DRAFT

MINUTES

May 23, 2024

Group Insurance Board

State of Wisconsin

Location:

Hill Farms State Office Building – CR N108
4822 Madison Yards Way, Madison, WI 53705
8:30 a.m. – 12:50 p.m.

BOARD MEMBERS PRESENT:

Herschel Day, Chair
Nathan Houdek, Vice Chair*
Nancy Thompson, Secretary
Dan Fields
Jen Flogel
Erin Hillson
Brian Keenan
Katy Lounsbury*
Brian Pahnke

BOARD MEMBERS ABSENT:

Nathan Ugoretz

PARTICIPATING EMPLOYEE TRUST FUNDS (ETF) STAFF:

Office of the Secretary:
John Voelker, Secretary
Shirley Eckes, Deputy Secretary
Erin Casper, Board Liaison
Kimberly Schnurr, Board Liaison

Department of Trust Finance:
Marie Ruetten, Deputy Administrator

Division of Benefits Administration:
Jim Guidry, Benefit Services Bureau Director

Office of Internal Audit:
Amanda Williams, Internal Auditor

Office of Strategic Health Policy:
Brian Stamm, Deputy Director
Jessica Rossner, Data and Compliance Unit Director
Renee Walk, Programs and Policy Unit Director
Arlene Larson, Federal Health Programs and Policy Manager
Tom Rasmussen, Life Insurance and Dental Insurance Program Manager
Tricia Sieg, Pharmacy Benefits Program Manager
Stephanie Trigsted, Health Care Data Quality and Integrations Analyst

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OTHERS PRESENT:

Office of the Secretary:
Pam Henning, Assistant Deputy Secretary

ETF Staff:
Kevin Acker*, Ruth Ballard*, Shellee Bauknecht*, Laura Brauer,

* Attended virtually.

Board	Mtg Date	Item #
GIB	08.14.24	2A

ETF Staff (Cont.):
Luis Caracas, Julie Coleman*, Taylor DeBroux, Omar Dumdum*, Molly Dunks, Victor Dupuy, Oladipo Fadiran, Diana Felsmann, Michelle Hoehne*, Tarna Hunter, Bruce Johnson*, Joanne Klaas*, Brittney Kruchten*, Mark Lamkins, David Maradiaga, Kadi Mbanefo*, Peggy McCullick, Laura Patterson*, Peter Rank, Dominic Schuh*, Shraddha Shrivastava*, Amelia Slaney*, Tim Steiner*, Ilana Sullivan*, Sarat Tadi, Barry Tucker, Laura Vang*, Xiong Vang, Douglas Wendt, Korbey White, Wade Whitmus*, Ramona Yee*, Kathryn Young

Anthem Blue Cross and Blue Shield:
Jimmy Bunch*

Benefitfocus:
Melanie Dubos*

Capital Results:
Greg Mills*

Carelon:
Alexandria Forbis*

Cottingham and Butler:
Anja Hartmann*, Sandy Matz*

Dean Health Plan:
Penny Bound*, Kyle Kasten*, Maria Schneider*, Timothy Taylor*

Delta Dental of Wisconsin:
Megan Wohlfeil*

Department of Administration (DOA):
Dana Gehrmann*, Sara Hynek*, Jennifer Kraus*, Meghan McKenna*, Julie Perry*, Derek Sherwin*, Danielle Tesch*, Lisa Tesch*

Department of Revenue:
Benjamin Gerber*

Duffy Communication Strategies:
Melissa Duffy

Elevance Health:
Elisabeth Portz*

Group Health Cooperative
Christina McConaughey*

Group Health Cooperative of South Central Wisconsin:
Tammy Adler*

Health Partners:
Kyle Long*, Elizabeth Tobias*

Jefferson County, WI:
Terri Palm*, Jessica Tucker*

Lake Country Fire & Rescue:
Mary Green*

Lilly:
Kelly Ruhland*

Mercyhealth:
Marc Dinnel*, Joan Fisher*, Betsy Fulmer*, Michael Lorhan*, Joshua Mummery*, Eric Quivers*, Morgyn Ray*, John Trochlell*

Milliman:
Maxwell Berube, Paul Correia

Navitus:
Tara Argall*, Karen Markstahler*, Ryan Olson*, Felicia Weihert*

Network Health Plan:
Elizabeth Benz*, John Braden*, Vanessa Cagal*, Cody LeBlanc*, Andrew Wheaton*

Northwest Regional Planning Commission:
Mariann Jones*

Quartz:
Brittany Coyne*

Securian:
Kjirsten Elsner*

Security Health Plan:
Angie Pero

Segal Consulting (Segal):
Patrick Klein, Ken Vieira

Trempealeau County Health Care Center:
Heather Brown*

UnitedHealthcare:
Andrew Baumann*

UW Health:
Sara Broge*, Emily Fairchild*, Natalie Hughes*, Hope Jackson*,

UW Health (Cont.):
Annette Phelps Revolinski*, Olivia Talma*, Lara Wolfe*
UW-Madison:
Marissa Isensee*, Mallory Nordin*, Karly Oppliger*, Tina Petrick*, Erin Schoonmaker*, Amanda Sonnenburg*
UW-Stout:
Jo Johnson*
UW System Administration:
Brianne Jobke*, Erin Schoonmaker*, Amanda Sonnenburg*
Vilas County, WI:
Kris Braynack*
Village of Cottage Grove, WI:
Cameron Sawyer*
Village of Little Chute, WI:
Lisa Remiker-DeWall*
Village of Mount Horeb, WI:
Andrea Murleau*
Watertown, WI:
Mark Stevens*
WebMD:
Emily Rosetter*
WI Court System:
Nicklaus Lutes*
WI Health News:
Sean Kirkby*
WPPI Energy:
Julie Zacher*
Public:
Stephanie Steel*, WisconsinEye*
Others (Unidentified):
15 individuals connected via telephone.

Mr. Day, Chair, called the meeting of the Group Insurance Board (Board) to order at 8:30 a.m.

ANNOUNCEMENTS

Ms. Eckes made the following announcements:

- Office of Strategic Health Policy (OSHP) Director, Eileen Mallow, retired. Recruitment for the position was underway with a goal of hiring a replacement by next month.
- Actuarial Audits will be launched this summer.
- Three Requests for Proposals (RFPs) were currently being worked on.

CONSIDERATION OF OPEN AND CLOSED SESSION MINUTES OF FEBRUARY 21, 2024, MEETING (Ref. GIB | 05.23.24 | 2A)

MOTION: Ms. Thompson moved to approve the open and closed session minutes of the Feb. 21, 2024, meeting as submitted by the Board Liaison. Mr. Fields seconded the motion, which passed unanimously on a voice vote.

BOARD EDUCATION: PHARMACY BENEFITS (Ref. GIB | 05.23.24 | 3)

Before Ms. Sieg began her presentation on pharmacy benefits, Mr. Day made an announcement that acknowledged the general public's interest in continuing the

discussion around anti-obesity medications (AOMs). He stated that during the Board meeting in August, ample time would be dedicated to this topic. Mr. Day also referred meeting attendees to the "Follow-Up on Anti-Obesity Medications (AOMs) Discussion From February 2024 Board Meeting and Current Events" memo (Ref. GIB | 05.23.24 | 10A) for additional information. Finally, he addressed his fellow Board members and encouraged them to consider questions they have on AOMs that they would like to have answered at the August meeting.

Ms. Sieg started her presentation by sharing the following expected learning outcomes:

- An understanding of how drug manufacturers, Pharmacy Benefit Managers (PBMs), third-party payers, drug wholesalers, pharmacies, and members all contribute to pharmacy benefits.
- An overview of the Board's pharmacy benefit
- The history and current landscape of the pharmacy benefit industry
- How federal and state laws impact pharmacy benefits

She shared a visual representation of the flow of prescription drugs, who all the players are, and their relationship to one another. She explained the following:

- Patients are the Board's members.
- Pharmacies are independent pharmacies, mail order pharmacies, specialty pharmacies, Walgreens, Kroger, and other statewide/nationwide chains.
- Third-party payers are the Board.
- PBMs are third parties administering pharmacy benefits, such as ETF's Navitus Health Solutions (Navitus).
- Manufacturers manufacture the drugs and there are several in the marketplace.
- Wholesalers purchase medication directly from drug manufacturers and then sell the medications to pharmacies. They have no direct relationship with PBMs, third-party payers, or patients.

Ms. Sieg provided an overview on drug manufacturers. Drug manufactures start the process of drugs getting to members. However, the preclinical research on possible new drugs begins many years before a member can have a prescription for any drug. This process involves testing thousands of compounds to find one that might be effective in treating a disease. This research can begin in a lab at a large drug company or in both public and private sector academic research centers. Of the thousands of compounds tested, 10 may make it to the clinical trial stage.

