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Correspondence Memorandum

Date: October 23, 2019

To: Group Insurance Board

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Subject: Summary of Programs Overseen by the Group Insurance Board

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

Introduction

This paper summarizes the history and current benefits overseen by the Group Insurance Board (Board). It is meant to provide the Board with context for the strategy discussion.

Per Wis. Stats. §40.03(6), the Board is charged with overseeing group insurance plans for eligible employees, retirees and their dependents. The current programs managed by the Board include:

- fully-insured medical benefits
- self-insured pharmacy benefits
- self-insured dental benefits
- wellness program
- supplemental insurance plans
- life insurance
- employee reimbursement account (ERA) and health savings account (HSA) programs[1]

Under statute, Board members serve as trustees to these programs; ETF serves as the administrator. ETF manages day-to-day operations of these programs on the Board's behalf. ETF also researches opportunities for program improvement and presents findings and recommendations to the Board.

[1] The Board also oversees the Income Continuation Insurance (ICI) program; this program will not be covered in this summary document.

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy
Eileen K Mallow Electronically Signed 10/29/19

Board	Mtg Date	Item #
GIB	11.13.19	5C

Programs Managed by the Board

Life Insurance

The Board was established as the Group Life Insurance Board in the early 1950s. That Board was tasked primarily with overseeing the life insurance product, which has been managed by a single vendor (now called Securian) since the program began. It provides coverage if an employee or retiree dies or is severely injured. The program is authorized under Wis. Stats. §40.70.

Three plans are offered through the group life insurance plan—the Basic Plan, Supplemental Plan and Additional Plan. The Basic Plan compensates equal to the employee's prior year earnings rounded to the next higher $1,000 increment (employees with less than one year of service at time of death have earnings estimated). The Supplemental Plan pays an additional year of earnings at the same rate as the initial year. The Additional Plan provides coverage in addition to the Basic Plan at up to three times the prior year's earnings. In each case, if the employee is still working at age 70, premiums cease to be charged, and the amount of insurance is adjusted based on a formula. Employees may continue Basic Plan coverage into retirement; Supplemental and Additional Plan coverage ends at age 65. Employer contributions are required for the Basic Plan and the Supplemental Plan; no employer contributions are required for the Additional Plan[2]. In addition to the direct payment of benefits, the life insurance benefit can also be converted into a cash benefit for the payment of either health insurance or long-term care insurance premiums.

As stated above, the life insurance plan has been administered by Securian since the program's inception; Securian has continued to win the contract through several requests for proposals (RFPs). The Board recently approved the next RFP for services for life insurance products, which will be released in January of 2020 (Ref. GIB | 2.20.19 | 7).

Health/Medical Insurance and Uniform Benefits

In 1959, the Group Life Insurance Board's authority was expanded to overseeing a group health insurance program (GHIP) for state employees. The Board began offering self-insured group health insurance benefits, in what became known as the Standard Plan (now known as the Access Plan), on April 1, 1960. In 1978, the Board began to offer new managed care plans, also known as Health Maintenance Organizations (HMOs), on a fully insured basis. 1983 Wisconsin Act 27 formalized the state's contribution to employee premium costs. The contribution formula laid out therein was intended to encourage employees to join managed care plans that were intended to be less expensive than the Access Plan. This began the competitive health plan model, known as "managed competition," where health plans bid to participate in the Board's program and then compete with one another for individual employees to elect their plan. Most state employees (more than 95%) now choose one of the managed care or cost-

[2] See the Wisconsin Public Employers Group Life Insurance Program Brochure, form ET-2101, for additional information.

effective Preferred Provider Organization (PPO) plans offered through the managed competition model for their health care coverage.

In 1994, the Board implemented a common certificate of benefits and coverage for all health plans participating in the program, referred to as Uniform Benefits (UB). All plans offered to active employees are required to offer the same benefits and service coverage as outlined in UB. However, UB provides plans the authority to develop medical policy, prior authorization criteria and implement utilization review as a part of their cost and medical management strategy, which means the actual experience of benefits by member may differ. UB was updated to include coverage for all essential health benefits (EHBs) identified in the Patient Protection and Affordable Care Act (ACA) of 2010. As a part of ACA implementation, ETF undertook the required benefits benchmarking activity described under ACA. The ACA allows non-federal governmental entities to use the benchmark plan identified by the Centers for Medicare and Medicaid Services (CMS) for their state, or a benchmark plan from another state. ETF opted to use the benchmark plan from Pennsylvania for benchmarking, as it was the closest in design to the benefits offered by the Board at that time (Ref. GIB | 5.21.13 | 4B). There are a handful of additional benefits beyond the EHBs covered by the Board's plans—temporomandibular joint treatments, hearing aids for adults, cochlear implants for adults, and dental implants—that have benefit limits. All EHBs are covered without benefit limits.

