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Correspondence Memorandum

Date: March 11, 2025 (Revised)

To: Group Insurance Board

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Subject: 2026 Final Benefit and Contract Changes

The Department of Employee Trust Funds (ETF) requests the Group Insurance Board (Board) approve modifications to the Program Agreement (PA), Uniform Benefits (UB) Certificates of Coverage (CoCs), wellness and condition management (CM), and the Uniform Pharmacy Benefits (UPB) as described in this memo.

I. Background

ETF presented initial change concepts to the Board for program year 2026 at the November 13, 2024, Board meeting (Ref. GIB | 11.13.24 | 12). This initial review was intended to provide the Board with a summary of possible changes being considered for the coming benefit year. Following the November meeting, ETF reviewed potential benefit changes with Group Health Insurance Program (GHIP) vendors, and Segal, the Board's actuary. Through this process, ETF identified a final set of proposed benefit changes. Highlighted recommended and not recommended changes are included in this memo. For a full list of benefit changes, please see Attachment A.

II. Program Agreement Changes

The section below provides detail on some of the more significant changes to the PA proposed for program year 2026. A full listing of changes with relevant contract language adjustments can be found in Attachment A to this memo.

Data Integration and Use

Currently, file specifications for wellness and CM, pharmacy, and the data warehouse are included in the health plan contract. Health plans who can incorporate and utilize wellness and CM data should work directly with the wellness and CM vendor to get the

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latest file specifications rather than getting the file specifications from ETF. This will ensure the health plans are receiving the latest specifications. Furthermore, some health plans are not able to integrate and utilize the data. Therefore, they should not be receiving the data to reduce the inherent risk related to data sharing and to protect member data.

Health plans will receive pharmacy benefit plan specifications from the pharmacy benefit manager (PBM) and the data warehouse file specifications from Merative, rather than from ETF.

Quarterly Performance Standards and Penalties

To make the quarterly performance standards for customer service more equitable to smaller plans, ETF has added language to the PA modifying the penalty assessment calculation based on the membership size of the health plan:

- **Small Plans:** Fewer than 10,000 members
- **Medium Plans:** 10,000–50,000 members
- **Large Plans:** More than 50,000 members

An example of how a penalty will be calculated based on this new method is as follows:

- **Small Plans**
  - Penalty: $1,000 per percentage point below 80% target metric
  - Example: Plan scores 75% → 5% shortfall × $1,000 = **$5,000 penalty**
- **Medium Plans**
  - Penalty: $3,000 per percentage point below 80% target metric
  - Example: Plan scores 75% → 5% shortfall × $3,000 = **$15,000 penalty**
- **Large Plans**
  - Penalty: $5,000 per percentage point below 80% target metric
  - Example: Plan B scores 75% → 5% shortfall × $5,000 **= $25,000 penalty**

ETF does not recommend extending the new quarterly penalty assessment to the other performance measures because the membership size of the health plans does not impact the scoring of other performance measures.

Communications

ETF will add language to the PA that requires health plans to include a link to the wellness and CM vendor and PBM's webpage(s) on their GHIP member-specific website and/or web portal to assist members with learning more about the benefits included in their GHIP coverage.

The language "microsite" will be added to the program agreement after any section referencing websites. Most vendors use a microsite to create specialized marketing materials that focus on specific topics.

Language has been added to the section of the PA referencing the frequency in which identification cards are to be distributed to members. Health plans must send out new

identification cards only if new members are enrolling or if there is a change in information to be printed on the card.

Care Management Department Initiative
Diabetes prevention and management continues to be an area of opportunity for health, quality, and cost containment in the GHIP. ETF had conversations with vendor partners regarding what they are doing to support members and started to identify additional possibilities to collaborate and expand support. ETF staff recommends adding diabetes management and prevention as a Department Initiative under Section III. G. 1. of the Agreement to formalize a commitment to continue the work going forward. ETF also recommends requiring health plans to demonstrate their efforts to promote the services available to GHIP members through the wellness and CM program.

2025 Program Agreement Amendment
The revised Quarterly Performance Standards penalty assessment calculation will be inserted as an amendment to the 2025 Program Agreement. This penalty assessment calculation modification will be implemented beginning in 2025.

See Attachment A for PA changes that are not recommended.

A. Cost-Neutral Benefit Changes

The section below provides detail on some of the more significant changes to the CoCs, pharmacy, and wellness and CM benefits proposed for program year 2026. A full listing of changes with relevant contract language adjustments can be found in Attachment A to this memo.

