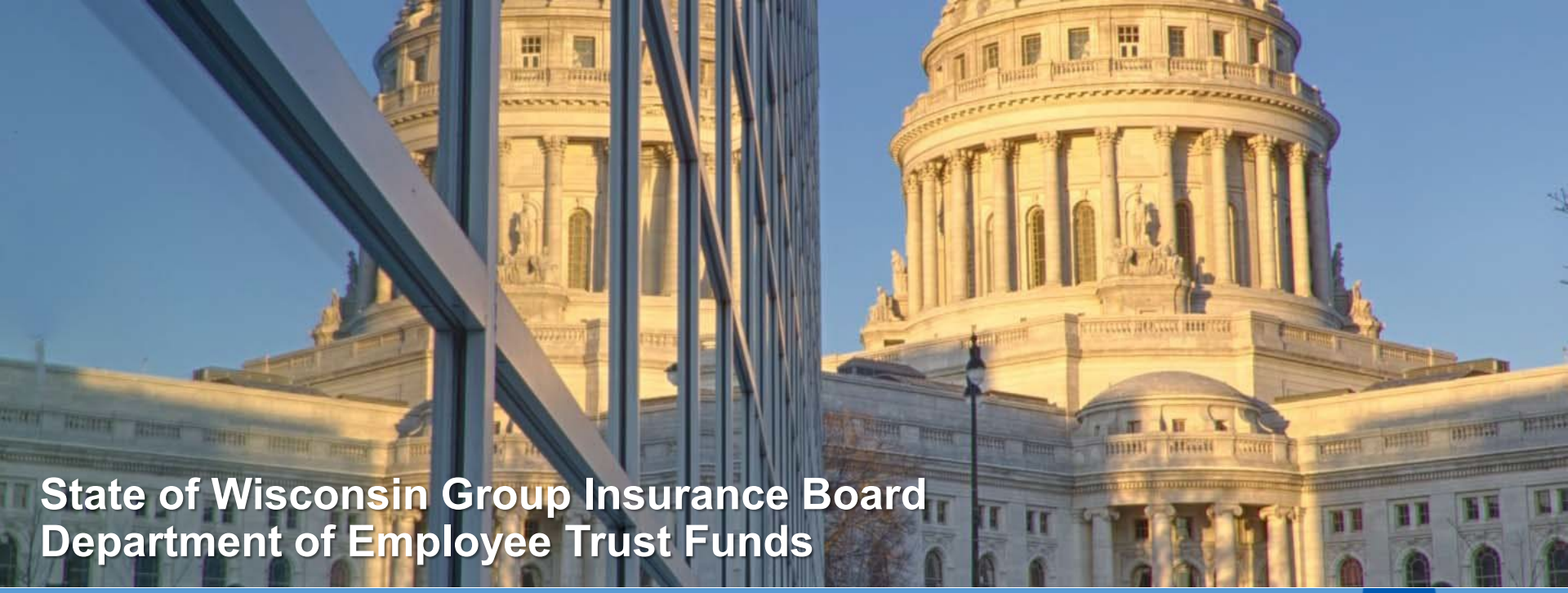

State of Wisconsin Group Insurance Board
Department of Employee Trust Funds

Rate Setting Actuarial Assumptions

February 26, 2025

Segal Consulting

1. **Overview**
2. Medical Rate Development
3. Prescription Drug Projections
4. Dental Projections

Rate Setting Overview

- Medical is fully insured
  - HMOs use Tier Rate/Model approach for Rate Setting
  - Access and SMP Rates are negotiated with Dean Health Plan
  - Medicare Advantage and Medicare Plus rates are negotiated with UHC
- Dental and Rx are self-insured and rates are calculated by Segal
  - Navitus is Pharmacy Benefits Manager
  - Delta Dental is Dental vendor
- ETF Admin fees are supplied by ETF and used to build in internal operational costs
- Reserve Projections can impact the final rates if the board elects to apply an additional buy-up or buy-down to help achieve a future fund balance target.
  - ETF plans to return with a further reserve discussion as we look at revising the approach at a coming meeting

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Medical Rate Development (HMO Group)

- The Tier Model is a group underwriting exercise for the Medical HMO's
  - Groupings are split by Dane, Non-Dane, and Local groups. Within each group:
    - Data is aggregated
    - Adjustments for plan specific cost and utilization experience
    - Baseline Claims Data PMPM (per member per month) is trended to renewal period using vendor assumptions up to Trend Limit
    - Vendor admin fee load assumption PMPM is applied up to the Admin Limit
    - Retrospective risk adjustments are applied
    - Total PMPM (Claims + Admin) is calculated for each plan
    - Weighted average PMPM is calculated based on plan's enrollment
    - A percentage is taken of the adjusted required premium per member per month (PMPM) to determine the Tier 1 and Tier 2 Breakpoint Limits
- The Tier Rate tool is used to determine the tiering of the preliminary bid for each plan
  - This rate is risk adjusted (age-sex, prospective Merative risk score, and regional score)
  - Adjusted for large catastrophic claims
  - Adjusted for the Quality Credit

Medical Rate Example

- Vendor A bids a preliminary bid of $800 (Single Rate)
- Bid is risk-adjusted, adjusted for catastrophic claims, and given a quality credit. After these adjustments, the new adjusted premium calculated by Segal is $750.
- Given a Tier 1 breakpoint of $700, a 6.7% reduction would be needed in the Best and Final Offer (BAFO) for the rate to be considered Tier 1.

