DRAFT

MINUTES

November 13, 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. – 12:30 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
Nathan Ugoretz*

PARTICIPATING EMPLOYEE TRUST FUNDS (ETF) STAFF:

Office of the Secretary:
John Voelker, Secretary
Kimberly Schnurr, Board Liaison

Office of Legal Services:
Diana Felsmann, General Counsel (Incoming Deputy Secretary)

Office of Strategic Health Policy (OSHP):
Renee Walk, Director
Jessica Rossner, Data and Compliance Unit Director
Molly Dunks, Disease Management and Wellness Program Manager

OSHP (Cont.):
Arlene Larson, Federal Health Programs and Policy Manager
Tom Rasmussen, Life Insurance and Dental Insurance Manager
Tricia Sieg, Pharmacy Benefits Program Manager
Douglas Wendt, Supplemental Plans Program Manager
Korbey White, Health Program Manager
Luis Caracas, Health Plan Policy Advisor

OTHERS PRESENT:

Office of the Secretary:
Pam Henning, Assistant Deputy Secretary

ETF Staff:
Shellee Bauknecht*, Laura Brauer, Beth Bucaida*, Erin Casper, Grace Cizma, Jule Coleman*, Liz Doss-Anderson,

ETF Staff (Cont.):
Omar Dumdum*, Sheila Gubin*, Jim Guidry, Dan Hayes*, Michelle Hoehne*, Tarna Hunter*, Steve Hurley*, Gene Janke, Bruce Johnson*, Joanne Klaas*, Cindy Klimke*, Brittney Kruchten*, Mark Lamkins, David Maradiaga,

* Attended virtually.

Board	Mtg Date	Item #
GIB	01.15.25	2A

ETF Staff (Cont.):
Peggy McCullick, Laura Patterson, Peter Rank, Marie Ruetten*, Tim Steiner*, Yikchau Sze*, Sarat Tadi*, Stephanie Trigsted, Xiong Vang, Mee Wartgow, Wade Whitmus*, Amanda Williams*, Kathryn Young
Anthem:
Paul Nobile*
Aspirus Health Plan:
Megan Umnus*
Capital Results:
Eli France*
Common Ground Healthcare Cooperative:
Melissa Duffy
Dean Health Plan:
Katie Beals*, Penny Bound*, Maria Schneider*
Delta Dental of Wisconsin:
Megan Wohlfeil
Department of Administration (DOA):
Dana Gehrmann*, Mary Hasselquist*, Jennifer Kraus*, Meghan McKenna*, Julie Perry*, Derek Sherwin*, Danielle Tesch*, Lisa Tesch*, Tina Updike*
Eli Lilly and Company:
Kelly Ruhland*
Group Health Cooperative of South Central Wisconsin:
Tammy Adler*
Group Health Cooperative of Eau Claire:
Christina McConaughey*
Hamilton Consulting Group:
Abbey Rude*
HealthPartners:
Kyle Long*
Hubbard Wilson and Zelenkova, LLC:
Dan Romportl*
Marquette University:
Paul Dion*
Medica:
Olivia Peterson*
Medical Associates:
Karen Brunton*
Merative:
Oladipo Fadiran
MercyCare Health:
Reid Buerer*, Marc Dinnel*, Eric Quivers*, Sherrie Sargent*, John Trochlell*
Michael Best Strategies:
Adam Barr*
Navitus:
Steven Alexander*, Tara Argall*, Ryan Olson*, Felicia Weihert*
Network Health Plan:
Vanessa Cagal*, Tammy Harker*
Novo Nordisk:
Stacy Hintzman*, Dave Moody*
Quartz:
Brittany Coyne*
Securian:
Kjirsten Elsner*
Security Health Plan:
Angela Pero*
Segal Consulting (Segal):
Patrick Klein*, Kenneth Vieira*
UW Health:
Olivia Talma*
UW-Madison:
Marissa Isensee*, Karly Oppliger*
UW-Stout:
Jo Johnson*
UW System Administration:
Brianne Jobke*, Erin Schoonmaker*, Amanda Sonnenburg*
Village of Little Chute, WI:
Lisa Remiker-DeWall*
WebMD:
Emily Rathjen*
Wisconsin Association of Health Plans:
Kyle Caudill*, HJ Waukau
Wisconsin Department of Health Services:
Debra Lafler*

Wisconsin Department of Military Affairs:
Sheilagh Lochner*, Stacie Meyer*
Wisconsin Health News:
Sean Kirkby*
WPPI Energy:
Mary Beth Weidenfeller*, Julie Zacher*
Public:
Jack Lawton*, Stephanie Steel*
Others (Unidentified):
5 individuals connected via telephone

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

ANNOUNCEMENTS

Mr. Voelker made the following announcement:

- Ms. Felsmann, ETF's General Counsel, is currently in a transition role until February 9, 2025, when she will be taking on the position of ETF's Deputy Secretary.

Ms. Walk made the following announcements:

- The Long-term Care Contract had been signed.
- Between the October 3 – November 13, 2024, the limited authority delegated by the Board to the ETF Secretary at the October meeting had not been used (Ref. GIB | 10.03.24 | 4). Therefore, no report was included in the "Insurance Administration System (IAS) Update" memo (Ref. GIB | 11.13.24 | 17B).
- In addition to the February 26, 2025, meeting, there were two extra Board meetings scheduled for January 15 and March 12. Details were included in the "Tentative First Quarter 2025 Agendas" memo (Ref. GIB | 11.13.24 | 18).
- A new health plan had applied to be part of the Group Health Insurance Program (GHIP), and more information would be shared at the February meeting.