Clarifying Language within Eligibility, Enrollment, and Termination
ETF recommends adding language to the Qualifying Life Event – Retirement and the COBRA Continuation sections of the CoC. This will provide clarification on member eligibility to change plans when enrolling in Medicare and how members obtain COBRA paperwork based on the implementation of the Insurance Administration System (IAS).

Aligning Definition of Dependent Student
ETF recommends aligning language under Out-of-Network Coverage for Full-Time Students to Wis. Stat. § 609.655, which defines a dependent student as a student within the state of Wisconsin.

Removing Prior Authorization Requirement
ETF recommends adjusting Prior Authorization language under Durable Medical Equipment and Medical Supplies to allow flexibility in authorization by changing “must” to “may.”

Awarding Discretion to ETF to Determine Reasonable Timeframe for Proof of Claim
ETF recommends adding clarity to the Proof of Claim section under Member Rights and Responsibilities, regarding when a claim needs to be filed after services. This change will give discretion to ETF to determine if the claim is submitted within a reasonable timeframe if it is submitted beyond the given 12-month period.

Changing Health Plan Following Death of Subscriber or Dependent
ETF recommends adding language to the Qualifying Life Event section to allow members to not only change from family to individual coverage, but to also change from one health plan to another after the death of a spouse or dependent. Per Segal, the cost of the change would be negligible.

Expanding Conditions Eligible Under Biofeedback
ETF recommends expanding the eligible conditions under biofeedback to align with evolving evidence and member need. The specific conditions being added include fecal incontinence, chronic constipation, and refractory severe tinnitus. National health plans as well as current GHIP health plans within their commercial plans, already cover these conditions. [1] Biofeedback is considered a medically necessary way to treat these conditions.

It's Your Health: Diabetes
Non-High Deductible Health Plan (non-HDHP) members who enroll in the *It's Your Health: Diabetes* pilot program receive lower copays on their diabetic prescriptions for participating in the Well Wisconsin condition management program. ETF shared a report highlighting favorable impacts on health, quality, and cost for members participating in the *It's Your Health: Diabetes* pilot program at the Board's November 13, 2024, meeting (Ref. GIB | 11.13.24 | 14). Since then, Merative has completed a financial assessment using a difference-in-differences approach to determine if the benefits/savings outweigh the costs of the pilot program. The analysis shows a negative return-on-investment (ROI) in 2021 (-22.7%), but positive ROIs in 2022 (35%) and 2023 (57.6%). See Attachment B, page 15, for more information. With the trend towards positive ROIs in the more recent years, ETF recommends shifting this program into a standard benefit offering beginning in 2026. ETF will continue to monitor the impact of the program.

Additional costs are not expected with this change since this pilot has not been limited to a subset of the population, and anyone who is interested has been able to participate.

Continuous Glucose Monitor (CGM) Coverage Under the Pharmacy Benefit
Since January 1, 2022, CGM has been covered under both the medical benefit and pharmacy benefit (Ref. GIB | 05.12.21 | 8F, pages 5-7). In 2022, 64.2% of member CGM claims were processed under the medical benefit.

[1] "Biofeedback," Aetna. Accessed January 8, 2025. https://www.aetna.com/cpb/medical/data/100_199/0132.html

The market has changed since 2022, and now a majority of public and private sector employers cover CGMs under their pharmacy benefit only. Through the first three quarters of 2024, 80% of members' CGMs and 87% of CGM supply claims were filed under the pharmacy benefit. According to data from ETF's data warehouse, the Board has been paying about $160 less for CGM units covered under the pharmacy benefit than those covered under the medical benefit since 2022.

Some of the Board's health plans have stated that ETF is one of their only clients still offering CGM coverage under medical insurance benefits. One of the Board's health plans told staff that 75% of their book of business covers CGMs solely under pharmacy benefits.

ETF's CGM coverage being an outlier has led to members getting incorrect CGM coverage information from health plans. Two different vendors have mailed information to their entire books of business regarding CGM coverage, including the Board's members. The information was accurate for everyone except the Board's members. The vendors had to send a separate follow-up mailing to the Board's members informing them that the initial mailing was inaccurate and should be disregarded. This confusion led to members contacting ETF's Member Services and employers reaching out to ETF Employer Services before the error was identified and the second mailing was sent. The current commercial pharmacy benefit covers Dexcom G6, Dexcom G7, Freestyle Libre 2, Freestyle Libre 3, Omnipod 5 G6, and Omnipod 5 G7 CGMs and supplies. All CGMs are currently covered on tier 2 of the commercial pharmacy formulary, with prior authorization requirements and varying quantity limits. Drugs on tier 2 have a 20% copay, with a $50.00 maximum, and no deductible for non-HDHP members. Under the medical benefit, CGMs are currently covered at 20% with no maximum, after the medical deductible is met.

