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Correspondence Memorandum

Date: November 22, 2016

To: Group Insurance Board

From: Lisa Ellinger, Director
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Rachel Carabell, Senior Health Policy Advisor
Arlene Larson, Federal Health Programs & Policy Manager
Joan Steele, Health Policy Advisor
Office of Strategic Health Policy

Subject: State of Wisconsin Group Health Insurance Program – Current State & Overview

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

Background

The current model for the State of Wisconsin Group Health Insurance Program (GHIP) has been in place since the mid-1990s, with a significant change to introduce "tiering" (discussed below) in 2004. The current model is a competitive market model which encourages fully-insured health plans to bid on the administration of a "uniform benefit". Health plans absorb the financial risk in this program, and are intrinsically and financially motivated to manage costs and the population health of the membership.

Tiering

A tiering approach was added to the model in 2004. In this revised structure, a risk-adjustment process is incorporated into annual negotiations to allow for an equitable comparison across health plans. Health plans are then placed into one of three tiers based on submitted bids. Plans that are most competitive are deemed "Tier 1", and others are placed in Tier 2 or Tier 3. Plans in these lower tiers are provided an opportunity to reduce bids in order to attain Tier 1 status. There is a small quality component in this process that provides up to a 1% "quality credit" for plans that score high on measures of quality care.

Employee premium contributions are based on the tier placement of their health plan. In other words, employees who choose the highest-quality and most financially competitive plans (i.e., Tier 1 plans) have the lowest premium contribution. This effectively influences employees to choose the most efficient plans.

Reviewed and approved by Lisa Ellinger, Director, Office of Strategic Health Policy

Electronically Signed 11/22/16

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As a result, tiering has proven to be an effective negotiation strategy with the health plans. Historically, plans that have fallen to Tier 2 or Tier 3 placement lose both market share and lower-risk members. In the early years of the program, health plans that experienced the negative impacts of lower-tier placement generally changed strategy to obtain Tier 1 placement moving forward. In recent years, plans have exited the program due to deteriorating risk, and/or an inability to meet Tier 1 premium requirements. This is depicted in Table 1.

Table 1: Plan History of Tiering Impacts

Health Plan Name	Tier*	Year(s) of Tier Placement	Year of Termination from Program or Return to Tier 1 Status
Anthem Blue Southeast	3	2017	2017
WPS Metro Choice Southeast	3	2014, 2013	2015
Anthem Blue Northwest**	3	2013	2014
Anthem Blue Northwest**	2	2009, 2008, 2007, 2006	See above
WPS Patient (later Metro) Choice Plan 2	2	2008, 2007, 2006	2009
Humana Western	2	2007, 2006	Returned to Tier 1 2008
CompcareBlue Southeast**	2	2006	Returned to Tier 1 2007
CompcareBlue Northeast**	2	2005, 2004	Returned to Tier 1 2006
Humana Eastern	2	2005, 2004	Returned to Tier 1 2006
GHC Eau Claire	2	2004	Returned to Tier 1 2005
Valley Health Plan	2	2004	2005

* for state employee program only (not local government program)
**Anthem Blue was CompcareBlue until 2008 when the name changed

It should also be noted that that the tiering methodology has evolved over time to require increasingly competitive bids to achieve Tier 1 status.

Service Area Requirements
Another aspect of the current structure is that it allows the health plan to dictate the service area where it is available. This allows the plans to participate in the program where they have the most competitive provider arrangements.

Major plan service area and network changes have occurred over time to address Tier 1 premium requirements, grow membership, and/or accommodate changing networking relationships. Significant provider network changes over the past decade are shown in Table 2.

Table 2: Provider Network Changes

Health Plan Name	Year of Change	Provider Network System Change
Network Health Plan	2017	ThedaCare removed
Security Health Plan – Valley	2017	ThedaCare offered
Arise Health Plan – Aspirus Arise	2017	Aspirus and entire plan removed
WEA Northwest PPO	2014	Splits plan to create two competing offerings: Mayo Clinic Health Systems versus Chippewa Valley. Includes significant out-of-network member cost share.
Physicians Plus	2013	UW Hospital and Clinics removed
GHC – Eau Claire	2012	Mayo removed
Anthem Blue Northeast	2011	Affinity added
Health Tradition Health Plan	2011	Luther Midelfort (Mayo) removed
Network Health Plan	2011	Thedacare added
Arise Health Plan	2010	Agnesian added
Humana – Western	2008	Luther Midelfort (Mayo) removed
Security Health Plan	2007	Plan enters program, primarily with Marshfield Clinic providers

Health Plan Quality and Performance

Annually, the Department of Employee Trust Funds (ETF) compiles a report card that provides comparative information to objectively evaluate health plan quality and performance. The report card consists of ratings that assess how well the health plans are performing, based on the following national measures:

- Healthcare Effectiveness Data and Information Set (HEDIS) measures that are defined by the National Committee for Quality Assurance (NCQA) and assist with comparing the performance of health plans across a variety of health and disease categories.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that is maintained by the Agency for Healthcare Quality and Research (AHQR). The CAHPS survey asks members to report and evaluate their experiences with health care service delivery.