Medical Rate Development Assumptions

- The following are in the medical rate development assumptions for the HMOs:
  - Tier Model
    - Experience Period for Claims and Enrollment
    - Fee for Service (FFS) Trend Limit
    - Capitation Trend Limit
    - Medical Admin Limit
    - Experience Adjustment
    - Tier Limits
  - Tier Rate
    - Conversion Factor
    - Catastrophic Claims Adjustment
    - Premium Caps (State & Local Caps)
    - Risk Scores
    - Quality Credits

Experience Period – Tier Model

- Enrollment and claims data are submitted to ETF and Segal by the health plans through the FUDS tool provided by Segal
  - Enrollment data
    - Segal uses 15 months of enrollment data. For the 2025 rate setting, the experience period was October 2022 through December 2023.
    - Contracts and member counts are collected by month split by single and family
  - Claims data
    - Segal uses 12 full months of claims data with 3 months of runout. For the 2025 rate setting, the experience period used was incurred claims from October 2022 to September 2023 and paid through December 2023.
- This experience period is selected to incorporate the most up-to-date data given the timing of deliverables

Claims Trend and Admin Fee Limits – Tier Model

- The experience period data needs to be trended to renewal period. We use a midpoint-to-midpoint approach, thus applying 27 months of trend.
- Trend limits are set in a joint effort by ETF and Segal based on market trends and budget constraints
- These limits are used to adjust for excessive trends reported by the plans, which helps prevent over-inflation of the breakpoint
  - Fee for Service Trend Limit
    - 6.5% used for Local, and 5.5% used for Dane and Non-Dane
  - Capitation Trend Limit
    - 5.5% used for Local, and 4.5% used for Dane and Non-Dane
- Medical Admin Fee limit adjusts admin fees reported by the vendors that exceed the threshold set by ETF and Segal, which also maintain a reasonable breakpoint
  - Medical Admin Fee Limit
    - $53.46 PMPM used for Local, $49.17 PMPM for Dane, and $51.90 PMPM for Non-Dane

Experience Adjustment – Tier Model

- Experience Adjustment is used to account for actual plan experience during the experience period and is dependent on the individual plan's reported cost and utilization
  - Data comes from ETF's Data Warehouse. This is a relatively new adjustment and was first implemented during COVID.
  - We recognized that some vendors had large costs per service increases. Paying providers significantly more than average to offset decreases in utilization.
  - In a capitation arrangement, the vendor is essentially paying themselves a higher amount
  - We analyze the Cost Per Service vs Utilization in the underlying experience and adjust for any unusual inflation to keep the breakpoint from artificially increasing

Tier Breakpoint Limits – Tier Model

- The percentages below are used to calculate each tier threshold by multiplying the percentage by the average of all plans Capped Required Premium (PMPM) for that group
- If the plan's risk adjusted premium falls below the tier limit, the plan is classified as that tier
- Plans are placed in either Tier 1, Tier 2, or Tier 3
- Tier Limits are set in a joint effort by ETF and Segal. They remain mostly consistent.
  - Tier 1 Limit
    - This is the maximum rate required for a plan to be classified as Tier 1
    - 91% used for Dane, 95% for Non-Dane, and 97.5% used for Local
  - Tier 2 Limit
    - This is the maximum rate required for a plan to be classified as Tier 2
    - 102% used for Dane and Non-Dane and 102.5% used for Local
  - Tier 3
    - Any rate outside of Tier 2 is considered Tier 3

Conversion Factor – Tier Rate

- Factor that converts the preliminary single bid to a PMPM rate
  - Conversion factor calculated based off contract mix of single and family contracts provided in the FUDS tool submission for each plan
- Purpose of this factor is to convert the bids to a PMPM basis, which is the same basis as the Tier Model

Catastrophic Claims Adjustment – Tier Rate

- Catastrophic Claims Pooling Charge is a weighted average of the catastrophic claims PMPM by plan. These are defined as claims over $100,000.
  - $46.58 PMPM for Local, $72.56 PMPM for Dane, and $76.68 PMPM for Non-Dane
- The Catastrophic Claims Adjustment gives an adjustment to plans that have larger or more catastrophic claims than the Catastrophic Claims Pooling Charge
- This adjustment allows plans to get a higher rate to offset them paying a greater share of cataphoric claims than average
- Taking a weighted average lets the adjustment act as a credit for plans who have larger or more catastrophic claims
  - For example, if a Non-Dane plan has a catastrophic claims PMPM of $85, they could get an $8.32 credit due to the adjustment limit

