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Correspondence Memorandum

Date: July 30, 2025

To: Group Insurance Board

From: Jessica Rossner, Data and Compliance Section Chief
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Office of Strategic Health Policy

Subject: Group Health Insurance Program Plan Design Analysis

This memo is for informational purposes only. No Board action is required.

Background

In 2025, the Group Insurance Board (Board) expressed interest in learning more about how Group Health Insurance Program (GHIP) plan designs compare to those offered by other employers, particularly public employers in other midwestern states. Aside from changes made to comply with federally required updates to the deductible and out-of-pocket limits (OOPLs) for the high-deductible health plan (HDHP), the last significant plan design changes were approved by the Board in May 2015, for the 2016 plan year, following recommendations from Segal (Ref. GIB | 05.19.15 | 3C) and cost reductions required by the 2015-2017 Biennial Budget.

Recent research from Mercer shows that a growing number of employers are considering adjustments to cost-sharing structures, signaling a clear response to cost pressures in the market. Mercer's recent survey of 711 large and small employers found that 51% are likely or very likely to raise employee cost-sharing for the 2026 plan year, compared to 45% for the 2025 plan year.[1] State employee health plan administrators have been implementing a variety of different cost-containment strategies, particularly in the last few years, as they brace for rising costs.[2]

Like other state employee health plans, the GHIP faces rising healthcare costs, increasing administrative complexity, and challenges related to member utilization. Additionally, the GHIP reserve has been experiencing negative cash flows (Ref. GIB |

[1] Mercer. 2025. *Survey on health & benefit strategies for 2026*. pdf-2025-us-survey-on-health-and-benefit-strategies-for-2026.pdf
[2] Georgetown University Center on Health Insurance Reforms. 2023, June. *Mixed results: state employee health plans face challenges, find opportunities to contain cost growth.* *https://sehpcostcontainment.chir.georgetown.edu/documents/Mixed-Results-Cost-Growth.pdf*

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Reviewed and approved by Renee Walk, Director, Office of Strategic Health Policy
Electronically Signed 07/29/2025

01.15.25 | 12). To restore the reserve fund to its target threshold, the Board may need to consider future adjustments to the GHIP plan designs to support long-term financial sustainability while continuing to address member needs.

This memo provides an overview of the GHIP plan designs and how they currently compare to other public sector plans, health insurance marketplace offerings, and national employer-sponsored coverage.

Current Plan Design Overview
The GHIP offers a variety of different plan options for members. All GHIP plan design options cover the same in-network Uniform Benefits.

Active state employees and non-Medicare retirees are eligible to enroll in plan design option PO1, or the It's Your Choice (IYC) Health Plan, which offers two types of coverage: a traditional health maintenance organization (HMO) plan and a HDHP. The Access Plan and Access HDHP are also available with in- and out-of-network statewide and nationwide coverage.

Members enrolled in the GHIP's local employer plan design options can only enroll in the options their employer selects. Some of those plan design options, such as the local IYC Health Plan PO6/P16, mirror the plan design of the IYC Health Plan. The local HDHP (PO7/17) has the same coverage and design as the state HDHP.

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

The Local Traditional Plan (PO2/P12) is an HMO plan with zero medical deductibles and copayments [except $60 emergency room (ER) copay] and requires a coinsurance payment on only a few medical services and equipment. Table 1 and 2 below provide a reference for the various GHIP plan designs.

Table 1: State Benefit Design Options (2025)

	IYC Health Plan and Access Plan (PO1)	HDHP and Access HDHP (PO1)
Deductible (Individual/Family)	$250/$500	$1,650/$3,300
OOPL (Individual/Family)	$1,250/$2,500	$2,500/$5,000
Coinsurance	10%	10%
Primary Care Provider (PCP) Office Visit	$15 copay	$15 copay, after deductible
Specialist Office Visit	$25 copay	$25 copay, after deductible
ER Visit	$75 copay	$75 copay, after deductible

Table 2: Local Benefit Design Options (2025)