2011 Wisconsin Acts 10 and 32 substantially changed state employee health program costs. Act 10 required the Board to reduce the cost of the GHIP by at least 5% with benefit changes to be effective January 1, 2012. Coinsurance was added to injury and illness-related services, and the copay for emergency services was increased from $60 to $75 for the traditional, non-Access plan option. These changes applied to active employees and non-Medicare eligible retirees[3]. Act 32 lowered the maximum age of an adult dependent child to 27 years, unless the child is a tax dependent. These acts further defined that the maximum amount that a state employer could pay for an employee's health insurance was 88% of the average, Tier 1 health plan premium, as calculated by the Department of Administration's personnel office.

The high-deductible health plan (HDHP) was initially considered due to a request for a paper under 2011 Wisconsin Act 32 that was presented to the Board at its November 8, 2011 meeting (Ref. GIB | 11.8.11 | 5A). This paper also discussed changes to the state's contribution rate structure that provides for single and family premium rates, not for couples, and reported on ETF's research regarding an online drug purchasing marketplace, health exchanges, and pooling our program with Medicaid. ETF discovered substantial limits in pooling the program with Medicaid, and the Board did not pursue that option or the exchange or drug marketplace options. The HDHP concept was tabled at that time.

[3] Department of Employee Trust Funds, "Recent Changes to Your WRS/Group Health Insurance Benefits" fact sheet, p. 16, https://etf.wi.gov/media/3926/direct

The Board gained flexibility in establishing benefits under 2013 Wisconsin Act 20. Previously the Board had been limited to only making changes that did not materially affect the overall premium of the program. After the change to Wis. Stats. §40.03(6)(c), the Board was permitted to modify or expand benefits, including those of the Access Plan, if the change would maintain or reduce premium costs for the state or its employees in the current or any future year. 2013 Wisconsin Act 20 also required that a HDHP be offered with a health savings account (HSA) to all state employees. ETF and Deloitte Consulting (Deloitte), the Board's actuary at the time, provided program analysis and a recommendation on February 19, 2014 (Ref. GIB | 2.19.14 | 5D) and May 21, 2014 (Ref. GIB | 5.21.14 | 4B1). The HDHP with an HSA was first offered to state members on January 1, 2015. Locals were also offered a HDHP program option in this year. The HDHP had a $1,500 deductible for individuals and $3,000 for family; post-deductible, the copays and coinsurance were designed to mirror those in the non-HDHP. The HDHP deductible has not changed since the program's inception.

Additional changes to UB and the medical benefits are covered below in the discussion of the Segal Reports and Self-Insuring RFP.

Pharmacy Benefits

In the early 2000s, the costs of prescription drugs were recognized as one of the main drivers of overall cost increases for the GHIP. However, prior to 2004, each health plan that participated in the GHIP independently administered prescription drugs for the members who were enrolled in their plans. The health plans did not provide detailed data to the Board; therefore, the Board was not able fully understand the scope of the member population's drug spend.

In 2002, ETF began investigating the possibility of carving out the pharmacy benefit from the medical benefits administered by the participating health plans. This idea originated in the work of the Health Insurance Study Group that convened annually to consider benefit changes to propose for the coming plan year. A memo to the Board in November 2002 outlined the positive impacts of carving out the pharmacy benefit from the medical plans, including:

- Access to better rebates and discounts;
- A single claims processing system for all claims which could alert members to dangerous drug interactions;
- Greater negotiating power for rebates, discounts, and clinical and ancillary services; and
- More flexibility to consider cost effective benefit designs when the drug benefit is managed by one entity – the pharmacy benefit manager (PBM) – versus many (the health plans and/or their own PBM).

In June 2003, after evaluating 13 PBM proposals submitted in response to an RFP, ETF recommended selecting DeanPoint, which later was renamed as Navitus Health Solutions (Navitus). Under the newly-developed model, the PBM would offer a full pass-through business model, meaning that all revenue and cost beyond the administrative fee is returned to the Board. The PBM also pursues the "lowest net cost" for the program—instead of focusing on the discounts achieved or rebates acquired, the PBM is required to simply provide the lowest total program expenses. This results in less incentive to "chase" rebates. In addition to these requirements, the PBM must provide an open, fully-transparent view of all company operations, including the contracts held with manufacturers, clinical program development, and the company's own finances. The PBM provides ETF with a seat on its Pharmacy and Therapeutics (P&T) committee, which oversees formulary development.

Effective January 1, 2004, the GHIP's pharmacy benefits were carved out and managed by a PBM. Navitus continues to be the Board's PBM following two additional RFPs. All members of the GHIP access their pharmacy benefits through the PBM.

The GHIP provides prescription drug benefits to employees and early retirees under our commercial (non-Medicare) prescription drug coverage, as well as for our Medicare enrolled/eligible retirees under our Medicare Part D coverage. All pharmacy benefits are governed by the Uniform Pharmacy Benefits (UPB) to maintain consistency no matter what plan the member selects. In addition, while there may be some variation between the benefits Medicare retirees get and the benefits provided to the non-Medicare members, the intent of the benefit design is to ensure, as much as possible, that the level of benefits an employee has while working carries over into their retirement.

