DRAFT

# MINUTES

**March 12, 2025**

## Group Insurance Board

State of Wisconsin

### Location:

This meeting was held virtually.
8:30 a.m. – 11:12 a.m.

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**BOARD MEMBERS PRESENT:**

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

**BOARD MEMBERS ABSENT:**

Erin Hillson

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

**Office of the Secretary:**
John Voelker, Secretary
Diana Felsmann, Deputy Secretary
Kimberly Schnurr, Board Liaison

**Division of Benefits Administration:**
Gene Janke, Benefit Services Bureau Director

**Office of Enterprise Initiatives:**
Michelle Baxter, Director

**Office of Strategic Health Policy (OSHP):**
Renee Walk, Director
Molly Dunks, Disease Management and Wellness Program Manager
Tricia Sieg, Pharmacy Benefits Program Manager
Korbey White, Health Program Manager
Luis Caracas, Policy Advisor

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**OTHERS PRESENT:**

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

**ETF Staff:**
Shellee Bauknecht, Phil Borden, Anne Boudreau, Laura Brauer, Beth Bucaida, Liz Doss-Anderson, Patti Epstein, Dan Hayes, Michelle Hoehne, Tarna Hunter, Jill Jorstad, Joanne Klaas, Cindy Klimke, Brittney Kruchten, Mark Lamkins, Arlene Larson, Peggy McCullick,

**ETF Staff (Cont.):**
Robin Nowakowski, Laura Patterson, Kurt Petrie, Peter Rank, Tom Rasmussen, Jessica Rossner, Marie Ruetten, Shraddha Shrivastava, Timothy Steiner, Sarat Tadi, Stephanie Trigsted, Laura Vang, Xiong Vang, Mee Wartgow, Douglas Wendt, Wade Whitmus, Amanda Williams, Mona Yee, Kathryn Young

**Aspirus Health Plan:**
Megan Umnus

| Board | Mtg Date | Item # |
|---|---|---|
| GIB | 05.21.25 | 2D |

**CareSource:**
Melissa Duffy
**Dean Health Plan:**
Katie Beals, Penny Bound, Maria Schneider, Julie Weichbrod
**Delta Dental of Wisconsin:**
Lyn Polster
**Department of Administration:**
Dana Gehrmann, Mary Hasselquist, Joe Kelly, Jennifer Kraus, Meghan McKenna, Julie Perry, Derek Sherwin, Danielle Tesch, Lisa Tesch, Tina Updike
**Department of Corrections:**
Timothy Harris
**Department of Justice:**
Lisa Dally, Sarah Huck, Alexander Thillman
**Department of Military Affairs:**
Janessa Kurtz
**Department of Transportation:**
Pam Capozziello
**Eli Lilly and Company:**
Kelly Ruhland
**Group Health Cooperative of Eau Claire:**
Christina McConaughey
**Hamilton Consulting Group:**
Abbey Rude
**Hawks Quindel, S.C.:**
Jessa Victor
**Health Partners:**
Kyle Long
**Jefferson County, WI:**
Jessica Tucker
**Juneau County, WI:**
Mechelle Thompson
**Medical Associates:**
Karen Brunton
**Merative:**
Oladipo Fadiran
**MercyCare Health:**
Marc Dinnel, Michael Lorhan, Besnik Sadiku, Sherrie Sargent, John Trochlell
**Michael Best Strategies:**
Adam Barr
**Navitus:**
Sharon Faust, Ryan Olson
**Network Health Plan:**
Vanessa Cagal
**Novo Nordisk:**
Stacy Hintzman, Nicole Knickmeyer, Dave Moody
**Quartz:**
Brittany Coyne
**Securian:**
Kjirsten Elsner
**Security Health Plan:**
Angela Pero
**Segal:**
Patrick Klein, Ken Vieira
**UnitedHealthcare:**
De Arcy Raybuck
**UW Health:**
Emily Fairchild, Olivia Talma
**UW-Madison:**
Deanna Deslover, Marissa Isensee, Karly Oppliger
**UW System Administration:**
Brianne Jobke, Erin Schoonmaker, Amanda Sonnenburg
**WebMD:**
Angela Fox, Jennifer Mance, Emily Rosetter
**Wisconsin Association of Health Plans:**
HJ Waukau
**Wisconsin Health News:**
Sean Kirkby
**Public:**
Jim Guidry, Jack Lawton, Brook Tylka
**Others (Unidentified):**
6 individuals connected via telephone