Clinical trials and human testing cannot begin until an Investigational New Drug Application (IND) is submitted by the drug company and receives approval from the

Food and Drug Administration (FDA). Once they receive the IND, the FDA can either grant permission to begin clinical trials or delay it due to safety concerns. This is also generally the time drug manufacturers seek and obtain patents on their drug's active ingredients. Clinical trials can take up to seven-and-a-half years or even longer.

Ms. Sieg explained the key phases of clinical trials. Phase 1 involves testing to see if a drug is safe; understanding any immediate side effects associated with increasing doses; how the drug is absorbed, metabolized, and excreted from the body; and requires 20-80 healthy volunteers.

Phase 2 includes drug safety and efficacy in people who have the condition the drug is trying to treat and consists of one group that receives the test drug and the other that receives a placebo.

Phase 3 involves hundreds to thousands of patients and are randomized, controlled, and blinded. After Phase 3, there should be enough evidence of the overall risk and benefit of the drug for the drug company to file a New Drug Application (NDA) with the FDA. Usually, the FDA prefers two Phase 3 trials before approval. However, there are some exceptions. For example, drugs that treat diseases and condition that do not already have cures in the market or drugs that are improvements of drugs already on the market may take an accelerated approval pathway. Upon receiving an NDA, the FDA has 60 days to decide if the application is complete or if more information is needed. If complete, the FDA has six months to review the application if the drug has been granted priority review; otherwise, it has 10 months for standard review. Once approved, a drug company can begin selling the drug to the public.

Phase 4 is sometimes required by the FDA and involves conducting trials to gather additional information about a drug's safety and clinical benefit after a new drug has been approved.

Ms. Sieg said that when a drug manufacturer applies for an IND, they seek patents on their drug's active ingredients. A drug patent is a 20-year period where the federal government allows a patent holder to exclude others from making, using, or offering to sell the patented issues. Patents allow brand-name drug manufacturers to prevent the creation of generic versions. Factoring in clinical trials, drug manufacturers will only have 12 years or less to sell the brand name before the patent ends.

Ms. Sieg explained that drug manufacturers may obtain dozens of patents for a single drug. Known as a "patent thicket," this is generally done to dissuade generic equivalents. However, the 1984 Hatch-Waxman Act established a shortened process for the FDA to approve generic drugs and compliments state laws, such as Wis. Stat. § 450.13. The savings between a brand-name drug and generic drug can be up to an 80-90% reduction in cost to the payer/member. The Hatch-Waxman Act also allowed generic drug manufacturers to challenge name-brand manufacturer patents. However, this has sometimes led to litigations and further delays of brand-name drugs. Ms. Sieg

reviewed several ongoing investigations and potential federal changes related to the manufacturing of generic drugs.

Ms. Sieg provided a glimpse into drug manufacturers and shared the 2022 and 2023 drug company revenues for four companies: Johnson & Johnson, Pfizer, Eli Lilly, and Novo Nordisk. In 2023, Johnson & Johnson had the highest revenue at $85 billion. She also shared that the top 30 revenue-generated drug companies in 2023 spent 23% of their revenue on research and development, with Johnson & Johnson leading in pharmaceuticals invention and Novo Nordisk on top in pharmaceutical innovation.

Ms. Sieg said that PBMs work with everyone when it comes to pharmacy benefits. They are often called “drug middlemen,” as they are the go-between for multiple groups. She said that the first PBM in the United States was founded in 1965. In 1974, the Employee Retirement Income Security Act (ERISA) allowed large employers, like the State of Wisconsin, to develop and deploy cost containment strategies for their population, including hiring PBMs to manage prescription drug benefits. Vertical integration of the PBM industry began in the 1970s, and by the 1990s, drug manufacturers, large health insurance companies, and national pharmacy chains started buying or establishing their own PBMs, which led to the current landscape in PBMs. The “big three” PBMs are CVS, Express Scripts, and Optum. In 2023, they held 79% of the pharmacy claims. PBMs have five functions for payers/patients: formulary design, utilization management, price negotiations, pharmacy network formation, and mail order pharmacy services.

Historically, there are two different PBM business models: the traditional (spread) and pass-through models. While some still adhere strictly to one or the other model, a growing number are a hybrid. Ms. Sieg said that the traditional model is the most popular, but the pass-through model is growing in use.

In the traditional model, the PBM is paid administrative fees (usually lower than in the pass-through model) for services, and clinical and analytics programs are provided at additional costs, with the PBM keeping a portion of rebates and other revenue sources. Transparency and access to contracts and records is limited in this model.

In the pass-through model, the PBM is paid administrative fees that may include clinical and analytics programs. All rebates and revenue sources are passed back to the payer, and there is full transparency and access to contracts with manufacturers and pharmacies.

A PBM provides lists of Maximum Allowable Cost (MAC) to both the payer and the pharmacy. The traditional model has multiple MAC lists that often exclude mail order and specialty distribution channels. The MAC list for pharmacy contracts tends to be at a lower cost, while the MAC list for payers tends to be at a higher cost, and payers are not always allowed to see the MAC list drug pricing. Meanwhile, the pass-through model only has one MAC list that applies to all retail, mail order and specialty distribution

channels. The pharmacy receives, and the payer pays, the MAC list cost for the drug, with payers receiving full disclosure of MAC list drug pricing for all drugs.

Ms. Sieg explained that rebates are agreements that PBMs make with drug manufacturers where the drug manufacturers give them money based on several distinct factors. In the traditional model, the PBM will share a portion of the rebate with payers but keep part of the rebate: the PBM keeps a portion of fees and incentives received from drug manufactures and manufacturer agreements, and pharmacy contracts are not always auditable by the payer. In the pass-through model, the PBM passes 100% of rebates to payers, payers receive all fees and incentives the PBM receives on behalf of members, and payers can view PBM's manufacturer and pharmacy agreements.

Ms. Sieg briefly touched on the different PBM-related initiatives in the most recent legislative session. Federal legislative initiatives included the PBM Transparency Act 2023, PBM Reform Act, PBM Accountability Act, Help Ensure Lower Patient Copays Act, and Prescription Pricing for the People Act. Meanwhile, state legislative initiatives included SB737/AB773 (PBM Accountability), SB718/AB747 (Creating a Prescription Drug Affordability Review), and SB100/AB103 (All Copays Count). She said that no federal or state initiatives had passed or were signed into law. However, state initiatives were likely to be reintroduced in the Wisconsin State Legislative session in January 2025.

Ms. Sieg said that while there is no direct relationship between third-party payers, such as the Board, and pharmacies, they both regularly interact with members. Pharmacies also have agreements with PBMs about prescription reimbursement and network participation. Some pharmacies, particularly independent pharmacies, belong to different Pharmacy Service Administrative Organizations (PSAOs), which negotiate contracts on their behalf. PSAOs give independent pharmacies the ability to bargain as a group with PBMs. The Board, as a third-party payer, then enters into an agreement with the PBM to administer the pharmacy benefit.

The Board currently pays the PBM an administrative fee, and the PBM passes on 100% of the rebates, except on rebates the PBM receives as part of a Group Purchasing Organization (GPO). On rebates received as part of a GPO, the PBM, charges a per-member-per-month fee (PMPM) as part of the administrative fee that gets deducted.

Ms. Sieg said that up until 2004, pharmacy benefits were part of insurance benefits (e.g., a member under Dean Health Insurance also had Dean pharmacy benefits). However, ETF's pharmacy benefit program now has the following attributes:

- Pharmacy benefits have been carved out from medical benefits.
- The Board's pharmacy benefit is a fully transparent, pass-through model.
- The Board pays monthly administrative fees, claims, e-health services, and member independent review fees.

- Members pay one premium for pharmacy, medical, and wellness.
- The Board's pharmacy benefit has two formularies: Commercial (non-Medicare) and Medicare/Employer Group Waiver Plan (EGWP).
- Non-Medicare members can participate in drug manufacturer coupon or co-pay assistance programs.

In reviewing the current pharmacy benefit for members on both the commercial plan and the Medicare/EGWP, Ms. Sieg said there is no deductible for the pharmacy benefit unless a member has a high deductible health plan (HDHP). She further explained the four tiers of the pharmacy benefit:

- Level 1 has a $5 copay and preferred generic drugs and certain lower-cost preferred brand name drugs.
- Level 2 tier has a 20% coinsurance ($50 max) and preferred brand name drugs and certain higher- cost preferred generic drugs.
- Level 3 has a 40% coinsurance ($150 max) and preferred non-preferred brand name drugs and certain high-cost generic drugs for which alternative/equivalent preferred generic and brand name drugs are covered.
- For commercial (non-Medicare) participants in a Level 4 tier, there was a mandatory $50 copay that included only specialty drugs filled at a preferred specialty pharmacy. In contrast, the Level 4 tier for Medicare members had a 40% coinsurance ($200 max) and had specialty drugs filled at a pharmacy other than a preferred specialty pharmacy.