The ratings measure overall performance, quality, care coordination and overuse of services, and include measures such as controlling high blood pressure, preventing readmissions to a hospital and avoiding overuse of antibiotics. The overall performance rating is used for the “quality credit” (noted earlier) that is provided to high-performing health plans during the rate negotiation process.

There is much variation noted among the health plans in report card performance, and no health plan is a top or a bottom performer in every rating category; however, some health plans, such as Dean Health Insurance (Dean), Gundersen Health Plan, and HealthPartners have consistently scored higher in overall performance in recent years.

Variation was also noted in a November 2015 report by the consulting actuary to the Group Insurance Board (Board), Segal Consulting’s (Segal). Segal evaluated performance amongst the health plans using the Wisconsin Health Information Organization (WHIO) data and uncovered wide variation in health plan performance.

Table 3 below shows the ratings participating health plans received in the past three report cards for Overall Performance.

Table 3: Health Plan Overall Performance Ratings

Rating	2014 Report Card	2015 Report Card	2016 Report Card
★★★★★ *Highest*	Gundersen Health Plan	Gundersen Health Plan	Dean Health Insurance ⬆ HealthPartners ⬆
★★★★☆	Dean Health Insurance HealthPartners MercyCare	Dean Health Insurance GHC of Eau Claire ⬆ HealthPartners	Gundersen Health Plan ⬇ Security Health Plan ⬆
★★★☆☆	GHC of South Central WI Health Tradition Humana Medical Associates Security Health Plan UnitedHealthcare of WI Unity	Anthem Blue ⬆ GHC of South Central WI Health Tradition Network Health ⬆ Physicians Plus ⬆ Security Health Plan Unity	Anthem Blue GHC of Eau Claire ⬇ GHC of South Central WI Health Tradition MercyCare ⬆ Physicians Plus Unity WEA Trust ⬆
★★☆☆☆	Arise Health Plan GHC of Eau Claire Network Health Physicians Plus	Arise Health Plan Humana ⬇ Medical Associates ⬇ WEA Trust ⬆	Arise Health Plan Humana Medical Associates
★☆☆☆☆ *Lowest*	Anthem Blue WEA Trust	MercyCare ⬇ UnitedHealthcare of WI ⬇	Network Health ⬇ UnitedHealthcare of WI

