DRAFT

# MINUTES

**August 14, 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. – 11:33 a.m.

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**BOARD MEMBERS PRESENT:**

Herschel Day, Chair
Nancy Thompson, Secretary
Dan Fields
Jen Flogel
Erin Hillson*
Brian Keenan
Katy Lounsbury*
Brian Pahnke
Jennifer Stegall†
Nathan Ugoretz*

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**PARTICIPATING EMPLOYEE TRUST FUNDS (ETF) STAFF:**

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

**Bureau of Information Security Management:**
David Maradiaga, Chief Information Security Officer

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

**Office of Policy, Privacy and Compliance:**
Steve Hurley, Director

**Office of Strategic Health Policy (OSHP):**
Renee Walk, Director
Brian Stamm, Deputy Director
Jessica Rossner, Data and Compliance Unit Director
Tom Rasmussen, Life Insurance and Dental Insurance Program Manager
Tricia Sieg, Pharmacy Benefits Program Manager
Douglas Wendt, Supplemental Plans Program Manager
Luis Caracas, Health Plan Policy Advisor

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**OTHERS PRESENT:**

**Office of the Secretary:**
Pam Henning, Assistant Deputy Secretary

**ETF Staff:**
Shellee Bauknecht*, Laura Brauer, Julie Coleman*, Taylor DeBroux, Travis Dillon*, Liz Doss-Anderson,

* Attended virtually.

† Commissioner of Insurance, Nathan Houdek's, designee.

| Board | Mtg Date | Item # |
| --- | --- | --- |
| GIB | 11.13.24 | 2A |

**ETF Staff (Cont.):**
Omar Dumdum*, Molly Dunks, Diana Felsmann, Sheila Gubin*, Dan Hayes, Michelle Hoehne*, Tarna Hunter, Bruce Johnson*, Joanne Klaas*, Cindy Klimke*, Brittney Kruchten*, Mark Lamkins, Arlene Larson, Rachel Leisemann Immel*, Kadi Mbanefo*, Peggy McCullick, Laura Patterson, Peter Rank, Marie Ruetten*, Shraddha Shrivastava*, Yikchau Sze*, Sarat Tadi*, Stephanie Trigsted, Barry Tucker, Xiong Vang, Mee Wartgow*, Korbey White, Wade Whitmus*, Amanda Williams*, Kathryn Young, Julie Zheng*
**Aspirus Health Plan:**
Megan Umnus*
**Capital Results:**
Greg Mills*
**City of Watertown, WI:**
Lisa Schwartz*
**Common Ground Healthcare Cooperative:**
Melissa Duffy
**Dean Health Plan:**
Katie Beals, Penny Bound*, Olivia Peterson, Maria Schneider*
**Delta Dental of Wisconsin:**
Megan Wohlfeil*
**Department of Administration (DOA):**
Dana Gehrmann*, Mary Hasselquist*, Joe Kelly*, Jennifer Kraus*, Meghan McKenna*, Julie Perry*, Derek Sherwin*, Danielle Tesch*, Lisa Tesch*,Tina Updike*
**Department of Military Affairs:**
Sheilagh Lochner*
**Elevance Health:**
Elisabeth Portz*
**Eli Lilly and Company:**
Amanda Bemmels*, William Reid*
**Group Health Cooperative of Eau Claire:**
Christina McConaughey*, Sarah North*
**Group Health Cooperative of South Central Wisconsin:**
Tammy Adler*
**HealthChoice Insurance Solutions:**
Bob Pearson*, Gary Praznik
**Health Partners:**
Kyle Long*, Elizabeth Tobias*
**Hubbard Wilson and Zelenkova, LLC:**
Dan Romportl*
**Merative:**
Oladipo Fadiran
**MercyCare Health:**
Reid Buerer*, Marc Dinnel*, Karol Frame*, Betsy Fulmer*, Dana Horner*, Michael Lorhan*, Eric Quivers*, Shelly Rick*, Sherrie Sargent*, John Trochlell*
**Michael Best Strategies:**
Adam Barr*
**Navitus:**
Steven Alexander*, Felicia Weihert*
**Network Health Plan:**
Vanessa Cagal*, Chantel Guyette*, Jesse Warner*
**Novo Nordisk:**
Stacy Hintzman*, Dave Moody*
**Quartz:**
Brittany Coyne*
**Reuters:**
Chad Terhune*
**Securian:**
Kjirsten Elsner, Hans Larsen
**Security Health Plan:**
Angela Pero*
**UnitedHealthcare:**
De Arcy Raybuck*
**UW Health:**
Emily Fairchild*, Annette Phelps Revolinski*
**UW-Madison:**
Marissa Isensee*, Karly Oppliger*
**UW System Administration:**
Brianne Jobke*, Erin Schoonmaker*, Amanda Sonnenburg*
**UW-Stout:**
Jo Johnson*