As of 2023, there were 241,487 eligible participants, of which 201,590 used the pharmacy benefit, filling up almost 3 million prescriptions, with a total cost of $415,993,896 (including Board and participant costs). Between 2022 and 2023, the total cost for prescriptions increased while the number of members using the benefit decreased. Ms. Sieg said that so far in 2024, the trend is about 14.2% higher in EGWP claims and 9% higher in commercial claims. Most members get their prescriptions filled at retail pharmacies. The Covid pandemic saw an increase in mail order prescriptions, and that number has remained consistent.

Ms. Sieg finished her presentation by breaking down all the pharmacy concepts she discussed into "real money." She provided an example of how things would work from start to finish with markups, discounts, rebates, etc.

Ms. Thompson asked if Ms. Sieg knew why more people did not use the mail order. Ms. Sieg said she thought it had something to do with how the medication gets delivered. She believed some people have concerns with current mailing systems (FedEx, UPS, etc.). In addition, some drugs need to be climate controlled. There is also the benefit of going to see a pharmacist and ask questions directly. Ms. Sieg mentioned that ETF

does incentivize the use of mail order, and there has been an increase. Mr. Day asked if ETF's current mail order numbers were different from national trends. Ms. Sieg said they were not.

Mr. Pahnke commented that there appeared to be a 3.7% increase in total prescriptions filled between 2021 and 2023, and a 26% increase in total cost. He wanted to know if Ms. Sieg had any thoughts on this. Ms. Sieg said there are more specialty drugs coming to the market that are more expensive. She said that the number of drugs for diabetes in 2023 had increased by roughly 16.4%, and those drugs are particularly pricey.

2025 GROUP HEALTH INSURANCE PROGRAM (GHIP) AND UNIFORM DENTAL BENEFIT RATES

Health Plan Quality Credit (Ref. GIB | 05.23.24 | 4A)

Ms. Trigsted began her presentation by defining quality credit, an incentive used to help focus the attention of health plans on healthcare topics affecting members of the GHIP. She provided a 10-year history and highlighted the following changes:

- 2014: The quality report card was redesigned from previous iterations.
- 2018: The scoring methodology and star assignments were revised.
- 2019: Changes were made to address the disease burden and target areas with the most room for improvement.
- 2021: The number of measures were revised from 9 to 16 (Phase 1), as well as the scoring calculation methodology.
- 2022: Five additional measures were added (Phase 2).

Since 2018, ETF has used a small subset of measures from the National Committee for Quality Assurance (NCQA). These measures included some from the Healthcare Effectiveness, Data, and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) quality scores. Healthcare plans submit HEDIS and CAHPS data annually based on their total commercial book of business.

Ms. Trigsted said that last year in August, she presented on some planned changes for this year's 2025 plan year quality credit program. Most significantly, ETF transitioned the Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS) rates from the HEDIS to Data Analytics and Insights (DAISI) warehouse. In addition, ETF moved from the book of business submitted HEDIS measures to DAISI derived measures to better capture and understand the specific experience of members of GHIP. She also mentioned that the decision to eliminate the Childhood Immunization Status (Combo #10) was based on some feedback received from the health plans during discussions last summer.

Ms. Trigsted said that due to the early rate setting timeline, ETF has not yet received this year's HEDIS and CAHPS submission for the health plans. Therefore, all other measures beside BCS and CCS are based on data from 2022. She then reviewed the ranked results and noted that there was minimal percent changed from plan year 2024, as the only values that changed were the BCS and CCS screening rates. She said that the top performing health plan received a 1% credit applied to the final rates, and the credit was tapered down to a half percent for the fifth-place health plan. All plans were informed of their rating and meetings were offered to each.

Ms. Trigsted said that ETF will evaluate all measures included in the scoring of the quality credit to determine their continued usability, as new HEDIS and CAHPS data becomes available in June. Staff will continue to explore opportunities to add GHIP member-specific data, program quality measures, and other member experience measures. If any potential changes to measures are identified, ETF will solicit feedback from health plans prior to bringing recommendations to the Board.

Mr. Day asked what caused the shifts related to the two cancer screenings. Ms. Trigsted said that the cervical cancer screening measure moved from hybrid to derived, and data did align with their expectations based on analysis and discussion from last year. However, ETF did not have a specific explanation for the shifts.

Mr. Day followed up asking if the Board had any recourse for providing something additional if the screening drops below a certain level. Ms. Trigsted said that sustained drops would be more concerning versus year-over-year fluctuations. Mr. Day also observed that the size of the plans was not indicated in the data provided. Ms. Trigsted said that some values are not reported, and this happens when there is not an adequate sample size. As a result, the total score possible was lowered, which means that the smaller plans are not affected due to their size.

Mr. Pahnke asked how long the credit has been going on. Ms. Trigsted said she believed since 2014. He followed up by asking if all plans can earn the credit. She said everyone, except the Medicare population, can earn a credit. Mr. Pahnke asked what the remaining plans received. Ms. Trigsted said that roughly 0.87% and lower. Mr. Pahnke asked for confirmation that 2022 data was used to award 2025 credits. Ms. Trigsted answered that he was correct and reiterated that this was due to the shift in the rate-setting timeline and having one year of overlapping data.

2025 GHIP Rates and Qualifications (Ref. GIB | 05.23.24 | 4B)

Ms. Walk discussed ETF's negotiations process, which was similar to prior years but had moved three months earlier. The process included the following:

- Preliminary bids and utilized data were submitted by health plans, and bid tools were submitted by pharmacy and dental benefit administrators.
- Segal analyzed information and gave tiering recommendations.

- ETF met with health plans about changes needed to achieve Tier 1 status.
- Health plans submitted their best and final offers (BAFOs).

Ms. Walk said that Segal also reviewed county qualifications. Tier status and county qualifications tells ETF which plans are available in a county and whether a State Maintenance Plan (SMP) needs to be offered. Like last year, only Florence County had no qualified Tier 1 health plans, and an SMP was available for Florence County participants. In the Local program, SMP counties continued to rise for 2025 with 41 counties total and approximately 7,000 newly eligible Local members for SMP.

Ms. Walk showed a visual representation of the SMP county growth between 2024 and 2025. She said that Waushara and Waupaca County were no longer part of the SMP in 2025. While most members in the Local program are still in a county that has a qualified Tier 1 health plan, SMP is now available in the majority of counties.

Ms. Walk reviewed the Access and SMP contract terms, which included the following:

- Access and SMP plans were administered by a single vendor, Dean Health Plan.
- If loss ratios are lower than 90%, the vendor credits 50% of excess premium amounts to the Board.
- If loss ratios are above 90%, the Board pays 100% of the premium deficiency.
- This term may be reassessed for future Access/SMP contracts.

Ms. Walk said that loss ratios are currently above 90%.

Ms. Ruetten then went on to discuss ETF's current state of fiscal health and reserve balances. She explained ETF's reserve balances are considered as part of the rate-setting process and informs the Board of a projected reserve surplus or deficit to assist in the decision to use the reserves in premium setting. Actual balances are significantly lower than projected during the 2024 rate setting and remain below target.

Ms. Ruetten reviewed ETF's preliminary State and Local health insurance program rates as of Dec. 31, 2023. She said the numbers were not finalized for year-end as some pieces of that process were still ongoing. She said that the largest change in total percentage was in investment income. The core return in 2022 was 12.9% and, in 2023, it was 11.4%. However, looking at the total remaining numbers in both State and Local, the contribution and investment income combined was less than the benefit expense.

Ms. Ruetten said administrative fees can be broken into two categories: ETF administrative costs and wellness program costs. ETF administrative costs included staff salaries, compliance audits, actuarial services, and system costs (e.g. Insurance Administration System or IAS, Data Warehouse). Wellness program costs included wellness and disease management program administration, coaching, biometric

screening, and incentive payments. Ms. Ruetten showed the trend of health administrative fees, which is increasing to about 13% increase this year, similar to last year's change. She said this increase is driven by the IAS, and this trend is expected to continue as ETF is not ready to implement IAS. However, the hope is it will level out after the IAS go-live date. The current estimate for per contract cost could go up to $35 for both administrative costs and the wellness program costs.