CONSIDERATION OF OPEN AND CLOSED MINUTES OF AUGUST 14, 2024, AND OCTOBER 3, 2024, MEETINGS

MOTION: Ms. Thompson moved to accept the Open and Closed Minutes of the August 14, 2024, Meeting and the Open and Closed Minutes of the October 3, 2024, Meeting as presented by the Board Liaisons. Mr. Fields seconded the motion, which passed unanimously on a voice vote.

OPEN ENROLLMENT (OE) COMMUNICATIONS (Ref. GIB | 11.13.24 | 3)

Mr. Rasmussen shared that there were minimal changes to plan year 2025 benefits. He said that the OE period was from September 30 to October 25 and provided an overview of the changes in campaign materials. He explained that these changes focused on medical benefit changes, a health plan name change, contribution limit changes for pre-tax savings accounts, the increase in the State Health Savings Account

(HSA) employer contribution, and the State Maintenance Plan (SMP) changes for Locals. He also highlighted the OE period's decision guides, employer kickoff meetings, vendor forums, eLearning videos, updates to the ETF website, and call center statistics.

The Board discussed how to make the information provided by Professor Justin Sydnor from the University of Wisconsin School of Business more accessible and educate members on how the out-of-pocket costs and healthcare usage differ between State of Wisconsin employees enrolled in the HDHP and those in It's Your Choice (IYC) health plan designs.

UNIFORM DENTAL BENEFIT (UBD) CONTRACT EXTENTION (Ref. GIB | 11.13.24 | 4)

Mr. Rasmussen began his presentation with background information on the existing contract the Board signed with Delta Dental (Delta) in July 2021 for the administration of the statewide UDB. The contract period was from January 1, 2022, through December 31, 2026, with the option for renewal for two additional two-year terms. Mr. Rasmussen said that Delta has disclosed to ETF that the administrative fee charged for the UDB program would increase from $1.10 per employee per month (PEPM) to $1.15. The increase was a result of inflation and additional costs related to information technology projects to support some of the custom IAS related functions. Mr. Rasmussen explained that the $1.15 PEPM was $.01 higher than the PEPM fee cost from plan years 2018-2021. Additionally, Delta had agreed to hold the $1.15 PEPM fee for the 2029–2030 contract years if the Board chooses to exercise the one remaining contract extension available.

Mr. Rasmussen said that during the current contract period, UDB membership has continued to grow. Delta demonstrated a strong commitment to maintaining the satisfaction of over 96,000 enrollees. He added that ETF has received feedback from members regarding providers leaving Delta's networks. He explained that ETF looked into these concerns, which resulted in the following findings:

- The PPO Plus Premier Network provides 88% of all unique access points in the state.
- Delta's annual network retention rates are 98% for state providers and 95% nationally.
- Providers, including those from both urban and rural areas, unanimously praised Delta as the easiest, or one of the easiest, carriers they work with.
- In February 2023, Delta strategically increased reimbursement rates for frequently performed dental procedures, benefiting over 75% of Wisconsin general dentists.

Mr. Rasmussen explained that ETF was recommending that the Board approve the extension of the UDB contract with Delta for an additional two years, beginning January 1, 2027, through December 31, 2028. If the Board approves the two-year extension, it

will retain the option for an additional two-year extension as part of the original UDB contract approved by the Board in 2021.

MOTION: Mr. Fields moved to approve the extension of the third-party administration of the UDB contract with Delta Dental of Wisconsin (Delta) for two years, beginning January 1, 2027, through December 31, 2028, as requested by ETF. Ms. Thompson seconded the motion, which passed unanimously on the following roll call vote:

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

Nays: None.

Absents: None.

SUPPLEMENTAL PLAN GUIDELINES CHANGES (Ref. GIB | 11.13.24 | 5)

Mr. Wendt began his presentation by saying that ETF was requesting that the Board approve the recommended modifications to the Supplemental Insurance Plan Guidelines (ET-7422) for vision and accident plan contracts, effective for the 2026 plan year. Upon the Board's approval, ETF will move forward with publishing the updated ET-7422 document and post the invitation to bid for the vision and accident programs on the ETF procurement website.

Mr. Wendt highlighted some of the proposed general changes to the Supplemental Insurance Plan Guidelines. These included:

- Updating the title page to reflect that proposals will only be accepted for the vision and accident plans with the contract period of January 1, 2026, through December 31, 2026.
- Modifying wording on timing for implementing the supplemental plans into ETF's data warehouse.
- Adding that ETF will request data on vendor complaint history from the Office of the Commissioner of Insurance (OCI) and the Department of Agriculture, Trade, and Consumer Protection (DATCP).
- Changing the penalty for not consistently meeting the loss ratio requirement.
- Changing the penalty for violations of the non-disclosure requirement.

Mr. Wendt then provided an overview of proposed changes related to the implementation of IAS. These were as follows:

- Removing the requirement for the vendor to offer an online enrollment portal for small employers.
- Removing three requirements for timeliness of processing enrollments and disenrollments by the vendor.

- Replacing the above three eliminated requirements with a requirement to process the enrollment file from ETF within two business days.

MOTION: Ms. Flogel moved to approve modifications to the Supplemental Insurance Plan Guidelines (ET-7422) for vision and accident plan contracts, effective for the 2026 plan year as requested by ETF. Mr. Pahnke seconded the motion, which passed unanimously on the following roll call vote:

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

Nays: None.

Absents: None.

MOVE TO CLOSED SESSION

Mr. Day announced that the Board would be meeting in closed session for consideration of Appeal 2023-011-GIB and to discuss a vendor security update and the Income Continuation Insurance (ICI) Program contract administrative services fee amendment. The Board will vote to reconvene in open session following the closed session.