If approved for the 2026 plan year, ETF will work with health plans to communicate this change to members and prescribers mid-2025, and again prior to the 2026 open enrollment period to ensure members have time to make any needed changes on how they obtain their CGM supplies. Information about the change in coverage will be available on ETF's website and in open enrollment materials.

See Attachment A for other medical benefit changes that are not recommended.

III. Cost Pressures Relevant to Benefit Changes that Increase Cost

The Board has had several discussions regarding coverage of anti-obesity medications (AOMs)[2] in recent years and has asked ETF to further examine coverage for 2026. The following sections do all of the following:

[2] See memos from the following meetings: May 18, 2022 (Ref. GIB | 05.18.22 | 5C), June 30, 2022 (Ref. GIB | 06.30.22 | 4), Nov. 16, 2022 (Ref. GIB | 11.16.22 | 13), May 17, 2023 (Ref. GIB | 05.17.23 | 3C), Feb. 21, 2024

- Identify GHIP cost pressures for 2026.
- Present options to the Board that address those cost pressures.
- Revisit options for AOM coverage.
- Offer ETF's recommendations for addressing cost pressures and for AOM coverage for 2026.

Balancing all cost pressures is a fiduciary responsibility for the board. These challenging decisions are increased for 2026 with the consideration of adding coverage for AOMs. Pursuant to statutory requirements, adding AOM coverage would require identifying corresponding cost savings to maintain or reduce premium costs for the state or its employees in the current or any future year. This memo identifies and evaluates potential benefit cuts that have been previously discussed by the board and provides information on options for increased member cost-sharing. As fiduciaries the board is required to balance the interests of all members in acting in the best interest of the Fund.

Based on the cost pressures identified below, and the impact of corresponding benefit reductions and significant increased cost sharing that would be necessary for all members, ETF is not recommending coverage of AOMs for 2026 either through a change in coverage or through a pilot program. ETF instead recommends prioritizing the financial stability of GHIP for plan year 2026; adjusting cost sharing to alleviate some of the cost pressures anticipated for 2026; continuing to evaluate the anticipated costs and savings associated with AOMs, as well as options for providing coverage that are not subject to excessive cost-sharing for AOMs, and ensuring the impacts of offsetting benefit reductions and member cost-sharing increases do not have a significant negative financial impact on all members. ETF recommends revisiting the topic of AOM coverage for plan year 2027.

A. Cost Pressures for 2026

At the outset, it is important to note cost pressures the board will need to balance in making 2026 benefits decisions that increase costs:

Reserve Fund
As discussed at the January 15, 2025, Board meeting, the GHIP reserves have begun experiencing negative cash flow in many months over the past year (Ref. GIB | 01.15.25 | 12). The increasing cost of the pharmacy benefit is one of the contributing factors to the state of the reserve fund.

(Ref. GIB | 02.21.24 | 7C), May 23, 2024 (Ref. GIB | 05.23.24 | 10A), August 14, 2024 (Ref. GIB | 08.14.24 | 4), and November 13, 2024 (Ref. GIB | 11.13.24 | 13)

Unfortunately, the cost of drugs is not projected to decrease in 2025 or beyond. Cost trends for overall prescription drug plans for 2025 are projecting a 11.4% increase, driven by a 13.3% projected rise in specialty drug costs.[3]

Dean Health Plan Settlement

Dean Health Plan's (Dean's) contract for administering the Access and State Maintenance Plans includes a risk-sharing arrangement. The provision required the Board to pay about $8 million to Dean for administering the programs in 2023 and another $8 million is projected for 2024 (Ref. GIB | 05.23.24 | 4B, Slide 6). There is also a possibility of an additional settlement payment due for 2025 and beyond.

Premium Increases

Health insurance costs continue to rise for both public and private sector employers. A recent survey by the Centers for Medicare and Medicaid Services (CMS) released projections for healthcare spending through 2032. The survey shows a projected increase in spending by third-party insurance payers, like the Board, from $366.3 billion in 2023 to $562.1 billion in 2032. Over that period, hospital expenditures are projected to increase by $73.8 billion and prescription drug costs by $2.8 billion.[4]

For the 2025 plan year, state employees saw a premium increase of 7.3%, and local employees experienced an increase of 11%.[5] The Board is scheduled to vote on 2026 premiums at the May 21, 2025, Board meeting. The projected savings from the plan design changes could be used to offset or reduce premium increases for 2026.