**WebMD:**
Emily Rosetter*
**Wisconsin Association of Health Plans:**
HJ Waukau

**Wisconsin Health News:**
Sean Kirkby*
**Public:**
Jack Lawton*, WisconsinEye*
**Others (Unidentified):**
12 individuals connected via telephone

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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:

- She welcomed Jen Stegall who was joining the Board for the meeting as Nathan Houdek's designee and the Office of the Commissioner of Insurance (OCI) representative.
- The Director position for OSHP had been filled by Renee Walk.
- Brian Stamm, OSHP Deputy Director, would be departing from ETF to pursue a career opportunity in the healthcare industry. He was leaving ETF in good hands and was actively transitioning his responsibilities with the Insurance Administration System (IAS) to other members of the project team.

Ms. Walk made the following announcements:

- Navitus and ETF were actively monitoring the status of Walgreens store closures that were reported in early July. ETF had asked Navitus to provide network maps to ensure there is still coverage in the affected areas for members.
- The three Request for Proposals (RFPs) were in progress, and a review of the proposals that had been received was underway. Results would be provided to the Board at upcoming meetings.

**CONSIDERATION OF OPEN AND CLOSED MINUTES OF MAY 23, 2024, MEETING**
(Ref. GIB | 08.14.24 | 2A)

***MOTION: Mr. Pahnke moved to approve the open and closed minutes of the May 23, 2024, meeting as presented by the Board Liaison. Ms. Thompson seconded the motion, which passed unanimously on the following roll call vote.***

***Ayes: Day, Fields, Flogel, Hillson, Keenan, Lounsbury, Pahnke, Stegall, Thompson, Ugoretz.***

***Nays: None.***

***Absents: None.***

**MERGERS AND ACQUISITIONS IN THE HEALTHCARE MARKET** (Ref. GIB | 08.14.24 | 3)

Mr. Caracas presented some background information on healthcare consolidation. He explained that healthcare consolidation often refers to hospitals and other healthcare entities joining under common ownership through a merger or acquisition. He explained three main types of mergers:

- Horizontal mergers occur when entities offering similar services consolidate, thereby enabling peer hospitals and/or health systems to reduce expenses by sharing services, staff members, and other resources.
- Vertical mergers occur when one healthcare organization purchases another offering different health care services to access new patients and sources of revenue. An example would be a hospital acquiring physician practices that are highly sought after.
- Cross-market mergers occur when there is consolidation between two providers that offer patient care in different geographic markets, such as when two health systems operating in different markets merge or when a healthcare system acquires an independent hospital in a market in which it does not currently operate.

Mr. Caracas noted that other forms of consolidation include private equity investment in healthcare and healthcare entities forming affiliations without changing ownership. The former is a for-profit ownership that involves private parties investing in healthcare facilities, while the latter is often referred to as a soft consolidation, where groups of doctors, hospitals, or other providers collaborate and share accountability for cost and quality of patient care or agreements on a joint venture (e.g., a new ambulatory surgery center).

According to Mr. Caracas, proponents of mergers and acquisitions argue that they reduce health care expenses and create financial stability for healthcare delivery, drive better quality through sharing of best practices, and improve access to rural and underserved communities. They can also be driven by federal policies and programs.

Some of the challenges and risks of mergers and acquisitions produce consequences for hospitals, providers, patients, insurers, and other stakeholders, such as:

- Leading to price increases of 5% or more
- Raising spending by $204 million in one year alone
- Reducing operating expenses by 6%, but increasing costs for patients by 5%
- No guarantee of improving performance

- Decreasing patient experience scores
- Lessening access to clinical services.

Mr. Caracas said that since 2019 there had been one merger and 14 acquisitions or proposed acquisitions by health systems within Wisconsin and presented a timeline for these cases based on information from OCI.

Mr. Caracas concluded with some strategies utilized by the Board to navigate through the current trend in the healthcare market and the impact on members, including the rate setting process, which analyzes each health plan's preliminary bid and utilization data to provide tiering recommendations. Tier placement and changes needed are then discussed, and the health plans submit their best and final offers (BAFOs). This negotiation process uses competition as a key strategy to control costs. He noted that the language within the Program Agreement protects against loss of quality by addressing customer service expectations and data protection. The Board needs to be aware of the consolidation trend and its impacts it has on the Group Health Insurance Program (GHIP), which helps them consider the best options in making informed decisions moving forward.

Mr. Day asked if there was anything else the Board should be doing about the increasing loss ratio costs that were reported by Segal for carriers participating in the GHIP. Mr. Day was also interested in hearing if there were other mechanisms outside of the rate setting process that the Board should be considering to mitigate against some of the price increase concerns.