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

**ANNOUNCEMENTS**

- OSHP's Life and Dental Insurance Program Manager Tom Rasmussen is retiring at the end of April. OSHP was working internally to transition Mr. Rasmussen's role to other members of the team to prevent disruptions to the Group Life Insurance Program and Dental Insurance Program.
- ETF received over 100 pieces of Board correspondence regarding anti-obesity medications (AOMs) leading up to the March meeting (Ref. GIB | 03.12.25 | 5H). ETF responded to communications received by members of the Group Health Insurance Program (GHIP).
- Between February 26–March 12, 2025, the limited authority delegated by the Board to the ETF secretary for the Insurance Administration System (IAS) Program was not used.

**INCOME CONTINUATION INSURANCE (ICI) CONTRACT EXTENSION** (Ref. GIB | 03.12.25 | 2) PPT

Mr. Janke began his presentation with background information on the current ICI contract. He said that back in November 2020, the Board approved a five-year contract to provide administrative services for the ICI program, which is scheduled to end December 31, 2026 (Ref. GIB | 11.18.20 | 16D). In November 2024, the Board approved a contract amendment that increased the annual retainer fee paid to The Hartford for 2025 and 2026 (Ref. GIB | 11.13.24 | 11C). The Hartford consistently met or exceeded the performance standards set forth in the contract.

Mr. Janke went through the advantages and disadvantages of the Board approving another contract extension with The Hartford for two years, effective January 1, 2027, through December 31, 2028. The advantages he listed included:

- Allowing staff resources to focus on the implementation and stabilization of My Insurance Benefits, which has a scheduled go-live date of July 2025.
- Prevent an overlap of resources between modernization efforts, such as My Insurance Benefits, and the time needed to develop a request for proposals (RFP), review those proposals, and select a vendor.
- Maintaining a strong partnership between The Hartford and ETF in the administration of the ICI program.
- Continuing to provide members access to The Hartford's experienced team, which included over 60% of key staff having at least seven years of experience working with the ICI program.

The disadvantage of extending the current contract with The Hartford included possible cost increases. The Hartford had indicated in preliminary discussions that fee increases

were likely. He noted that fee increases were also likely if ETF issued an RFP, and a different vendor was awarded the contract due to the ICI third party administrator landscape.

***MOTION: Mr. Fields moved to approve the extension of the contract for third party administration of the ICI program with The Hartford for two years, effective January 1, 2027, through December 31, 2028. Ms. Thompson seconded the motion, which passed on the following roll call vote:***

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

***Nays: None.***

***Absents: Hillson.***

**HEALTH INSURANCE AND PHARMACY BENEFITS**

2026 Open Enrollment Period (Ref. GIB | 03.12.25 | 3A) PPT

Mr. White presented the proposed 2026 open enrollment period to the Board. ETF proposed the open enrollment period begin on the Monday of week 41 of the calendar year: October 6 to October 31, 2026.

Mr. White shared the considerations that went into making the recommendation:

- The time required to process retiree retirement annuity benefits.
- The feedback received from key payroll centers.
- The time it would take to possibly onboard new program administrators.
- The time ETF staff would be spending on internal projects.

Mr. White said that ETF planned to work closely with the payroll centers in advance of the 2026 open enrollment period to provide benefit change and file specification details as soon as possible.