AOMs in Medicare Part D

There may be a federally required change to the Employer Group Waiver Plan (EGWP), also known as Medicare Part D, which could increase costs significantly in 2026. On November 26, 2024, CMS proposed a new rule that would "reinterpret the statute to no longer exclude (AOMs) for treatment of obesity from coverage under Medicare Part D."[6] This new proposed rule would require all Medicare Part D plan providers, including EGWP providers like the Board, to cover drugs that treat obesity.

The change, proposed by the previous administration, still requires approval from the current administration. At this time, no official statement or action has been made regarding the proposed rule change for 2026.

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[3] The Segal Group, "What Are the Projected Health Plan Cost Trends for 2025?" September 18, 2024, https://www.segalco.com/consulting-insights/2025-health-plan-cost-trend-survey

[4] Center for Medicare & Medicaid Services, "NHE Fact Sheet", https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet

[5] Wisconsin Department of Employee Trust Funds "Health Premium Increases for 2025 Plan Year" https://etf.wi.gov/health-premium-increases-2025-plan-year

[6] "Biden-Harris Administration Announces Medicare Advantage and Medicare Part D Prescription Drug Proposes that Aim to Improve Care and Access for Enrollees" CMS, November 27, 2024, https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-medicare-advantage-and-medicare-part-d-prescription-drug

Segal examined the impact of adding coverage for Wegovy and Zepbound to the EGWP formulary for all Medicare members. Segal estimates that if AOMs are included for the Board's Medicare members who meet the Food and Drug Administration's (FDA's) Body Mass Index (BMI) recommendation for coverage, the benefit would result in an additional $5,356,395 in spending for the EGWP benefit. If CMS permits EGWP plan providers such as the Board to adjust the BMI coverage requirements to 35 or higher, Segal estimates the cost would be $4,197,915 during the first year of coverage.

Well Wisconsin Incentive for Medicare Advantage Members

All GHIP subscribers, including Medicare Advantage (MA), currently pay the wellness administration fee as part of their overall health premiums which funds the Well Wisconsin program and the incentives. To date, GHIP MA members have had access to Well Wisconsin resources and services but not the $150 incentive. MA members have not historically had access to the Well Wisconsin $150 incentive based on information previously provided by UHC that allowing MA members access to that incentive may impact their CMS star ratings, which help keep premiums low; UHC has since changed their position on MA members receiving the incentive. ETF has identified a fiduciary concern with having MA members pay the full wellness administration fee without having access to the full benefit. To address this concern, the Board could decide to allow MA members access to the $150 incentive. In the alternative, the Board could decide to remove MA members from Well Wisconsin.

ETF recommends allowing MA members to earn the Well Wisconsin incentive beginning in 2026. The Board approved contracting with UnitedHealthcare (UHC) for the MA health plan beginning in 2026 at its January 15, 2025, meeting (Ref. GIB | 01.15.25 | 11B). UHC will continue to offer incentives to its MA members since their incentives are related to activities to support higher CMS star ratings, which helps keep medical premiums low. The average incentive amount earned by UHC members was $40.64 in 2024. UHC does not have concerns with the change ETF is recommending.

If the Board approves the recommended change, ETF anticipates an increase in the number of Well Wisconsin incentives earned. Additional costs would need to be added to the wellness administration fee and split across all GHIP contracts to fund the additional incentives. For cost estimation purposes, 10.5% of non-MA retirees who are currently eligible to earn the Well Wisconsin incentive do so, while 35.9% of MA members (6,386 members) earn incentives through UHC. Applying these percentages, ETF estimates that adding the Well Wisconsin incentive benefit for MA members would increase the total wellness administration fee by $280K to $960K per year. This cost would be split across all the contracts and add approximately $0.20 to $0.69 to the wellness administration fee per contract per month. ETF estimates the additional cost to be on the lower end of the range because UHC automatically sent incentives to approximately half of the incentive earners for completing a home visit with a health care practitioner.

Alternatively, the Board can remove MA members from the Well Wisconsin program to address the fiduciary concern. If the Board chooses this option, implementation will need to be deferred until a future date, due to resource constraints related to the IAS project. Removing MA members from the Well Wisconsin program would impact rates, since the wellness administration fee would no longer be included in MA contracts. The fees MA members are paying would shift to non-MA contracts. It would add approximately $0.73 to the wellness administration fee per non-MA contract per month and decrease MA contracts by $10.83 per month.

B. Alternatives to Mitigate Costs for 2026

The Board has two alternatives for mitigating costs as described below. The first is the elimination or reduction of existing benefits. Many benefits are required and could not be considered for elimination or reduction. One benefit reduction previously discussed is redirecting funds from the Well Wisconsin program. ETF is not recommending this alternative at this time. Rather, ETF's recommendation is to move forward with the planned Well Wisconsin return-on-investment (ROI) evaluation for 2026.