Employee Reimbursement Accounts

The Board also offers employee-funded reimbursement accounts (ERA), as authorized under Wis. Stats. §40.85. These accounts were established by 1987 Wisconsin Act 399, and are compliant with Internal Revenue Code, 26 U.S. Code §125, 26 U.S. Code §105, and 26 U.S. Code §129. They are intended to provide employees with additional pre-tax mechanisms for setting aside money to cover health and dependent day care expenses. The Board currently offers a health care flexible spending account (FSA), a limited-purpose FSA (LPFSA), and a dependent day care account, all of which are offered pre-tax to state employees. There is also a commuter fringe benefits account, a qualified transportation benefit plan authorized under 26 U.S. Code §132, which began in 2002. It allows state employees to deduct money from their paychecks pre-tax for qualified expenses such as parking and mass transit. The Board contracts with a third-party vendor to provide ERA benefits to employees, and in 2019 is in the process of transitioning that vendor relationship from Total Administrative Service Corporation (TASC) to Connect Your Care (CYC).

These benefits are only offered to active state employees. Local employers and retirees are not eligible for these benefits. In August 2018, following changes related to the Tax Cuts and Jobs Act (TCJA) of 2017, a change in the allowed tax expenses for certain entities caused the University of Wisconsin Hospital and Clinics (UWHC) and the University of Wisconsin System (UWS) to withdraw from the commuter benefits portion of this program (Ref. GIB | 5.16.18 | 2.5), due to a substantial change in their tax liability. The Board exercised its authority to freeze plan participation for UWS employees as of May 31, 2018 and for UWHC employees as of November 1, 2018 (Ref. GIB | 8.22.18 | 5). This change did not apply to state agencies.

In addition to these accounts, the Board offers a HSA through the same vendor that manages the other ERAs. The HSA is required to be offered in conjunction with the Board's HDHP as mentioned above (see Wis. Stats. §40.515). Additional information on the HDHP and HSA are covered in the discussion of the Health/Medical Benefits above and of the Segal Reports and Self-Insuring RFP below.

Supplemental Insurance Plans

Wis. Stats. §40.03(6)(b) authorizes the Board to approve group insurance plans where the employee pays all the cost of the benefits. Further, Wis. Stats. §20.921(1)(a)(3) and Wis. Admin Code ETF 10.20 give the Board the authority to approve any group insurance plan for which payment is deducted from an employee's paycheck. For many years, state employers that participated in the GHIP also offered a variety of employee-pay-all insurance benefits, including supplemental dental plans, accidental death & dismemberment (AD&D) plans, and other indemnity plans. The inconsistency between agencies once caused challenges for employees who would transfer between agencies; therefore, ETF developed guidelines at the request of the Board to provide minimum requirements for those plans that wished to offer benefits to state employees through payroll deductions. The Board further standardized the requirements for plans in 2015, when it published the *Guidelines for Optional Insurance*, now called the *Supplemental Insurance Plan Guidelines (ET-7422)*. These guidelines specify minimum product loss ratios, maximum annual premium increases, and other plan performance standards and reporting requirements that help the Board assure high-quality benefits are provided to employees.

In 2017, the Board approved an alignment strategy that streamlined the number of plans offered to employees (Ref. GIB | 11.15.17 | 7A). This change was made in part to reduce the burden of administering programs for employers and ETF, but primarily to simplify the benefit selection process for state employees. Prior to 2019, the Board had four different vendors that offered eleven different plan options (Ref. GIB | 5.16.18| 5A). Beginning in 2019, the Board reduced to one dental plan vendor, one vision plan vendor, and one AD&D vendor; for 2020, the AD&D contract will be provided by the Board's current life insurance vendor, further reducing the total number of vendors.

Historically, supplemental insurance plans have only been offered to state employees and retirees in most cases. The Board approved extending the dental offering to local employers as well for 2020 (Ref. GIB | 5.15.19 | 9).

The Board also has the authority to offer long term care (LTC) insurance under Wis. Stats. §40.55. Unlike the other programs offered by the Board, LTC plans offered to state employees are individual insurance plans, not group plans. The board has in the past worked with a broker in addition to the actual LTC insurance carrier to provide a benefit option. The landscape of LTC in the broader insurance marketplace has changed substantially in recent years, and as a result there is currently only one broker, HealthChoice, who offers an LTC plan to state employees. The LTC plan sold to state employees is offered by Mutual of Omaha. The Board keeps a separate set of requirements for LTC vendors called the *Long Term Care Insurance Standards*. The *Standards* in part require that the Board contract directly with the insurance provider as well as the broker, so the Board can ensure quality services. As of the drafting of this memorandum, there is no three-party contract for services for long term care for 2020 (Ref. GIB | 8.21.19 | 10A) and therefore no LTC plan will be marketed to state employees in 2020. ETF continues to work with the broker and the insurer to come to terms for 2021. Because the policies are individually-purchased, members who have bought LTC policies in the past will be able to keep those policies.