Ms. Walk provided a summary of the 2025 rate increases. She highlighted the following:

- The State program's overall increase was 6.9% with a medical increase of 6.2%.
- The Local program's overall increase was 10.4% with a medical increase of 10.2%.
- Dental rates increased by 2%.
- Medicare advantage for both State and Local members increase was 37.9%.
- Pharmacy rates for State increased by 10.6%.
- Pharmacy rates for Locals increased by 11.5%.

Ms. Walk said that for active employees in the State program, there will be an increase of 5.8% for this year. (Premium share increases typically correlate with increases projected for the non-Medicare portion of the State program.) For active employees in the Local program, there will be an increase of 6.0-7.9% for non-SMP plans this year. (A calculation of 88% of the average premium of all Tier 1 health plans in the county is used, because employers cannot contribute more than this toward their employees' insurance per state law.)

Ms. Walk said a decision still needs to be made about the increase for Local SMP members because in counties where there is no Tier 1 plan, the SMP becomes the Tier 1 plan.

For Medicare-enrolled retirees, both the State and Local programs pay any changes to the premium directly and the increases are plan specific. Therefore, Ms. Walk shared the State range increase will be anywhere between 0.8–15% and the Local increase will be anywhere between 1.6–30.6%. In addition to the Medicare Advantage increase of 37.9%, Medicare Plus will also increase 5%.

Ms. Walk returned to the discussion of Local SMP rates. She said that the increase in enrollment and the early rate-setting schedule led to some challenges when setting premium rates for the group. She said they anticipate continued growth in SMP in 2025, with the addition of 11 more Local SMP counties. In addition, ETF's vendor, Dean, was unaware of the additional 11 counties until after they submitted their bid. Therefore, Dean's bid may not be sufficient to cover claims, leaving the Board liable for another large settlement in 2025.

Ms. Walk reviewed the Local SMP rates options. There were as follows:

- Local SMP Option 1: Pay Dean a higher rate increase than requested.
- Local SMP Option 2: Add a Plan Stabilization Charge (PSC) to the Local SMP premium.
- Local SMP Option 3: Make no changes to the Local SMP rate; adjust overall Local rate.

Local SMP Option 1 involved paying Dean a higher rate increase than requested, which would be approximately a 15% rate increase (above the 8.4% cap). She said the good thing about Option 1 is it would prefund any liability. On the other end, if there was a good year, ETF would only receive half of the excess back.

Local SMP Option 2 would add a Plan Stabilization Charge (PSC) to the Local SMP premium. Ms. Walk added that the PSC is a tool the Board has had for many years but hasn't used it since the 1990s. In Option 2, ETF would pay the rate to Dean, but would charge a full 15% increase to members. The additional money would go to the trust fund and then be used to pay any settlement. Ms. Walk explained that the benefit to Option 2 is that it would prefund any liability. However, it would increase Local rates and potentially setback Local budgets.

Local SMP Option 3 involved making no changes to the Local SMP rate, and the Board could only charge the overall 8.4% increase rate. Ms. Walk said the benefit to Option 3 is that ETF would continue to have a mechanism to refund the reserves and would not have to program a specific rate for Local SMPs.

Ms. Walk discussed the overall rate and reserve options. These were:

- Rate Option 1: Accept premiums with no stabilization increase.
- Rate Option 2: Add a stabilization increase, targeting low end of reserve range.
- Rate Option 3: Add a stabilization increase, targeting midpoint by 2026.
- Rate Option 4: Add a stabilization increase, targeting midpoint by 2027.

ETF's recommendation is that the Board choose Local SMP Option 3 and Rate Option 4. Ms. Walk said that with Option 3, the changes in the general premium stabilization increases proposed in Rate Options 2–4 were small versus the impact to the Local SMP rate. An inflated Local SMP rate will impact the 88% premium calculations done by Local employers to determine their premium share, increasing the amount of required contributions by Local employers. Ms. Walk said that ETF recommended Rate Option 4 due to the current funding levels of both reserve funds, future potential liabilities, and the Board's previously approved reserve fund policy.

If the Board chooses to go with Rate Option 1, and no stabilization increase was added, ETF recommends the Local SMP Option 2 to ensure funding for the Local program reserve.

Mr. Pahnke asked what the estimated percent increase was a year ago for ETF administrative expenses under the State plan, as he felt it was concerning that it went up 23.6%. Ms. Ruetten said she would have to look that number up and get back to the Board. Mr. Pahnke expressed his concern with health insurance administrative fees continuing to go up, potentially to $35. Ms. Ruetten said that ETF had outstanding costs related to IAS. Mr. Voelker added that this information had not been called out so directly in past meetings, but that ETF felt it was necessary to be transparent about those costs because of the upcoming changes and impact of modernization. Projects like implementing IAS are expensive and require resources to successfully complete.

Segal Presentation

Mr. Vieira provided an overview of Segal's presentation, including reviewing the medical, prescription, and dental plans and aggregate renewal, fund balance/reserve, and 2025 premium alternatives.

Mr. Klein said that medical renewals make up about 80% of the total premium spent. He began by discussing State Health Maintenance Organization (HMO) renewals. He said that several HMOs participate in the tier competition model. Segal sets the breakpoints each year. Mr. Klein highlighted the following:

- Dane County tier breakpoint increased by 5.8%.
- Non-Dane County tier breakpoint increased by 5.4%.
- The overall preliminary bid increase from inforce rates was 11.2%.
- After negotiations, all plans remained in Tier 1, making the total State aggregate increase 5.7%.

Mr. Klein discussed Local HMO renewals and highlighted the following:

- Four plans remained in Tier 1: GHC-SCW Dane Choice, Network, Quartz UW, and Quartz West.
- The overall preliminary bid increase from inforce rates was 16.9%.
- After negotiations, the total Local aggregate increase was 10.2%.
- The 10.2% may be less if members migrate into lower cost Tier 1 plans from those that had sizable increases and are no longer Tier 1.

Mr. Vieira said that there is less incentive in the Local plan to become a Tier 1. Mr. Klein spoke about Access Plan and SMP renewals. He said that Dean manages the Access

Plan and SMP, and rates increased at the rate cap of 8.4%. Dean initially proposed a 15.9% increase; however, the contract terms incentivize the Board to minimize rate increases to prevent paying Dean more than the 10% retention target. Mr. Klein said that the estimated settlement owed to Dean for 2023 claims is $9.2 and projected settlements for 2024 and 2025 are $6.5 million and $5.3 million, respectively.

Mr. Pahnke asked how many years the rate cap of 8.4% is in effect. Ms. Walk said she thinks it is year over year. Mr. Pahnke asked what the cap is for next year. Mr. Vieira responded that they are just receiving data and did not have a conclusive answer at that time. Mr. Pahnke asked if Segal was already projecting to lose more from the reserve in both State and Local. Mr. Klein said yes, and these amounts were built into the projections and, financially, it makes sense to exercise the cap. Ms. Walk returned to Mr. Pahnke's original question and added that the last year of the 8.4% rate cap would be 2025 according to the current contract. Mr. Day asked if the rate cap was specified in the contract and Ms. Walk confirmed it was.

Mr. Klein moved on to discuss SMPs. He said SMP is the designated Tier 1 plan in every county where there is no other qualified Tier 1 plan. In 2025, SMP will be offered in one county for State, Florence County, which is the same as 2024. However, SMP will be offered in 41 counties for Local in 2025, which is up 30 counties since 2024.

Mr. Klein highlighted the following regarding Medicare plans:

- UnitedHealthcare (UHC) administers the fully insured Medicare Plus plan for Medicare-eligible retirees and increased 5.0%.
- UHC also administers the fully insured Medical Advantage plan for Medicare-eligible retirees and increased 38%.

The renewal process resulted in a $85.7 million savings, which was a 4.8% reduction from between the 2025 Preliminary Bids and the 2025 Best and Final Offer Rates.

Mr. Klein discussed the prescription drug plan. He provided a comparison between GHIP and the historical pharmacy "top line" trend. He said the GHIP increases have been higher than normal over the past five years and are projected to increase 10.6% overall for State and 11.5% for Local from 2024 to 2025.

Mr. Pahnke asked what ETF was compared to on the graph (what data the Rx Trend Survey line represented). Mr. Klein replied that the line represented national numbers. Mr. Pahnke followed up by asking what his thoughts were on why ETF's increases have been higher than the norm over the past five years. Mr. Vieira responded by referencing Ms. Seig's comment about a larger demand for specialty drugs, which were more expensive. He said that traditional ETF rates have been lower, but rebate challenges have also contributed to the increase.

Mr. Day asked for clarification as to why ETF's rebates were not growing with the top line trend. Mr. Klein responded that it was unclear whether it was due to a rebate or top line issue. Mr. Day asked if ETF could follow up with Navitus to better understand why the rebates are a problem.

