Department of Employee Trust Funds

Health Care Benefits Consultant

Second Report—Observations and Recommendations for 2017 and Beyond

November 17, 2015

Segal Consulting

1. Introduction
2. Total Health Management
3. Program Structure
4. Pharmacy
5. Data Management
6. Market Observations
7. Self-Insurance
8. Retiree Coverage
9. Local Government Plan
10. ACA Update and Strategies
11. Summary and Next Steps

Introduction

- The authority of the Wisconsin Group Insurance Board (GIB) was recently expanded to provide additional oversight and strategic direction for the state employee health insurance program.
- Segal was retained by the GIB in November 2014 to conduct a full review of the State's health insurance program for employees and retirees.
- The primary objective of the project is to analyze data from a variety of sources to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program.
- Segal's first report was delivered in March of 2015 and presented to the GIB on March 25th. After some refinements with ETF staff, Segal presented 2016 recommendations to the GIB on May 19th, which were approved.
- This report is the second of two deliverables anticipated by the contract and focuses on analysis and recommendations for consideration for 2017 and beyond.
- Segal reviewed data from a variety of sources, including WHIO, health plan submissions, market survey data, and discussions directly with current ETF vendors and other organizations in the market.

Introduction *continued*

- 98% of members are covered in the Uniform Benefit Design ("IYC Health Plan")
  - Primarily insured HMOs—18 plan options
- Standard Plan PPO ("IYC Access Health Plan") provides national and "gap" coverage (and is self-insured)
- The Pharmacy Benefit is self-insured and carved-out with Navitus
- The Dental Benefit is transitioning to self-insurance for 2016 and is carved-out with Delta Dental
- Estimate of 2016 costs based on negotiated premiums, admin costs and latest claims and enrollment (in $ millions):

	Actives/Non-Medicare Retirees	Medicare Retirees	Total
Total Medical Costs	$896	$84	$980
Total Pharmacy Costs	$176	$69	$245
Total Dental Costs	$44	$8	$52
Total Administrative Fees	$80	$12	$92
Total Annual Costs	**$1,196**	**$173**	**$1,369**
Member Premiums	($204)	($173)	($377)*
Net ETF Costs	**$992**	**$0**	**$992**

* Retiree premium contributions include sick leave funding from the State

Report 1 Benchmarking

- Report 1 from March 2015 included benchmarking and comparisons with
  - State health plans regionally: Minnesota, Iowa, Illinois, Indiana, Michigan
  - State health plans nationally
  - Federal Employees Health Benefit Program plans offered in Wisconsin
- Comparisons based on 2014 data
- Conclusions included:
  - ETF Uniform Benefit Design (UBD) has one of the highest actuarial value at 96%
    - UBD benefits match, or exceed, virtually every benefit compared (deductible, copay, etc)
  - UBD premiums vary significantly among health plans
    - Lowest premiums compare favorably with benchmarks for similar plans
    - Highest premiums do not compare favorably
  - Standard Plan also higher than benchmarks with an actuarial value of 93%
  - HDHP/HSA premium does not compare favorably with other benchmark plans and has an actuarial value of 83%
- Savings opportunities enabled the:
  - UBD and Standard Plan to remain competitive compared to benchmarks
  - HDHP/HSA to become a more attractive option

2016 Recommendations

- The State's budget has assumed savings in the next biennium with a targeted reduction of $81 million. That would include $54 million for CY16 and an additional $27 million in CY17.
- With the 40% Excise Tax looming in 2018, savings achieved in 2016 and 2017 will minimize the changes that may be necessary in 2018.
- With this in mind, the Board approved the following changes to the Medical Benefits:
  - Uniform Benefit Design (UBD)
    - Introduced $250 deductible,
    - Increased total out-of-pocket maximum to $1,250
    - Introduced office visit copays of $15/$25
  - Standard Plan
    - Increased deductible to $250
    - Increased out-of-pocket maximum to $1,000
    - Like UBD, added office visit copays
    - Increased member cost share for out-of-network benefits
  - High Deductible Health Plan with HSA (HDHP/HSA)
    - Raised HSA contribution to $750

2016 Recommendations *continued*

The Board also approved the following changes :

- Pharmacy Benefits
  - Introduced coinsurance for Level 2 (20%) and Level 3 (40%)
  - Increased Level 4 member cost share: Preferred - $50 copay; non-Preferred (40% with $200 max copay)
- Health Plan Negotiations & Renewal Process
  - Worked with ETF to modify the tiering process
  - Updated addenda to collect additional financial exhibits and require CFO/Actuary signature
  - Required detailed data submission to match addenda