***MOTION: Ms. Flogel moved to approve October 6 to October 31, 2025, as the open enrollment period for plan year 2026. Ms. Lounsbury seconded the motion, which passed on the following roll call vote:***

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

***Nays: None.***

***Absents: Hillson.***

2026 Final Benefit and Contract Changes (Ref. GIB | 03.12.25 | 3B) PPT

Mr. White provided background information on actions that have been taken to develop the 2026 final benefit and contract changes ETF recommended that the Board approve. The initial change concepts for program year 2026 were presented at the November 13, 2024, meeting (Ref. GIB | 11.13.24 | 12) 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.

Mr. White reviewed the recommended Health Program Agreement (PA) changes. The first of these changes pertained to data integration. Mr. White explained that file specifications for wellness and condition management (CM), pharmacy, and the data warehouse are included in the health plan contract. However, health plans who could incorporate and utilize wellness and CM data should work directly with the wellness and CM vendor to get the latest file specifications rather than getting the file specifications from ETF. This would ensure health plans received the latest specifications. Health plans that were not able to integrate and utilize the data should not be receiving the data. This reduced the inherent risk related to data sharing and protected member personal health information. Health plans should receive the pharmacy benefit plan specifications from the pharmacy benefit manager (PBM) and the data warehouse specifications from Merative rather than from ETF.

Another PA change Mr. White recommended was regarding the quarterly health performance standards and penalties. He explained that ETF had added language to the PA modifying the penalty assessment calculation based on the membership size of the health plan in order to make the quarterly performance standards for customer service more equitable to smaller plans. Mr. White defined small plans as those with fewer than 10,000 members, medium plans as those with 10,000–50,000 members, and large plans as those with over 50,000 members. He provided examples that illustrated how the penalty assessment would be calculated. Mr. White noted that ETF was not recommending that the new quarterly penalty assessment be extended to other performance measures. This was because the membership size of the health plans did not impact the scoring of other performance measures.

Mr. White also reviewed changes in the PA that pertained to health plans' communications with members. This included adding language that required health plans to include a link to the wellness and CM vendor and PBM's webpage(s) on their Group Health Insurance Program (GHIP) member-specific website and/or web portal. The purpose of this modification to the PA was to assist members with learning more about the benefits included in their GHIP coverage. ETF also recommended adding "microsite" to the PA after any section that referenced website materials. Additionally, language was added to the section of the PA that said health plans must send out new

identification cards only to newly enrolled members or if there was a change in the information being printed on the cards.

Mr. White said that ETF recommended adding diabetes management and prevention as a Department Initiative under Section III. G. 1. of the PA. Additionally, ETF recommended requiring health plans to demonstrate their efforts to promote the diabetes management and prevention services available to GHIP members through the wellness and CM program.

Mr. Caracas provided an overview of the cost-neutral changes to the Certificates of Coverage (CoCs), pharmacy, and wellness and CM benefits proposed for program year 2026. One of these changes was to add language to the "Qualifying Life Event – Retirement" and the "COBRA Continuation" sections of the CoC to 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). Additional cost-neutral CoC changes ETF recommended included the following:

- Aligning the 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.
- Adjusting Prior Authorization language under "Durable Medical Equipment and Medical Supplies" to allow flexibility in authorization by changing "must" to "may."
- Adding clarity regarding when a claim needs to be filed after services to the "Proof of Claim" section under "Member Rights and Responsibilities."
- 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.
- Including fecal incontinence, chronic constipation, and refractory severe tinnitus to the list of eligible conditions under biofeedback to align with evolving evidence and member need.

Mr. Caracas also discussed cost-neutral wellness and CM and pharmacy benefit changes recommended by ETF. The first of these changes was to shift the *It's Your Health: Diabetes* pilot program into a standard benefit offering beginning in 2026. Mr. Caracas explained that Merative had completed a financial assessment that showed a trend towards positive return-on-investments (ROIs) of the pilot program in 2022 and 2023. He referred the Board to page 15 in Attachment B of the memo for additional information on Merative's analysis.