The second alternative is to increase member cost-sharing. ETF is recommending increased member cost-sharing for 2026 for the purpose of managing the expected cost pressures on premiums as discussed above. This memo offers four options and is recommending the increased cost-sharing option identified in Table 5.

Benefits Elimination or Reduction: Redirecting Funds from Well Wisconsin

ETF provided information on an option to redirect approximately $16 million in funds from Well Wisconsin at the November 13, 2024, Board meeting to help offset the projected costs of AOM coverage (Ref. GIB | 11.13.24 | 13). The program currently supports over 50,000 members with managing and preventing a variety of chronic conditions, including overweight and obesity. Furthermore, the Positively Me weight management program available through Well Wisconsin could be a uniform lifestyle management option to pair with a GLP-1 prescription if the Board were to approve AOMs for the GHIP, or this could be established as part of a pilot program. Members would be able to work directly with the Well Wisconsin vendor to enroll in the comprehensive weight management program and participate in lifestyle management related activities, and the vendor can share participant information with Navitus who can then fill the prescription. This is similar to the process the two vendors have already used with the *It's Your Health: Diabetes* program. Alternatively, members do have access to nutritional counseling through medical providers.

Board members inquired during the November 13, 2024, meeting whether the Board can end or reduce the $150 Well Wisconsin incentive while still offering other Well Wisconsin services to help offset projected costs of AOM coverage. While the Board can do this and realize approximately $7.5 million in savings, ETF believes it would deter some participants from engaging in the program. Extrinsic motivators, like an incentive, can help encourage people to engage in well-being activities and help

establish a relationship with a well-being provider who can provide further support when participants are intrinsically ready.[7] Furthermore, the $150 incentive is well below the norms other employers are offering their employees. A recent report revealed the weighted average annual incentive amount per employee was $737 in 2024.[8]

Deductible and Copay/Coinsurance Increases

The Board currently offers six different plan options for non-Medicare members. The Board can make changes to the plan designs and increase member cost share to help reduce the impact of cost pressures on increasing premiums.

Active state employees and non-Medicare retirees must enroll in plan option PO1, which offers two types of coverage: a traditional health maintenance organization (HMO) and a HDHP plan.

Members enrolled in the Board's local member health plans can only enroll in the options their employer selects. Some of those options, such as the Local Health Plan Insurance (PO6/P16) and the Local Annuitant Health Program (LAHP), also known as PO8, mirror the plan design of the PO1 traditional HMO. The Local HDHP Plan (PO7/17) has the same coverage and design as the PO1 HDHP.

The Local Deductible Plan (PO4/P14) is an HMO plan that offers a higher deductible than other non-HDHP plans and requires members to pay all medical costs until the deductible is met.

The Local Traditional Plan (PO2/P12) is an HMO plan that offers zero deductibles, copayments, and requires a coinsurance payment on only a few medical services and equipment.

[7] Ozer, Ira. 2014. Wellness Incentives Encourage Participation and Engagement. Occupational Health and Safety. https://ohsonline.com/Articles/2014/09/01/Wellness-Incentives-Encourage-Participation-and-Engagement.aspx?admgarea=news

[8] Motion Connected. 2024. The Current State of Employee Well-being & Engagement Report. https://www.wellnesscouncilwi.org/WCWI/Documents/2024-Employee-Wellbeing-Engagement-Trend-Report.pdf

Table 1: 2025 Plan Designs Comparison

Plan Design	PO1, PO6/P16, and PO8	PO4/P14	HDHP PO1 and PO7/P17
Deductible (Individual/Family)	$250/$500	$500/$1,000	$1,650/$3,300
Out-of-Pocket Limit (Individual/Family)	$1,250/$2,500	$9,200/$18,400	$2,500/$5,000
Coinsurance	10%	0%	10%
Primary Care Office Visit Copay	$15	100%*	$15*
Specialist Office Visit Copay	$25	100%*	$25*
ER Copay	$75 ($60 for PO8)	$60*	$75*

* Member pays 100% until deductible is met.

Actuarial values (AVs) represent the percentage of a person's medical expenses that will be covered by health plans within each tier.[9]

CMS' guidance on AVs states: "The statute groups health plans into four levels: bronze with an AV of 60 percent; silver, with an AV or 70 percent; gold, with an AV of 80 percent; and platinum, with an AV or 90 percent."[10] Health insurance plans with an AV of 90% or higher will cover, on average of 90% or more of a person's medical expenses.