Mr. Caracas noted healthcare costs are rising, and as mergers and acquisitions would continue to take place, the number and diversity of health plans participating in the rate setting process could be limited as a result. However, the National Academy of State Health Policy (NASHP) had developed a hospital cost tool (HCT), which was first presented to the Board in the "Wisconsin Health Market Report" memo at the November 2022 meeting (Ref. GIB | 11.16.22 | 7). The HCT's purpose is to demystify hospital costs to the public by allowing individuals to compare information between hospitals, examine a specific hospital or health system, or look at hospital costs by state. He stated that the Board could use some of the data points in the HCT, such as hospital operating costs versus revenue, as an additional mechanism to enhance competition along with the rate setting process.

**WEIGHT-LOSS DRUGS ANALYSIS AND COVERAGE CONSIDERATIONS** (Ref. GIB | 08.14.24 | 4)

Ms. Sieg provided the Board with an analysis and coverage considerations for weight-loss drugs, also known as anti-obesity medications (AOMs) and glucagon-like peptides 1 (GLP-1s).

Ms. Sieg gave a brief context about AOMs. She said that during clinical trials and in post drug release research on GLP-1 agonists used to treat type 2 diabetes, it was discovered that people taking GLP-1 drugs saw significant weight loss. This led to Novo Nordisk releasing Saxenda in 2014, the first GLP-1 drug intended specifically to treat obesity. In 2017, Novo Nordisk released Ozempic, a GLP-1 drug to treat type 2 diabetes. She highlighted that since its release in 2017 Ozempic has not been approved for weight loss. The Food and Drug Administration (FDA) has only approved it for type 2 diabetes treatment. However, in 2021, Novo Nordisk gained FDA approval of Wegovy, a GLP-1 drug, for the treatment of obesity but it has not been approved for type 2 diabetes treatment. In 2022, Eli Lilly gained FDA approval of Mounjaro, a GLP-1 drug for the treatment of type 2 diabetes. In 2023, FDA approved Zepbound, a drug for chronic weight management.

Ms. Sieg said that Ozempic and Mounjaro are currently covered under the Board's Commercial and Medicare drug formularies for the treatment of type 2 diabetes only. Both drugs require a doctor to attest that the person has a history of type 2 diabetes. In 2023, there were 2,774 members utilizing Ozempic, and 1,217 members were utilizing Mounjaro. She noted that Mounjaro was not covered under the Board's Employer Group Waiver Plan (EGWP) formulary until January 1, 2024.

Ms. Sieg stated that drugs approved by the FDA for weight loss (Saxenda, Wegovy, Zepbound, etc.) have been excluded from the GHIP. However, over the last three years, there has been continued and growing interest from members in adding weight-loss drug coverage to the pharmacy benefit. Highlights included:

- In late 2021, Navitus's Pharmacy and Therapeutics Committee voted to allow Navitus's clients the option to add weight-loss drugs to their non-Medicare formularies.
- In the "2023 Health and Pharmacy Benefit Changes" memo presented to the Board in May 2022 (Ref. GIB | 05.18.22 | 5C), Segal provided ETF with an analysis of adding Wegovy to the Commercial pharmacy formulary. At that time, Segal assumed that 20% of GHIP members would be interested in weight loss, and 3% of those members would be prescribed the drug, which would lead to a cost increase of $20 million to $30 million a year. The Board is limited to Wis. Stat. § 40.03(6)(c) from entering into contracts that would increase the cost of the program without concurrent savings elsewhere. During the meeting, neither Segal nor ETF determined any projected savings from adding Wegovy to the formulary.
- The Board requested a special meeting be held for the purpose of receiving more information and discussing the possibility of adding weight-loss drugs. During the June 30, 2022, meeting, the Board received updated information in the "Weight-Loss Drug Coverage Options Review" materials (Ref. GIB | 06.30.22 | 4), where Segal's estimated cost for adding weight-loss drugs to the formulary lowered to a range of $12 million to $17 million after receiving new information from Navitus.

- A year later, in the "2024 Program Agreement and Benefit Changes" memo discussed at the May 2023 meeting (Ref. GIB | 05.17.23 | 3C), Segal estimated a cost increase of between $9 million to $14 million annually if weight-loss drug coverage was added to the commercial pharmacy formulary (assuming a 0.6% utilization rate from members).
- At the February 21, 2024, meeting, the Board received findings from Segal's cost/saving analysis for covering weight-loss drugs under the Board's pharmacy benefit through the "2025 Final Benefit Changes" memo (Ref. GIB | 02.21.24 | 7C). Late in 2023, Zepbound was approved for weight loss by the FDA. This new product, along with new research on weight-loss drug usage and Segal's experience with other clients, led Segal to assume that 25% of members with a body mass index (BMI) of 35 or higher would take a weight-loss drug. Segal also assumed that the rate would increase by 5% a year through 2030. Using these assumptions, Segal concluded in their cost analysis that adding Wegovy and Zepbound to the formulary would lead to a net loss of over $21 million in 2025. In the same analysis, Segal found that the yearly net loss from 2025 to 2030 would be between $19.6 million and $27.4 million a year.