The final cost-neutral benefit change Mr. Caracas shared was ETF's recommendation to move Continuous Glucose Monitor (CGM) coverage out from under the medical benefit and have it offered solely under the pharmacy benefit. This recommendation was based on changes in the market since 2022 that showed a majority of public and private sector employers covering CGMs under their pharmacy benefit only. During the first three quarters of 2024, 80% of members' CGMs claims and 87% of CGM supply

claims were filed under the pharmacy benefit. According to data from ETF's data warehouse, DAISI, the Board was paying about $160 less for CGM units under the pharmacy benefit than those covered under the medical benefit since 2022. Mr. Caracas said that some of the Board's health plans provided feedback that ETF was one of their only clients that still offered CGM coverage under medical insurance benefits. He described how ETF being an outlier by offering CGMs under both medical and pharmacy benefits led to members getting incorrect CGM coverage information from health plans. Mr. Caracas stressed that, if approved for the 2026 plan year, ETF would work with health plans to communicate this change to members and prescribers mid-2025, and again prior to the 2026 open enrollment period. This would give members time to change how they obtained their CGM supplies if necessary.

Ms. Dunks identified the cost pressures the Board would need to balance in making 2026 benefit decisions that increase costs. The first cost pressure was that the GHIP reserved began experiencing negative cash flow, which was detailed in the "Group Health Insurance Program Reserve Status" materials the Board discussed at the January 15, 2025, meeting (Ref. GIB | 01.15.25 | 12). As described in the January memo, the increasing cost of the pharmacy benefit was one of the contributing factors why the reserve fund was experiencing negative cash flow. The cost of drugs continued to increase with trends for overall prescription drug plans for 2025 projecting a 11.4% increase, driven by a 13.3% projected rise in specialty drug costs.

Another cost pressure was the Dean Health Plan (Dean) settlement. Dean's contract for administering the Access and Statement Maintenance Plans (SMP) included a risk-sharing arrangement. The provision required the Board to pay about $8M to Dean for administering the programs in 2023, and another $8M was projected for 2024. Additionally, there was a possibility of an additional settlement payment due for 2025 and beyond.

Ms. Dunks said that health insurance costs also continued to increase for both private and public sector employers. She explained that for the 2025 plan year, state employees saw a premium increase of 7.3%, and local employees experienced an increase of 11%. The Board is scheduled to vote on 2026 premiums at the upcoming meeting May 21, 2025. She added that the projected savings from the plan design changes could be used to offset or reduce premium increases for 2026.

Additionally, a federally required change to the Employer Group Waiver Plan (EGWP), also known as Medicare Part D, could increase costs significantly in 2026. On November 26, 2024, the Centers for Medicare and Medicaid Services (CMS) proposed a new rule that would require all Medicare Part D plan providers, including EGWP providers like the Board, to cover drugs that treat obesity. The rule change proposed by CMS was made under the previous administration and still requires approval from the current administration. No official statement or action has been made, however. Segal examined the impact of adding coverage for Wegovy and Zepbound to the EGWP formulary for all Medicare members. 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 — that is, a BMI of 30 or greater or a BMI of 27 with at least one weight-related comorbidity — 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 estimated the cost would be $4,197,915 during the first year of coverage.

The final cost pressure Ms. Dunks addressed was whether the Board decided to allow Medicare Advantage (MA) members to access the Well Wisconsin $150 incentive or remove MA members from Well Wisconsin. Currently, all GHIP subscribers, including MA members, paid the wellness administration fee as part of their overall health premiums. This funds the Well Wisconsin program and the incentives. While GHIP MA members had access to Well Wisconsin Resources and services, they did not have access to the $150 incentive. This was due to information previously provided by UHC that indicated allowing MA members to access the incentive may impact their CMS star ratings, which helps keep premiums low; UHC has since changed its position on MA members receiving the full incentive. ETF had 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 GHIP MA members to access the $150 incentive or remove MA members from Well Wisconsin.