MOTION: Mr. Pahnke moved to go to closed session pursuant to the exemptions contained in Wis. Stat. §19.85 (1) (a) for quasi-judicial deliberations, Wis. Stat. § 19.85 (1) (d) to consider strategy for crime detection or prevention, and Wis. Stat. § 19.85 (1) (e) to deliberate or negotiate the investing of public funds or to conduct other specified public business, whenever competitive or bargaining reasons require a closed session. If a closed session is held, the Board may vote to reconvene into open session following the closed session. Mr. Fields seconded the motion, which passed unanimously on the following roll call vote:

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

Nays: None.

Absents: None.

The Board convened in closed session at 9:15 a.m.

The Board returned to open session at 10:20 a.m.

ANNOUNCEMENT AND VOTE ON BUSINESS DELIBERATED DURING CLOSED SESSION DISCUSSION

Announcement of Action Taken on Appeals Deliberated During Closed Session

Mr. Day announced that the Board met in closed session to consider appeal 2023-011-GIB and adopted the Hearing Examiner's proposed decision with counsel's recommended modifications.

Announcement on Business Deliberated During Closed Session Discussion

Mr. Day announced that the Board also met in closed session to discuss a Vendor Security Update and the ICI Program Contract Administrative Services Fee Amendment.

Vote on ICI Program Contract Administrative Services Fee Amendment

MOTION: Ms. Thompson moved to approve an amendment to the current ICI contract with The Hartford to increase the administrative fee to $3,136,440, effective January 1, 2025, and to $3,334,036, effective January 1, 2026, as recommended by ETF. Mr. Fields seconded the motion, which passed unanimously on the following roll call vote:

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

Nays: None.

Absents: None.

2026 PRELIMINARY AGREEMENT & BENEFIT CHANGES (Ref. GIB | 11.13.24 | 12)

Mr. White began the presentation with an overview on the work completed as part of the 2026 Program Agreement (Agreement) and Certificate of Coverage (Certificate) process. In September 2023, ETF asked contracted health plans, the UDB, wellness and disease management, and the Pharmacy Benefit Manager (PBM) vendors for ideas for changes. Vendors returned their benefit changes and pilot program proposals to ETF in October 2024, and the summary of these changes was sent to health plans and the PBM for their review. ETF, members, and other stakeholders also provided suggestions for changes to ETF.

Mr. Caracas said that health plans requested changes to the Agreement pertaining to to web-portal security and certification, storage, and transmission of confidential information outside of the United States and territories, and a review of Quarterly Performance Standards related to metrics and penalties. Additionally, proposed changes include administrative revisions to the Certificate and Schedules of Benefits (Schedules), such as clarifying definitions and refining language related to

covered benefits and exclusions. He said that ETF will identify modifications on cost sharing to simply benefits, as needed. ETF will also review the feasibility of moving continuous glucose monitoring solely to the pharmacy benefit.

Mr. Caracas went on to explain that proposed uniform pharmacy benefit changes, such as anti-obesity medications coverage, would be discussed with the Board before the new contract is signed. He said that the Board was scheduled to assess and deliberate on awarding the Third-Party Administration of Pharmacy Benefits Program contract at the January 15, 2025, Board meeting. Mr. Caracas also said that no new pilot programs were being proposed for 2026. The Board would receive an update on existing pilot programs later in the meeting.

Mr. Caracas said some of ETF's next steps include continuing its review of the proposed changes, the Board's vendors, and Segal before presenting final changes to the Board in March 2025.

WEIGHT-LOSS DRUGS: CURRENT EVENTS, OPTIONS, AND COST ANALYSIS
(Ref. GIB | 11.13.24 | 13)

Ms. Sieg's presentation to the Board included an updated anti-obesity medication (AOM) drug cost analysis from Segal, an update on future AOM options, other states' public employee AOM drug coverage, weight-loss drug current events, and next steps. Her presentation also followed up on information the Board had requested at the August 14, 2024, meeting (Ref. GIB | 11.13.24 | 2A).

Ms. Sieg provided an overview of the drugs Ozempic, Wegovy, Mounjaro, and Zepbound. She provided information on each of the four drugs, which included the approval year, the Food and Drug Administration (FDA) approved indications, and whether or not the drug was covered by the GHIP. Ms. Sieg explained that the two best-selling glucagon-like peptide 1 agonist (GLP-1) drugs currently on the market for weight loss were Wegovy, manufactured by Novo Nordisk, and Zepbound, by Eli Lilly. Neither Wegovy nor Zepbound are covered by the GHIP.

ETF had asked Segal to conduct an updated cost/savings analysis for covering AOMs under the Board's pharmacy benefit. Ms. Sieg said that Segal's two new cost-savings analyses reflected new agreements with Eli Lilly and Novo Nordisk held by Navitus Health Solutions (Navitus), the Board's PBM, that were signed during the past spring and summer. These new agreements include new prices and rebates for Zepbound and Wegovy. Additionally, the agreements include tiered pricing/rebates if a payer did not adhere to the FDA's recommendation for coverage. Ms. Sieg explained that the FDA recommended Wegovy and Zepbound coverage for weight loss only for people with a body mass index (BMI) of 30 or greater, or a BMI of 27 with at least one weight-related comorbidity. She said that according to the agreements, there were still some changes a payer could make to their coverage that would eliminate all rebates offered by the drug manufacturers, such as creating a new AOM drug formulary level and lifetime

limits on AOM coverage. Ms. Sieg noted that Segal had used a BMI requirement of 35 or greater in the cost analysis they presented in February (Ref. GIB | 02.21.24 | 7C).