Table 2: Actuarial Values for 2025 Board Health Plans

Plan Options	Actuarial Value
PO1, PO6/PO16, and PO8	94.3%
PO4/P14	96.1%
HDHP PO1 and PO7/P17	86.8%

Segal has prepared different options that increase deductibles, OOPLs, coinsurance, and copays for primary care, specialty office visits, and emergency room (ER) visits for each of health plan designs. These options are detailed below in Tables 3-7 using the February 4, 2025, membership.

[9] The Hendry Kaiser Family Foundation, What the Actuarial Values in the Affordable Care Act Mean, 2011 April, https://www.kff.org/wp-content/uploads/2013/01/8177.pdf
[10] Center for Medicare & Medicaid (CMS), Final 2025 Actuarial Value Calculator Methody, 2024 April 2, https://www.cms.gov/files/document/final-2025-av-calculator-methodology.pdf

Table 3: Option 1, 2026 Plan Design Change for PO1, PO6/16, PO8, HDHP PO1, and PO7/P17

Plan Design (PO1, PO6/P16, PO8)	Current State 180,466 Members	Proposed Change
Deductible (Individual/Family)	$250/$500	$1,000/$2,000
OOPL (Individual/Family)	$1,250/$2,500	$1,750/$3,500
Coinsurance	10%	20%
Primary Care Office Visit Copay	$15	$25
Specialist Office Visit Copay	$25	$40
ER Copay	$75	$200
Actuarial Value	94.3%	91.5%

Plan Design (HDHP PO1, PO7/P17)	Current State 39,088 Members	Proposed Change
OOPL	$2,500/$5,000	$3,000/$6,000
Coinsurance	10%	20%
Primary Care Office Visit Copay	$15	$25
Specialty Office Visit Copay	$25	$40
ER Copay	$75	$200
Actuarial Value	86.8%	86%
Projected yearly savings: $56,112,061		

Table 4: Option 2, 2026 Plan Design Change for PO1, PO6/16, PO8, HDHP PO1, and PO7/P17

Plan Design (PO1, PO6/P16, PO8)	Current State 180,466 Members	Proposed Change
Deductible (Individual/Family)	$250/$500	$750/$1,500
OOPL (Individual/Family)	$1,250/$2,500	$1,750/$3,500
Coinsurance	10%	20%
Primary Care Office Visit Copay	$15	$25
Specialist Office Visit Copay	$25	$40
ER Copay	$75	$200
Actuarial Value	94.3%	92.1%
Plan Design (HDHP PO1, PO7/P17)	**Current State 39,088 Members**	**Proposed Change**
OOPL	$2,500/$5,000	$3,000/$6,000
Coinsurance	10%	20%
Primary Care Office Visit Copay	$15	$25
Specialty Office Visit Copay	$25	$40
ER Copay	$75	$200
Actuarial Value	86.8%	86%
Projected yearly savings: $49,720,889		

Table 5: Option 3: 2026 Plan Design Change for PO1, PO6/16, PO8, and HDHP PO1, PO7/P17

Plan Design	Current State 180,466 Members	Proposed Change
Deductible (Individual/Family)	$250/$500	$500/$1,000
OOPL (Individual/Family)	$1,250/$2,500	$1,750/$3,500
Coinsurance	10%	20%
Primary Care Office Visit Copay	$15	$25
Specialist Office Visit Copay	$25	$40
ER Copay	$75	$200
Actuarial Value	94.3%	93.1%
Plan Design (HDHP PO1, PO7/P17)	**Current State 39,088 Members**	**Proposed Change**
OOPL	$2,500/$5,000	$3,000/$6,000
Coinsurance	10%	20%
Primary Care Office Visit Copay	$15	$25
Specialty Office Visit Copay	$25	$40
ER Copay	$75	$200
Actuarial Value	86.8%	86%
Projected yearly savings: $41,790,236		

Table 6: Option 4 2026 Plan Design Changes for PO4/P14

Plan Design	Current State 19,430 Members	Proposed Change
Deductible (Individual/Family)	$500/$1,000	$750/$1,500
Coinsurance	0%	20%
ER Copay	$60	$200
Actuarial Value	96.1%	86.1%
Projected yearly savings: $13,165,185		

Table 7: Plan Design Option Change Comparison

	Option 1	Option 2	Option 3	Option 4
Plan Design	PO1, PO6/16, PO8, HDHP PO1, and PO7/17	PO1, PO6/16, PO8, HDHP PO1, and PO7/17	PO1, PO6/16, PO8, HDHP PO1, and PO7/17	PO4/14
Non-HDHP Deductible	$1,000/$2,000	$750/$1,500	$500/$1,000	$750/$1,500
Non-HDHP OOPL	$1,750/$3,500	$1,750/$3,500	$1,750/$3,500	NC
Coinsurance	20%	20%	20%	20%
Primary Care Office Visit	$25	$25	$25	NC
Specialty Office Visit	$40	$40	$40	NC
ER Copay	$200	$200	$200	$200
HDHP OOPL	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000	NC
Projected Savings	$56,112,061	$49,720,889	$41,790,236	$13,165,185