Of the two options, ETF's recommendation was that the Board allow MA members to earn the Well Wisconsin incentive beginning in 2026. UHC was awarded the contract for MA health plans by the Board at the January 15, 2025, meeting. Going forward, UHC would continue to offer incentives to its MA members since their incentives are related to activities to support higher CMS star ratings, which keep medical premiums low. The average incentive amount earned by UHC members was $40.64 in 2024. Ms. Dunks said that UHC did not have concerns with the change ETF was recommending.

Allowing MA members to earn the Well Wisconsin incentive would increase the number of incentives earned. To fund these additional incentives, additional costs would need to be added to the wellness administration fee and split across all GHIP contracts. For cost estimation purposes, ETF took current percentages of the non-MA retirees that are eligible to earn the Well Wisconsin incentive and the current percentages of MA members that earn incentives through UHC. This came to 10.5% and 35.9%, respectively. As a result, ETF estimated that adding the Well Wisconsin incentive benefit for MA members would increase the total wellness administration fee by $280K–$960K per year, which would be split across all the contracts and add approximately $0.20–$0.69 to the wellness administration fee per contract per month. ETF was estimating the additional cost to be on the lower end of the range because UHC automatically sends incentives to approximately half of incentive earners for completing a home visit with a health care practitioner.

Ms. Dunks also explained the potential impacts of the Board choosing to remove MA members from the Well Wisconsin program to address the fiduciary concern. To begin

with, implementing this change would need to be deferred until a future date, due to resource constraints related to the implementation of the IAS program. Removing MA members from the Well Wisconsin program would also impact rates, since the wellness administration fee would no longer be included in MA contracts. The fees MA members were paying would shift to non-MA contracts. This 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.

Ms. Dunks provided an overview of the two alternatives the Board has to mitigate costs for 2026: eliminate or reduce existing benefits, and/or increase member cost-sharing. One benefit reduction that the Board discussed previously was redirecting funds from the Well Wisconsin program. At the November 13, 2024, Board meeting, ETF provided the option of redirecting approximately $16M in funds from Well Wisconsin to help offset the projected costs of AOM coverage (Ref. GIB | 11.13.24 | 13). Ms. Dunks said that the program currently supports over 50,000 members with managing and preventing a variety of chronic conditions, including being overweight and obesity. She also said that 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. Similar to the process already used with the *It's Your Health: Diabetes* 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.

At the November 2024 meeting, Board members inquired about ending or reducing the $150 Well Wisconsin incentive while still offering other Well Wisconsin services to help offset projected costs of AOM coverage. If the Board went with this option, they could realize approximately $7.5 million in savings. However, ETF did not recommend moving forward with this as it would deter some participants from engaging in the program. Ms. Dunks explained that extrinsic motivators, like an incentive, help encourage people to engage in well-being activities and establish a relationship with a well-being provider who can provide further support when the participant is ready. A $150 incentive was already well below the normal rate other employers offered their employees for similar programs. A recent report published on the Wellness Council of Wisconsin website found the weighted average annual incentive amount per employee was approximately $737 in 2024.

Ms. Dunks walked the Board through the six different plan options for non-Medicare members. She explained that the Board could make changes to the plan designs and increase member cost share to help reduce the impact of cost pressures on increasing premiums.

Ms. Dunks presented the Board with optional plan design changes for 2026, which are also documented in Tables 3–7 in the memo. Segal prepared different options that

increased deductibles, out-of-pocket limits (OOPLs), coinsurance, and copays for primary care, specialty office visits, and emergency room (ER) visits for each of the six aforementioned health plan designs. Segal had also calculated the projected savings under each of the proposed plan design change options.