	Total Savings (in $Millions)	
	Original Estimate	After Negotiations
Medical Benefit Changes	$50	$46
Pharmacy Benefit Changes	$8	$8
Health Plan Negotiations	$10	$35
Total Calendar 2016	**$68**	**$89**

1. Introduction
2. Total Health Management
3. Program Structure
4. Pharmacy
5. Data Management
6. Market Observations
7. Self-Insurance
8. Retiree Coverage
9. Local Government Plan
10. ACA Update and Strategies
11. Summary and Next Steps

Total Health Management

- In our first report, we observed a significant variation in the effectiveness of the health plans' health management programs.
- Using WHIO data, 64% of ETF's membership was identified as having one or more chronic condition, accounting for 90% of claims. This is slightly higher than CDC reported national benchmarks of 50% and 84%, respectively.
- The benefits of the Well Wisconsin program are underutilized, with approximately 17% participation in 2015. Other states report participation in the 70-90% range.
- Increasing member engagement in both wellness and disease management programs will improve overall member health and reduce future cost increases to ETF. The programs available to members need to be effective, and vendors need to be able to demonstrate their effectiveness.
- A combination of incentives for members to engage in health management programs and appropriate required performance metrics with meaningful financial incentives for vendors should accomplish these goals.

Total Health Management—*Recommendations*

In the following areas, Segal recommends that ETF:

Medical Management

- Integrate disease management and complex case management with the health plans (as is the case currently)
- Require that vendors meet outcome based performance metrics and attach meaningful financial incentives
- For members with a manageable chronic condition, reduce office visit copays and copays for maintenance medications by $5 or $10 to incent member engagement

Wellness and Health Promotion

- Utilize a separate best-in-class vendor and design the program to be uniform across the membership
- The vendor should be able to manage health risk assessments, biometric collection, lifestyle coaching, education, reward tracking, etc.
- Institute a premium based incentive of $50 per month for completion of designated wellness and health promotion activities (employee/spouse, active/pre65 retiree)

Total Health Management—*Recommendations continued*

In the following areas, Segal recommends that ETF:

Data Analytics

- Require vendors to provide complete and comprehensive data and engage the technology necessary to perform data analysis and health risk modeling

Telemedicine

- Working with the plans ETF should develop standards that align with best market practices (ensuring member safety and convenience)

On-site Clinics

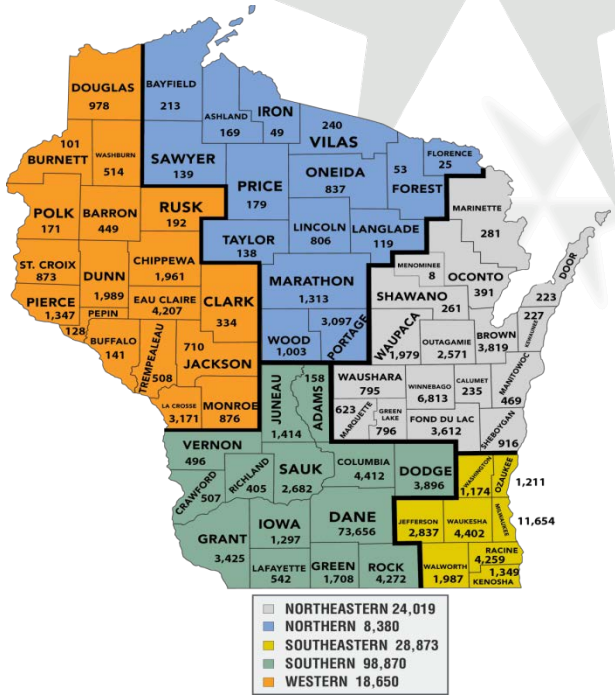
- Conduct initial assessment of potential on-site clinic opportunity and how that could provide reasonable return for ETF as a component in ETF's long-term strategy

ETF should be able to ultimately eliminate at least $60-$80 million of $267 million in annual unnecessary medical expenses. Estimated first year savings are $10-$30 million, which is between 1% and 3% of plan costs. Savings will increase annually.