Ms. Sieg said that since the February 2024 meeting, Eli Lilly had started to offer rebates on Zepbound, which in turn could lower Segal's cost analysis. Additionally, ETF was concerned that Segal's estimate of the number of members who would start weight-loss drugs was low. This was based on the increase in production of Zepbound and Wegovy, the number of members interested in weight-loss drug coverage, and knowledge of GHIP members' demographics. Ms. Sieg added that Segal's estimate from February is still believed to be accurate based on Navitus's prices for the drug.

Ms. Sieg discussed the results of a May 2024 survey of public employers and multiemployer plans in the US by the International Foundation of Employee Benefit Plans (IFEBP) whereby 63% cover GLP-1 drugs for diabetes only and 26% cover the drugs for both diabetes and weight loss. When asked if they were considering offering coverage for GLP-1 drugs for weight-loss, 72% said no, while only 15% said yes. The survey found that some of the cost-control mechanisms in place for GLP-1 drugs for public employers and multiemployer plans include utilization management, step therapy, eligibility requirements, and annual maximums.

Ms. Sieg shared some developments regarding weight-loss drugs, which included the following:

- FDA's approval of Wegovy as a treatment to reduce the risk of cardiovascular death, heart attack, and stroke in adults with cardiovascular disease who are either obese or overweight.
- Roche, a Swiss drug manufacturer, released early results from studies on CT996, their once-daily weight-loss pill, where patients lost 7.3% of their body weight at the full week mark. This data appears to be even better than Eli Lilly's

early study results on their similar pill that is currently being developed. Roche plans to fast-track their drug for potential FDA approval in 2028.

- Viking Therapeutics is moving into phase three in their study on their VK2735 drug. The phase two study saw nearly a 15% weight loss over three months, with no plateau. VK2735 will be possibly introduced to the marketplace in a few years.

Ms. Sieg then discussed several coverage options for the Board to consider, in line with Wis. Stat. § 40.03(6)(c). She reiterated that the Board is limited to Wis. Stat. § 40.03(6)(c) from entering into contracts that would increase the cost of the program without concurrent savings elsewhere. Additionally, the coverage options she provided were also in line with the Board's Healthcare Triple Aim strategy of examining the effects of any change on members' quality of life, program quality, and affordability.

1. The first option is to offset the cost of weight-loss drugs with either a pharmacy benefit reduction or a premium increase. This option would affect all commercial members, including those not taking weight-loss drugs. With an average number of commercial pharmacy members per month at 205,400 in 2023, this option would lead to an increase of $102.24 to $131.45 a year, on top of any increases from medical, wellness, or other pharmacy costs.
2. The second option is increasing copays and deductibles paid by non-Medicare members. Based on Segal's February estimate of a $21 million increase in costs with AOM coverage for 2025, Ms. Sieg compared the 2024 copays and deductibles to the proposed changes to offset AOM costs for the State GHIP's non- high-deductible health plan (HDHP) option and correlating Local GHIP program. She explained that additional modeling would be needed to determine changes to the HDHP and other local program options. Ultimately, this option would increase copays and deductibles to all non-Medicare GHIP members, but the proposed changes would allow members to have the same current health and pharmacy benefits with the addition of AOMs while keeping the GHIPs deductibles and copays below state and national averages.
3. A third option is to reduce or end benefits to help offset the cost of weight-loss drugs. However, various state and federal laws mandated what benefits must be offered under medical and pharmacy insurance. Ms. Sieg stated that a series of small reductions, such as limiting the number of physical therapy appointments versus eliminating them altogether, may add up to cover the cost of adding weight-loss drugs. She noted that some reductions in benefits or services could cause disruption to members.
4. The Board could also consider adding a pilot program that allowed a small subset of members who fit a pre-determined list of criteria to have prescriptions filled for AOMs. The pilot program could include coaching and nutritional counseling, as well as the possibility of including weight-loss oriented benefits within the wellness and/or medical programs. This option would allow some members to receive AOMs and support while taking the drug, while giving the Board a chance to examine the fiscal effects on a limited basis. However, pilot

programs could only be offered for a limited time, and if the Board chose not to extend the program, members would then lose coverage of the drug and have to stop taking the drug or pay for the full cost of the drug out of pocket.