⬆ Higher rating than prior year
⬇ Lower rating than prior year

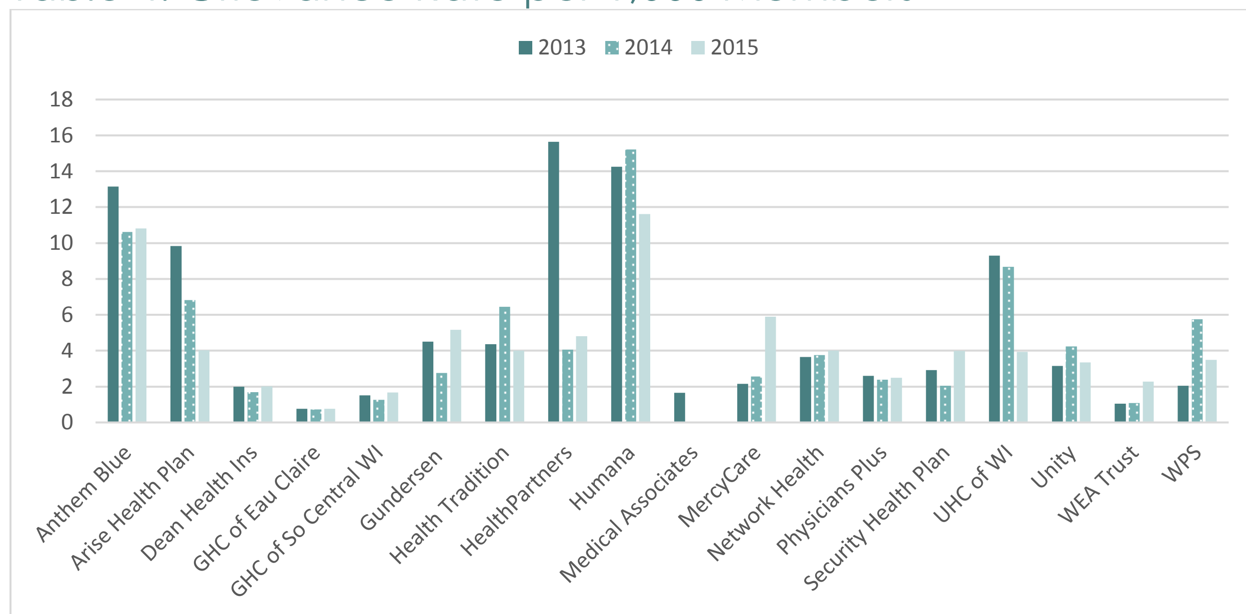
Grievances

The health plan grievance process is the first step in resolving member complaints. In addition to the composite ratings described above, the report card also includes a component pertaining to grievance rating. The grievance rating is based on the number of grievances filed per 1,000 members enrolled in the health plan.

Again, there are consistent trends in performance in this area. The following plans typically score best on this measure: Dean, GHC Eau Claire, GHC South Central Wisconsin, Medical Associates, and WEA Trust. Anthem and Humana have consistently had the highest rates of grievances filed.

Table 4 depicts the grievance rate per 1,000 members for the past three years.

Table 4: Grievance Rate per 1,000 Members



Premium Trends and Negotiations
As stated above, the current structure has served as a powerful negotiation tool. In the annual negotiation process, health plans submit a “preliminary bid,” which is compared to competing vendors and used to establish initial tier status. Plans are later afforded an opportunity to lower the bid to move into Tier 1.

Table 5 shows a 9-year history of preliminary bids versus final premium increases. Two trends are worth noting. The first is that the average increase of 3.7% over the 9 years is less than half the 7.6% premium increase requested in the preliminary bids. While the latter is much more in line with national premium trends, the GHIP has experienced very competitive premium increases. It should be noted that the reductions in 2012 and 2016 were greatly influenced by state budget-required benefit changes that shifted additional costs to program members. It should also be noted that this sort of cost shift is also a national trend and is factored into comparative trend rates.

Table 5: Preliminary Bids versus Final Increases

Year	Final Premium Increase	Preliminary Bid	Negotiation "Savings" (in Millions)
2017	1.6%	5.4%	$37.9
2016	-2.5%	7.7%	$56.4
2015	5%	6.9%	$19.3
2014	3.5%	8.2%	$45.5
2013	5.1%	8.7%	$33.1
2012	-1.5%	2.1%	$30.1
2011	6.3%	9.5%	$28
2010	7.7%	10%	$18.8
2009	8.1%	10%	$13.5
Average	3.7%	7.6%	--

The final figure worth highlighting is the fact that this structure has accounted for nearly $283 million in cost reductions over 9 years (the difference between the preliminary and final bids).

Limitations/Challenges of Current Program Structure
There are a number of challenges and areas for improvement associated with the current program structure. Examples include:

- Administrative complexity due to managing numerous plans
- Variation in plan administration of prior authorizations, referrals, medical policy, determinations of medical necessity, etc.
- Variation in plan data submissions due to inconsistencies in claim code data aggregation, annual provider network classification, and timely completion of the regular full file compare of eligibility feeds
- Limited leverage to influence plan behavior where state membership is low
- Complex and time intensive annual rate setting process, involving multiple bids, analysis, and negotiations
- Complex and time intensive service area qualification process
- Plans may join the program with relative ease and lower quality plans or those with less steerage to efficient, high quality providers may participate

It should also be noted that administration of a revised structure could be equally complex, but with staff changing roles and responsibilities.

Despite the cost containment successes noted in the previous section above, the $1 billion budget for the state employee program will continue to face competition for scarce state resources moving forward.

Recent studies indicate that the GHIP premiums may be higher than those paid by employers in Wisconsin and surrounding states. Table 6 presents data from a Commonwealth Fund analysis, compared to the 2015 average premium for active state employees in the GHIP program. This is the most recent year for which the benchmark data is available.

The 2015 premiums do not reflect the benefit design changes the Board adopted for 2016. The higher GHIP premiums relative to benchmarks are likely due to differences in benefit design, higher costs of care in Wisconsin, and the higher disease burden of GHIP members.