Mr. Klein briefly touched on the dental plan. He remarked that it continued to remain steady with a 2% increase.

Mr. Klein discussed the administrative increase of 13.4%. Adding administration, dental, prescription, and medical together, ETF was at a total State increase of 6.9% and a total Local increase of 10.4% for a total rate-to-rate increase of 7.4%. He said historically Segal has accounted for a 5% overall increase, so ETF is about 2% over target.

Mr. Vieira presented information on ETF's State fund balance/reserve. He reminded the Board that the fund balance decreased $104.6 million in 2023 because the entire surplus had been used. For 2024, Segal is projecting an additional $11.7 million fund balance decrease, which would result in a fund balance of $28.8 million.

Mr. Day asked what caused Segal's projection to change from the original $36 million to $28.8 million. Mr. Klein said they received updated pharmacy cost information on pre-rebates.

Mr. Vieira said that at the August 2023 Board meeting, Segal's projection was higher than the actual results, which caused the reserves to be lower than anticipated. Their projection was $63.5 million, and the actual was $40.5 million, creating a total 2023 reserve loss of $23 million. He broke down the State gains and losses as follows:

- Investment Income had a gain of $3.8 million.
- Pharmacy Experience had a loss of $15 million.
- Access/SMP Settlement had a loss of $7 million.
- Medical had a loss of $4.8 million.

Mr. Vieira said that medical losses were primarily administration related, and the settlement was an unexpected loss, as well. Segal's ending fund balance projection used ETF transactional data through Feb. 29, 2024, and ETF provides an investment income assumption of 6.5% used for 2024 and beyond. He said that the projected Dec. 31, 2024, balance was $67.7 million, making a total loss of $38.9 million. Mr. Klein said that the projection did include the settlement for 2024.

Mr. Vieira said that the situation was similar for the Local fund balance, but with smaller numbers. Segal originally projected a balance of $12.9 million but now are predicting $6 million, for a total loss of $6.9 million.

Mr. Pahnke asked why Segal had originally used a 6.7% investment income assumption but was now using 6.5%. Ms. Ruetten and Mr. Voelker said that SWIB had provided the 6.7% projection. In previous years, ETF had used the Wisconsin Retirement System (WRS) assumed rate but are getting away from this to be more specific. This is the second year ETF has used the 6.5% estimate.

Mr. Pahnke asked if Segal could also comment on why the assumed annual increased cost went from 5% to 6%. Mr. Vieira said that costs were so high over the last two years, and Segal expected costs to remain high.

Mr. Vieira moved on to discuss how Segal calculates reserves for medical, pharmacy, and dental across State and Local programs. He shared the projected fund balances for Dec. 31, 2024, and said that pharmacy is going to need to be reanalyzed. Mr. Vieira added that, based on the mid-point reserve target, the State has a deficit of $82.5 million and Locals have a deficit of $11.6 million. This means that both programs are under the lower boundary of the reserve target. He said that per last year's Board Approved Option 1, Segal recommends the State and Local programs continue the plan to get reserves within the target range. He added that historically there had been frequent buy-downs to move toward the Board Reserve Policy. However, 2024 had no buy-down because there was no projected surplus.

Mr. Vieira a breakdown of all the State options:

- State Option 1
    - No reserve build-up in 2025 – 6.9% renewal increase.
    - 2026 and 2027 have a 1.2% premium load to reach the Low-End Target Reserve by the end of 2027 (projected to be 6% without reserve build-up).
    - Rates Increase of 6.9% / 7.2% / 7.2%.
- State Option 2
    - Incrementally build-up reserve to reach the Low-End Target Reserve by the end of 2027.
    - 2025–2027 all include a 0.6% premium load to build the reserve.
    - Rate increases of 7.5% / 6.6% / 6.6%.
- State Option 3
    - Continue Board approved strategy of reaching Midpoint Target by end of 2026.
    - 2025 and 2026 include a 1.6% premium load to build the reserve.
    - 2027 increase mitigated by past premium loads as the rates realign with expenses.
    - Rate Increases of 8.5% / 7.6% / 2.9%.

- State Option 4
  - Incrementally build-up reserve to reach the Midpoint Target Reserve by the end of 2027.
  - 2025–2027 all include a 0.8% premium load to build the reserve.
  - Rate Increases of 7.7% / 6.8% / 6.8%.

Mr. Vieira then offered the following breakdown the Local options:

- Local Option 1
  - No reserve build-up in 2025 – 10.4% renewal increase.
  - 2026 and 2027 have a 1.2% premium load to reach the Low-End Target Reserve by the end of 2027 (projected to be 6% without reserve build-up).
  - Rate Increases of 10.4% / 7.2% / 7.2%.
- Local Option 2
  - Incrementally build-up reserve to reach the Low-End Target Reserve by the end of 2027.
  - 2025–2027 all include a 0.6% premium load to build the reserve.
  - Rate Increases of 11.0% / 6.6% / 6.6%.
- Local Option 3
  - Continue Board approved strategy of reaching Midpoint Target by end of 2026.
  - 2025 and 2026 include a 1.6% premium load to build the reserve.
  - 2027 increase mitigated by past premium loads as the rates realign with expenses.
  - Rate Increases of 12.0% / 7.6% / 3.0%.
- Local Option 4
  - Incrementally build-up reserve to reach the Midpoint Target Reserve by the end of 2027.
  - 2025–2027 all include a 0.8% premium load to build the reserve.
  - Rate Increases of 11.2% / 6.8% / 6.8%.

Mr. Klein then reviewed a final option:

- Local Option 4 with SMP Premium Stabilization Charge (PSC)
  - Incrementally build-up reserve to reach the Midpoint Target Reserve by the end of 2027.

- Includes an addition $0.7 million reserve build-up by increasing SMP Medical rate 15%.
- Rate Increases of 11.3% / 6.7% / 6.7% (11.1% for non-SMP rates).
- A 0.1% reduction from Local Option 4 for non-SMP rates.

Mr. Vieira went through all the State and Local options and the 2025 premium rate alternatives for each.

Mr. Pahnke referred to the Appendix section of Segal's slide deck and asked if they could speak about two statements. The first said, "The actual net prescription costs were higher than prior Navitus assumptions, yielding a loss." The second said, "The Navitus recast of 2024 and 2025 cost assumptions further drove the composite (State and Local) rate increase of 10.7%."

Mr. Klein said the first statement was looking at the actual experience in 2023 and how that differed from assumptions. Each year, Segal has their meeting with Navitus. Navitus provides updated cost assumptions at this meeting, which not only effect 2025 projections, but also update information for 2024.

Mr. Day addressed the Board about deciding which option to go with. He said that he was personally not a huge fan of just "kicking the can" and continuing to do nothing to build up the reserves. He said that his top choice was Option 4 for both State and Local to get to the Midpoint Target Reserve by the end of 2027. Mr. Pahnke agreed with ETF's recommendation to add a stabilization increases to State and Local Rates, targeting the midpoint of the reserve range by 2027; and not to separate Local SMP stabilization charge, but include in the overall increase for locals. Ms. Flogel said she thought that getting the reserve balance to a more comfortable place was important. She leaned towards State and Local Option 4 for this reason, as well. Mr. Keenan concurred. He observed that Option 4 spread out the rate increases more evenly than Option 2, so his preference was to go with Option 4. Mr. Day agreed that he also felt Option 4 helped spread things out better than Option 2.

MOTION: Mr. Pahnke moved to accept ETF's recommendation to approve the recommended health, pharmacy, and dental rates presented by the Board's actuary, Segal, for plan year 2025. ETF also recommends the Board approve Option 4, add stabilization increases to State and Local Rates, targeting midpoint of the reserve range by 2027, and Local SMP Option 3, to not add a separate Local SMP stabilization charge but include it in the overall increase for locals. Ms. Flogel seconded the motion, which passed unanimously on a voice vote.

MOTION: Ms. Thompson moved to approve ETF to make any additional, minor adjustments to health plan service areas after they are finalized. Mr. Fields seconded the motion, which passed unanimously on a voice vote.

The Board took a break from 10:28 a.m. to 10:38 a.m.

LOCAL PROGRAM INITIAL ANALYSIS (Ref. GIB | 05.23.24 | 5)

Ms. Larson said that the Board requested ETF to prioritize the Local GHIP as a strategic initiative due to premium increases and the concern that the program remained sustainable. In response, she said ETF gathered information and she was there to provide a little history, talk about ETF's efforts and progress, and give some initial options.