5. Another option is to implement a lifetime limit on either monetary amount or prescriptions filled for GLP-1 coverage. After meeting the maximum, a member would have to pay the whole cost of the drug. Furthermore, according to Navitus's agreements with Eli Lilly and Novo Nordisk, manufacturer rebates that the Board was currently receiving for drugs on the formulary could be reduced or removed. Maintaining records of members' limits could also lead to an increase in administrative costs.
6. The Board could also create a new AOM drug formulary level. This option means that only members taking AOMs would pay a higher cost, thereby increasing out-of-pocket costs. Potential repercussions of this option include creating member and pharmacy confusion by adding a new formulary tier. Like the previous option, there was also the risk that manufacturer rebates for drugs on the formulary could be reduced or removed.
7. The last option is to increase BMI requirements. The FDA recommends GLP-1s be covered for members that either have a BMI of 30 or greater or have a BMI of 27 with at least one weight-related comorbidity. The National Health Service's BMI requirement is 35 or greater, or a BMI of 30 with at least one weight-related comorbidity. Increasing the BMI requirement of 35 or higher for AOM coverage would align with the BMI requirement for bariatric surgery but decrease the number of members eligible for AOM coverage. According to Navitus, this decreased number of members receiving the drug would lower the drug's cost, even with the loss of rebates from the drug manufacturers. However, higher BMI could lead to members having more comorbidities before they gain coverage.

Ms. Sieg discussed the next steps ETF would be taking. At the November 2024 meeting, the Board would receive an operational update on the ever-changing AOM landscape, with an update on bariatric surgery.

After Ms. Sieg's presentation, the Board's discussion resulted in some new options that the Board requested ETF to look into. These included the following:

- Ms. Lounsbury asked what it would look like if the Wellness Program was eliminated, and whether that would be enough to offset the cost of adding weight-loss drugs to the commercial pharmacy formulary. She stated she was specifically interested in an analysis of weight-loss coaching and an assessment on the success of the Wellness Program overall.
- Ms. Lounsbury and Mr. Day were also interested in getting a holistic view of weight-loss benefits already available across the medical, pharmacy, and wellness programs. The Board was curious to hear more about the long-term benefits of AOMs as research continued to develop on GLP-1s. Additionally, the

Board wanted an update on litigations regarding AOMs and their reported side effects.

- The Board was interested in clarifying the data reported in Segal's February estimate. During the discussion, a difference between Segal's estimates and Milliman's estimates was noted, leading the Board to request additional information to explain what caused the discrepancy between the two. As part of revisiting Segal's estimates, the Board wanted more information on the gains and losses involved with manufacturer rebates and Navitus's agreements with Eli Lilly and Novo Nordisk on manufacturer rebates.

**GROUP LIFE INSURANCE PROGRAM ANNUAL REPORT** (Ref. GIB | 08.14.24 | 5)

Mr. Rasmussen shared highlights from the State Plan:

- Covered lives total to 87,487.
- Total life insurance coverage in force is $13.8 billion.
- Claims for employees is lower than targeted but within normal volatility.
- Claims on Spouse and Dependent is higher than targeted.
- Employee premium increased by 5%.
- Asset reserve is at 88.2%.

He shared that in 2019, the Board approved a 5% annual premium increase through April 1, 2028, and ETF does not recommend any changes to that plan. No premium action was being recommended to the Board for the Spouse and Dependent premiums for the State plan. Mr. Rasmussen added that the State plan valuation decreased slightly, and Securian and ETF would continue to monitor it to determine if any changes to the premium strategy would be brought to the Board next year.

Mr. Rasmussen discussed the 2023 Local plan highlights including:

- Covered lives total to 126,277.
- Participating employers cover 759 local governments.
- Claims for employee coverage is lower than targeted.
- Claims on Spouse and Dependent coverage is higher than targeted.
- Asset reserve is at 110.6%, which reflects a rate hold strategy for 2025.

Mr. Rasmussen stated that there was no recommended premium action for the Local plan. Additionally, no premium action was being recommended to the Board for the Spouse and Dependent premiums for the Local plan.

Mr. Rasmussen provided an overview of Empathy, a new benefit recently added to Securian's resources. Empathy offers a holistic approach to bereavement support. Insured individuals could receive personalized guidance and care for the administrative, emotional, legal, and financial challenges both when preparing for a loss, and after their loved one passes away. There is no additional fee associated with Empathy to ETF, employers, or members. The services were available to all members enrolled in the life insurance program and their immediate family members and may be accessed on a voluntary basis.