Actuarial values (AVs) represent the percentage of a person's medical expenses that would be covered by health plans within each tier. Currently, the CMS' guidance on AVs grouped health plans into four levels: bronze for those with an AV of 60%, silver for an AV of 70%, gold for an AV of 80%, and platinum for an AV of 90%. While the proposed increase in member cost within each plan design change option decreased the AV of each plan, each of the options would remain in the platinum level tier except option 4. The proposed changes to option 4, the PO4/P14 plan, would decrease the AV from platinum to gold tier. Ms. Dunks referred the Board to Attachment C in the memo and explained that, when compared to the eight public sector employers' AVs, each of the proposed 2026 plan design change options would maintain comparable, and in most cases, higher AVs than those offered by other states.

Ms. Walk commented that ETF and Segal could present more options in May if the Board wanted to explore other plan design changes as a way of mitigating cost pressures.

Ms. Sieg started her discussion on weight loss drugs and cost sharing considerations with a recap on fiduciary duties. She said that Board members adhered to fiduciary duties, which required acting in the best interest of plan participants. Ms. Sieg added that when subgroups of plan participants have competing interests, the Board has a responsibility to balance those competing interest in a way that is reasonable. Additionally, the Board needs to follow Wis. Stat. §40.03(6)(c), which required any cost increases to be offset by projected savings or benefit reductions. The cost of weight-loss drugs hadn't decreased, and independent scientific studies haven't shown that the cost of the drugs was offset by long-term medical savings. She then provided a recap of the two options presented to the Board at the November 13, 2024, meeting (Ref. GIB | 11.13.24 | 13).

The first option was adding AOMs to the commercial pharmacy formulary At the November 2024 meeting, Segal provided an AOM cost analyses for different possible coverage scenarios. One of these was 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 entered into agreements with the manufacturers of Wegovy and Zepbound, which provide full rebates if the FDA's BMI recommendation was followed. These agreements have remained unchanged since November 2024. Therefore, Segal's AOM cost analysis with full rebates, which was presented at the November 13 meeting, was still valid. Based on the current agreements between Navitus and the manufacturers of Wegovy and Zepbound, Segal

estimated that each of the first six years of coverage would cost the Board $25.8M–$37.3M after any realized medical savings from the drugs.

Ms. Sieg presented the Board with Segal's AOM cost analysis with partial rebates. The agreements between Navitus and the AOM drug manufacturers only awarded partial rebates if the BMI requirement was changed from the FDA recommendation to a BMI of 35 or higher. Segal's cost analysis found that during the first six years of coverage, AOMs would cost the Board $23.4M–$31.4M each year after any medical savings was realized.

The second option the Board could consider for adding coverage of AOMs was to pilot a program for GLP-1s for weight management. Ms. Sieg referred the Board to the "Weight-Loss Drugs: Current Events, Options, and Cost Analysis" memo that was discussed at the November meeting (Ref. GIB | 11.13.24 | 13). The pilot program would be administered via the Well Wisconsin vendor and PBM.

Since November 2024, ETF confirmed with Navitus that a pilot program would eliminate all rebates. This would result in an estimated cost of $14.4M per year to cover the GLP-1 costs, as well as $335K per year for a coaching program, for a targeted population of 1,000 members. Concerns that were brought up in November still remain, however. Findings of the pilot program are likely to be similar, which means the cost of the pilot program would outweigh the savings. Additionally, members that were part of the pilot program could be adversely impacted if their coverage of AOMs were to end in the middle of treatment. Other considerations the Board would want to account for before approving a pilot program for a 2026 implementation included the additional resources required to develop processes and the length of time needed to evaluate the impact of the pilot program. If implemented, it was recommended that the Board offer it for at least three years, which would be a total cost of approximately $45M.

The costs of a pilot program of GLP-1s for weight management would need to be paid out of the health insurance reserve. She referred to Ms. Dunk's earlier points about cost pressures facing the GHIP. Any implementation of a pilot program for AOM coverage would need to consider the status of the health insurance reserve.