Segal Reports & Self-Insurance RFP

In 2014, the ETF Board selected Segal Consulting (Segal) as the Board's actuary, replacing Deloitte. The ETF Board subsequently awarded an additional contract to Segal to act as a benefit consultant to review the GHIP and offer strategies to improve health outcomes and efficient delivery of quality health care to members. Oversight of the GHIP actuary has since been transferred from the ETF Board to the Group Insurance Board.

The Group Insurance Board sought strategies to address budget reduction targets starting in 2016. Segal made several recommendations in its reports to the Board on topics regarding self-insurance; offering an HDHP in conjunction with a Health Savings Account (HSA); data warehouse resources and their use for total health management; a uniform wellness program; alternatives for annual premium rate negotiations and others.

Self-insuring the program had been reviewed by Deloitte in the past. Deloitte reported to the Board's Strategic Workgroup on February 25, 2013, and to the Board on August 27, 2013 (Ref. GIB | 8.27.13 | 3D), that such a change could cause either a net gain or a net loss. However, Segal disagreed and presented findings to the Board on March 25, 2015 (Ref. GIB | 3.25.15 | 4C), and November 17, 2015 (Ref. GIB | 11.17.15 | 3A), where they estimated savings of $42.3 million annually. As a result, the Board opted to pursue self-insuring the GHIP, as well as creating program regions and reducing the number of health plans offered per region. At the May 19, 2015, Board meeting, Segal also advised increasing the state's HSA contribution and lower the actuarial value of the program (Ref. GIB | 5.19.15 | 3B) as they determined Deloitte's value did not account

for all utilization changes typically seen in an HDHP. These recommendations were adopted.

Investigating the pros and cons of self-insuring and regionalizing the program became a significant project for the Board and ETF staff from 2016 through 2017. ETF developed an RFP with input from Segal. The evaluation of proposers was presented to the Board on December 13, 2016 (Ref. GIB | 12.13.16 | 4A). Over the course of the investigation, updates and information were shared with the Board regularly, wrapping up at the August 20, 2017, meeting when the Board was notified the legislature's Joint Committee on Finance (JCF) rejected the negotiated self-insured contracts on June 15, 2017. Due to the late date the contracts were rejected by JCF, ETF recommended continuing the program in the fully-insured structure without regions, but with the newly-developed contract language that included health plan performance standards (Ref. GIB | 8.27.17 | 7A & Ref. GIB | 8.27.17 | 7B). Following the RFP and subsequent reversion to a fully-insured structure, six health plans opted not to renew their contracts for the following benefit year and approximately 53,000 members were required to change to new health plans.

Other benefit changes resulted from the Segal Reports, as well as from budget targets issued following their release. In 2016, the Board approved the first deductibles in UB: $250 for an individual and $500 for a family. They also modified office visit coinsurances to be flat copays (Ref. GIB | 5.19.15 | 3C) for the state employee plan. This change impacted both active employees and retirees without Medicare. Because Medicare pays first for Medicare-covered services, retirees with Medicare experienced less change to cost sharing. The Board preserved the "traditional" health insurance plan option for local employers, but the new plan with the higher deductible was added as an option that they could elect.

Segal also recommended aligning benefits covered between the It's Your Choice Health Plan and the Access Plan, the goal being to increase administrative simplicity. The Board approved aligning benefits, including in-network out of pocket amounts and benefits covered, for plan year 2018 (Ref. GIB | 2.8.17 | 8C). This removed the only coverage offered for bariatric surgery at the time and reduced the amount of coverage for oral surgery but increased the coverage for transplants and adult hearing aids and cochlear implants.

Uniform Dental Benefits

Prior to the Board's Strategic Workgroup and the benefits consulting work from Segal, health plans offered dental benefits as a part of UB coverage, and the benefits offered were at the discretion of the health plan. In April 2014, the Strategic Workgroup discussed the option of a stand-alone dental plan (Ref. GIB SPW | 4.16.14 | 4C). The Board approved carving out the dental benefit program at its November 18, 2014 meeting, establishing a Uniform Dental Benefit (UDB), and self-insuring that program as well (Ref. GIB | 11.18.2014 | 3B). Delta Dental of Wisconsin (Delta) was selected as the

first dental benefits administrator (Ref. GIB | 5.19.15 | 6); the initial contract will expire December 31, 2021, after executing all available renewal periods.
UDB provides a preventive-focused benefit to members. Cleanings and minimal restorative work are covered by the benefit. Services such as crowns are not covered. There is an annual benefit maximum of $1,000 per person. Members must elect health insurance coverage to receive the lowest premium for the UDB, though there will be a preventive-only supplemental plan option available in 2020 for members without health insurance. Members who elect health insurance, however, may opt out of the UDB.

Wellness Program

In the change noted earlier to Wis. Stats. §40.03(6)(c) regarding the ability to modify or expand benefits that result in maintaining or reducing premium costs, the Legislature included a provision that this, "…shall not be construed to prohibit the group insurance board from encouraging participation in wellness or disease management programs…" In 2012, six of the Board's then-18 health insurance plans offered a wellness incentive program of the plans' own design. At its May 22, 2012, meeting, the Board approved a wellness program for 2013 (Ref. GIB | 5.22.12 | 5A) which included requiring plans to provide a health risk assessment and biometric screening. The goal participation rate for the program as 30% to 50% of adult membership. As part of this requirement, plans could provide incentives of up to $150 in value to members completing both components, and the Board in turn offered a credit for this incentive during negotiations. The biennial budget had included a proposed tobacco use surcharge as well, but the provision was vetoed in the final budget due to administrative burden and federal guidance related to reasonable accommodations.