1. Introduction
2. Total Health Management
3. Program Structure
4. Pharmacy
5. Data Management
6. Market Observations
7. Self-Insurance
8. Retiree Coverage
9. Local Government Plan
10. ACA Update and Strategies
11. Summary and Next Steps

Program Structure

- ETF works with 17 different plans throughout the State
- Segal conducted a review and analysis of the plans, as well as the pricing and access available in the market they currently serve
- Segal utilized the 5 current Medicaid regions as a basis
- Below is brief summary of plans and enrollment by region



Medicaid Region	Number of Plans	State Members Non-Medicare
Northeastern	7	24,019
Northern	5	8,380
Southeastern	7	28,873
Southern	9	98,870
Western	7	18,650
Statewide	17	178,792

Program Structure *continued*

- Pricing varies significantly among the plans and across the state, with risk-adjusted experience varying by $276 PMPM from the lowest to the highest.
- Using addendum data, self-reported by plans, we further reviewed the financial variation, focusing on the "net" discounts.

Medicaid Region	Net Discount	Experience PMPM	Relative Cost	Discount Only PMPM	Relative Cost
Northeastern	41%	$421	1.012	$421	1.014
Northern	29%	$493	1.184	$508	1.223
Southeastern	44%	$439	1.055	$400	0.962
Southern	46%	$383	0.921	$385	0.927
Western	23%	$490	1.179	$551	1.325
Statewide	42%	$416	1.000	$416	1.000

- The analysis above compares the experience PMPM to a simple discount adjusted PMPM. Results show a correlation between net reported discounts and plan experience.

Program Structure—*Regions*

- A Request for Information (RFI) was issued to gather additional data on provider discounts, network coverage and disruption at the provider level.
- The RFI data collected supplements information gathered during 2016 negotiations, which is limited to current health plans and current service areas.
  - Pricing information is consistent for most plans between the RFI and addendum data.
  - Many plans report networks with access exceeding standards and broader service areas.
- Based on analysis, we recommend three geographic regions:
  - In the **Southern Region**, there are many plans with a service area focused in, and around, Madison and Dane County. This region has approximately 99,000 members, which is roughly 50% of the total membership.
  - Many plans operate in both the Northeast and Southeast regions, indicating that a combined **Eastern Region** is practical. The combined region would have 53,000 members.
  - There are approximately 27,000 members in the Northern and Western regions. There are at least two health plans with an ETF service area currently covering the majority of the combined **Northwestern Region.** Although preliminary results indicate a combined region is feasible, has good access and would be cost effective, there would likely be significant disruption in the Northern region. As ETF moves forward, this region, in particular, may need to remain subdivided initially.

Program Structure—*Regions* *continued*

- Goal is to improve overall pricing for ETF while continuing to provide access to quality providers
- Using the discount data from the RFI, in combination with the variation in current premiums, we estimate the opportunity cost savings for consolidation

	Southern Region	Eastern Region	Northwestern Region
Number of Plans with Virtually 100% GeoAccess	9	4	4
Estimated Discount Improvement Opportunity	3.0%	5.0%	5.0%
Estimated Associated Claims Savings	$22.5M	$24.1M	$10.9M

Based on our analysis, we conclude there is an opportunity for ETF to achieve $45-70M in medical claims savings from consolidating the number of health plans and converting to a regional approach with regions determined by ETF and uniform for all health plans.

Program Structure—*Benefit Design*

- Our recommended benefit design incorporates structural features beyond the typical cost-sharing provisions.
  - **Tiered Networks—**Providers achieving higher efficiency and/or quality scores are placed in the preferred tier, and patients are given a financial incentive to choose these providers.
  - **Reference Based Pricing—**Reference based pricing utilizes an identified network of providers willing to render targeted services at or below a pre-determined price.
  - **Centers of Excellence—**All providers are not created equal and outcomes vary widely between providers. The concept of having designated providers, typically hospitals, as “centers of excellence” has been around for many years and is being applied to an ever-expanding number of procedures.
- The benefits are designed to support the Total Health Management strategy and promote utilization of more efficient providers. Overall benefit design should be cost neutral to members.

Program Structure—*Benefit Design continued*

The following recommended designs build off the IYC Access Health Plan. Those using the preferred networks and participating in medical management programs should see a moderate benefit improvement.

	IYC Tiered Network Plan Design			IYC HDHP
	Preferred	**In-Network**	**Out-Network**	
Annual Deductible				
Individual	N/A	$250	$500	$1,500
Family	N/A	$500	$1,000	$3,000
HSA Employer Contribution				
Individual	N/A	N/A	N/A	$750
Family	N/A	N/A	N/A	$1,500
Office Visit				
PCP	$15	$25	30%	$15, after deductible
Specialist	$25	$35	30%	$25, after deductible
Emergency Room	$75	$75	$75	$75, after deductible
Coinsurance	10%	20%	30%	10%
OOP Limits				
Individual	$1,250		$2,500	$2,500
Family	$2,500		$5,000	$5,000
	Members who engage in disease management have a $5-$10 reduction to their physician copayment (in addition to pharmacy enhancements)			