The AV of each plan design decreases with the proposed increases in member cost within each option. However, each option would remain in the platinum level tier, except for option 4. The proposed changes to the PO4/P14 plan would be lowered to a gold tier. When compared to the eight public sector employers' AVs shown in Attachment C, the Board's plan designs would still maintain comparable AVs, and in most cases, a higher AV than those shown by the other states.

It should be noted that local employers enrolled in the PO4/P14, such as the City of Madison, have collective bargaining agreements with their employees. If the Board were to change the PO4/P14 plan design, ETF would need to communicate the change to the local employers, and the changes may need to be incorporated into new collective bargaining agreements.

IV. Benefit Changes with an Associated Cost Increase

Weight Loss Drugs and Cost Sharing Considerations

As with any decision to add or reduce benefits, the board as fiduciaries is required to act in the best interest of plan participants. When subgroups of plan participants have competing interest, the board must balance those competing interests in a way that is reasonable.

At a high level, there are two options for adding coverage of AOMs:

1. **Adding weight loss drugs to the commercial pharmacy formulary:** Based on state law, this option would require identifying corresponding cost savings either through benefit cuts, increased member cost-sharing or both. The board would need to balance the interests of members who would receive coverage of AOMs against members who would not receive that coverage but would be subject to the same across-the-board benefit cuts or increased member cost-sharing
2. **Adding a weight loss drug pilot program:** This option would require the costs of the pilot program to be paid out of the health insurance reserve. The same fiduciary concern of balancing the competing interests of members would exist in this scenario. In addition, the board would need to consider the current status of the health insurance reserve.

Adding Weight-Loss Drugs to the Commercial Pharmacy Formulary

The addition of weight-loss drugs, also known as AOMs, to the commercial pharmacy formulary is an item that the Board has discussed in several meetings since 2022. The same issues discussed in previous memos and at Board meetings persist. The cost of weight-loss drugs has not decreased, and independent scientific studies have not shown that the cost of the drugs is offset by long-term medical savings. Additionally, the Board must still adhere to Wis. Stat. §40.03(6)(c), which requires any cost increases to be offset by projected savings or benefit reductions.

In November of 2024, Segal prepared AOM cost analyses for the Board for different possible coverage scenarios. One of those analyses assumed coverage that followed the FDA's recommendation for coverage of AOMs. The FDA approved the use of weight loss drugs like Wegovy and Zepbound for individuals with a BMI of 30 or greater, or a BMI of 27 with at least one weight-related comorbidity.

Navitus has entered into agreements with the manufacturers of these two drugs, which provide full rebates if the FDA's BMI recommendation is followed. The agreements have remained unchanged since November 2024, and Segal's assumptions are still valid (Ref. GIB | 11.13.24 | 13, pages 2-3). Based on the current agreements, Segal estimates that in each of the first six years of coverage, it would cost the Board between $25.8 million to $37.3 million, after any realized medical savings from the drugs.

Table 8: Segal Weight-Loss Drug Cost Analysis: First 6 Years with Full Rebates

Year of Coverage	Utilizers	AOMs Prescriptions	AOM Cost	Medical Savings	Net Loss
Year 1	13,053	56,129	$37,185,614	$6,175,060	$31,010,553
Year 2	16,234	84,530	$59,012,775	$21,716,516	$37,296,259
Year 3	17,078	97,049	$71,382,889	$34,977,832	$36,405,057
Year 4	17,461	106,382	$82,425,828	$48,469,853	$33,955,975
Year 5	17,520	113,381	$92,524,228	$62,186,799	$30,337,428
Year 6	17,355	118,429	$101,772,140	$75,948,834	$25,822,306

The agreements between Navitus and the AOM drug manufacturers only award partial rebates if a BMI requirement is changed to be 35 or higher. Segal's cost analysis below found that during the first six years of coverage AOMs would cost the Board between $23.4 million to $31.4 million in each year after any medical savings was realized.