In February of 2021, Ms. Larson and Brian Stamm presented on an extensive memo to the Board about the local GHIP's current state, policy alternatives, and opportunities for improvement. She said ETF's primary recommendation was to improve marketing for the GHIP, as larger pools are more stable. In addition, they discussed talking more with the local advisory group created during the study and surveying Locals on changes to the plan designs. She said the memo found 11 other possible changes. One of these changes was a request from employers to give them rate renewal information before their budgets concluded in the summer. Ms. Larson said that ETF met this goal by setting rates at the current May meeting.

Ms. Larson said, given the concerns over the 2025 rate increases and the growth of SMP in the local GHIP, ETF believes it is time to reevaluate the options.

Ms. Larson summarized the current state of the Local GHIP. She said that ETF and Segal compared Local to State PMPM claim costs, ages, risk scores, and geographic cost differences in six regions. Overall, ETF discovered that Locals have a lower PMPM cost (-3.32%), are younger, have a worse risk score (+1%), and cover more dependents. She said the results of the analysis did not align with some health plan comments about the Local pool being worse than the State pool and a need for much higher rates for Locals.

Due to this, ETF talked with the plans. Ms. said ETF also asked for some limited input from Local employers. She used the word "limited" because they only completed a few targeted interviews. The plan is to conduct more interviews. ETF wanted to get a sense from a handful of Locals what their experience is but also what they want related to changes in the program. Ms. Walk highlighted the following overall discoveries:

- Employees like low out-of-pocket costs and provider choice.
- Cost is particularly important to employees, and many will change plans to have lower premium contributions.
- If Program Options were reduced from four, employers request a lot of lead time. They would explore all marketplace options.

Based on ETF's findings, they produced the following preliminary options for consideration:

- Sole-source or regionalized vendor options.
- Value-based plan designs or other innovative contracting.
- Dual plan offerings for local employers.
- Dedicate an ETF staff person to managing the local GHIP.

Ms. Walk asked the Board for any thoughts on ETF's discoveries and options. Mr. Pahnke referred to a section of the memo that said, "most Locals offer their employees richer plan designs than are offered to State employees." He asked if Ms. Larson or Ms. Walk could comment more on that, specifically what "most" and "richer" meant in this context. The richest option, she said, is Program Option 2 or the Traditional Plan. She said this plan is basically 100% coverage for medical services, except for some Medicare Advantage items, and there is a 20% coinsurance up to $500 max. In addition, she said that Program Option 4, or the Deductible Plan, (the plan is like Program Option 6 that most State employees have) is slightly richer because it has an upfront $500 individual $1,000 family deductible but then 100% coverage like the Traditional Plan. Ms. Larson said these are ETF's most popular program options.

Ms. Larson said that ETF has seen some interest in the HDHP and Program Option 6. When speaking with the Locals, they mentioned that they use the plans competitively to entice employees into their program.

Ms. Hillson asked if the percentage could be broken down into both employers and percentage of members. She then asked what ETF has seen in terms of increase for employers and members since the 2021 recommendation. Ms. Larson said she would follow up with the Board on that information. She said that growth has been slow. Ms. Walk said that the memo provided during the February Board meeting (Ref. GIB | 02.21.24 | 10J) reported that ETF's largest change was a 4.6% increase in the number of employers in 2023.

Ms. Larson mentioned that during discussions with a few Locals in the course of investigating options for the Local GHIP, participating Locals expressed interest in offering the HDHP design alongside another benefit design, like the State does. The State offers the It's Your Choice Health Plan alongside the HDHP to employees. It should be noted that most participating Locals offer either the Traditional or Deductible plan designs. Mr. Day asked what it would mean to offer the two State options side-by-side — how significant of a change would that be. Ms. Larson provided the following actuarial factors that show the relative value of current plan designs that are offered to Locals:

- Traditional Plan is 1.0.
- Deductible Plan is 0.92.

- It's Your Choice Health Plan is 0.94.
- High Deductible Health Plan is 0.81

Ms. Larson said that those numbers have not been examined in several years. ETF has discussed with Segal if it is time to adjust those, but that has not been done yet.

Mr. Day asked if Ms. Larson remembered the concern Locals had several years ago about eliminating Option 4 even though Option 6 is similar. Ms. Larson said part of it is that you go from one upfront deductible to a lot of office visit copays. In addition, there is a slight cost increase to the employer for Option 4. Mr. Day said that it sounded like there was an educational component to potentially making this shift, which makes sense given that part of the feedback received was having plenty of lead time.

Ms. Day addressed the Board and asked if there were any further questions. He requested all options remain on the table for future discussion.

Ms. Thompson asked if there was a timeline in place. Ms. Walk said that part of this process is going to be a request to release information. Right now, further discussion is scheduled for the August Board meeting but may be pushed to November depending on how much information ETF is able to gather between May and August.

INTERNAL AUDIT REVIEW OF HEALTH INSURANCE PROGRAM (Ref. GIB | 05.23.24 | 6)

Ms. Williams began by providing background on what the review looked at. She said that quarterly reports are submitted by the health plans for performance standards metrics and cover claim processing, customer service, and enrollment file, and ID card generation. In addition, she said that health plans are in compliance with reporting and terms of the program agreement with each report.

Ms. Williams said that OSHP management requested the OIA review and said that the selection of most audits is around risk assessment. However, management can request a process review for feedback and ways to improve. This was what prompted the GHIP Performance Standards audit. The review period was January 2022–March 2023 and reviewed the following areas:

- Reporting to GIB: Verified accuracy of GIB summary reports.
- Penalties and Waivers: Ensured a penalty was assessed, or a waiver was granted and approved by OSHP Leadership when a performance measure was not met.
- Validation of Health Plan Reports: Recalculated the performance standards using the health plans' data to validate the results submitted.

Ms. Williams said there were errors in all but one of the quarterly reports. These errors included transposing of numbers and other errors. She commented that compiling the reports is a manual process, and with any manual process, there is a higher risk for error. She said the errors were corrected, and OIA recommended that in the future, a secondary review of the GIB quarterly summary report of the Performance Standards be performed to verify that the performance standards reported by the health plans are accurately included in the GIB report. Ms. Williams said that OSHP is working on a process to automate the compiling of the report, which should reduce the number of errors as well as increase efficiency. Ms. Williams said that all penalties and waivers were assessed or waived appropriately.

Ms. Williams moved on to discuss the validation of health plan reports. She shared the following findings:

- 10 out of 11 health plans provided their report data.
- There were methodology differences between health plans.
- No recalculation exceptions in 3 out of 10 health plans reviewed.
- One penalty assessed because of OIA review.

She said there were some performance standards OIA was unable to calculate because the health plan either did not have the information available or the data provided was not sufficient for the testing. Based on the findings, OIA recommended a periodic review of the performance standards submitted by the health plans and use of updated wording to define how the performance standards were calculated. OIA also suggested adding a penalty for supporting documentation that was not provided timely or accurately.

Ms. Williams said that OSHP plans to include this penalty in the 2026 program agreement and has agreed to OIA’s suggestions.

Ms. Thompson asked if there was anything to ensure that a plan provide data since one plan refused to do so. Ms. Williams said that plan had concerns related to the confidentiality of its data. OIA did not feel that the data requested would breach HIPPA/privacy laws, but the plan still denied release of the data. She mentioned that including a penalty moving forward would help ensure health plans provided data on time.

Mr. Pahnke asked if the health plan still had not submitted data by the time of the meeting. Ms. Williams said they had not, but that OSHP had been in further contact with them about it. Mr. Pahnke asked OSHP what the plan was moving forward. Mr. Stamm said that contractually, there is nothing that can be done at this time, which is why OSHP is looking to update the contract in the future.

Mr. Day asked what specifically was meant by a regular basis when it came to reviews. Ms. Williams said that it is to be decided, but the intent is that the reviews happen more frequently than they have in the past.

LIFE INSURANCE OPEN ENROLLMENT FOR JANUARY 2026 (Ref. GIB | 05.23.24 | 7)

Mr. Rasmussen began with a background of the life insurance program. He explained how Wisconsin State Statute, Administrative Code, and the policy between the Board and Securian governed the Wisconsin Public Employers Group Life Insurance Program (Program). The Board is the policy holder and responsible for the Program's oversight, and Securian underwrites and assists ETF with administration. Mr. Rasmussen said that there are five levels of coverage that a state employee can take. He highlighted two, Basic and Supplemental. He said each coverage equals one times a person's highest salary rounded up to the next thousandth. Mr. Rasmussen said that the Local plan is similar, but the current proposal was for the State plan only.