Table 6: Average Health Premium for Employer-Sponsored Plans

2015 Average Health Premium*	Single	Family
GHIP**	**$687.12**	**$1,830.85**
Wisconsin	$500.92	$1,471.83
Illinois	$504.58	$1,435.58
Minnesota	$470.92	$1,410.42
Iowa	$464.25	$1,354.75
Michigan	$480.92	$1,302.33
* Employer-based health plans according to the Commonwealth Fund, using the Medical Expenditure Panel Survey - Insurance Component		
** Based on active state employees only and includes both the employer and employee share of premium		

Self-Insurance: Background and Considerations
The Board has considered self-insuring the medical portion of the GHIP periodically over the past five years, as outlined in the February 2016 memo (see Attachment A): http://etf.wi.gov/boards/agenda-items-2016/gib0217/item5b.pdf

The Board and ETF have significant experience administering self-insured benefit plans. The IYC Access Plan (formerly called the Standard Plan), the State Maintenance Plan, the Uniform Benefits Dental Plan, and the Pharmacy Plan, are all self-funded plans, meaning the State and Wisconsin Public Employers (WPE) are financially responsible for all claims costs incurred under the plans. The Board contracts with third-party vendors to process claims, provide customer service and other operational services for these benefit plans.

The Kaiser Family Foundation and Health Research and Education Trust report that 61% of employees with employer-based health coverage are in partially or fully self-insured plans. The National Conference of State Legislatures reports that all but four states partially or fully self-insure their health plans. Employers that choose to self-insure usually do so for a number of reasons. Some of these reasons apply to the Board and some do not. The following section highlights issues the Board may want to consider as it deliberates a self-insured program structure.

Benefits of Self-Insuring

There are a number of potential benefits associated with offering a self-insured model, as described below.

ACA Insurer Market Share Fees

As noted in previous reports by Segal, the Affordable Care Act (ACA) Market Share Fees add costs to the program totaling approximately 2% of premium. These fees apply annually starting in 2014, with a moratorium in 2017, and do not apply to self-insured plans. These fees would not apply if the program was self-insured.

Recent political events have called into question the future of the ACA and its associated fees.

Insurance Risk Charge and Profit Margin

Insurers include a “risk charge” in fully insured premiums, which is an amount that compensates insurers for taking on the risk of the employer’s health benefit costs. This risk charge is sometimes referred to as a risk and profit charge. In a self-insured arrangement, the state and WPE employers would not be subject to such charges. Segal indicates that often this risk charge is 2-4%, but is lower in the GHIP program, with the average profit and risk load in 2016 reporting at 1.2% in the aggregate.

Cash Flow and Reserves

When converting from a fully-insured plan to a self-insured plan, many employers see an initial improvement in cash flow because the employer shifts from a known monthly premium payment in the month in which coverage is provided, to paying claims after services have been received and providers submit claims for reimbursement. Segal estimates this reduction in cash flow usually lasts between four and eight weeks.

However, many employers find they must use this improvement in cash flow to set up reserves to account for the fluctuations in payment of claims and to pay for claims that have been incurred by not reported (IBNR). Segal has advised the Board that it will need to increase reserves to account for such variability in cash flow and IBNR if the Board decides to proceed with self-insuring some or all of the health benefit program but that the lag in cash flow should be sufficient to establish the appropriate reserves level.

In 2011, the Board established a reserves policy to maintain a targeted net fund balance. The projected net fund balance for December 31, 2016 is estimated to be $165.1 million, which could be utilized in a transition to a self-insured model.

Control and Management

Many employers self-insure their health benefits because they want more direct control of their benefits. This includes choice over the benefits offered and the ability to contract with a pharmacy benefits manager (PBM), medical management or wellness vendor of their choosing. Because these employers bear the financial risk of claims cost, they also receive all of the rewards when they are better able to manage their claims costs through wellness, disease and case management and improved employee engagement in their health. In many ways, under the current model, the Board already has significant control over its plans, compared with other employers that purchase fully insured health benefits, including benefit design and use of a PBM and wellness vendor.

While many employers choose self-insurance to avoid the costs of mandated coverage of certain benefits under state insurance laws, state law requires that health benefits provided under Chapter 40 of the Wisconsin Statutes be subject to the same mandated benefits that apply to insured health plans in Wisconsin, regardless of the funding model.

Access to Data

Many employers view access to their own claims data as one of the significant advantages of self-insuring. With this data, employers are better able to identify cost drivers, customize wellness programs, and target cost and utilization control strategies based on claims experience. Although the Board is separately pursuing a data warehouse and has been working with plans to gain access to more detailed claims data, under the current model this effort has been a challenge. Under a self-insured model, the state would own the claims data.

Administrative Costs

Many employers find that the administrative costs charged by third party administrators are lower than the administrative costs charged by insurers.

Concerns with Self-Insuring

There are also several concerns to be considered when offering a self-insured model, as described below.

Risk

By self-insuring, employers are financially responsible for all claims risk. This means that if claims experience worsens, the employer pays more, but if claims experience improves, the employer pays less. WHIO data has shown that the GHIP population has a higher disease burden than other commercial plans included in its database. The full amount of this risk will be borne by the state and WPE if the Board moves forward with

self-insurance. Segal's November 2015 report to the Board indicated that ETF's membership has chronic condition rates that exceed national norms (64% vs. 50%).