Mr. Rasmussen highlighted the following 2023 Annual Performance Standards. These included:

- 36,325 transactions subject to performance standards
- Overall performance success rate of 99.65%
- Met or exceeded 8 of 9 standards

Mr. Hansen discussed the Group Life Insurance State and Local Government Plan components, shared the State Plan 2023 policy report, and provided the following highlights:

- Employees: 2023 Claims are lower than expected, but within normal volatility. Recent three years' mortality experience is higher than expected, driven by COVID-19 in 2021 and 2022.
- Spouse & Dependent: 2023 Claims are in line with expectation of drawing down the reserve. Recent three years' experience is in line with expectation as well.
- Aviation-Related Accidental Death Benefit: There were no claims in 2023.

Mr. Hansen said there was no recommendation to change the State Employee Life Insurance or to the previously approved premium increase schedule. Premium rates will increase according to schedule approved in 2019. Also, premium increases were implemented to maintain post-retirement benefit funding. Further, there was no recommendation to change the premium rate for Spouse and Dependents, as the current premium rate allows for gradual draw down of the stabilization reserve.

The 2023 Local Government plan employee claims are lower than expected, with the recent last three years' experience better than expected despite COVID-19. For spouse and dependents, 2023 claims were in line with expectation of drawing down the reserve. Recent three years' experience were in line with this expectation, as well. Further, no changes to premium rates in 2025 were recommended for the Local Employee Life Insurance or for the Spouse and Dependents. The Local Employee Life Insurance premiums were prudent to hold premium rates at current levels, consistent with valuation assumption, while the Local Spouse and Dependents premium rates are set to gradually draw down the stabilization reserve.

Ms. Hillson left the meeting at 9:53 a.m.

***MOTION: Ms. Thompson moved to accept the annual WPE Group Life Insurance 2023 Policy Year Report by Securian. Ms. Flogel seconded the motion, which passed on the following roll call vote:***

***Ayes: Day, Fields, Flogel, Keenan, Lounsbury, Pahnke, Stegall, Thompson, Ugoretz.***

***Nays: None.***

***Absents: Hillson.***

The Board took a break from 10:09 a.m. to 10:19 a.m.

**VENDOR SECURITY FRAMEWORK AND CONTRACT CONSIDERATIONS** (Ref. GIB | 08.14.24 | 6)

Mr. Hurley recapped the actions of the Board and ETF since November 2023, when ETF recommended for the Board to standardize required reporting on information security controls. The Board voted to require all vendors under contract to provide a SOC-2, Type II report by December 31, 2025. He said that staff had identified challenges in implementing the recommendation due to certain contractual arrangements and in meeting the December 31, 2025, deadline. As a result, the Board voted to suspend the November 2023 motion at the May 23, 2024, meeting. However, ETF was asked to return at the August meeting with alternatives to a SOC-2 report if a vendor was unable to provide one.

Mr. Hurley said that since the May meeting, a larger review had been undertaken of ETF's security program across the agency, including the framework and steps on mitigating cybersecurity risks (which Mr. Maradiaga, Mr. Hurley, and Ms. Walk presented in more detail later). Mr. Hurley, then, discussed records confidentiality requirements under state and federal laws that applies to ETF and relates to contractual arrangements with vendors. He highlighted Wis. Stat. § 134.98 (Notice of Unauthorized Acquisition of Personal Information), Wis. Stat. § 40.07 (Records), and Wis. Admin. Code § ETF 10.70 (Individual Personal Information) as the primary state-level privacy laws that applied to ETF's administration of benefits. At the federal level, the Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rule applied to ETF regarding the GHIP, and other plans administered under Chapter 40. He added that the HIPAA Privacy Rule does not cover all of ETF's business areas, as it is a health insurance law. Excluded from HIPAA are non-health-insurance activities and plans, such as the retirement plan, deferred compensation, disability/income continuation insurance, life insurance, and accident insurance.

If a party performs certain functions or services for a HIPAA covered entity, that require the party to receive or access the covered entity's PHI, then that party is a HIPAA business associate. HIPAA requires that specific contractual requirements be in place for such business associates. Mr. Hurley said ETF is compliant with HIPAA's business associate requirements if the vendor signs a HIPAA-compliant business associate agreement (BAA). A compliant BAA is already included ETF's Department Terms and Conditions. While the BAA provides a contractual control for safeguarding PHI, the BAA additionally makes the vendor directly and independently regulated by HIPAA. Monitoring of the vendor and review of its risk analyses are not required under HIPAA. However, if ETF becomes aware of a pattern or practice of the business associate that is a material breach of the BAA contract, ETF must take step to mitigate the situation or, if mitigation is not possible, to terminate the contract.