Mr. Rasmussen reviewed eligibility and enrollment and highlighted the following:

- Eligible employee is defined per Wis. Stat. § 40.02(25)(a) or (c).
- Eligible employees may enroll with guaranteed issue with timely application.
- Eligible employees may enroll or increase coverage due to a qualified family change event.
- An application can be sent through Evidence of Insurability (EOI) at any time.

Mr. Rasmussen explained that the University of Wisconsin (UW) has historically offered separate life insurance policies in addition to the Program. However, about a year ago, UW expressed interest in eliminating several life policies with the goal of simplification and utilization of IAS. UW asked ETF to examine the possibility of offering a one-time special enrollment to the Program for employees who were losing coverage. ETF discussed this possibility and considered multiple options with Securian. The best option was a one-time enrollment opportunity for *all* eligible, active state employees with an effective date of Jan. 1, 2026. This aligned with the 2025 open enrollment period.

However, this option was contingent on the successful implementation of IAS. Mr. Rasmussen commented that without IAS implementation, the influx of applications would not be manageable.

Mr. Rasmussen went on to explain coverage and eligibility. Enrollment would be open to all eligible, State active employees with the following stipulations:

- Employees can enroll in coverage or increase their insurance coverage by one level.
- Employees already at five times coverage will not be able to increase coverage.

- Employees 70 years and older can enroll in the already existing additional coverage by one level.
- Does not apply to spouse or dependent coverage.

Mr. Rasmussen reiterated that IAS would make this open enrollment possible. In addition, aligning it with the 2025 It's Your Choice open enrollment period would increase awareness, be convenient for employees already accessing the system and materials, and help employees think about their total benefit package.

If approved by the Board, Securian projected a 7.5% enrollment growth, an increase of employer-paid premiums of $400,000 annually, and an increase of employee-paid premiums of $1.2 million annually. Mr. Rasmussen said that the growth should have negligible impact to funding valuation and should strengthen the plan long term by increasing membership and premiums.

Ms. Flogel asked if an employee currently has coverage through the Program and they chose not to take any action, will they lose their coverage or will it remain the same. Mr. Rasmussen confirmed that no loss of coverage would occur in this situation.

Ms. Hillson asked if Mr. Rasmussen could share the number of Local employers that participate and explain the justification for providing an open enrollment for all State employees but not expanding it to Locals. Mr. Rasmussen said there are approximately 755 Local employers, and it came down to this being more of a test run. If this proves to be successful, Mr. Rasmussen said he may address the Board again in two years to implement this for Local employers. ETF decided to focus on the State given UW's request and since the Local and State plans are financially separate, there is no effect to Locals.

> ***MOTION: Mr. Fields moved to approve an open enrollment for the State Life Insurance Plan for the plan year beginning Jan. 1, 2026, contingent on the successful implementation of IAS. Ms. Flogel seconded the motion, which passed unanimously on a voice vote.***

LIFE INSURANCE PREMIUM EFFECTIVE DATE MODIFICATION AND ANNUITY EFFECTIVE DATE CHANGE (Ref. GIB | 05.23.24 | 8)

Mr. Rasmussen began by discussing the life insurance premium effective date change. Under the current model he highlighted the following:

- The State and Local Plan are similar in benefits but financially separate.
- Employers report employee's earnings from the previous year to ETF by Jan. 31.
- ETF provides earnings to Securian, which are used to update coverage amounts.
- Updated premiums go into effect on April 1 for State and July 1 for Locals.

The proposed change would align the State and Local premium effective date to April 1. Mr. Rasmussen explained that IAs made this proposal possible, which was the reason for bringing it to the Board for consideration. Currently, the process is manually intensive and impossible to complete without the two plans being staggered. However, with the implementation of IAS, he said the process will become more automated. This change will not only align the State and Local premium effective date, but it will also more closely align the benefit amount and the premium billing date. In addition, Mr. Rasmussen said the change would minimize the complexities of IAS configuration.

Mr. Rasmussen said that the impact to Local employers should be minimal, with no significant impact to the funding. ETF reached out to Local employers for feedback through the ETF update in November or December and by sending 757 surveys in December. There was a 48% response rate on the survey and 79% of respondents felt the change would not cause an adverse impact for them.

Mr. Rasmussen said that the most common concerns were that the change will require additional resources and it may be difficult to plan for budgets as the date does not align with their fiscal year. Mr. Rasmussen also said that 12% of respondents requested moving the life insurance premium effective date to Jan. 1. However, this is not possible due to timing. Mr. Rasmussen said that premiums will still be decided at the August Board meeting, which will give Local employers six months to plan.

If approved, Mr. Rasmussen said ETF will heavily promote the awareness of the change in the following ways:

- ETF Updates.
- IAS Employer Education Workgroups.
- ETF Employer News.
- ETF Employee News.
- ETF website.

Mr. Rasmussen moved on to discuss the change in the timeframe for retirees to begin their annuity to automatically continue life insurance. Under the current policy, eligible retirees have up to 31 days after their coverage ends to begin taking their annuity to have life insurance continue automatically. Premiums are taken from the retiree's annuity. If an employee does not immediately begin their annuity, they can file an application with ETF to continue their life insurance, and retirees are billed directly. The proposed change would modify the program's contract and policy language to reduce by one the number of days (from 31 to 30 days) allowed for a retiree to begin their annuity to have their life insurance continue automatically. Mr. Rasmussen said that the change would make it consistent with ICI and the health insurance policy, in addition to easing the administrative complexities and IAS configuration.

If approved, Mr. Rasmussen said that ETF planned to communicate the change through member and employer newsletters, ETF updates, updating the administrative manual, and IAS.

MOTION: Mr. Pahnke moved to approve the following changes to the Program:

- ***Modify the Local Plan premium rate effective date to April 1 instead of the current date of July 1. This change would be effective April 1, 2026, contingent on the implementation date of ETF's Insurance Administration System IAS.***
- ***Modify the Program contract and policy for retirees whose life insurance will automatically continue when taking an immediate annuity to 30 days from the date coverage ends. The change would be effective immediately following the implementation of ETF's IAS.***

Mr. Fields seconded the motion, which passed on the following roll call vote:

Ayes: Day, Fields, Flogel, Hillson, Houdek, Keenan, Lounsbury, Pahnke, Thompson.

Nays: None.

Absents: Ugoretz.

ACCEPTANCE OF STATE AND LOCAL INCOME CONTINUATION INSURANCE (ICI) ACTUARIAL VALUATIONS (Ref. GIB | 05.23.24 | 9)

Mr. Guidry began by providing a review of ICI premium rates history between 2021 and 2024. He said that the Local program has been in a premium holiday since 2012. Prior to 2021, the Board adopted a series of rate hikes for the State program, ending in 2020. He stated this eliminated a significant actuarial deficit. Since then, ETF has been able to avoid premium increases in the State plan.

Mr. Guidry explained that the scenario ETF recommends would continue to finetune the State's ICI premium rates, and this aligns with the Board's preference to avoid large swings in the ICI premiums from year to year. He said the target reserve range policy was adopted for both the State and Local plans in 2019 and reviewed with no changes made in 2022. It will be up for review once more in 2025.

Mr. Guidry reviewed several recent changes in the ICI program. In 2023, program eligibility was expanded beyond age 70. This year, the following has occurred:

- Increased standard income coverage to $120,000, which eliminated Supplemental coverage.
- Simplified premium rate tables.

- Shifted premium effective date to April 1.

ETF is in discussion with Hartford renegotiating its annual administrative fee of $2.6 million. The new administrative fee should take effect in 2025.

Mr. Guidry turned the presentation over to Mr. Berube and Mr. Correia. Mr. Correia discussed actuarial valuation assumptions Milliman used this year. He said that the ICI program provides monthly income benefits to participants who become disabled, and those benefits continue until either recovery, death, or the end of the benefit period. Mr. Correia said that participants may qualify for benefits from other sources. He said Milliman has developed assumptions for estimating liabilities that include probabilities related to recovery and death, as well as estimated offset assumptions. He said the same claim termination rate and estimated offset assumption as last year was applied, but that updated assumptions for computing liabilities for incurred but not reported (IBNR) claims were used. For State ICI, the prior IBNR factor was 25%, but the current factor is 17%. For Local ICI, the prior IBNR factor was 25% but the current factor is 26%.

Mr. Correia shared the State ICI valuation estimated liabilities as of Dec. 31, 2023, and included estimated liabilities for open claims, IBNR claims, the loss adjustment expenses across the standard benefit, supplemental benefit, and the $75 add-on fee. The total liability was as follows:

- Open Claims: $78,067,082
- IBNR Claims: $2,773,094
- Loss Adjustment Expense: $4,254,193
- Grand Total: $85,094,369.