Late in 2013, it became apparent that plans were not going to meet their 30% participation targets. ETF recommended revising the health plan contracts to require that plans offer a uniform $150 wellness incentive, which the Board approved for 2014 (Ref. GIB | 5.21.13 | 4B). Following the advice of tax counsel, ETF (and its employer customers) began to report the $150 incentive and all other health plan incentives as taxable income. Also in 2013, the Department of Administration signed a two-year contract with OptumHealth to provide employer-hosted, onsite biometric screening events through calendar year 2016 (Ref. GIB | 3.25.15 | 4D).

Per Segal's recommendation in its second report to the Board, the Board released an RFP for wellness and disease management program administration in March 2016. Proposals were returned in April 2016, and a contract was awarded to StayWell Company LLC (StayWell) in July 2016 (Ref. GIB | 7.12.16 | 5) for program administration. Beginning in 2017, health plans were no longer expected to provide wellness programming or the $150 incentive to members; however, while StayWell provided a core set of disease management services to members, health plans could continue working with members on case and disease management. Health plans were encouraged to partner with StayWell for referrals of complex members.

Program participation rates increased from an overall rate of 15% in 2016 to 25% in 2017 (Ref. GIB | 5.16.18 | 7B). At the recommendation of both Segal and StayWell, the Board approved transitioning the $150 incentive to a premium differential (Ref. GIB | 2.8.17 | 8B). Some health plans continued to offer additional incentives such as community-supported agriculture share or fitness membership reimbursements, though the number of plans doing so began to decline. The Board approved adding a well-being activity to the required steps to receive the wellness incentive in 2018, and despite this change participation rates continued to increase. In its annual program review in early 2019, StayWell reported an overall risk reduction for repeat participants of 2%, health coaching participant health risk improvement f 10%, and disease management participant risk improvement of 6.5% (Ref. GIB | 5.15.19 | 7B). The Board has approved additional enhancements to the wellness program, including an expansion of the Ignite weight management and diabetes prevention program to 200 members in 2020. The wellness premium differential has not yet been implemented due to ETF systems limitations, but ETF aims to roll out that change in 2022 and will continue to update the Board.

Pilot Programs & Department Initiatives

Outside of UB, the Board has offered different programs and strategies to promote innovation among plans, while helping members to manage medical conditions. In 2008, the Board implemented requirements around treatment of low back pain, and in subsequent years pursued additional requirements for health plans to provide medical management services for members (Ref. GIB | 11.12.13 | 3C). These requirements were codified in the health program contracts as the Department Initiatives. Currently there are six Department Initiatives: care coordination, high-tech radiology, low back surgery, shared decision-making, advance care planning/palliative care, and monitoring of low-value services. Plans are required to implement minimum requirements around these areas of focus. They report annually on these programs to ETF.

As mentioned above, the Board has certain statutory limits regarding how it may change health insurance benefits, and it specifically cannot add benefits without either a legislative mandate or a cost offset. The Board has interpreted this offset requirement to mean either a simple reduction in other benefits or, in certain limited cases, adding benefits with a calculable return on investment based on evidence.

The GHIP contract includes language that allows health plans to offer pilot programs to the Board's members if those programs are at no cost to the Board. ETF solicited the first round of proposals for pilots in 2018 for implementation in 2019 (Ref. GIB | 5.16.18 | 4A). Health plans submitted a summary of the programs, including the intended audience and effect, and a plan for implementation. Programs were required to be evidence-based, and the plan was required to have experience implementing the program for other parts of its book of business. Any incentives offered were required to follow the Board's general incentive guidance, either being of de minimis value or reported as incentives and taxed. ETF received proposals for four pilot programs for 2019, and another three programs in 2020. Programs will run for a minimum of one year

before data is collected and the impact is analyzed. ETF reports annually to the Board on pilot program outcomes and costs to the health plans and will request guidance from the Board in May of 2020 regarding whether any of the 2019 pilot programs should be added as a full benefit, discontinued, or remain as a pilot for another year to gather more information.

Populations Served by the Board's Programs

Eligibility for the Board's programs is defined primarily at Wis. Stats. §40.02, Wis. Stats. §40.51, and ETF 10.01 and varies somewhat between state and local programs. All state agencies, the University of Wisconsin System (UWS), and authorities such as the University Hospitals and Clinics (UWHC) are statutorily required to participate in the programs offered by the Board. Local public employers (e.g., municipalities, counties, school districts, etc.) may file a resolution to join or exit from the Board's program; if a local employer chooses to leave the program, however, that employer must wait at least three (3) years before applying to return. Large local employers who want to join the program must submit to large group underwriting. The Board's consulting actuary, Segal, evaluates the risk of the group compared to the current pool. If the risk is adverse, a surcharge is added, generally for 24 months.