	"Traditional" PO2/P12	"Deductible" PO4/P14	"IYC Health Plan" PO6/P16	"HDHP" PO7/P17
Deductible (Individual/Family)	None	$500/$1,000	$250/$500	$1,650/$3,300
Medical OOPL (Individual/Family)	$500 per person DME only*	$500/$1000 +$500 per person DME only*	$1,250/$2,500	$2,500/$5,000
Coinsurance	None, pays 100% for most services*	None, pays 100% for most services*	10%	10%
PCP Office Visit	$0 copay	$0, after deductible	$15 copay	$15 copay, after deductible
Specialist Office Visit	$0 copay	$0, after deductible	$25 copay	$25 copay, after deductible
ER Visit	$60 copay	$60 copay	$75 copay	$75 copay, after deductible

*After deductible is met, coinsurance for durable medical equipment (DME), adult hearing aids, and cochlear implants is still 20% until the $500 OOPL is reached; after that, these medical services are covered at 100%. For pharmacy benefits, members will have out-of-pocket costs up to federal maximum out of pocket limit (MOOP).

Medical Benefit Comparison to Public Sector Plans

To better understand the GHIP positioning within the regional health benefits landscape, ETF conducted a comparative analysis of our non-Medicare plan designs against those of other state and local employee benefit programs. This review, based on 2025 plan year data, focused specifically on the state IYC Health Plan, the HDHP and the highest-enrolled local employer plan design the "Local Deductible Plan" (PO4/PO14). Our comparisons included health plans from Michigan, Minnesota, Illinois, Indiana, Tennessee, and New Jersey, offering a broad perspective on benefit structures and member offerings. The analysis found that, in most cases, the GHIP plan designs feature lower member cost share than those of the comparison states.

State IYC Health Plan

Table 3 provides a side-by-side comparison of the state IYC Health Plan design to other public sector plans across the midwestern region. The IYC Health Plan consistently falls at the lower end of the cost-sharing spectrum for services like deductible, OOPL, office visits, and inpatient care. In most benefit areas, the IYC Health Plan offers cost-sharing that is either lower or in line with regional public sector plans. Another distinction is that

while most benefits under the IYC Health Plan fall under its standard OOPL, services that are not Essential Health Benefits as defined by the Affordable Care Act accumulate to the federal MOOP instead of the lower medical OOPL. This structure is less common among peer plans; most peer plans use either OOPL or a MOOP, but not both. This distinction can create confusion for members trying to understand their total cost share.

Table 3: State IYC Health Plan Compared to Regional Public Sector Plans (2025)

Benefit Area	State IYC Health Plan	Comparison States
Deductible (Individual/Family)	$250/$500	$400/$800
OOPL (Individual/Family)	$1,250/$2,500	$1,000-$2,000 $2,000-$4,000 Most on the higher end of the range
Coinsurance	10%	5%-10%
PCP Office Visit	$15 copay	$20-$40 copay
Chiropractic Office Visit	$15 copay	$15-$40 copay
Specialist Office Visit	$25 copay	$20-$40 copay, in some states the deductible applies
Telehealth	$0-$25 copay	$0-$10 copay
Urgent Care	$25 copay	$15-$40 copay
ER Visit	$75 copay	$100-$275 copay
General Radiology/Lab	10% coinsurance, after deductible	5%-10% coinsurance, after deductible
Advanced Radiology	10% coinsurance, after deductible	10% coinsurance or $30 copay
Physical, Occupational, and Speech Therapy	$15 copay per visit	10% coinsurance or $35-$40 copay
Outpatient Services	10% coinsurance, after deductible	5%-10% coinsurance
Inpatient Services	10% coinsurance, after deductible	10%-20% coinsurance or $100-$425 copay per admission

State HDHP

The state HDHP is broadly aligned with peer state HDHPs on key structural elements, such as deductibles and coinsurance, with most comparison states also applying 10% coinsurance after the deductible. However, the state HDHP plan differs in its use of fixed copays for office visits, therapy, and urgent/emergency care, which can enhance predictability and affordability for members.

From a plan management perspective, these structured copays may lead to higher utilization of certain services, potentially increasing plan costs compared to HDHPs with

pure coinsurance models. Additionally, the lower OOPLs may shift a greater share of costs to the plan once members meet their thresholds. These differences are summarized in Table 4. ETF's past analysis of a coinsurance-only model found it would be more expensive to the plan than the copay plan unless the predominant coinsurance rate was increased to 20% (versus 10%).