Ms. Sieg provided a recap of the changes ETF was not recommending for the 2026 benefit year. Changes that were not being proposed included adding coverage of AOMs to the commercial pharmacy formulary, ending or diverting funds from the Well Wisconsin program as a means of paying for AOMs, and implementing an AOM pilot program.

Ms. Sieg summarized the 2026 changes ETF was recommending for the 2026 plan year. This included recommending that the Board approve the following:

- All cost-neutral benefit changes
- Allow MA members to earn the Well Wisconsin $150 incentive
- Increase ER copays across all plan designs

- Plan design option 3

Ms. Sieg explained that ETF was recommending that the Board approve increasing ER visit copays across all commercial plan options to $200. Segal estimated the impact of increasing ER copays from $60 or $75 to $200 would decrease the AV of the plan by 0.1%–0.3% depending on the plan, which was equivalent to an estimated annual savings of $2.2M. ETF had presented on the strategic initiative on ER visits at the November 18, 2020, meeting (Ref. GIB | 11.18.20 | 4A). As part of the strategic initiative to reduce GHIP costs for ER visits, ETF worked with stakeholders to educate members on care options with a “Get Medical Care When You Need It Fast” campaign. However, avoidable ER visits continued to rise.

Ms. Sieg said that the $200 copay was within the range of ER copays of $100–$450 that larger health plans see for their clients in their book of business. She also noted that the ER copay was waived if an individual was admitted directly from the ER or kept for observation for 24 hours or longer.

Ms. Sieg referred to the 2026 plan design changes Ms. Dunks presented earlier with four options the Board could consider to help offset cost pressures. If the Board chooses to move forward with adopting plan design changes for 2026, ETF’s recommendation is to implement option 3, which can be found on Table 5 in the “2026 Final Benefit and Contract Changes” memo. Ms. Sieg explained that this recommendation would increase cost sharing amounts for all state active employees, non-Medicare retirees, and local members enrolled in plans PO6/P16, PO7/P17, and PO8; which encompassed approximately 219,500 members altogether. This option kept the copayments and coinsurances for HDHP and state traditional health plan members consistent with one another. Ms. Sieg said that ETF also recommended 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 did not alter the AV tier for any of the plan options.

Ms. Sieg concluded the presentation by saying that the 2026 changes recommended by ETF would allow the Board to offset additional, expected cost-pressures without having to cut covered benefits.

The Board deliberated extensively on the options recommended by ETF and acknowledged the seriousness of the cost pressures facing the GHIP. There will be premium increases for the 2026 plan year even if all the changes ETF recommended are adopted. However, the Board could lessen the severity of the premium increases depending on which of the options described in the “2026 Final Benefit and Contract Changes” memo they choose. Ms. Walk also referred the Board to Attachment D, which is a one-page document that breaks down the four plan design change options Ms. Dunks had discussed. Attachment D also included the projected savings of discontinuing the Well Wisconsin $150 incentive under “Other Change Options” for the Board to reference as another cost mitigating strategy.

The Board agreed with ETF's recommendation to prioritize the financial stability of the GHIP for plan year 2026. Therefore, the Board would not be adding AOMs to the commercial pharmacy, implementing an AOM pilot program, or diverting funds from the Well Wisconsin program. They concluded that the topic of AOM coverage would be revisited for plan year 2027.

The Board discussed at length about the proposed plan change options. They recognized that the premium increase would be reduced slightly if they accepted ETF's recommendation to go with Option 3. However, Board members expressed concern with the increase costs presented in all four of the plan design options, which proposed increases to the deductible amounts and OOPLs for individuals and families, coinsurances, primary care and specialty office visit copays, and ER copays. Board members also expressed concern about the current volatility of the market and the impact the increases proposed in the plan design options would have to households already struggling under rising cost-of-living expenses and inflation.