All state employees have the option to continue their health insurance coverage in retirement. Retirees are responsible for the full cost of their health insurance coverage and may pay for that coverage either through accumulated sick leave conversion credits, via their pension, directly to the health plan, or in limited cases by converting the value of their life insurance benefit to pay health premiums. The Board and ETF have worked to keep benefits for retirees affordable and comprehensive.

Participating local employers have been able to join the program since 1987 under Wis. Stats. §40.51 (7). Initially the Board only offered one program option, or benefit structure, to local employers. However, over time employers requested more choices. Effective January 1, 2005, three options with greater member out-of-pocket costs were made available following a request by employers and the legislature. These offered a lower premium cost and all the administrative assistance of ETF, such as for renewals, employee communications and employer support. Program options were modernized effective January 1, 2013 to eliminate an unpopular option and adjust out-of-pocket amounts for some other options to more closely align with benefits offered to state employees. This facilitated administrative simplicity with health plans and ETF.

All group health insurance program subscribers and spouses are eligible to participate in the Well Wisconsin program, with the exception of Medicare Advantage members, who have similar resources and incentives available via their health plan. Participation in the Medicare Advantage health plan's program supports the plan's CMS star rating, which is directly connected to premium costs. Child dependents are not eligible to participate in the Well Wisconsin program, due to the Genetic Information Nondiscrimination Act (GINA).

Approximately 240,000 total members are enrolled in the GHIP. A summary of enrollment statistics is provided to the Board every quarter by IBM Watson Health. The most recent quarter of data is included in Item 11B in the materials presented at this meeting (Ref. GIB | 11.13.19 | 11B). While the GHIP is often thought of as a Wisconsin program, the Board has members living in all 50 states, as well as in other countries. Figures 1-3 below show the distribution of members nationwide, as well as the counties where state and local program members reside.