Table 4: State HDHP Compared to Regional Public Sector HDHP Plans (2025)

Benefit Area	State HDHP	Comparison States
Deductible (Individual/Family)	$1,650/$3,300	$1,600-$3,000 Individual $3,200-$6,000 Family
OOPL (Individual/Family)	$2,500/$5,000	$3,000-$4,500 Individual $6,000-$9,000 Family
Coinsurance	10%	10%-20%, most states had 10% coinsurance
PCP Office Visit	$15 copay, after deductible	10%-20%, most states had 10% coinsurance
Chiropractic Office Visit	$15 copay, after deductible	10%-20%, most states had 10% coinsurance
Specialist Office Visit	$25 copay, after deductible	10%-20%, most states had 10% coinsurance
Telehealth Visit (PCP/Specialist)	$15/$25, after deductible	10%-20%, most states had 10% coinsurance
Urgent Care	$25 copay, after deductible	10%-20%, most states had 10% coinsurance
ER Visit	$75 copay, after deductible	10%-20%, most states had 10% coinsurance
General Radiology/Lab	10% coinsurance, after deductible	10%-20%, most states had 10% coinsurance
Advanced Radiology	10% coinsurance, after deductible	10%-20%, most states had 10% coinsurance
Physical, Occupational, and Speech Therapy	$15 copay, after deductible	10%-20%, most states had 10% coinsurance
Outpatient Services	10% coinsurance, after deductible	10%-20%, most states had 10% coinsurance
Inpatient Services	10% coinsurance, after deductible	10%-20%, most states had 10% coinsurance

Local Deductible Plan

In addition to evaluating our state GHIP plan designs, ETF also conducted a comparison of the local GHIP employer benefit offerings against those of other states with public sector local programs. For the purposes of this memo, the focus is on the highest enrolled local plan, the Local Deductible Plan (PO4/P14). The Local Deductible Plan covers more than 15,000 members. Given the limited number of states that offer local public sector benefit programs, we expanded our review to include states with

similar structures. The comparison includes local employer programs from Illinois, Minnesota, Tennessee, and New Jersey.

Overall, the Local Deductible Plan offers significantly more comprehensive coverage compared to peer public sector plans in other states. It features lower out-of-pocket costs, no coinsurance for most services, and $0 cost-sharing after the deductible for most medical services. In contrast, comparison states generally require member cost-sharing through copays or coinsurance for many common services. The Local Deductible Plan's streamlined cost structure, particularly the absence of coinsurance and low OOPL, stands out as a key differentiator. These differences are outlined below in Table 5.

Table 5: Local Deductible Plan Compared to Regional Public Sector Plans (2025)

Medical Benefit Area	Local Deductible Plan	Comparison States
Deductible (Individual/Family)	$500/$1,000	$100-$1,300 individual $250-$3,250 family
OOPL (Individual/Family)	$500/$1000 +$500 per person DME only*	$400-$2,000 individual $1,000-$4,000 family
Coinsurance	None, pays 100% for most services*	10%-20% coinsurance
PCP Office Visit	$0, after deductible	$15-$30 copay
Chiropractic Office Visit	$0, after deductible	$15-$30 per visit for visits 1-20 $15-$50 per visit for visits 21-50
Specialist Office Visit	$0, after deductible	$30-$50 copay
Telehealth	$0, after deductible	$10-$15 copay
Urgent Care	$0, after deductible	$15-$50 copay
ER Visit	$60 copay	$100-$400 copay or 15%-20% coinsurance
General Radiology/Lab	$0, after deductible	10%-20% coinsurance, after deductible
Advanced Radiology	$0, after deductible	10%-20% coinsurance, after deductible
Physical, Occupational, and Speech Therapy	$0, after deductible	10%-20% coinsurance, after deductible
Outpatient Services	$0, after deductible	10%-20% coinsurance, after deductible
Inpatient Services	$0, after deductible	10%-20% coinsurance, after deductible

*After the deductible is met, coinsurance for DME, adult hearing aids, and cochlear implants is 20% until the $500 OOPL is reached; after that, these services are covered at 100%.