Many employers hedge against this risk by purchasing stop loss insurance. Given the size of the GHIP, it is not clear if stop loss insurance will be necessary. Segal will advise the Board on whether stop loss is prudent if the Board decides to move forward with a self-insuring approach.

Value-Based Provider Payment Models

Several vendors responding to the self-insurance and regionalization Request for Proposals (RFP), discussed below, have indicated that some of their value-based provider payment models, including shared savings and pay-for-performance, are only available in a fully-insured model or may be much more challenging to establish under a self-insured model. These vendors specified that changes would be needed in administration, funding arrangements, contractual provider reimbursements and additional legal review. If the Board is not able to take advantage of such models under a self-insured approach, it could reduce cost savings.

Medical Management Effort

There is a risk that by contracting with health plans to provide third-party administrative services, including medical management services, those vendors will not be as effective at managing the claims risk if they are not also at risk financially for claims costs. Segal recommends that the contracts with any third party administrators also include gain sharing provisions and performance metrics to mitigate this concern. The RFP included questions that asked vendors to describe outcomes and returns on investment for their medical management programs for evaluation.

Administrative Costs

Some employers find that their own administrative costs increase when they transition to self-insurance because of the additional financial and management duties incumbent on employers that self-insure. ETF recognizes that improved access to data and increased oversight and management of financial transactions will create new administrative responsibilities that would likely exceed the capacity current staff resources.

Legal Liability

Some employers find that they have increased liability to legal action when moving to self-insurance. Based on comments and feedback collected throughout the RFP process, it is reasonable to assume that the exposure for the Board, the state and/or employers could increase to some degree in a self-insured world. Vendor willingness to share responsibility in this area would be deliberated in the contract negotiation process.

Regionalization: Background and Considerations
Currently, service areas are determined by health plans as they negotiate with hospitals, clinics and independent physicians in various areas of the state. Plan networks frequently follow distinctions between provider groups and can result in both provider competition in some areas, or significant overlap in other regions where many plans offer the same provider systems.

Establishing four regions in the state where vendors must offer adequate access to providers will result in a change from the structure of current networks, and potentially the health plans, in the program. Inherent to the discussion of regionalization is the potential for the state to contract with fewer vendors. This is a likely outcome, as many of the smaller participating health plans do not have networks that cover the required regional service areas.

It should also be noted that the Board could pursue a regionalization strategy regardless of whether the state moves to a self-insured structure.

Benefits of Regionalization
Defined service areas and/or fewer insurers could ease administration for ETF staff and ease communication of plan options and availability for members. Vendors with significant group health insurance program membership may be able to leverage market share to negotiate more cost effective contracts with providers. This market leverage may also have the impact of stabilizing provider network changes, as the increased market share may be an attractive negotiation point to maintain longer term provider contracts, potentially minimizing provider disruption for members. The burdensome annual provider qualification process would also be simplified.

Concerns with Regionalization
Fewer and/or different health plans could mean that certain provider groups are no longer available. On a related note, any major shifts in population to fewer health plans could test the capacity of the remaining plans, which could adversely impact service delivery. For decades, the program has leveraged Wisconsin’s uniquely competitive health insurance marketplace to maintain reasonable premium increases and offer choice to our members. If there are fewer qualified health insurers to compete for our member population, it could impact ETF’s ability to negotiate reasonable premium increases.

Evaluation of Changes to Existing Program Structure
At the February 17, 2016 meeting, the Board approved moving forward with the development and distribution of an RFP to evaluate self-insuring and a regional/statewide structure for the GHIP.

The primary purpose of the RFP was to collect the information necessary to bring the Board various program structure alternatives for its consideration. In development of the

RFP, ETF and Segal completed a Request for Comment (RFC) in May 2016, a Request for Information (RFI) in June 2016, leading to the RFP's release in July 2016.

Request for Comment (RFC)
The RFC was initially released on May 4, 2016 and asked current and potential RFP bidders to comment on the proposed regional structure, provider access standards, the repricing file exercise and other data specifications. ETF received 18 responses and numerous comments from potential proposers. There were comments on the proposed regions, including suggestions to combine the northeast and southeast region into one eastern region. Commenters also raised concerns about sharing confidential information, including personal health information and provider-level data. This feedback was shared with the Board at its May 18 meeting and was incorporated into the final RFP as appropriate.

Request for Information (RFI)
The RFI was released June 13, 2016 and included a draft of the RFP, a draft of the pro forma contract, terms and conditions, data specifications and other documents intended to be released as part of the RFP. The RFI specifically asked commenters to identify draft requirements that would decrease competition or dramatically increase costs, and/or requirements that were not industry standard practice or were otherwise confusing and unclear. Responses were due June 24, 2016.