Figure 1. Map of All Members by State, 2019

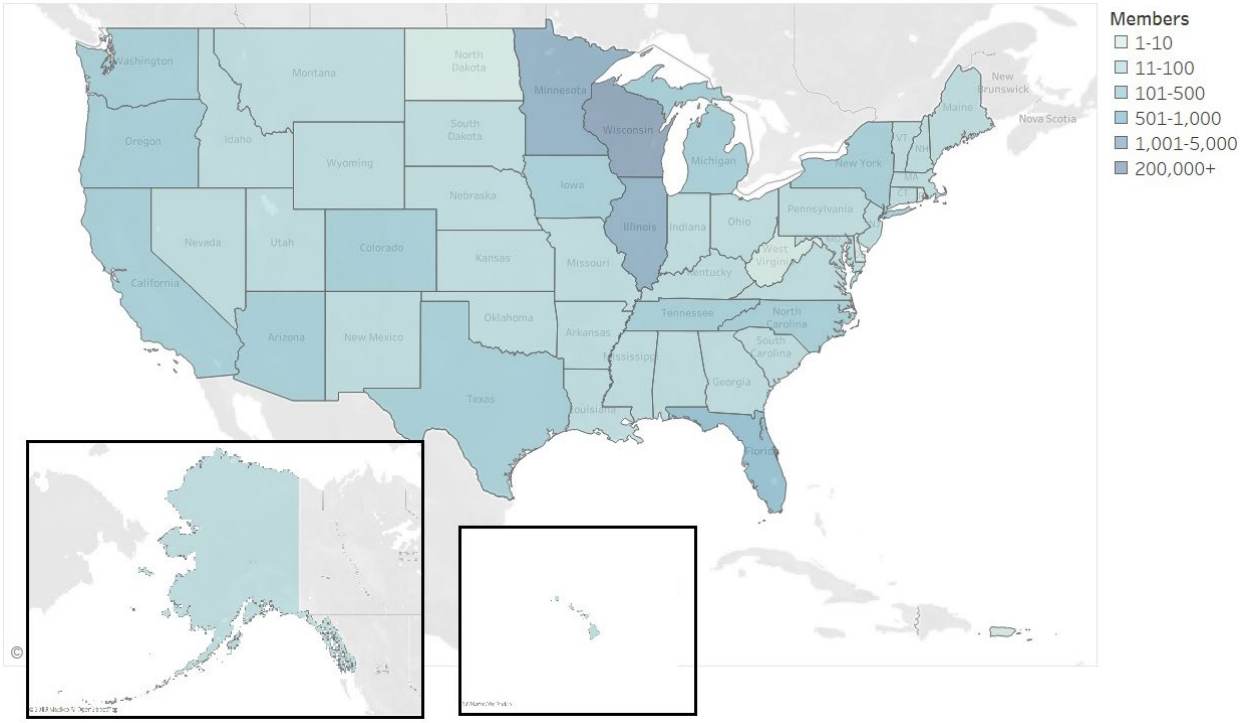


Figure 2. Map of State Program Members by County, 2019

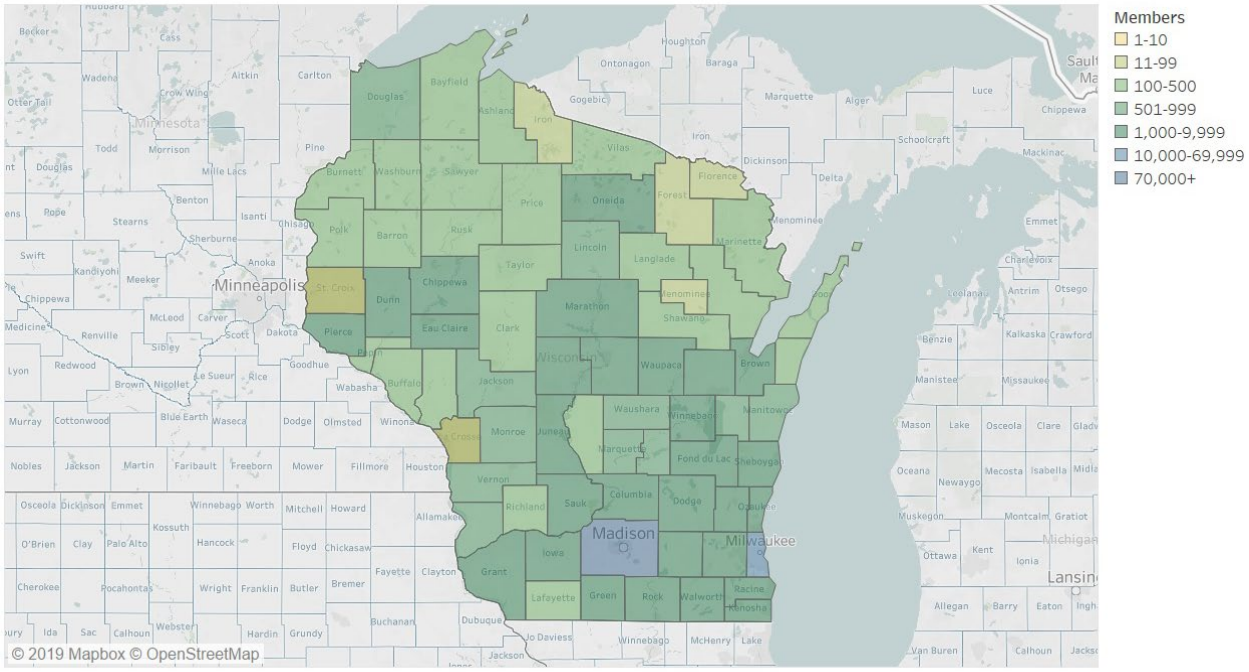
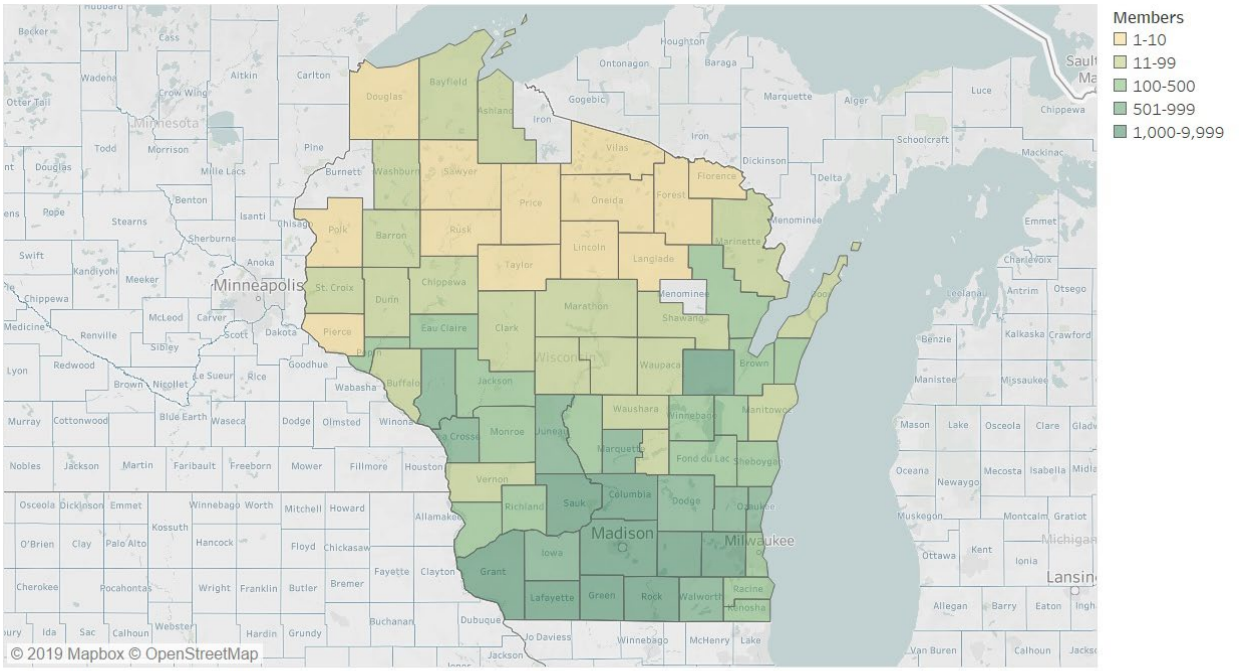


Figure 3. Map of Local Program Members by County, 2019



The two Wisconsin maps above show the distribution of members within Wisconsin. State program membership is heavily concentrated in Dane County, with another larger concentration in the Milwaukee area. The local program is also more concentrated in

the southern portion of the state, though less specifically in Dane County. The GHIP does have members living in all 72 Wisconsin counties.