Ms. Sieg provided a table that illustrated what Segal projected the cost-savings of AOMs would be to the Board if FDA BMI indications were adhered to, and the Board realized all the rebates available. She noted that although the Board did not include AOM coverage for 2025, the information was included in the table as a comparison to Segal's cost analysis from February 2024. Ms. Sieg referred the Board to page 2 in the "Weight-Loss Drugs: Current Events, Options, and Cost Analysis" memo for a list of the key assumptions and links to sources that Segal had used in the analysis. She highlighted one of these assumptions, which was the medical savings included inpatient visits, physician-office visits, emergency room visits, and pharmacy costs.

Ms. Sieg noted similarities and differences between Segal's cost analysis and Milliman's. She said that both Segal's and Milliman's reports assumed similar scripts per person. Additionally, both assumed that 50% of the eligible population utilized Wegovy and the remaining 50% took Zepbound. Ms. Sieg said that Segal's analysis used exact AOM pricing and assumed a 5% cost trend. Milliman's, however, doesn't state the exact starting point of AOM costs and assumed a 6% decrease in net pricing due to anticipated competition of AOMs available. Ms. Sieg noted that, while there were approximately 133 weight-loss drugs in various stages of approval, no new AOMs had been submitted to the FDA for approval since Zepbound was approved in November 2020.

Ms. Sieg said that the biggest difference between Segal's and Milliman's reports was the number of eligible members who would use AOMs. Segal assumed a 20%–25% utilization rate, which was four times more than the assumption used in Milliman's report. Ms. Sieg added that the 20%–25% utilization rate reflected input she'd received from public sector employers who provided AOM coverage for their members, which could be found on page 13 in the "Weight-Loss Drugs: Current Events, Options, and Cost Analysis" memo. Based on Segal's experience with other clients covering AOMs for obesity, in 2025, 20% of those eligible would take an AOM, and that rate would increase by 5% a year through 2030 based on Segal's experience with other clients covering AOMs for obesity, in 2025. Segal's assumption of 20% was based off of Segal's experience with other clients covering AOMs for obesity in 2025. The 20% assumption was used to create the cost-saving analysis if FDA BMI indications were adhered to, and the Board realized all the rebates available. Meanwhile, in the cost-savings analysis with only partial rebates available, Segal assumed 25% of those eligible, not 20%, would take a weight-loss drug in 2025 and that rate would increase by 5% a year through 2030. Segal attributed the utilization rate increase to findings showing that the greater a person's BMI, the more likely that person was to take an AOM and continue taking the drug.

Ms. Sieg explained that at the August meeting, ETF had outlined possible AOM coverage options. Additionally, new options had been posed during the Board's conversation on the topic. She provided follow-up information on these items.

The first follow-up option was to increase the BMI requirements for AOM coverage to help manage program costs. If the Board required a BMI of 35 or higher, it would align the requirements for both AOMs and bariatric surgery. However, the increased BMI requirement may eliminate some people from coverage. Ms. Sieg also reiterated that rebates available to the Board would be limited if the BMI requirements are changed from the FDA's indications according to Navitus's new agreements with Novo Nordisk and Eli Lilly. As a result of fewer rebates being realized, Segal's current cost-savings analysis reported the cumulative loss for covering AOMs, inclusive of medical savings, was $166,126,771.

The second follow-up option Ms. Sieg presented was for the Board to add a new AOM drug formulary Level. She explained that adding a new Level for just AOMs could require members to pay a higher copayment for the drugs. Only members who were prescribed AOMs would shoulder the cost instead of all members being required to pay higher premiums and copays. Ms. Sieg noted that, due to AOM drug manufacturers' agreements with Navitus, a new formulary Level would not allow the Board to realize any rebate payments for the drugs. Ms. Sieg presented the member copays required to cover the cost of AOMs in a table. She explained that the copay required per prescription to pay for adding AOMs to the drug formulary on a newly created tier decreased from 2025–2030. However, the amount required with the current price of AOMs would create significant costs for members. Ms. Sieg added that, at this time, members would be eligible to participate in drug manufacturer coupon and copay assistance programs that would help to offset their copay costs for AOMs.

The third follow-up option was to increase copays and deductibles for all State GHIP non-HDHP options and correlating Local GHIP members. Using Segal's most recent AOM cost analyses for full and partial rebates, she provided a comparison of the copays and deductibles for 2024 compared to the proposed change required to offset AOM costs. She noted that the cost of AOMs could decrease; or rebates could change based on new drugs, new variations, or new indications of AOMs currently on the market. Ms. Sieg said that the new copay/coinsurance structures for 2026 would be considered as part of annual benefit changes presented to the Board at the March 12, 2025, meeting.

Ms. Dunks presented the fourth follow-up option that would require nutritional counseling for anyone taking an AOM. She explained that nutritional counseling will be covered under the GHIP for all members beginning January 1, 2025. Ms. Dunks said that with the 2025 expansion in nutritional counseling coverage, the Board could attach a requirement to any coverage of AOMs for nutritional counseling through the health plans, and/or nutritional coaching through the wellness and disease management vendor. She added that if the Board chose to require nutritional counseling and/or coaching either before or during coverage for AOMs, it would require Navitus and the

health plans and/or wellness and disease management vendor to work together in coordinating coverage for members. She said that requiring nutritional counseling for AOM coverage could lead to added costs for members who would have to pay their medical deductible and any copays that were required for nutritional counseling.

Ms. Dunks also talked about the option proposed at the August meeting to redirect funds from Well Wisconsin to help pay for AOMs. She explained that ETF had reviewed the total cost of the Well Wisconsin Program over each of the last three years (approximately $16M), including program administration fees and incentives paid to members, alongside Segal's recent AOM cost analyses for full and partial rebates. They found that redirecting funds solely from the Well Wisconsin Program would not be enough to cover the expected costs of AOMs. Furthermore, the Board would need to take funding from other health and/or pharmacy benefits to increase member cost-share to offset the total estimated cost of coverage for AOMs.