We received responses from 15 health plans, two provider networks and a quality improvement organization. Some commenters provided thorough feedback, while other commenters responded with minimal comments. Comments received from multiple commenters included:

- Concerns about sharing proprietary or confidential data
- Geographic boundaries of proposed regions
- Basis for the quality measures and targets
- Length of the contract (five years)
- Quantity and specific nature of some reporting requirements and performance guarantees
- Concerns about claims liability
- Requirements to provide legal counsel
- Operational timelines
- Financial/banking arrangements

These comments were incorporated into the final RFP, as appropriate.

Request for Proposal (RFP)
The RFP was released on July 22, 2016 and letters of intent to submit responses were due August 5, 2016. Proposals were due September 19, 2016.

The RFP asked vendors to answer general questions about their business, staffing, customer service and data security. In addition, it asked technical questions about provider management and reimbursement, medical management, total health management and data integration.

The RFP asked vendors to bid on any of the four defined regions and/or submit a statewide bid. Vendors could propose changes to the region's borders, but only changes to counties bordering a region would be considered. The RFP also asked vendors to submit an administrative cost proposal and complete a repricing exercise. For the repricing exercise, Segal provided a detailed claim file and the proposing vendor was asked to reprice those claims based on their provider contracts and to project claims costs under a self-insured model for the five-year contract period.

Although the RFP did not specify whether Medicare annuitants would be served under the proposed contract, vendors were asked to submit information about their Medicare Advantage plans—but these responses were not scored. ETF is reviewing this information and will separately present the Board with a recommendation on how to proceed with covering Medicare annuitants.

Of the 15 vendors that submitted a letter of intent, 9 submitted formal proposals. Two vendors that submitted a letter of intent but declined to submit a proposal sent follow-up letters explaining their decisions. One large, national vendor indicated that the mandatory requirements were beyond the scope of similar work they do for other similarly sized public sector employers and, in particular, raised concerns that the RFP prohibited vendors from submitting assumptions and exceptions to certain provisions in the pro forma contract. These provisions, listed in Table 5 of the RFP (see Attachment B), included indemnification provisions, performance standards, uniform benefits, grievance procedures, and other provisions. A smaller regional plan declined to participate indicating that it could not compete without significant investments, given the proposed regions and the administrative requirements included in the RFP.

The proposals received were scored based on their responses to the general questions, the technical questions, and the cost proposal. A total of 1,000 points were available, with general questions receiving a maximum of 200 points, technical questions receiving a maximum of 400 points, and the cost proposal receiving a maximum of 400 points. Two separate teams evaluated the responses. Segal scored the cost proposals and a team of three ETF staff members and two external evaluators scored the general and technical responses. Of all the responses received, the combined scored total ranged from a low of 594 to a high of 791.

Chapter 40 Procurement Requirements

The RFP was authorized under Chapter 40 Wis. Stats., which gives the Board broad authority to contract for health care services, including defining the process for selecting vendors. However, the process used by ETF very closely follows the processes spelled out in the State Procurement Manual, which is governed by Chapter 16, Wis. Stats. The

primary difference between the standard processes included in the State Procurement Manual and the process used in this RFP is that Segal was responsible for scoring the cost proposals, due to the complex financial analysis required, rather than the evaluation team that scored the general and technical responses. One other difference from most state procurements is that in this case, all vendor proposals are being presented to the Board for their consideration under a variety of regional and statewide scenarios, rather than presenting just the top scoring vendors for consideration. The Board is not required to select the highest-scoring proposals – as they would be under a Chapter 16 procurement. The Board needs to act in the best interest of the GHIP.

State Legislature Oversight in Self-Insuring
2015 Wisconsin Act 55 (the 2015-17 biennial budget) requires the Board, in consultation with the Division of Personnel Management in the Department of Administration, to report to the Legislature's Joint Committee on Finance (Committee) under a passive review process if it intends to execute a contract to provide self-insured group health plans on a regional or statewide basis to state employees.

Under this passive review process, if the Committee co-chairs do not notify the Board that the Committee has scheduled a meeting on the proposed contract within 21 working days after the notification to the Committee, the Board may execute the contract. However, if, within 21 working days after the notification to the Committee, the co-chairs notify the Board that the Committee has scheduled a meeting on the proposed contract, the Board may not execute the contract without the Committee's approval.

It is expected that if the Board decides to proceed with a self-insuring contract, ETF, on behalf of the Board, would send the appropriate notification to the Committee in early 2017.

Next Steps
At the November 30 Board meeting, the Board will be presented with the findings from the RFP. Segal and ETF staff will be seeking feedback and guidance on preferred scenarios.