The Board also discussed their commitment to building back the GHIP reserves, which were essential to the rate setting process and mitigating premium increases. They requested a status update on the premium stabilization credit (PSC) that was approved as part of 2025 rates. The PSC has been estimated to result in approximately $17M additional dollars in 2025, which would help return the GHIP to a positive cash flow position. Ms. Walk confirmed this information would be included along with offers for any appropriate changes to the Board's health insurance reserve policy at the May 21, 2025, meeting.

The Board also directed ETF to be aggressive in the premium rate negotiations with plans.

Ms. Lounsbury left the meeting at 9:56 a.m.

***MOTION: Mr. Pahnke 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 recommended in the materials provided by ETF without any plan design changes. Mr. Houdek seconded the motion, which passed on the following roll call vote:***

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

***Nays: None.***

***Absents: Hillson, Lounsbury.***

**INSURANCE ADMINISTRATION SYSTEM IMPLEMENTATION UPDATE** (Ref. GIB | 03.12.25 | 4) PPT

Ms. Baxter began with a summary of the Insurance Administration (IAS) Program. She reported that the overall program status is "At Risk." She explained that while the IAS Program has made significant progress towards milestones, several critical challenges and watch points required ongoing attention. Teams began contingency planning for two critical areas to mitigate some key risks and additional areas that may require contingency planning were being identified.

Ms. Baxter provided an overview of the upcoming goals of the IAS Program, which included the completion of end-to-end testing, completion of member portal testing, resolution of invoice-related issues, finalization of key reporting and payment integrations, and preparation for cutover activities. She added that data migration would require extensive involvement from ETF staff to validate and manually enter any of the items that were not converted.

After Ms. Baxter concluded her presentation, Ms. Flogel shared DOA's feedback as an employer that had been involved in end-to-end testing since December 2024. She spoke to some of the challenges impacting the program that Ms. Baxter identified throughout the presentation.

**OPERATIONAL UPDATES**

Ms. Walk highlighted the following Operational Updates:

- Board Question Follow-Up: 2024 Pharmacy Costs (Ref. GIB | 03.12.25 | 5A)
- 2025 Open Enrollment Results (Ref. GIB | 03.12.25 | 5B)
- GHIP Dashboards (Ref. GIB | 03.12.25 | 5D)
- Board Correspondence (Ref. GIB | 03.12.25 | 5H)

**TENTATIVE MAY 2025 AGENDA** (Ref. GIB | 03.12.25 | 6)

Ms. Walk provided an overview of the topics planned for the May 2025 meeting. She reiterated that the Board would be asked to approve the final 2026 rates at this meeting. ETF will bring the following items for the Board to consider prior to taking action to set rates for the 2026 plan year:

- A review and recommendation on any appropriate changes to the Board's health insurance reserve policy.
- A status update on the PSC approved by the Board at the May 2024 meeting.
- A historical analysis at projections for pharmacy and reserve surplus.

**MOVE TO CLOSED SESSION**

Mr. Day announced that the Board would be going into closed session for consideration of appeals 2024-007-GIB and 2024-012-GIB. The Board voted to reconvene in open session following the closed session.

***MOTION: Mr. Fields moved to go into closed session pursuant to the exemption contained in Wis. Stat. § 19.85 (1) (a) for quasi-judicial deliberations. Ms. Thompson seconded the motion, which passed on the following roll call vote:***

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

***Nays: None.***

***Absents: Hillson, Lounsbury.***

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

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

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

Mr. Day announced that the Board met in closed session to consider appeal 2024-007-GIB and took no action. The Board will revisit appeal 2024-007-GIB at the next regularly scheduled meeting on May 21, 2025.

Mr. Day announced that the Board met in closed session to consider appeal 2024-012-GIB and adopted the Hearing Examiner's proposed decision with counsel's recommended modifications.

**ADJOURNMENT**

Mr. Day adjourned the meeting at 11:12 a.m.

Date Approved: _____

Signed: _____
Nancy Thompson, Secretary
Group Insurance Board