Ms. Dunks said that excluding Well Wisconsin from the GHIP would remove availability of uniform wellness services and that these services were aligned with the Total Health Management approach to healthcare. She said that Well Wisconsin services, which included weight-loss services — such as lifestyle management coaching; intensive weight-loss programming; and additional physical activity and nutrition-based classes, challenges, and education — directly benefit the members who would be prescribed AOMs. Ms. Dunks emphasized that the FDA approved AOMs "for use *in addition* to a reduced calorie diet and increasing physical activity." Both reducing calories and increasing physical activity was currently available via the Well Wisconsin Program.

Ms. Dunks provided an overview of how the Well Wisconsin Program helped members manage other conditions. Well Wisconsin provided services such as the Diabetes Prevention Program, mental health coaching for depression, anxiety, stress management, etc. (added as a benefit in 2024). Well Wisconsin also provided condition management services for diabetes, asthma, chronic obstructive pulmonary disease, congestive heart failure, and coronary artery disease. She said that the loss of the program would impact members who used Well Wisconsin for condition management and would remove these services from members who were not considered overweight or obese.

Ms. Dunks provided follow-up information discussed at the August meeting to create a pilot program that would allow a small subset of members who fit a pre-determined list of criteria, such as receiving coaching and nutritional counseling, to have prescriptions for AOMs paid according to terms that were defined in the pilot program. She said that this kind of pilot program would differ from the current pilot programs ETF had with health plans. Current pilot programs were not allowed to assess a fee or pass along costs to ETF.

ETF's Office of Legal Services (OLS) reviewed whether covering the cost of a prescription medication for patients who are registered within a defined pilot program

through the self-funded prescription drug program would fall under the “agreement to modify or expand benefits under any group insurance plan” under Wis. Stat. § 40.03(6)(c). OLS determined that pilot program benefits do not modify or expand benefits that a member is entitle to when they enroll in GHIP coverage.

Ms. Dunks explained that members who were accepted in this pilot program would qualify to receive only what was defined within the program in consideration for their participation and compliance with the pilot program requirements. Therefore, it may be possible to consider a pilot program in which participants receive AOMs while also receiving existing GHIP benefits, including coaching and nutritional counseling, for the purpose of the Board gathering data on the fiscal effect of AOM coverage. Ms. Dunks emphasized that establishing the criteria for a limited number of members to participate in the pilot program would create challenges and legal risk in additional appeals. The Board would also be required to exercise its fiduciary responsibility of evaluating the costs and benefits of any proposed pilot program.

Ms. Dunks said that any pilot program design would be limited to a small subset of commercial members enrolled in the GHIP with a BMI of 35 or higher who utilized AOMs, which in 2025, was 7,406, according to Segal’s estimates. If the pilot program enrollment limit was 1,000 members, an estimated 6,406 people would be eliminated from participating in the pilot program. Some of these 6,406 members could appeal the determination that they weren’t accepted for the pilot program.

Ms. Dunks said that a 1,000-person pilot program, under Navitus’s new agreements with Novo Nordisk and Eli Lilly, would cost about $8.6M with full rebates. This assumed 500 members filling prescriptions for each drug for a full year. With partial rebates, the cost of AOMs would rise to about $10.7M for 1,000 members. If no rebates were realized by the Board due to any restrictions or changes, AOMs for 1,000 members would cost approximately $14.4M.

Ms. Dunks said that the Board’s general guidance was to implement a pilot program for three to five years, after which the Board would need to decide to continue with the pilot program, implement the program as a uniform benefit for all members, or end the program. This amount of time was necessary in order to collect and evaluate data. For a pilot program that covered AOMs, data would come from DAISI and Merative. ETF could use claims data to identify participants in the pilot program to evaluate changes in participants’ health spending and health outcomes.

Ms. Dunks said that if the Board decided to end the pilot program, participants would lose coverage for AOMs, possibly in the middle of treatment. This would cause members to stop taking AOMs or pay the full cost of the drugs out of pocket. She said that the Board could approve an off-ramp benefit from the pilot program, which could include extending coverage of AOMs through the end of the pilot program for a set time or dollar amount. This would require the PBM to help pilot program members enroll in

rebate or manufacturer coupon programs and the Board covering health lifestyle services for members after the pilot program ends.

Ms. Dunks said that none of the Board's health insurance vendors, PBM, or wellness and disease management vendors could currently offer a pilot program that included prescriptions for AOMs and coaching and nutritional counseling for members. Historically, some vendors in the GHIP had partnered together to offer pilots, such as the *It's Your Choice: Diabetes* program administered by WebMD and Navitus. However, existing vendors had limited experience in designing, implementing, and evaluating a comprehensive weight management program that included AOMs. Therefore, ETF would need to design and oversee the pilot. Ms. Dunks also said that offering a pilot program through one insurer could drive members to enroll with that insurer because of the pilot program, which contradicted the philosophy behind the GHIP offering Uniform Benefits.

Ms. Dunks added that the Board could alternatively choose to release an RFP to seek a vendor to administer a pilot program for qualifying members. This would allow the Board to find a vendor that had experience administering all aspects of a proposed pilot program. However, it would take approximately two to three years before a new vendor could be procured through the RFP process, which means implementation wouldn't be possible until 2028 or 2029. Ms. Dunks said that member education would be needed if the Board opted to contract with a vendor that solely offered a weight management pilot program.