It's Your Choice Open Enrollment

All eligible employees and retirees are given the opportunity to change plans, add or cancel coverage, or change from family to single or vice versa during the It's Your Choice (IYC) Open Enrollment period. Coverage becomes effective on January 1 of the following year. Eligible but uninsured employees could enroll with limitations prior to January 1, 2012 during IYC, but that restriction was eliminated with ACA changes to pre-existing limitation clauses under the Health Insurance Portability and Accountability Act (HIPAA). Eligible employees and retirees may also change certain program options if they have a HIPAA qualifying event or life change event.

Program Expenditures/Cost

Employers and employees who participate in the Board's programs pay monthly premiums for their benefits. These premiums are made up of four component parts—medical insurance, pharmacy benefits, dental benefits, and an administrative fee.

The medical insurance component covers the UB discussed earlier in this document. As reported by Segal, the cost of state medical insurance rates in 2019 and projected for 2020 is estimated to be as follows (Ref. GIB | 8.21.19 | 5F):

Table 1. Medical Benefit Annualized Premiums, 2019 and 2020

Medical Program Category	2019 Rates (in millions)	2020 Rates (in millions)
IYC Health Plan - State	$1,035.8	$1,076.3
IYC Health Plan – Local	$163.6	$170.6
IYC Access Plan & SMP State	$45.4	$45.4
IYC Access Plan & SMP Local	$1.0	$1.0
Medicare Advantage – State	$8.6	$8.6
Medicare Advantage - Local	$0.3	$0.3
Medical Program Total	$1,253.7	$1,302.2

The pharmacy and dental benefit annual costs, both single plan options provided by sole benefit administrators, were reported as follows:

Table 2. Pharmacy and Dental Benefit Annualized Premiums, 2019 and 2020

Benefit Program Category	2019 Rates (in millions)	2020 Rates (in millions)
Pharmacy Benefits – State	$215.4	$210.5

Pharmacy Benefits – Local	$29.9	$31.1
Dental Benefits – State	$58.3	$58.3
Dental Benefits – Local	$1.4	$1.4
Dental & Pharmacy Total	$305	$301.3

Note the above pharmacy rates are reported pre-buy down. The Board has chosen to buy down the calculated rates in each of the past several years, in order to reduce the amount of reserves held for the programs. The Board maintains a reserve fund for dental and pharmacy benefits if claims costs overrun the premiums collected in any given year. Strong management and investment returns have resulted in substantially lower pharmacy trend than projected in recent years, which in turn has caused a reserve surplus. For the medical benefit, the Board maintains a reserve to help smooth premiums if there are major cost shifts between years. The Board had been building an additional reserve fund in anticipation of self-insurance in 2016; following the rejection of the self-insured contracts, they have been spending down the excess balance above their reserve policy.

The final component of the rates paid by employers and employees is the administrative fee, which is also broken into three parts—wellness, data warehouse fees, and ETF administrative costs. The monthly administrative fees per employee per month for 2019 and 2020 are as follows:

Table 3. Administrative Fees by Month, 2019 and 2020

Fee Type	2019 Fee	2020 Fee
ETF Administrative	$8.64	$8.84
Data Warehouse	$0.32	$0.42
Wellness	$11.92	$13.50

The data warehouse fees collected in 2017 were enough to cover the costs of administering the data warehouse in 2019 and 2020, and so these fees have not been charged to employers. All fees are divided by the number of employees enrolled in the health plan, and then again by 12 to get a monthly value.

ETF Administration of Benefits

ETF is an agency that administers retirement, insurance, and other benefit programs for approximately 630,000 current and former public employees, retirees, and their beneficiaries. ETF is responsible for collective all money due to the trust funds, calculating and assuring proper benefits are disbursed or paid, providing information to participating employees and employers, and establishing protocols to ensure proper administration and security for the programs it oversees. ETF has approximately 300 employees, and its Secretary is appointed by the ETF Board.

The unit that administers the benefits overseen by the Board at ETF is called the Office of Strategic Health Policy (OSHP). OSHP consists of a director, a deputy director,

thirteen program managers and policy advisors and three contracted staff to perform data analytics and work on communications. OSHP provides general contract oversight for vendor contracts, rate negotiations, program and policy development, data analysis and research, and communications and member education to the Board, employers, and employees.

Staff will be available at the meeting to answer questions.