Premium Caps – Tier Rate

- State
  - Cap imposed to limit the increase of the state premium year over year from the inforce rate for each plan
  - There was no premium cap used for 2025 rate setting
- Two types of Caps for Locals
  - Rate Increase Caps
    - Cap imposed to limit the increase of the Local premium year over year from the inforce rate for each plan
      - Tier 1 Cap – 10% Rate Increase Cap from In-Force Rate
      - Tier 2 Cap – 20% Rate Increase Cap from In-Force Rate
      - Tier 3 Cap – 30% Rate Increase Cap from In-Force Rate
  - % of State Rate Caps
    - Cap imposed to limit the increase of the Local Rate compared to the State Tier 1 Rate for that plan
      - Tier 1 – Cap is 120% of the State Tier 1 Rate
      - Tier 2 – Cap is 130% of the State Tier 1 Rate
      - Tier 3 – Cap is 140% of the State Tier 1 Rate

Risk Scores – Tier Rate

- Risk Scores are used to determine the risk for each individual plan and are comprised of an age-sex factor, prospective Merative risk score, and regional score
  - Age-Sex factor calculated through enrollment data submitted by the plans in the FUDS tool
  - Prospective claims risk score comes from the Merative Data Warehouse
  - Regional factors calculated based on Individual market medical data for the State of Wisconsin
- The scores are normalized and are combined into an overall risk factor to adjust premiums accordingly
  - Scores were weighted 20% for age-sex, 30% for risk, and 50% for regional

Quality Credits – Tier Rate

- Quality Credits are given to the top 5 plans based on a select group of Health Effectiveness Data and Information Set (HEDIS) measures
- ETF does the calculations and provides the results to Segal
  - First place is given to the plan with the best scoring and receives the largest premium credit, which is applied to the adjusted required PMPM for that plan
  - Segal applies premium credits of 1%, 0.875%, 0.75%, 0.625%, and 0.5%

Medical Rate Development (Access, SMP, & Medicare Groups)

- Different than HMO's Tier Model Process
- Access and SMP Rates are negotiated with Dean Health Plan
- Medicare Advantage and Medicare Plus rates are negotiated with UHC
- Vendors submit their renewals and provide data and assumptions used in the process
  - Segal reviews assumptions and renewal
  - Segal negotiates fair rate based on any assumptions that may be out of line

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Prescription Drug Projection Assumptions

- Prescription Drug assumptions are reviewed and discussed with Navitus
- Experience Period for plan year 2025
  - Baseline data utilized the most recent 12 months of paid claims, February 2023 through January 2024. This data is provided by Navitus to Segal.
- The following groups are pooled together during rate setting:
  - State Non-Medicare, Non-Grad
  - State Grads
  - State Medicare
  - Local Non-Medicare, Non-Grad
  - Local Medicare
- Trend
  - In past years, Segal used a mix of Segal's Rx trend survey and trend supplied by Navitus to determine Rx trend. In 2025, Segal used trend given by Navitus because it reflects their Humira biosimilar strategy.
  - Annual trend of 6.2% was used for Actives and 7.1% was used for Retirees

Prescription Drug Projection Assumptions (Cont.)

- Rebates were provided by Navitus
  - State
    - $103.5M for Non-Medicare and $45.6M for Medicare
  - Local
    - $20.9M for Non-Medicare and $3M for Medicare
- Medicare Subsidies were provided by Navitus for Direct Subsidies, Manufacturer Discount Program (MDP), Low Income Subsidy Cost Sharing (LICS), and Reinsurance
  - State
    - $22.8M for Direct Subsidies, $43.5M for MDP, $601K for LICS, and $25.6M for Reinsurance
  - Local
    - $1.3M for Direct Subsidies, $3.2M for MDP, $76K for LICS, and $1.5M for Reinsurance
- Admin Fees were provided by Navitus
  - $2.10 PMPM was used for Non-Medicare and $10.88 PMPM was used for Medicare
  - Same for State and Local
- Single rates are used for both single and family contracts when calculating the total revenue for the plan year
  - Family contracts are multiplied by a factor of 2.5 for the average family contract size for Non-Medicare groups and by a factor of 2.0 for Medicare groups

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Dental Projection Assumptions

- There is one combined risk pool for both State and Local
- Experience Period
  - Segal uses projected incurred claims from January 2023 through December 2023 with one month of paid runout (January 2024) for the 2025 Dental rate setting
  - This data is provided by Delta Dental in the Delta Dental Template Tool that is created by Segal
- Completion Factors are used to calculate the total projected incurred claims
  - Calculated based on historical claims lags
- Trend
  - Trend is determined by Segal trend survey and discussions with Delta Dental
  - Annual trend of 4% was used for all Actives and Retirees
- Plan design changes are provided by Delta Dental and validated by Segal; however, there were no plan changes for the 2025 plan year
- Admin Fee is provided by Delta Dental
  - $1.10 PEPM (per employee per month)
- Single rates are multiplied by a factor of 2.5 for the family rate

Questions & Discussion

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