Ms. Sieg provided the Board with an update from the information provided in August on how other states were handling AOM coverage for their state employees. She said that in September, ETF received results of a questionnaire the Washington State Health Care authority sent to members of the State and Local Government Benefits Association list serve. Ms. Sieg summarized responses from the Alabama State Employee Insurance Board, State of Arizona Employees, State of Kansas, South Carolina Public Employee Benefit Authority, Tennessee Group Insurance Program, and Utah Public Employees. She also shared information ETF had gathered through the National Academy for State Health Policy. Ms. Sieg noted that one of these takeaways had been that some state employee health plans had tried reaching out to AOM manufacturers directly or through their PBM to negotiate lower prices for AOMs but had been unsuccessful. Additionally, both state employee health plans staff and Milliman (in its Novo Nordisk commissioned report on the impact of AOM coverage in the Medicaid and commercial markets) voiced frustration that there were no independent studies that examined all groups of people on the long-term effects and possible savings on AOM drugs.

Ms. Sieg went on to update the Board on current events related to AOMs. She highlighted the following events that had taken place in October 2024:

- October 24: Prime Therapeutics study found no medical cost offset in medical treatment for those taking AOMs over two years.

- October 21: Northwestern University researchers publish findings comparing the cost-effectiveness of bariatric surgery and AOMs.
- October 17: New study found people taking semaglutide or tirzepatide had a 40% lower rate of opioid overdose and a 50% lower rate of intoxication than those not taking the drugs.

Ms. Sieg stated that at the January 15, 2025, special meeting, the Board would deliberate on awarding the Third-Party Administration of Pharmacy Benefits Program contract. In the RFP for this contract, ETF posed questions to potential vendors regarding AOM coverage. After the Board votes on issuance of a letter of intent to award the contract, ETF will begin negotiating with the vendor on the contract that that would be effective January 1, 2026. Ms. Sieg noted that any proposed benefit changes, such as AOM coverage, would be discussed with the Board before the new contract was signed. Additionally, ETF would provide an operational update at the February 26, 2025, Board meeting regarding AOM utilization, costs, changes in the drug class, legislation, and litigation.

Mr. Day addressed the representatives from Segal, Patrick Klein and Ken Vieira, for clarification on how they determined a 5% increase a year through 2030 in their recent AOM cost/savings analyses. Mr. Klein responded that Segal looked at overall pharmacy trends and normally assumed around 10% of growth a year. However, Segal had taken into account that there was no guarantee that AOMs would decrease in price. Mr. Klein explained that even though there were many other AOMs being developed in various stages of FDA approval, there was no evidence that the increased competition would decrease the prices of AOMs in current and future agreements signed by the Board's PBM and AOM manufacturers, such as Eli Lilly and Novo Nordisk. Mr. Klein said that Segal assumed there would be some growth in manufacturer rebates, which would bring the cost down below the 10% market trend rate.

Mr. Vieira added that Segal looked at what percentage of members would be eligible to take AOMs, which required examining BMI indicators to get a target population. After that, Segal looked at what percentage of the target population would take the AOMs. Mr. Vieira said that Segal then had to review the cost of AOMs. They also had to evaluate the amount of medical savings involved. All of these assumptions were what resulted in calculating the net loss in both of their cost-savings analyses.

Mr. Vieira said that the Per Member Per Month (PMPM) costs in Milliman's report was different than Segal's experience with other clients covering AOMs for obesity. The Milliman report had PMPM costs of less than a dollar. Segal's other clients that provided GLP-1 coverage reported PMPM costs of $5–$6. Mr. Vieira shared that recently the State of North Carolina, one of Segal's larger clients, had voted to remove their coverage of AOMs due to the overwhelming increase in PMPM costs. He shared that the costs had doubled each year between 2021 and 2023, starting at a PMPM cost of $4 to $8 to $16. Eventually, they could no longer afford it and voted to remove covering

AOMs. Mr. Vieira stated that he believed the PMPM for the Board would result in about $8 to $12. If rates were slightly lower, he would put that number at $6 to $10 PMPM.

Ms. Sieg said that she had heard from other state employee health plan staffers that covered GLP-1 drugs that they were struggling to afford AOMs due to the costs of the drugs. She added that situations such as the North Carolina example Mr. Vieira shared were especially difficult as it meant an individual that was currently taking AOMs would no longer have those drugs covered, which could interrupt weight management and weight-loss treatment plans.

Mr. Pahnke referred to page 18 in the "Weight-Loss Drugs: Current Events, Options, and Cost Analysis" memo, and asked for additional information regarding the meeting ETF had with Novo Nordisk on September 13. Ms. Sieg and Ms. Walk explained that there was no additional information aside from what was already presented in the Board's materials. Both Ms. Sieg and Ms. Walk said that the information presented by Novo Nordisk was limited to the research that they had available at that time. However, when Ms. Walk and Ms. Sieg had asked Novo Nordisk for evidence to show the 6% reduction of cost that Milliman referenced in its report, they were unable to show evidence to prove the decreased cost. They could only state that they expected the cost to come down but couldn't quantify where the 6% net price decrease from Milliman had come from.

The Board requested that additional follow-up information be provided before the February 26, 2025, meeting, which would allow enough time to review the materials before the vote on final 2026 benefit changes planned on March 12. Members of the Board were specifically interested in receiving updated cost information from Navitus. The Board acknowledged the timing of the PBM RFP discussion that was planned for January 15 but stressed the importance of having this updated information available regardless as it was critical to their decision on final 2026 benefit changes.

The Board also asked that Segal review the assumptions in Milliman's Novo Nordisk commissioned report on the impact of AOM coverage in the Medicaid and commercial markets.

VENDOR PROPOSED PILOT PROGRAMS (Ref. GIB | 11.13.24 | 14)

Ms. Dunks began her presentation with some background information on pilot programs. She emphasized that pilot programs provided opportunities to evaluate benefit changes before they were offered as uniform benefits. Her presentation focused on the evaluation results for the two longest standing pilots: acupuncture and *It's Your Health: Diabetes*. She also provided information on the Triple Aim analysis conducted by Merative for 2020–2023 across participants and eligible non-participants.