Program Structure—*Employee Premiums*

- We recommend a modified three-tiered approach for determining employee premiums
  - Tier 2 is for plans that are meeting performance standards. It is expected that the majority of plans will be in Tier 2 and be the basis for initial budgets.
  - Tier 1 must demonstrate significant financial advantage over Tier 2, estimated to be 10% in our example. Savings shared between ETF and the member.
  - Tier 3 plans will have entire premium differential paid by the member. ETF will lock into the budgeted rate of the Tier 2 plan.
- Integrate wellness participation into premium structure—A member that meets his or her wellness requirements would receive a $50 monthly premium reduction ($100 for family coverage).
- Employees in Tier 2 plans completing the wellness program requirements are anticipated to have lower premiums than today
  - Reduction is funded by higher premiums for non-participating employees

Program Structure—*Employee Premiums continued*

2016 ETF PLAN DESIGNS

	HDHP	Tier 1	Tier 2	Tier 3
Single	$29	$83	$168	$253
Family	$73	$209	$421	$632

Rates do not include dental.

RECOMMENDED PLAN OFFERINGS—ILLUSTRATIVE PREMIUMS

	HDHP	Tier 1*	Tier 2	Tier 3**
W/O Wellness				
Single	$79	$102	$123	$203
Family	$173	$235	$289	$483
W/Wellness				
Single	$29	$52	$73	$153
Family	$73	$135	$189	$383
	Employee and Spouse participation required. Penalty is $50/$100 Single/Family			

Rates are illustrative and do not include dental.

* Tier 1 premiums will be established to share the value provided by higher performing health plans, which, for purposes of this illustration, are expected to provide costs 10% or more below Tier 2 plans.

** Tier 3 premiums will be established to pass the full differential in costs between Tier 3 and Tier 2 plans, which is expected to be 10%. With this approach, ETF will be financially neutral regarding Tier 2 and Tier 3 enrollments.

Program Structure—*Summary*

- Below is a comparison of some of the key design differences between the current plan and the recommended plan.

	Current Plan	Recommended Plan
Statewide/National Option	✓	✓
Competitive Statewide Plan	✗	✓
Service Areas Defined by Plans	✓	✗
Uniform Regions	✗	✓
Tiered Networks	✗	✓
Closed Network Option	✓	✓**(Maybe)**
Value Based Copays	✗	✓
Wellness Incentives	✓	✓
Wellness Participation Premium Incentive/Penalty	✗	✓
Reference Based Pricing	✗	✓
Integrated Telemedicine	✗	✓
Gain Sharing	✗	✓

- We do note that some of the current plans may have an element marked with "✗" above, but this would be considered an outlier and not representative of the entire program structure.

1. Introduction
2. Total Health Management
3. Program Structure
4. Pharmacy
5. Data Management
6. Market Observations
7. Self-Insurance
8. Retiree Coverage
9. Local Government Plan
10. ACA Update and Strategies
11. Summary and Next Steps

Pharmacy

- ETF's pharmacy benefit expenses as a percentage of overall medical plan costs (medical and drug combined) are reasonable compared to other large plan sponsors.
- Program already includes a number of important and effective measures to control costs and manage expenses appropriately.
- Overall, the steps ETF has taken for 2016 will mitigate a portion of future plan cost trends. Additional steps should be taken to continue to manage per capita cost trends to single digits in the years ahead.
  - Generic Dispensing Rate (GDR)—ETF should encourage its PBM to take an active role in driving utilization toward generics by introducing GDR targets by health condition as a performance guarantee.
  - Tiered Networks—Limiting the retail pharmacy network can produce 1-3% Rx savings. The market's capability to support this opportunity should be explored in next PBM RFP.
  - Limited Specialty Drug Network—Deeper discounts exist for specialty pharmacies by concentrating the volume through fewer providers. However, the true savings and benefits lie in the enhanced clinical outcomes and reduction of waste these specialized pharmacies provide. Requires additional study and should be explored in next RFP.
- Support Navitus contract extension through 2017

Pharmacy *continued*

Recommended potential changes to the program include

- **Consider narrow or tiered networks—**Annual savings $3 to $3.5 million per year on retail non-specialty ingredient costs
- **Move to exclusive contracting for specialty—**Annual savings $2 to $3 million per year in specialty savings from improved pricing and utilization controls
- **Obtain better Retail 90 pricing either through bids or custom contracting—**Annual savings will vary based on custom contracting and current terms for 90 day retail supply
- **Tighten up medication management services—**Annual savings of 1% to 2% of program costs
- **Add a new lower cost Medicare Part D plan option—**Will allow for the offering of substantially lower cost retiree premium option and will provide greater choice for retirees
- **Pursue new contracting concepts with either the current PBM or through bids**
- **Add performance guarantees around clinical outcomes**

Associated annual savings estimated to be $10-20 million. Further research will need to be done to solidify these savings.