Table 9: Segal Weight-Loss Drug Cost Analysis: First 6 Years with Partial Rebates

Year of Coverage	Utilizers	AOMs Prescriptions	AOM Cost	Medical Savings	Net Loss
Year 1	7,406	31,844	$26,908,178	$3,503,319	$23,404,859
Year 2	9,315	48,406	$43,069,498	$12,373,407	$30,696,091
Year 3	9,602	54,802	$51,335,325	$19,912,500	$31,422,825
Year 4	9,412	58,174	$57,363,445	$27,175,462	$30,187,983
Year 5	8,950	59,520	$61,774,139	$34,048,327	$27,725,812
Year 6	8,390	59,612	$65,112,307	$40,423,105	$24,689,201

Pilot Program

ETF presented some considerations at the November 13, 2024, meeting regarding a pilot program for GLP-1s for weight management. The Board can choose to pilot AOM coverage at a cost of approximately $14.4 million per year for a targeted population of 1,000 members. ETF confirmed with Navitus that a pilot would eliminate all rebates, hence the $8.6 million to $14.4 million estimate provided in November has been updated to $14.4 million.

ETF asked all GHIP health plans and the Well Wisconsin vendor if they would be willing to provide input on the AOM pilot with Navitus. Four health plans offered to provide input. The Well Wisconsin vendor provided input and is willing to implement a pilot program on the Board's behalf. Working with select health plans would not provide an equitable opportunity for members to participate. Working with the Well Wisconsin vendor would alleviate this concern since services are available to all GHIP subscribers and spouses. Additionally, the Well Wisconsin program already has been and is positioned to continue supporting members with lifestyle and condition management.

A pilot program plan is under development with the Well Wisconsin vendor and includes:

- Target audience: 1,000 GHIP subscribers and spouses who have a BMI of 35+ and do not have a diabetes diagnosis randomly selected from a pool of interested candidates. Medicare members are not eligible.
- Program Engagement Requirements:
    - Complete and submit the physician authorization form to the vendor that includes the physician's attestation that the member is a candidate for GLP-1s and baseline biometric data (e.g., labs, height, weight, BMI).
    - Enroll in Positively Me weight management program, and complete one call per month.
    - Complete annual health assessment.
    - Submit updated form with biometric data at least two times per year.

Administration costs of the pilot program may be offset using existing contract provisions, and without additional costs to the Board since the current contract includes $75,000 to be used for innovative programming and/or pilot programs. Positively Me weight management coaching is $335 per person. This cost is part of the existing contract as well, and the Board may see an uptick in these fees as the number of utilizers may increase.

Concerns remain regarding this pilot program and the likelihood that savings do not outweigh the costs, as well as the impact to members if their coverage of AOMs ends.

If the Board approves the pilot program for 2026 implementation, further details and processes will need to be developed, and additional evaluation plans will need to be considered. The Board should also consider the length of time to evaluate the impact of the pilot program. If implemented, it should be available for at least three years, which means the cost would be approximately $45 million.

V. Summary of Recommendations

ETF does not recommend commercial pharmacy coverage of AOMs for the 2026 benefit year. There are numerous significant cost pressures on the GHIP premium for the 2026 plan year, as well as pressures of the Fund reserve. There is no option for benefits reduction or cost savings available to the Board that can be utilized to offset the

cost of AOMs while also allowing the Board an ability to offset appreciable portions of other projected cost increases in 2026 and in future plan years.

In addition, ETF does not recommend ending the Well Wisconsin program as a means of paying for AOMs because many of the services offered by Well Wisconsin specifically support weight loss. Further, Well Wisconsin offers many non-weight loss benefits used by members that would also end with the program's termination.

ETF does not recommend the pilot program option due to significant concerns around defining a pilot population and the limited evidence in current research that a pilot could demonstrate adequate savings.

ETF does, however, recommend the Board implement Option 3, found in Table 5 of this memo, to help offset other expected increases. This recommendation will increase cost-sharing amounts for all state active employees, non-Medicare retirees, and local members enrolled in plans PO6/P16, PO7/P17, and PO8 — about 219,500 members. It will keep the copayments and coinsurances for HDHP and state traditional health plan members consistent with one another. ETF recommends increasing ER copays to $200 across all the plan options to assist in additional cost savings and support a reduction in avoidable ER visits. These changes do not alter the AV tier for any of the plan options.

ETF also recommends the Board approve the PA and cost-neutral benefit changes outlined in the memo and allowing MA members to earn the Well Wisconsin incentive.

These recommendations allow the Board to offset additional cost pressures expected in 2026 without having to cut benefits covered.

Staff will be at the Board meeting to answer any questions.

Attachment A: Final 2026 Benefit Changes

Attachment B: Merative's *It's Your Health: Diabetes* Evaluation

Attachment C: Public Sector Employee Health Plan Designs

Attachment D: Plan Design Changes by Cost Impact