Pharmacy Benefit Comparison

State IYC/Local Deductible Pharmacy Benefit

The GHIP's pharmacy plan designs differ in several ways from other public sector plans. Most comparison states have higher Tier 1 copays. Like the GHIP, several states use narrower pharmacy networks and require the use of designated specialty pharmacy vendors to help manage specialty drug costs and utilization. Some states also encourage the use of preferred and biosimilar drugs through lower copays.

In discussions with Navitus, the GHIP's pharmacy benefit manager, the GHIP was noted as an outlier in two key areas:

- A $5 Tier 1 copay, which is lower than the more typical $10 copay among peer plans.
- The use of two separate pharmacy OOPLs, while most of their clients use a single OOPL, often combined with medical.

Table 6 highlights key differences in deductible structures, OOPLs, and tiered drug pricing that may affect cost-sharing, member experience, and benefit alignment with broader public sector trends.

Table 6: State IYC/Local Deductible Benefit Comparison to Public Sector Plans (2025)

	State IYC/Local Deductible	Comparison States
Deductibles		
All Tiers	None	$175 per member, none, or combined with medical
OOPLs		
Level 1 and 2 Combined (Individual/Family)	$600/$1,200, in addition to medical OOPL	$2,000-$5,850 Individual $4,000-$11,700 Family Only one OOPL, no separate OOPLs by tier level
Level 3 (Individual/Family)	$9,200/$18,400, in addition to medical OOPL	
Level 4 (Individual/Family)	$9,200/$18,400, in addition to medical OOPL	
Drug Tiers		
Tier 1	$5 copay	$7-$20 copay
Tier 2	20% coinsurance, $50 maximum	$25-$30 copay, flat copays, no maximum
Tier 3	40% coinsurance* ($150 max)	$50-$60 copay, flat copays, no maximum
Tier 4	$50 copay	Other states had a maximum of three tiers

*Dispense as written drugs require 40% coinsurance plus apply the cost difference between the brand name and generic drugs unless the member has a medical need, and their doctor has submitted a one-time Flexible Spending Account (FSA) MedWatch form.

State and Local HDHP Pharmacy Benefit

The state and local HDHP pharmacy benefit is generally aligned with other public sector HDHP offerings. As shown in Table 8, deductible and OOPL amounts for the GHIP plans fall within the typical range observed among peer plans, with all plans featuring combined medical and pharmacy cost structures.

Tiered cost-sharing after the deductible varies across states. The GHIP maintains a lower Tier 1 copay ($5), compared to the more common $10 copay in other states. Similar to other plans, for Tiers 2 and 3, the GHIP uses coinsurance with dollar caps, though some comparison states include both minimum and maximum thresholds for member cost-sharing. Table 7 outlines these comparisons in more detail across deductible levels, OOPLs, and drug tier cost structures.

Table 7: State and Local HDHP Pharmacy Benefit Comparison to Public Sector Plans (2025)

	IYC HDHP	Comparison States
Deductibles		
All Tiers (Individual/Family)	$1,650/$3,300 combined medical and pharmacy	$1,600 - $3,000 Individual $3,200 - $6,000 Family Combined medical and pharmacy
OOPLs		
Level 1 and 2 Combined	$2,500/$5,000 combined medical and pharmacy	$3,000-$4,500 Individual $6,000-$9,000 Family Combined medical and pharmacy
Level 3		
Level 4		
Drug Tiers		
Tier 1	$5 copay	Most $10 copay after deductible, some 10% coinsurance after deductible
Tier 2	20% coinsurance, $50 maximum, after deductible	10%-20% coinsurance after deductible. In addition to coinsurance, some had a minimum ($30) and maximum amount ($50)
Tier 3	40% coinsurance*, $150 maximum, after deductible	Most had 40% coinsurance after deductible. In addition to the coinsurance, some had a minimum ($50) and maximum amount ($70)
Tier 4	$50 copay	

*Dispense as written drugs require 40% coinsurance plus apply the cost difference between the brand name and generic drugs applied unless the member has a medical need, and their doctor has submitted a one-time FSA MedWatch form.