1. Introduction
2. Total Health Management
3. Program Structure
4. Pharmacy
5. Data Management
6. Market Observations
7. Self-Insurance
8. Retiree Coverage
9. Local Government Plan
10. ACA Update and Strategies
11. Summary and Next Steps

Data Management

WHIO data analytics do not fully meet ETF needs to effectively manage a major state program and develop future strategies. ETF needs include:

- **Financial Management**—Measure and analyze the aspects of a health plan that are related to budgets, forecasts, rate setting, and reporting
- **Benefit Design & Network Management—**Identify and evaluate services that support design effectiveness, network performance, cost sharing strategies, and vendor management
- **Medical and Pharmacy Quality Adherence**—Measure and evaluate preventive services compliance, compliance with standards of care, and prescription drug adherence
- **Health Management & Wellness Program Design**—Perform analyses that support wellness design, including health risk assessment data analysis, chronic conditions profiling and program design modeling
- **Vendor Performance & Contract Adherence**—Enhanced ability to evaluate and monitor targeted performance guarantees, conduct discount analysis and review payment accuracy
- **Provider Quality—**As ETF considers longer term and additional value based components in the program's design and strategy, there needs to be the capability to evaluate and compare quality and efficiency at the provider, or provider group, level

Segal recommends issuing an RFP to determine how the market can best support these needs.

1. Introduction
2. Total Health Management
3. Program Structure
4. Pharmacy
5. Data Management
6. Market Observations
7. Self-Insurance
8. Retiree Coverage
9. Local Government Plan
10. ACA Update and Strategies
11. Summary and Next Steps

Market Observations

Minnesota State Employees Group Insurance Program (SEGIP)

- SEGIP benefits are richer than the UBD; all benefits are self-insured
- Utilizes three health plans statewide offering same benefits
- Providers are tiered—Primary Care Clinic chosen by EE determines benefit
- Navitus is PBM
- Average monthly costs ($525) are significantly lower than for UBD ($689) for single coverage

National and Regional Market Changes

- AboutHealth, IHN and The Alliance are Wisconsin organizations with interesting value propositions. They are not currently health plans, but their evolution and market impact should be monitored.
- Nationally, some market consolidation
  - Aetna purchasing Humana
  - OptumRx purchasing Catamaran
  - Anthem's bid to purchase CIGNA

Market Observations *continued*

Wisconsin State Marketplace (Exchange)

- Database of 2016 plans and premiums released October 30, 2015. Segal updated the comparison analysis from our first report.
- UBD most comparable to Platinum Plans on Exchange
- In 2015 2,000 ETF members live in an area without a Platinum plan option on the Exchange—in 2016 there will be 40,000—all ETF members live in area with Gold Plan options. Compared against Gold Plans:

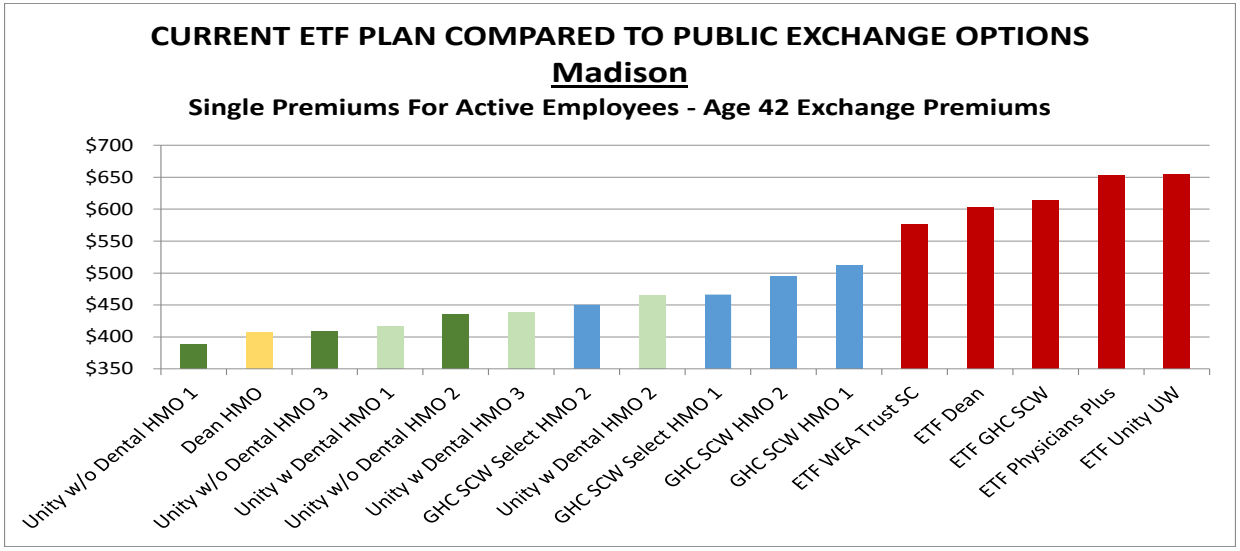
Scenario	2016 Projected Costs	Difference
Baseline/ETF	$1.152 B	
Choose Highest Gold Plans	$1.164 B	$12 M (1.0%)
Choose Average Gold Plans	$0.945 B	-$207 M (-18.0%)
Choose Lowest Gold Plans	$0.781 B	-$371 M (-32.2%)