Ms. Dunks provided a timeline of the acupuncture pilot programs under Dean Health Plan (Dean), Network Health, and Quartz. She said that in 2022, the exclusion of

acupuncture was removed from the Certificate of Coverage (CoC), citing the Alternate Care Provision of Uniform Benefits. She provided information on acupuncture claims and experience. Ms. Dunks said that acupuncture as a form of alternate pain management had relatively low patient utilization, which had not noticeably increased since removing the exclusion from the CoC. Additionally, the cost of acupuncture services was low and comparable to chiropractic care. At $60 per visit, the cost was much less than physical therapy. Finally, accessibility of acupuncturists posed challenges. Ms. Dunks said that Dean was discontinuing the acupuncture pilot program for 2026, and that health plans could continue to offer acupuncture benefits under the Alternate Care Provision.

Ms. Dunks also discussed the *It's Your Health: Diabetes* pilot program. She said that it was a pilot program with Navitus and WebMD since 2019. Non-High Deductible Health Plan subscribers and spouses who completed at least one diabetes management coaching call received a reduced pharmacy copayment for several antidiabetic prescription drugs. She reported that 41,252 prescriptions had been filled, which resulted in $1.7M member copays savings from 2019–2023.

Ms. Dunks moved on to discuss the 2020–2023 Triple Aim analysis. She said that Merative had found evidence that participants had better healthcare engagement compared to a matched cohort of eligible non-participants. Additionally, participants maintained or improved their disease stage at a slightly better rate compared to non-participants. Ms. Dunks also noted that increases in medical and diabetes prescription cost trends were lower. She said that medical and prescription allowed amounts increased 25.7% for participants and 41.5% for non-participants, and medical allowed amounts varied more substantially (increases of 10.6% vs. 47.2%).

BENEFIT CHANGE EVALUATION (Ref. GIB | 11.13.24 | 15)

Ms. Rossner's presentation focused on the evaluations of benefit changes to the Group Health Insurance Program (GHIP) for non-Medicare members: bariatric surgery and specialty pharmacy clear bagging. She said that Merative had completed the evaluations for both benefit changes using data from the Board's claims data warehouse, Data Analytics and Insights (DAISI).

Ms. Rossner provided background information on the bariatric surgery benefit change. She said that in 2019, ETF proposed adding coverage for bariatric surgery to all health insurance plan designs offered by the Board for the 2020 plan year. The Board approved adding coverage for individuals with a body mass index (BMI) of 35 or higher. Plans could allow surgeries for BMIs under 35 based on evidence-based criteria. Ms. Rossner said that bariatric surgery required prior authorization from the health plan, and patients must undergo services like nutritional and mental health counseling to ensure readiness. This benefit change was approved and implemented for the 2020 plan year. Ms. Rossner said that the analysis of the bariatric surgery benefit used claims data from the beginning of 2020, when it was approved as a uniform benefit, through the end of

the 2023 plan year, which was the last full year of available claims data. The analysis provided evidence on bariatric surgery utilization, costs, and health outcomes for GHIP members.

Ms. Sieg presented an overview of the clear bagging program. She explained that drug bagging was the practice of having specialty drugs that are administered in a hospital, infusion center, or clinic setting supplied by a specialty pharmacy contracted with the PBM, rather than the health plan. Additionally, bagging options allowed the specialty drug to be processed under the PBM rather than the health plan. Clear bagging programs specifically called for the provider's own internal specialty pharmacy to dispense the prescription and transport it to where the drug is administered. Ms. Sieg said that a clear bagging program meant that fewer individuals touched a drug before it was administered, and the drug could not be handled by a non-medical professional. Clear bagging also allows members to continue to have their drug administered in the same location and by the same medical professionals as before the program is established. Ms. Sieg said that the clear bagging program was established and started January 1, 2023. The program was through the UW-Specialty Pharmacy for non-Medicare members with Quartz health insurance who received their specialty drug infusions at UW Hospitals and Clinics. The benefit change evaluation for the clear bagging program used the claims experience of the GHIP commercial members for all of 2023.

Mr. Fadiran, Lead Consultant at Merative, provided details of Merative's assessment of the bariatric surgery benefit change. He went over background and analytic parameters of Merative's evaluation and talked about the findings of members who qualified for bariatric surgery, GHIP bariatric surgery patients, and post bariatric surgery assessment. In his review of members qualified for bariatric surgery, he highlighted demographic trends, top comorbidities, and cost trends. He talked about the utilization trends, demographics, and cost trends of GHIP bariatric surgery patients. The post bariatric surgery assessment included information on the disease progression and preliminary financial assessment.

Mr. Fadiran also discussed Merative's evaluation of the clear bagging program benefit change. He provided background information on the analysis and highlighted that the evaluation compared costs under the pharmacy and medical benefits. He shared results on the clear bagging program's utilization, costs, and potential savings.

Ms. Rossner referred to the findings Mr. Fadiran had presented on the bariatric surgery benefit. She said that the benefit was effective in reducing obesity among GHIP members who underwent the procedure. In the first two years following surgery (2022 and 2023), the study group exhibited a more significant decrease in the prevalence of obesity and comorbidities compared to a matched control group that qualified for surgery but did not receive it. Ms. Rossner said that this improvement in health outcomes had led to a decreased utilization of medical and prescription drug services for the study group, which resulted in lower average costs compared to the control

group. Looking ahead, Ms. Rossner said that future evaluations were needed in order to assess if the relatively lower costs and health outcomes for the study group were sustained over time and if they justified the expenses associated with the bariatric surgery benefit. Staff will continue to monitor the viability of the bariatric surgery benefit in the context of overall member health outcomes and expenditures for the GHIP.