Mr. Maradiaga discussed the importance of having a vendor security framework in place. He illustrated the financial repercussions of security data breaches across various industries, which cost the healthcare industry $10.93 million in 2023 and $9.77 million in 2024. He explained that the healthcare industry was specifically vulnerable to data breaches due to outdated technologies, the time and process involved with pushing out patches to reinforce existing security systems, and the high value that came from the stealing and selling of protected health and personally identifiable information (PHI/PII) to actors incentivized to create breaches.

Mr. Maradiaga said that ETF had developed a third-party cybersecurity risk management framework from the National Institute of Standards and Technology (NIST) to assess the risk exposure incurred as a part of conducting contracted services. The framework would assess risk profile of a vendor across cybersecurity functions. Vendors would provide a report to demonstrate control effectiveness. In some cases, SOC-2, Type II reports may meet the highest level of control reporting, while other reports would be approved on a case-by-case basis. After the vendor provides the report, ETF would classify any risk identified in vendor's cybersecurity practices according to three risk level assignments: low, medium, or high. In November, ETF would present the initial findings of all risk management reports to the Board and report risk levels of new/potential vendors when recommendations were brought to the Board as part of the final vendor decisions for procurement.

Ms. Walk explained how ETF would handle vendors that were unable to provide a report to demonstrate control effectiveness. ETF would attempt to negotiate alternatives with vendors, and if ETF is unable to negotiate alternatives, the following factors would be considered as part of the options to be brought to the Board:

- Necessity of contracting with the specific vendor
- Financial risks to the program with/without the vendor
- Reputational risks with/without the vendor
- Options to mitigate risks.

For vendors with medium and high-risk scores, Ms. Walk said that part of the risk management reports to the Board in November would include corrective action plans. ETF would, then, periodically report to the Board based on the progress made to the corrective action plan.

Ms. Walk stated that ETF would use the framework to evaluate reporting needs for all vendors with a goal of evaluating all vendor contracts by December 2025. For vendors with in-force contracts that extend past December 2025, ETF would compare the evaluated need versus reporting already being provided and determine whether changes to reporting should be negotiated as part of the next contract renewal. For in-progress procurements, the framework would be used to guide what level of reporting would be requested as part of negotiations. Vendors who provided a SOC-2, Type II report would typically meet the required level of reporting. She explained that ETF had issued an addendum to the most recent RFPs to clarify that proposers who do not currently have a SOC-2 report could submit "other alternative independent service auditor report(s), including attestation that clearly articulates and demonstrates the overall design and operating effectiveness of the Proposer's internal controls, coverage period testing, subservice organizations, and the specific systems and services to be used in the delivery of services to the Department for consideration." These would be evaluated for sufficiency versus the framework.

**MOVE TO CLOSED SESSION**

Mr. Day announced that the Board would be meeting in closed session to get an update on information security contract requirements and receive an assessment on the Long-Term Care (LTC) contract.

> ***MOTION: Ms. Thompson moved to approve moving to closed session pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (d) and (e) to consider strategy for crime detection or prevention, and 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. Mr. Fields seconded the motion, which passed on the following roll call vote:***
>
> ***Ayes: Day, Fields, Flogel, Keenan, Lounsbury, Pahnke, Stegall, Thompson, Ugoretz.***
>
> ***Nays: None.***
>
> ***Absents: Hillson.***

The Board convened in closed session at 10:43 a.m.

The Board returned to open session at 11:00 a.m.

**ANNOUNCEMENT OF BUSINESS DELIBERATED DURING CLOSED SESSION DISCUSSION**

Mr. Day announced that the Board met in closed session and got an update on information security contract requirements and received an assessment on the LTC contract.

**LTC INSURANCE CONTRACT RECOMMENDATION** (Ref. GIB | 08.14.24 | 12)

Mr. Wendt began by highlighting the uniqueness of the LTC program and contract. These included:

- It is a three-party agreement between ETF, HealthChoice (agent), and Mutual of Omaha (insurer).
- ETF has no involvement in the enrollment or premium payment process.
- There is limited data sharing for marketing outreach.
- Only the member and/or provider provides protected health information.
- Interested members apply for the insurance online directly through the Mutual of Omaha.
- Coverage is underwritten and issued to approved eligible members as an individual plan, not group plan.
- Coverage continues with the member regardless of contractual relationship with ETF and the Board or WRS eligibility.

Mr. Wendt explained the steps in the RFP process that started on November 27, 2023, with an invitation to negotiate posted online. ETF received an inquiry from a broker on January 18, 2024, wanting to bypass the procurement process and do a sales call. Proposals were, then, submitted by the deadline of January 31, 2024, with only one proposal received from the current approved agent/insurer pairing of HealthChoice and Mutual of Omaha. Inquiries were sent to OCI, the Department of Agriculture, Trade and Consumer Protection, and ETF Ombudsperson Services to check for consumer complaints, with positive results.