- After accounting for the 13% difference in benefit value between UBD (92%) and Gold Plans (80%), 5% of the difference remains unexplained in the comparison with average Gold premiums and 17% remains unexplained in the comparison with the most competitively priced Gold plans.

Market Observations *continued*

Wisconsin State Marketplace (Exchange)

- The State Exchange is an individual market: Individuals purchasing coverage on the Exchange would be expected to have higher health risk than that found in a demographically similar large group.
- Reviewing the Madison Market demonstrates ETF has higher rates than what the same plans are offering on Exchange.



While plans are fully-insured, we would recommend that ETF require premiums to not exceed the actuarially adjusted State Exchange rates

Market Observations *continued*

Health Care Pricing Transparency Tools

- A variety of tools exist that provide consumers with data on the cost and quality of care. These tools are becoming increasingly sophisticated and are based on an expanding database of provider and pharmacy pricing.
- Despite these developments, consumer utilization of transparency tools has not increased significantly, but some plans and employers are including member incentives to increase utilization.
- Currently available evidence to measure and report on the impact of these tools is not conclusive.

Consumer Directed Health Update

- According to the Kaiser Family Foundation 2015 Employer Health Benefits Survey, almost a quarter, 24 percent, of covered workers are enrolled in an HDHP with a savings option. That percentage is nearly double the enrollment of those plans from just 5 years ago.
- This is consistent with the observations in our first report.

1. Introduction
2. Total Health Management
3. Program Structure
4. Pharmacy
5. Data Management
6. Market Observations
7. Self-Insurance
8. Retiree Coverage
9. Local Government Plan
10. ACA Update and Strategies
11. Summary and Next Steps

Self-Insurance

- Self-Insurance is not a new concept for Wisconsin
  - Pharmacy self-insured since 2004—results appear successful
  - Dental transitioning to self-insurance in 2016—initially viewed as successful
  - State-wide PPO is self-insured—successful over long-term but low enrollment
  - State's worker's compensation program is self-insured
- Significant majority of large groups and state-level health plans self-insure (see Report 1 Benchmarking)
- Non-Financial Benefits of self-insuring:
  - Data collection
  - Control of plan design
  - National provider network for out of state retirees and traveling employees
  - Custom provider network
  - Mandatory benefits from state are often optional
  - Cost reporting

Self-Insurance—*Financial Reasons to Self-Insure*

- **Elimination of most premium tax**—There is no premium tax on the self-insured claim expenditures. Net impact to ETF is about 0.1% since Wisconsin plans do not pay premium tax: **$0.9 million annual savings**
- **Elimination of Affordable Care Act (ACA) Market Share Fees**—This fee was introduced by ACA and applies to all fully insured medical and/or dental business and is approximately 2%: **$18.3 million annual savings**
- **Lower cost of administration**—Compared UBD effective admin costs with market data. UBD rate is estimated to be $14 PEPM higher: **$11.2 million annual savings**
- **Carrier profit margin and risk charge eliminated**—Nationally this is about 2-4%, but is reported lower for ETF. Reported information is somewhat suspect due to the plan/provider relationships that exist: **$11.0 million annual savings**
- **Cash flow benefit**—The employer does not have to pre-pay for coverage, thereby providing for improved cash flow: **$0.7 million in annual savings**
- **Excise Tax Exposure**—Can manage exposure by using aggregate rate instead of plan-specific rates.