Ms. Sieg referred to the findings Mr. Fadiran had presented on the clear bagging program. She said that Merative's evaluation showed the cost of the sample of specialty drugs provided under the clear bagging program was considerably lower than the average cost of the same drugs provided under the medical benefit. She said that the clear bagging program would continue as-is for 2025. Staff will continue to monitor the program for member and cost benefits. Ms. Sieg added that expanding the clear bagging program to other health systems and other insurers will be discussed during contract negotiations on the new Third-Party Administration of Pharmacy Benefits Program agreement set to begin January 1, 2026.

LOCAL PROGRAM ANALYSIS AND OPTIONS (Ref. GIB | 11.13.24 | 16)

Mr. Caracas highlighted background information on the local GHIP. He said that rates for the local GHIP have been increasing at a faster rate than the state GHIP and that the local GHIP had a smaller reserve fund. Mr. Caracas said that local employers had four Program Options they could choose: Traditional, Deductible, Local, and HDHP. The Program Options varied based on premiums and employee out-of-pocket costs. However, all Program Options have Uniform Benefits, meaning that they covered the same medical services and procedures with the same deductible, copayment, and coinsurance.

Mr. Caracas also said that staff gathered input from local employers. He also shared the results of a recent Request for Information (RFI) to solicit input from vendors interested in the Access Plan, State Maintenance Plan (SMP), and/or the local GHIP. He said that staff were exploring additional options with Segal to determine a cost analysis for potential RFP construction.

Mr. Caracas presented on the feedback received from local employers. Local employers reported quality of benefits and lower premium rates as key reasons they participated in the local GHIP. Local employers also expressed interest in having access to specific provider networks and offering the option of a HDHP alongside another Program Option or benefit plan design.

Mr. Caracas said that an RFI was sent to vendors who possessed the resources and expertise to provide uniform health benefits, including current GHIP health plan vendors and non-participating national carriers. The RFI included two parts. The first was regarding state and local employees and retirees who had selected either the Access Plan or SMP that were part of the GHIP. The second part was regarding all employees and retirees of participating local governmental entities.

Mr. Caracas said that four responses to the RFI were received. Three responses were submitted by current GHIP vendors (Dean, Network Health, and Quartz). The fourth submission was from the Wisconsin Association of Health Plans (Association). Dean and Quartz indicated they were interested in bidding for all three programs (Access Plan, SMP, and the local GHIP). Network Health expressed interest in only the local GHIP. Mr. Caracas said that the Association did not support the option of having a sole-source vendor for the local GHIP and promoted the benefits of competition among health plans. The Association also expressed the desire that health plans vendors choose the region within Wisconsin in which they offer providers, instead of being required to contract with providers in borders set by ETF.

Mr. Caracas explained that ETF had taken this input back to Segal and developed a series of options for changes to the structure of the local GHIP to help flatten annual rate increases and maintain stability. The following options were presented with pros and cons listed for each:

- Tiering Option: Switch Locals from 88%/105% tables for rates to being tiered like the State GHIP.
- PO4/P14 Option: Promote this Program Option to Locals as a cost management alternative.
- Regional Option: Create three to six regions across Wisconsin for health plans to bid on to better manage costs.
- HDHP + One Program Option: Offer the HDHP program option along with another option.
- Two Local Program Options: Consolidate the number of Local Program Options available from four to two.
- Sole Vendor Option: Create one population bundle for service by one health plan.

Mr. Caracas reiterated that ETF was exploring an analysis on the local GHIP options with Segal, including cost implications and potential RFP development. The results of this analysis and option recommendations will be provided to the Board at a future meeting.

Mr. Day expressed a desire to minimize member disruptions as part of the Board's consideration on the options for changing to the structure of the local GHIP. He asked that data on member distributions across the four available Local Program Options be provided at a future Board meeting.

Mr. Houdek asked if any of the options would require statutory changes. Mr. Caracas said that the Tiering Option would require adjusting the language in the statute.

The Board asked for clarification on when they could expect follow-up information on the options Mr. Caracas presented for changing the local GHIP structure. Ms. Walk said that additional information and options, particularly those with shorter-term effects and

simplest to enact, will be presented at the March 12, 2025, meeting. Ms. Walk also clarified that the Board would not be asked to release an RFP until 2026 at the earliest, as RFP development was still underway between ETF and Segal.

OPERATIONAL UPDATES

Ms. Walk said that the "Audit of the Pharmacy Benefit Manager" memo (Ref. GIB | 11.13.24 | 17A) was listed under the Operational Updates section as there were no significant findings to present to the Board.

Mr. Pahnke asked for details on the "IAS Update" memo (Ref. GIB | 11.13.24 | 17B). Mr. Voelker stated that the IAS Program is progressing, but several key challenges, mostly on the retiree-side, required continued attention to ensure successful execution and readiness for go-live. Mr. Voelker stated that he believed there was optimism throughout the agency that they could reach IAS implementation by July 1, 2025.

TENTATIVE FIRST QUARTER 2025 AGENDAS (Ref. GIB | 11.13.24 | 18)

Ms. Walk said that three Board meetings are scheduled for the first quarter of 2025 to ensure that critical RFPs were resolved prior to benefit change approvals. The meetings would be held on January 15, February 26, and March 12. The January meeting will be focused on the Medicare Advantage and Medicare Plus RFP results and the PBM RFP results. The February meeting will be focused on the Pre-Tax RFP results, the health actuarial audit, the ICI actuarial audit, and the life actuarial audit. Finally, the March meeting will include the final 2026 benefit changes and the 2026 open enrollment dates.

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 12:30 p.m.

Date Approved: _____

Signed: _____
Nancy Thompson, Secretary
Group Insurance Board