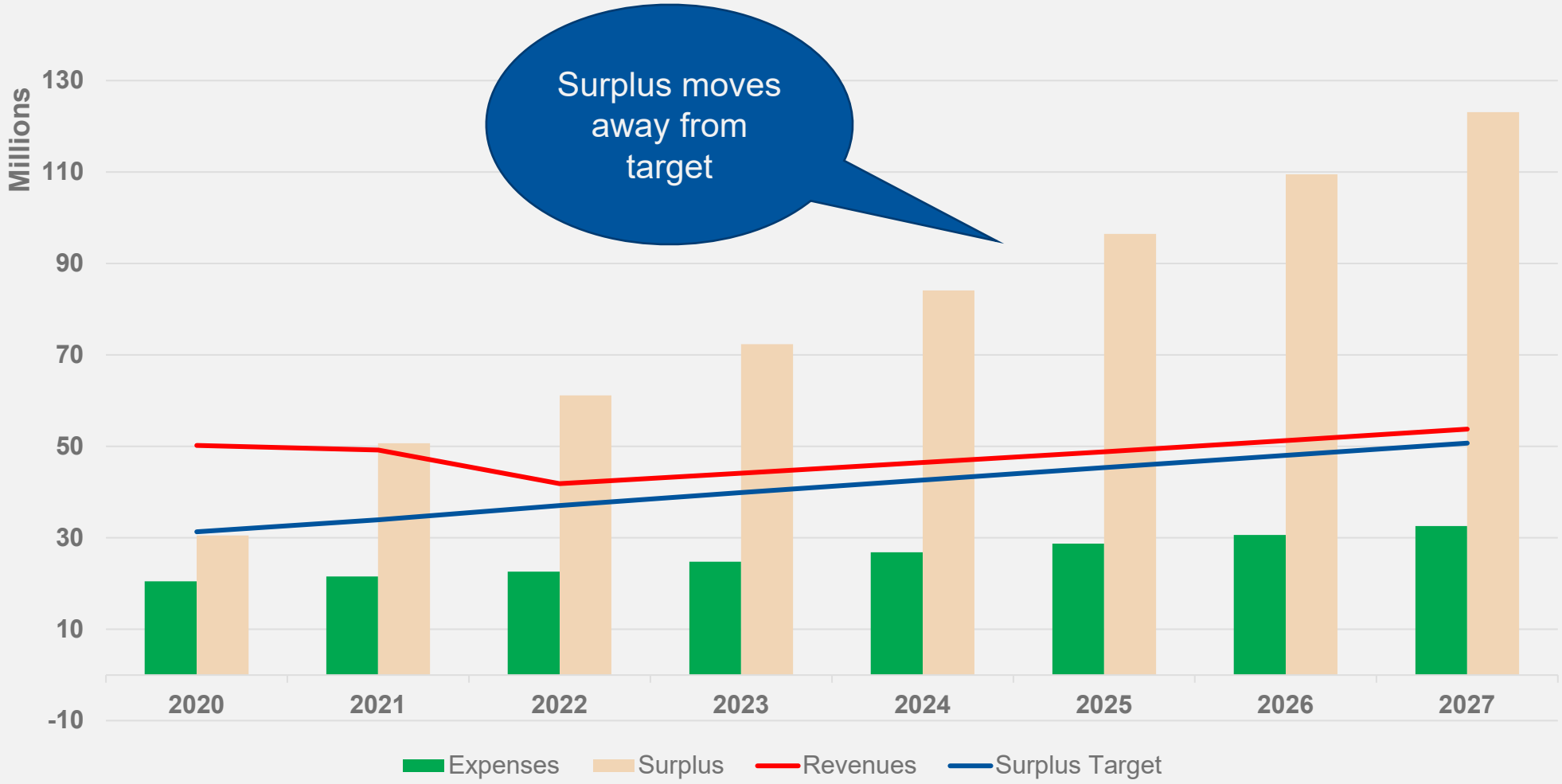
State ICI Premium Rate Action

- Board approved 20% premium rate increases for 2016-2020
- Funding the deficit and current claims
  - Deficit was $32 million in 2015 on $82 million of liabilities at the end of 2015
  - 61% of liabilities
- 2020 Fund balance at 134%
  - No longer need to fill in the deficit hole.