Self-Insurance—*Financial Impact*

- Below is the total projected savings for ETF transitioning to self-funding

Component	First Year Impact
Premium Tax	$0.9 M
ACA Market Share Fees	$18.3 M
Administrative Costs	$11.2M
Profit Margin and Risk Charge	$11.0 M
Improved Cashflow	$0.7 M
Total	**$42.1 M**

- This is an estimate of the impact on fixed dollar costs and does not account for any changes in plans, claims or program structure that could also affect costs.
- Conservatively, we estimate the annual savings should be $40-50 million.

Self-Insurance

Reserving

- Run-in period will fund initial IBNR
- Recommend total reserve approximately 10% above IBNR to include solvency reserve

Gain Sharing

- Incorporate gain-sharing into incentives for health plans to manage costs
- Shares portion of savings when total costs are below pre-set target
- Can tie to other performance metrics, such as outcome based goals for total health management and clinical measures

Possible Transition

- 2017: Require plans to provide complete claims and encounter data including all financial fields
- 2018: Regional plans and begin transition to self-insurance

Our recommendation is to combine a conversion to self-insurance with the regional restructuring provided in the Program Structure section. This may be achieved by phasing in self-insurance.

1. Introduction
2. Total Health Management
3. Program Structure
4. Pharmacy
5. Data Management
6. Market Observations
7. Self-Insurance
8. Retiree Coverage
9. Local Government Plan
10. ACA Update and Strategies
11. Summary and Next Steps

Retiree Coverage

- Employees at retirement can continue medical, pharmacy and dental benefits by paying the full premium.
  - For pre-Medicare retirees, premium is based on blended active/retiree experience, resulting in the actives subsidizing the retirees (approximately $30-60 million in aggregate)
- Unused leave, in conjunction with pay, is converted into a notional account balance that can be used to cover the cost of medical, drug and dental premiums.
- Monthly premiums for Pre-Medicare retirees vary by as much as $200.
  - Lower premium plans generally have higher enrollment
  - Self-insured Medicare Plus plan and the Humana MA-PPO have the lowest 2016 premiums
- Group Medicare Advantage PPO plans provide the same access as Medicare Supplement (MedSupp) plans and utilize health management programs to improve health risk and leverage savings against federal subsidies.
  - Premiums are typically significantly lower vs. MedSupp plans with similar benefits

Retiree Coverage *continued*

- Issued RFI to the two largest group MA plans, plus another national carrier

	Medical Only	Medical & Pharmacy
ETF - Medicare Plus	$188	$400
ETF - Medicare UBD	$246	$447
RFI - Medicare Advantage Plans	$100 – $150	$300 – $350

- Medical only MA would be paired with existing EGWP. Medical and pharmacy MA (MAPD) would replace existing EGWP.
- We recommend one nationwide/statewide MA-PPO with regional plans providing Medicare options, preferably MA-HMOs.

Savings opportunity estimated to be $50-100 pmpm, or $17-34 million, for retirees. OPEB liability would likely be reduced.

1. Introduction
2. Total Health Management
3. Program Structure
4. Pharmacy
5. Data Management
6. Market Observations
7. Self-Insurance
8. Retiree Coverage
9. Local Government Plan
10. ACA Update and Strategies
11. Summary and Next Steps

Local Government Plan

- Current program utilizes 18 health plans to offer 8 benefit options.
- Enrollment in many of these options is sparse and there is a significant variation in premiums.
  - Seven plans cover approximately 80% of the members
  - Premiums for these seven plans are among the lowest
  - Aggregate local government premium is lower than State's aggregate premium
- Recommendation is to revise the program to match the state plan:
  - Regional structure
  - Self-insurance (similar transition plan)
  - Total health management incentives and requirements
- Could be pooled with State plan, or remain separate Trust
  - If separate trust, more conservative reserving policy advisable, or possibly reinsurance, which could take the form of some pooling with State plan
  - This may require statutory changes

1. Introduction
2. Total Health Management
3. Program Structure
4. Pharmacy
5. Data Management
6. Market Observations
7. Self-Insurance
8. Retiree Coverage
9. Local Government Plan
10. ACA Update and Strategies
11. Summary and Next Steps

ACA Update and Strategies

- 40% Excise Tax is effective in 2018
  - Based on value of medical and pharmacy
  - Other benefits count under certain circumstances
  - FSA and HSA employee and employer contributions count
- 2018 thresholds: $10,200 (single) and $27,500 (family)
  - Higher for pre-Medicare retirees and hazardous duty employees
- Based on total cost—can't shift premium cost to employees to manage tax
- No regional adjustments
- Paid by plan administrator—but still unclear if benefit is provided by multiple plan sponsors
- Measured on individual member basis
- Variance in health plan premiums generates tax exposure to ETF