Mr. Correia said that the total liability under supplemental benefits will be reduced in future evaluations because the Board eliminated the supplemental benefits option. However, there are still some people receiving supplemental benefits as part of their ICI claim and will continue to receive supplemental benefits until their benefits terminate. Compared to the prior year, Mr. Correia said the total liability decreased by 3.6% from $88.3 million as of Dec. 31, 2022, to $85.1 million as of Dec. 31, 2023.

Mr. Correia then turned the presentation over to Mr. Berube. Mr. Berube showed a comparison between the State ICI valuation reserve balance and actuarial liabilities over the past couple of years. He reported the following as of Dec. 31, 2023:

- Reserve Balance: $172,458,596
- Actuarial Liability: $85,094,369
- Surplus / Deficit: $87,364,227

- Reserve Ratio: 203%
- Reserve Balance Percent Change: 6%
- Target Reserve Ratio Policy: 130% to 140%.

His presentation showed that the State ICI reserve increased by $9.3 million between Dec. 31, 2022, and Dec. 31, 2023, and as of Dec. the reserve balance is equal to 203% of the actuarial liability. Mr. Berube explained that because the current reserve ratio is high, there are some opportunities to employ some rate cuts. He provided the following scenarios:

- Baseline Scenario: 2024 contribution rates are held level in future years.
- Scenario 1: Contribution rates are reduced by 10% in 2025 and again in 2026, then held level in future years.
- Scenario 2: Contribution rates are reduced by 10% in 2025 and again in 2026, then held level in future years. Assumed investment income of -15% in 2024.
- Scenario 3: Contribution rates are reduced by 20% in 2025 and then held level.
- Scenario 4: Contribution rates are held level in future years. Assumed investment income of -25% in 2024.

He showed the projected fund ratios for each scenario through 2029.

Mr. Day referred to the baseline scenario for 2025 that showed premium contributions at $16,966,362. He asked why, if applying Scenario 1 at a 10% reduction, the premium only goes down 7.5%. Mr. Correia said Milliman reflects the premium rate effective date of April 1 in their projections.

Mr. Correia summarized the Local ICI valuation estimated liabilities as of Dec. 31, 2023, and includes estimated liabilities for open claims; IBNR claims; and the loss adjustment expenses across the standard benefit, supplemental benefit, and $75 add-on fee. The total liability was as follows:

- Open Claims: $6,546,361
- IBNR Claims: $505,510
- Loss Adjustment Expense: $466,290
- Grand Total: $7,518,161.

Compared to the prior year, Mr. Correia said the total liability decreased by 8.3% from $8.2 million as of Dec. 31, 2022, to $7.5 million as of Dec. 31, 2023.

Mr. Berube again showed a comparison between the Local ICI valuation reserve

balance and actuarial liabilities over the past couple of years. He reported the following as of Dec. 31, 2023:

- Reserve Balance: $43,924,074
- Actuarial Liability: $7,518,161
- Surplus / Deficit: $36,405,913
- Reserve Ratio: 584%
- Reserve Balance % Change: 1.6%
- Target Reserve Ratio Policy: 140% to 155%.

His presentation indicated that the Local ICI reserve balance is equal to 584% of the actuarial liability, and the funding analysis indicated the premium waiver can be continued for the near future.

Mr. Correia said that this year Milliman worked with ETF to get some more data on participation in the Local plan, and it appears participation has increased over time.

Ms. Thompson asked for some historical background on how the Local program became that high. Mr. Guidry suspected it had something to do with the volatility of the program. He said because it is a small program, it can be difficult to estimate what the actual results are going to be. In addition, he said that in the past, there was no reserve target.

MOTION: Ms. Thompson moved to accept the State and Local ICI Actuarial Valuations as of Dec. 31, 2023. ETF also recommends the Board adopt Scenario 1 for the State ICI plan, which would reduce current premium rates by 10% for the 2025 plan year and by 10% for the 2026 plan year and also adopt the Baseline Scenario for the Local ICI plan, resulting in a continuation of the premium holiday in the 2025 plan year. Mr. Fields seconded the motion, which passed on the following roll call vote:

Ayes: Day, Fields, Flogel, Hillson, Houdek, Keenan, Lounsbury, Pahnke, Thompson.

Nays: None.

Absents: Ugoretz.

OPERATIONAL UPDATES

- Follow-Up on Anti-Obesity Medications (AOMs) Discussion from February 2024 Board Meeting and Current Events (Ref. GIB | 05.23.24 | 10A)
- Follow-Up on the 2024 Open Enrollment Results (Ref. GIB | 05.23.24 | 10B)

- 2024–2026 Strategic Initiatives Update (Ref. GIB | 05.23.24 | 10C)
- State of Wisconsin Group Health Benefits Annual Report 2023 (Ref. GIB | 05.23.24 | 10D)
- 2023 Health Plan Performance Standards Report (Ref. GIB | 05.23.24 | 10E)
- Insurance Administration System (IAS) Update (Ref. GIB | 05.23.24 | 10F)
- 2023 Annual ICI Program Report (Ref. GIB | 05.23.24 | 10G)
- GHIP Dashboards (Ref. GIB | 05.23.24 | 10H)
- Board Authority Contracts Updates (Ref. GIB | 05.23.24 | 10I)
- Board Correspondence (Ref. GIB | 05.23.24 | 10J)
- Legislative Update (Ref. GIB | 05.23.24 | 10K)
- Ombudsperson Services 2023 Annual Case Report (Ref. GIB | 05.23.24 | 10L)
- 2023 Health Plan and PBM Grievance and Independent Review Report (Ref. GIB | 05.23.24 | 10M)
- Quarterly Audit Report of all OIA Activities (Ref. GIB | 05.23.24 | 10N)

Mr. Day asked the Board if they had any questions during the August meeting related to AOMs. Mr. Day said he would like to see more of a range of data/studies versus a best estimate from Segal. In addition, he wanted to know what type of benefit offset would be necessary to cover AOMs — what would the deductible need to change to?

Ms. Thompson wanted to know more about other state's experiences with AOMs, any updates related to the different types of AOMs coming out, and why rebates stopped in some areas.

Mr. Keenan wanted to know how the Board and ETF should factor in the cost of AOMs versus savings on health plans, while complying with State Statute.

Mr. Day asked if there were any other questions or comments related to the other Operational Updates provided in the meeting materials.

TENTATIVE AUGUST 2024 AGENDA (Ref. GIB | 05.23.24 | 11)

Ms. Walk briefly reviewed the tentative agenda for August. This includes the following items:

- Healthcare Market Update
- Life Insurance Annual Report
- RFP Updates
- IAS Update
- Board Initiative: Local Plan Analysis
- System and Organization Controls (SOC) 2 Guidelines

- Pilot Programs Review
- Weight Loss Drug Analysis
- Educational Item: RFP Process.

Mr. Pahnke asked if the Board needed to vote on the new IRS deadlines. Ms. Walk said no but the Board would receive updates to any changes going forward.

MOVE TO CLOSED SESSION

Mr. Day said that the Board would meet in closed session to get an update on information security contract requirements.

MOTION: Ms. Thompson moved to approve moving to closed session pursuant to the exemption contained in Wis. Stat. § 19.85 (1) (d) to consider strategy for crime detection or prevention. If a closed session is held, the Board may vote to reconvene in open session following the closed session. Mr. Fields seconded the motion, which passed on the following roll call vote:

Ayes: Day, Fields, Flogel, Hillson, Houdek, Keenan, Lounsbury, Pahnke, Thompson.

Nays: None.

Absents: Ugoretz.

The Board convened in closed session at 12:10 p.m.

The Board returned to open session at 12:48 p.m.

ANNOUNCEMENT AND VOTE ON BUSINESS DELIBERATED DURING CLOSED SESSION DISCUSSION

Announcement on Business Deliberated During Closed Session Discussion

Mr. Day announced that the Board met in closed session to receive an update on information security contract requirements.

Vote on Information Security Contract Requirements

MOTION: Ms. Flogel moved to temporarily suspend the motion made at the November 2023 Board meeting regarding SOC 2 requirements in order to further refine the motion and overall approach, and request that ETF report back on acceptable security alternatives in August. Mr. Fields seconded the motion, which passed on the following roll call vote:

Ayes: Day, Fields, Flogel, Hillson, Houdek, Keenan, Lounsbury, Pahnke, Thompson.

Nays: None.

Absents: Ugoretz.

ADJOURNMENT

MOTION: Ms. Thompson moved to adjourn the meeting. Mr. Fields seconded the motion, which passed unanimously on a voice vote.

The meeting adjourned at 12:50 p.m.

Date Approved: _____

Signed: _____
Nancy Thompson, Secretary
Group Insurance Board