Medical Benefit Comparison to Platinum Marketplace Plans
ETF also reviewed the Affordable Care Act (ACA) Marketplace plans available in Wisconsin for a broader plan design comparison. Segal has previously noted that Marketplace plans with an actuarial value of 90% or higher are classified as Platinum plans on the Marketplace (Ref. GIB | 03.25.15 | 4C). With a higher than 90% actuarial value, the state IYC standard plan compares most closely with Platinum plans on the Marketplace.

However, Platinum plans are limited in Wisconsin. Only three were identified for the 2025 plan year, all offered exclusively in Dane County. Table 8 below outlines how these individual Marketplace plans compare to the IYC individual plan. Notably, the IYC individual plan features lower OOPLs and ER copays than all three Marketplace options.

Table 8: Comparison of State and Local IYC Health Plan to Wisconsin ACA Marketplace Individual Platinum Plans (2025)

Benefit Area	State/Local IYC	Marketplace Platinum Plans
Deductible	$250	Two: $0, One: $500
OOPL	$1,250	$1,500, $2,800, and $4,300
PCP Copay	$15	Two: $10, One: $20
Specialist Copay	$25	Two: $20, One $40
Urgent Care	$25	$10, $15, $20
ER Copay	$75	Two: $100, One: $450
Radiology	10%	Two: 20%, One $30
Level 1 (Generic) Drugs	$5	One: $5, Two: $10

National Employer Plan Comparison
For a broader perspective beyond the regional public sector and marketplace, ETF also reviewed data from the most recent KFF Employer Health Benefits Survey, conducted in 2024.[3] This nationally representative survey provides insight into cost-sharing trends among private sector employers of various sizes. ETF identified the following cost-sharing comparisons of note:

- Deductibles: The average deductible for employees with single coverage is $1,787, and $1,538 at larger employers, both significantly higher than the $250 single coverage deductible under the IYC plan.
- Office Visit Copays: The national average copay is $26 for primary care visits and $42 for specialist visits. Both averages are higher than the IYC plan copays of $15 (primary care) and $25 (specialist).

[3] KFF. 2024, October 9. *2024 Employer Health Benefits Survey*. https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/

These findings highlight that GHIP plan designs offer lower member cost-sharing when compared to both public and private sector employer plans, as well as ACA marketplace offerings.

Rationale for Potential Plan Design Changes It has been more than a decade since the last significant change to the health and pharmacy benefit structure. Given the evolving landscape of healthcare costs, member needs, and administrative demands, this presents a timely opportunity to modernize the plan design to better align with peer programs, improve cost sustainability, and promote more appropriate and effective utilization of services.

Market Alignment, Cost Containment, and Financial Sustainability
Our current benefit designs offer lower member cost-sharing compared to many public sector plans in the Midwest. While this provides greater coverage at the time of service for our members, it also contributes to rising health plan costs that are outpacing inflation and placing increasing financial pressure on the GHIP.

For example, current pharmacy benefit designs include features that are more generous than many peer public sector plans in the region. The GHIP pharmacy Tier 1 copayment remains at $5, which is below typical market levels. Additionally, maintaining separate OOPLs for Tier 1 and Tier 2 medications is uncommon and creates administrative complexity. Specialty drug copayments (Tier 4) are also comparatively low given the high costs associated with these medications.

Aligning these elements more closely with market benchmarks presents an opportunity to modernize the benefit design, improve administrative efficiency, and support long-term plan sustainability. Some options for doing this include increasing the Tier 1 copayment, consolidating OOPLS across tiers, and adjusting Tier 4 copayments, Additionally, adjustments to other key benefit elements, such as ER copays, coinsurance, deductibles, and OOPLS, can strengthen the plan's sustainability and encourage more efficient care utilization.

Targeted updates to plan designs or other cost sharing strategies could be used to address major cost drivers like high-cost outpatient services, increasing specialty drug expenses, inappropriate ER use, and low-value or avoidable care. While comprehensive structural changes may not be feasible at this time, strategic benefit adjustments can still be implemented. Enhancing cost-sharing alignment with service value and guiding members toward lower-cost, clinically appropriate settings can help reduce unnecessary spending while maintaining access to essential services. However, these measures alone may not fully address the root causes of healthcare costs. Relying heavily on cost-sharing alignment and steering members toward lower-cost settings risks creating barriers to care, particularly for vulnerable populations who might delay or avoid necessary treatment because of increased out-of-pocket costs. Furthermore, such strategies may unintentionally shift costs, placing additional financial strain on members and potentially leading to poorer health outcomes.