Specifically, ETF staff and Segal will model options based on the RFP results and compare various scenarios to the current program structure. Deliberation will focus on whether to self-insure, whether to regionalize, alternative strategies, and the pros/cons and cost-savings associated with all the aforementioned strategies. This portion of the meeting will be held in closed session due to the confidential and proprietary information that will be discussed in reviewing the scored proposals.

A follow-up meeting of the Board is scheduled for December 13, where Segal and staff will present the Board with actionable recommendations.

Attachment A: Self-Insuring Medical Claims – Request for Proposals
Attachment B: Table 5 – No Assumptions or Exemptions Allowed

Attachment A

State of Wisconsin
Department of Employee Trust Funds
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Correspondence Memorandum

Date: February 9, 2016

To: Group Insurance Board

From: Lisa Ellinger, Director
Office of Strategic Health Policy

Subject: Self-Insuring Medical Claims – Request for Proposals

Based on the recommendations of the current benefits consultant, and current and previous consulting actuaries, staff recommends that the Board approve the development and issuance of a Request for Proposals (RFP) to evaluate the impact of self-insuring the group health insurance program.

Summary
Self-insuring is currently the prevalent model adopted by most states for employee health insurance coverage, with 46 states reporting that they partially or totally self-insure. The Group Insurance Board (Board) has considered self-insuring the medical portion of the group health insurance program periodically over the past four years. Two consulting actuarial firms – Deloitte and Segal – considered the financial impact of self-insuring the group insurance program. Both firms concluded that an RFP is the advisable next step to thoughtfully evaluate program structure options. With approval from the Board, ETF will prepare more detailed information regarding the contents of an RFP for Board discussion at the May 2016 Board meeting. It is anticipated that the RFP would be issued in July 2016.

Background
The Board has considered self-insuring the medical portion of the group health insurance program periodically over the past four years. A brief history of self-insured analysis and discussion conducted by the Board follows below.

- Oct 26, 2012: At the request of the Board, the Board's consulting actuary – Deloitte Consulting (Deloitte) – prepared a report analyzing the financial impact of self-insuring the group health insurance program. The report noted that, "a more detailed analysis would be needed to further refine the estimated financial impact."
- February 25, 2013: The Board convened a Strategic Planning Workgroup and discussed developing and issuing a Request for Information (RFI) to gather

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additional information to assess the impact of self-insuring the group health insurance program.

- April 1, 2013: ETF/Deloitte issued a “Supplemental Information Request” to health plans participating in the group health insurance program. Non-participating insurers were also invited to respond to a request for information.
- August 27, 2013: results of the supplemental information request and RFI were presented to the Board, which determined this topic would be discussed further at the next meeting of the Strategic Planning Workgroup.
- October 8, 2013: The Strategic Planning Workgroup considered recommendations based on results of the supplemental information request and RFI. ETF staff presented several options to the Board and recommended proceeding with an RFP to collect additional information. The Workgroup tabled further discussion on self-insuring and directed staff to collect additional information about the cost drivers, utilization patterns and areas of variation in the administration of the group health insurance program.
- January 7, 2014: The Strategic Planning Workgroup recommended hiring a benefits consultant to assist with the analysis of program structure and plan design.
- April 16, 2014: Segal Consulting was awarded the contract for consulting actuarial services.
- May 23, 2014: ETF issued an RFP for benefit consulting services.
- September 2014: Segal Consulting was awarded the contract for benefit consulting services.
- March 25, 2015: Segal presented its first report to the Board, “Observations and 2016 Recommendations,” which noted potential savings of 5-7% from self-insuring and recommended additional study.
- August 2015: Segal issued an RFI to collect additional information from both participating and non-participating insurers to evaluate provider access and network discounts. This information was collected to inform the November 2015 recommendations to the Board.
- November 17, 2015: Segal presented its second report to the Board, “Observations and Recommendations for 2017 and Beyond.” The report noted that, “An actual request for proposals (RFP), accompanied with full claims and encounter data, would be necessary to confirm and validate the RFI results.”
- January 7, 2016: The Board convened to continue the discussion of the Segal report. This discussion included the recommendation that an RFP was the best way to determine the impact of self-insuring the group health insurance program.

Actuarial Approaches to Analyzing Impact of Self-Insuring

The two consulting actuarial firms – Deloitte and Segal – considered various impacts on plan costs resulting from a self-insured approach, and arrived at different cost estimates. Both actuaries considered the following elements in their recommendations:

Affordable Care Act (ACA) taxes and fees, administrative costs, carrier profit margin and risk charges, and premium taxes. Deloitte estimated the financial impact to range from 2% (savings) to -10% (additional cost). Segal estimated a financial impact with savings up to $42.3 million annually.