Mr. Wendt said that the LTC contract requirements had incorporated the LTC standards that had been approved by the Board in November 2023. These standards reflected the Board's decision to require SOC 2 Type II reports from all vendors for contracts starting after Dec. 31, 2025. However, the current contract with HealthChoice and Mutual of Omaha's does not have a SOC 2 Type II contract requirement.

Mr. Wendt noted that HealthChoice had been working with ETF in good faith and provided Mutual of Omaha's Information Security program summary document.

Unfortunately, this documentation did not provide the needed transparency and documentation for ETF to accurately assess the existing security posture. On August 5, 2024, ETF met with HealthChoice to discuss the issue, and HealthChoice said it was currently working on obtaining the necessary transparency and documentation.

Mr. Wendt explained some contractual provisions and protections in the LTC Standards. For example, the insurer and, if applicable, the agent, had to comply with applicable state and federal laws and regulations concerning the confidentiality, privacy, or security of PII created, received, or otherwise accessed by the insurer. The insurance offering must also be approved by OCI. These were incorporated into the contract.

Mr. Wendt presented two contracting options for the Board's consideration:

- Contract Option 1: Approve a three-year contract with HealthChoice and Mutual of Omaha for LTC insurance for the term from January 1, 2025, to December 31, 2027, as specified in the Board's November 2023 LTC standards. Over the course of the contract, ETF will work with the vendor to obtain documentation to assess their existing security posture using the new security framework.
- Contract Option 2: Approve a one-year contract from January 1 to December 31, 2025, according to the Board's November 2023 LTC standards and work to negotiate a contract extension from January 1, 2026, to December 31, 2027, that incorporates the new security framework into the contract.

Mr. Wendt said that ETF's recommendation was Contract Option 1, due to the uniqueness of the program, the contractual provisions and protections in place, and the good faith effort from the vendor to date. Throughout the course of the contract, ETF would work with HealthChoice and Mutual of Omaha to obtain information and documentation, complete the full assessment, and work together to address any findings. The security framework would then be added to the LTC standards and included in the next contract.

***MOTION: Ms. Flogel moved to approve the recommendation from ETF for a three-year contract with HealthChoice and Mutual of Omaha for LTC Insurance for the term from Jan. 1, 2025, to Dec. 31, 2027, as specified in the Board's November 2023 LTC standards (ET-7423); and, over the course of the contract, ETF will work with the vendor to obtain documentation to assess their existing security posture using the new security framework (Contract Option 1). Mr. Fields seconded the motion, which passed on the following roll call vote:***

***Ayes: Day, Fields, Flogel, Keenan, Pahnke, Stegall, Thompson, Ugoretz.***

***Nays: None.***

***No Response: Lounsbury.***

***Absents: Hillson.***

**OPERATIONAL UPDATES**

Ms. Walk highlighted the following Operational Updates:

- Healthcare Legal Update (Ref. GIB | 08.14.24 | 13A)
- Federal Rule Compliance Update (Ref. GIB | 08.14.24 | 13B)
- Cafeteria Plan Updates (Ref. GIB | 08.14.24 | 13E)
- Group Health Insurance Program (GHIP) Dashboards (Ref. GIB | 08.14.24 | 13H)
- Board Authority Contracts Updates (Ref. GIB | 08.14.24 | 13I).

**TENTATIVE NOVEMBER 2024 AGENDA** (Ref. GIB | 08.14.24 | 14)

Ms. Walk provided an overview of the topics planned for the November 2024 meeting. One of these items would be an evaluation of historical benefit changes, including bariatric surgery and clear bagging. The Board was invited to contact Ms. Walk if there were any items they wanted to discuss at one of the upcoming Board meetings.

**MOVE TO CLOSED SESSION**

Mr. Day announced that the Board would be meeting in closed session for consideration of Appeal 2023-012-GIB.

***MOTION: Mr. Pahnke moved to approve moving to closed session pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (a) for quasi-judicial deliberations The Board will vote to reconvene in open session following the closed session. Ms. Stegall seconded the motion, which passed on the following roll call vote:***

***Ayes: Day, Fields, Flogel, Keenan, Lounsbury, Pahnke, Stegall, Thompson, Ugoretz.***

***Nays: None.***

***Absents: Hillson.***

The Board convened in closed session at 11:17 a.m.

The Board returned to open session at 11:29 a.m.

**ANNOUNCEMENT OF ACTION TAKEN ON APPEALS DELIBERATED DURING CLOSED SESSION**

Mr. Day announced that the Board met in closed session to consider appeal 2023-012-GIB and adopted the Hearing Examiner's proposed decision with counsel's recommended modifications.

**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 11:33 a.m.

Date Approved: ____________________

Signed: ______________________
Nancy Thompson, Secretary
Group Insurance Board