Encouraging Better Consumer Behavior

Current benefit levels do not sufficiently encourage members to make high-value care decisions or discourage unnecessary, high-cost utilization. For example, avoidable emergency room visits have steadily increased each year from 2020 through 2024 and are now approximately 17% above the levels prior to the Board's avoidable ER initiative interventions. This and similar use trends highlight the need to explore benefit design changes that support more informed decision-making and encourage the use of lower-cost, clinically appropriate sites of care.

Additionally, ETF will explore opportunities to enhance the benefit design to better support management of chronic conditions. Evidence indicates that improving medication adherence and encouraging earlier intervention can slow disease progression and reduce avoidable complications. While some changes may result in higher upfront costs, they have the potential to reduce long-term expenditures by limiting the need for more intensive or acute care. ETF will evaluate all proposed adjustments to ensure administrative simplicity and operational efficiency to minimize implementation burdens.

Overall, benefit design updates that encourage members to seek preventive care and condition management services in the most appropriate setting of care (e.g., primary care) offer a meaningful opportunity to improve member health outcomes while contributing to long-term cost sustainability.

Administrative Simplification

Finally, aligning benefit structures with market norms could improve administrative efficiency. As outlined above, the GHIP offers several different plan design options, which can be confusing for members to navigate, even if they are not eligible for all options. The complexity and variety of plan offerings within the GHIP increase the administrative burden for ETF, the health plans, and the pharmacy benefit manager. Simplifying some aspects of the plan designs could reduce the administrative burden, improve operational efficiency, and create a better member experience.

Potential areas of simplification may include therapy limits and pharmacy tiers. Our current combined limit on physical, occupational, and speech therapy visits is difficult for health plans to administer and creates confusion for members. Moving to separate, standardized limits, consistent with industry standards, could reduce administrative complexity and improve member experience.

Additionally, the use of different OOPLs based on drug tier adds complexity for both members and administrators. Simplifying these limits could improve clarity and ease of administration.

Key Considerations for Plan Design Evaluation
As plan design options are evaluated, ETF will consider several key factors to ensure changes are thoughtful and well-balanced. The following factors will guide the evaluation of any proposed benefit design changes:

- Competitiveness: Maintain benefit designs that support recruitment and retention in a competitive labor market.
- Access for all member populations: Ensure changes do not create unintended barriers for specific groups, such as those in rural or underserved areas, and support consistent access to care across the member population.
- Simplicity: Streamline benefit structures, where possible, to reduce administrative complexity and member confusion.
- Consumer behavior: Encourage high-value care decisions through more strategic cost-sharing and benefit alignment.
- Preventive and chronic care support: Consider benefit designs that promote early intervention and adherence for chronic conditions.
- Long-term sustainability: Evaluate the financial impact over time to ensure the program remains viable and responsive to future cost pressures.
- Member experience: Balance cost containment with a positive and predictable member experience.

Next Steps
ETF plans to present detailed plan design change recommendations to the Board at the November 2025 meeting. ETF will then seek Board approval for any proposed changes at the February 2026 meeting, with implementation of approved changes targeted for the 2027 plan year.

To prepare for the November meeting, ETF will undertake a comprehensive analytic process in collaboration with key external partners. This includes working with Truven by Merative (Truven), ETF's health care data warehouse vendor, to conduct an in-depth analysis of trend drivers and to identify strategic opportunities for cost containment and savings. Segal, the actuarial consulting firm, will perform a thorough benchmarking study to assess how the GHIP's current plan designs compare with those of other states, focusing on actuarial value and market competitiveness. ETF will also engage Navitus to evaluate the financial and member impact of potential cost-sharing adjustments.

ETF will collaborate with Segal and Truven to model various benefit design scenarios that address the critical goals of aligning with market standards, enhancing financial sustainability, promoting responsible consumer behavior, and streamlining administrative processes. Additionally, ETF will actively engage with the health plans to identify opportunities for aligning benefit designs with standard offerings. This effort is aimed at improving the member experience, reducing administrative complexity, and fostering operational efficiencies.

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