ACA Update and Strategies *continued*

2016 negotiations improved ETF's Excise Tax exposure, but overall premium levels, and variation in premiums, result in 2018 exposure

ETF PROJECTED EXCISE TAX
($ Millions)

	Based on 2015 Premiums		Based on 2016 Premiums	
Year	Tax with 4% Trend	Tax with 6% Trend	Tax with 4% Trend	Tax with 6% Trend
2018	$7	$13	$3	$5
2019	$7	$20	$4	$7
2020	$8	$31	$4	$11
2021	$11	$43	$5	$17
2022	$14	$58	$6	$28
2023	$17	$76	$7	$40
2024	$21	$99	$9	$55
2025	$26	$127	$11	$71
2026	$32	$158	$14	$93
2027	$39	$193	$18	$118

ACA Update and Strategies *continued*

Strategies to Manage Costs

- Calculation Strategies
  - Aggregation and disaggregation protocols
  - Self-insurance more likely to enable aggregation methodologies
- Retiree Strategies
  - Separate plans for retirees
- Cost Control Strategies
  - Plan consolidation
  - Continue aggressive negotiation techniques during renewals
  - Vendor management
  - Health management
  - Plan design management

Continue to monitor legislation as it emerges

1. Introduction
2. Total Health Management
3. Program Structure
4. Pharmacy
5. Data Management
6. Market Observations
7. Self-Insurance
8. Retiree Coverage
9. Local Government Plan
10. ACA Update and Strategies
11. Summary and Next Steps

Recommendations and Next Steps

- Our report contains many recommendations, which could total approximately $105-170 million in annual savings to ETF
- An additional $17-34 million in annual savings could be provided to retirees
- In the near term, implementing these strategies will require additional GIB approval and ETF resources for RFPs, vendor implementation, employee communications, etc.
- Many initiatives could be implemented as early as 2017, but it may be prudent to phase in implementation in 2018 or later, depending on availability of ETF resources and impact on long-term ETF strategy

Recommendations and Next Steps *continued*

Recommendation	Estimated ETF Annual Savings	Potential Timing of Key Activities
Total Health Management	$10 – 30M	• Market wellness vendor for 2017 (RFP in 2016) • Implement wellness and premium surcharges for 2017 • Health management performance initiatives for 2018
Program Structure	$45 – 70M	• Market Statewide Self-Insured PPO/HDHP for 2017 (RFP in 2016) • Market Regional Plans for 2018 (begin three-year self-insurance transition) • Implement Value-Based Benefit Design with Tiered Provider Networks in 2018 • New employee premium structure in 2018
Pharmacy	$10 – 20M	• Extend Navitus contract for 2017 • Pharmacy RFI in preparation for PBM RFP in 2017 • Begin implementing strategic changes in 2017 • Fully implement changes in 2018 (RFP in 2017)
Data Warehouse	($0.2M) – COST	• Market in 2016 and implement in 2017 (RFP)
Self-Insurance	$40 – 50M	• Expand self-insurance with improved State-wide PPO/HDHP for 2017 • Require collection of detailed claims information for 2017 renewals • Begin transition to self-insurance
Retirees	None	• Statewide MAPD for 2017 (RFP in 2016) • Additional Medicare choices in 2018 in conjunction with regional plans
Local Government	None	• Match changes in State plan (2017-2020)
ACA/Excise Tax	Varies	• Now through 2018

Recommendations and Next Steps *continued*

- The recommendation include a significant amount of initiatives and commitments in 2016 for ETF staff.
- Some tasks are less intensive and can be completed with current staff:
  - 2016 PBM RFI
  - 2017 PBM Contract Extension
- Others will push the limitations of the current staff, not only for the procurement efforts, but in implementation of the long-term strategic initiatives recommended:
  - 2017 Wellness vendor (RFP)
  - 2017 Data Warehousing vendor (RFP)
  - 2017 Statewide Self Insured vendor (RFP)
  - 2017 Med Adv vendor (RFP)
- In addition, ETF will have to begin the transition to self-insurance, requiring a great amount of financial support

Questions & Discussion

Segal Consulting

Rick Johnson
Senior Vice President
RJohnson@segalco.com

Segal Consulting

Kenneth Vieira, FSA, FCA, MAAA
Senior Vice President
KVieira@segalco.com

Segal Consulting

Richard Ward, FSA, FCA, MAAA
Senior Vice President
RWard@segalco.com