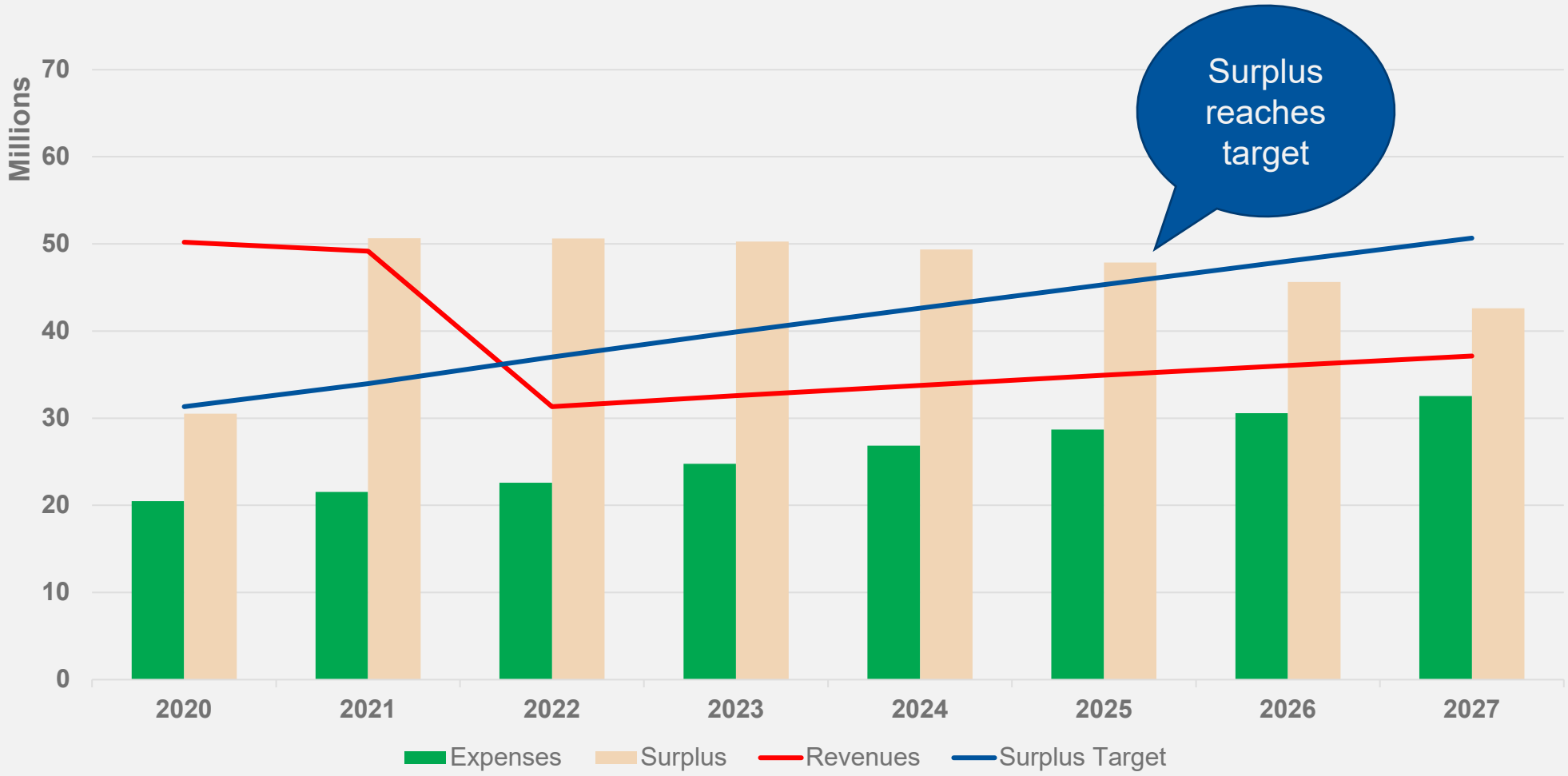
The Deficit Hole



Scenario 1 – 25% Decrease in 2022



Scenario 2 – 50% Decrease in 2022



ICI Program Update

- Budget Update
  - Decoupling Sick Leave currently not included
  - Moving Authority to ETF Board currently included
- ICI Contract
  - Ongoing negotiations – technical issues

Action Items

- **ETF recommends the Board approve the State ICI Actuarial Valuation as of December 31, 2020 and adopt Scenario 2 which would result in a 50% premium decrease for the 2022 plan year**
- **ETF recommends the Board approve the Local ICI Actuarial Valuation as of December 31, 2020 and the baseline scenario to continue the local ICI plan premium holiday for the 2022 plan year.**

Actuarial Valuation of ICI Plans
Limitations of Analysis

- We relied on information provided by ETF and The Hartford. If it is inaccurate or incomplete, our results may be affected.
- The valuation uses actuarial assumptions that are individually reasonable and that, in combination, offer our best estimate of anticipated experience.
- To the extent that actual experience varies from the assumptions, the emerging costs of the plan will vary from the projections we have prepared.
- The calculations in this presentation are consistent with our understanding of ETF funding requirements and goals. Additional determinations may be needed for other purposes.
- Milliman's work product was prepared exclusively for ETF for a specific and limited purpose. It is not for the use or benefit of any third party for any purpose.
- I, Paul Correia, am a Consulting Actuary with Milliman and a member of the American Academy of Actuaries. I meet the Academy's qualification standards to render the actuarial opinion contained herein.

Questions?

Operational Updates

Item 14A – 14L – Memos Only

Future Items for Discussion

Item 15 – Memo Only

Eileen Mallow, Director

Office of Strategic Health Policy

Adjournment

Item 16 - No Memo

Next Meeting:

August 18, 2021