The primary difference between the actuary findings pertains to assumptions about how network discounts would be affected as the market reacts to a change in program structure. Deloitte assumed that many of the discounts currently factored into the existing managed competition model may not be obtainable in a self-insured model. The Segal report assumed all current discounts would continue to be available in a self-insured structure, and could increase if patient volume to specific cost-efficient networks increases.

It should also be noted that Segal collected more in-depth data for the most recent analysis, and considered a variety of relevant changes to the current plan design and structure.

Discussion Points
As noted, self-insuring is currently the prevalent model adopted by most states for employee health insurance coverage, with 46 states reporting that they partially or totally self-insure. The State of Wisconsin program currently self-insures pharmacy, dental and a small portion of health insurance coverage.

The discussion of self-insuring is separate and distinct from any discussion regarding the number of participating insurers, member access to available providers, and the level of benefits offered. Self-insuring is the mechanism for paying for medical claims, and assuming the associated risk.

In the recommended RFP, ETF will request information to evaluate the ability of submitting proposers to support the strategic initiatives presented in the November Segal report. The RFP will be structured to evaluate the following components.

- Program Structure: regional, statewide, and national
  Information will be collected to enable the Board to compare potential costs/ savings associated with different program models. For example, information will allow the Board to weigh the pros and cons of a self-insured program under a regional structure using multiple insurers versus a single, statewide administrator approach.

- Performance Measures
  Insurers will be required to demonstrate the ability to meet various operational and health-related performance measures. As recommended in the Segal report, baseline metrics will established in areas such as: treatment compliance, medication adherence, clinical outcomes, utilization improvement, engagement in medical management, and wellness programs.

Such metrics will help the Board evaluate the impact of insurer medical management programs on unnecessary and avoidable claims, and reducing risk factors in the covered population.

- Multi-year Contracting
  Proposers will be required to indicate a willingness to enter into three and five-year contracts and note the cost differentials associated with these options. This information will allow the Board to evaluate the benefits of multi-year contracts.

- Provider Access
  Proposers will be required to demonstrate adequate provider access in the regions they propose to serve. Information submitted will allow the Board to evaluate the provider systems available, as well as the number of primary care physicians and specialty physicians available in the proposed networks.

- Cost Impact
  Summary information of the anticipated cost to the state under the various proposals will be available in a standardized format for the Board to review.

- Value Based Plan Design
  Each submitting proposer will be required to demonstrate the capability to provide value based plan design options, such as: provider-level tiering, reference value/pricing, and centers of excellence.

Timeline
While the two most recent actuarial firms retained by the Board have reached different conclusions about the financial impact of self-insuring, both have concluded that an RFP is the advisable next step to thoughtfully evaluate program structure options.

If the Board approves the recommendation to proceed with the RFP, ETF staff will prepare more detailed information regarding the RFP for additional Board discussion at the May 2016 Board meeting. The 2016 timeline for RFP-related activities follows below.

Proposed Implementation Timeline

- RFP Development: January – July 2016
- RFP Distribution: July 2016
- RFP Responses Due: August – September 2016
- RFP Evaluation: September – November 2016
- RFP Results Presentation to GIB: November 2016

As noted above, ETF staff will present summary findings from the RFP at the November 2016 Board meeting.

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

Attachment B

The Department will not allow any assumptions or exceptions by the Proposer to any of the following items listed in Table 5. Any Proposal with an assumption or exception to any of the items listed in Table 5 will be rejected.

Table 5 No Assumptions or Exceptions Allowed

No.	Document	Item/Section	Page(s)
1	Exhibit 1	135D Recovery of Overpayments	24 - 26
2	Exhibit 1	135E Amounts Owed by Contractor	26
3	Exhibit 1	155B Performance Standards and Penalties	34
4	Exhibit 1	155G Privacy Breach Notification	37 - 38
5	Exhibit 1	155I Contract Termination	38 - 39
6	Exhibit 1	220 Benefits	46 - 50
7	Exhibit 1	245 Grievances	54 - 57
8	Exhibit 1	400 Uniform Benefits	87 - 153
9	Exhibit 2	15.0 Applicable Law and Compliance	2
10	Exhibit 2	17.0 Assignment	2
11	Exhibit 2	32.0 Hold Harmless	3
12	Exhibit 4	6.0 Audit Provision	2
13	Exhibit 4	13.0 Contract Dispute Resolution	3 - 4
14	Exhibit 4	14.0 Controlling Law	4
15	Exhibit 4	16.0 Termination of this Contract	4
16	Exhibit 4	17.0 Termination for Cause	4
17	Exhibit 4	18.0 Remedies of the State	5
18	Exhibit 4	22.0 Confidential Information and HIPPA Business Associate Agreement	5 - 8
19	Exhibit 4	23.0 Indemnification	8 - 9