STATE OF WISCONSIN
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

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February 9, 2017

The Honorable Alberta Darling, Co-Chair
Joint Committee on Finance
317 East, State Capitol
Madison, WI 53701

The Honorable John Nygren, Co-Chair
Joint Committee on Finance
309 East, State Capitol
Madison, WI 53701

Dear Senator Darling and Representative Nygren:

The Group Insurance Board (Board) has approved an intent to award contracts to provide self-insured group health plans on a regional and statewide basis to state employees, effective January 1, 2018.

At its February 8, 2017 meeting, the Board approved issuing letters of intent to award contracts to the following vendors to provide administrative services to the State of Wisconsin Health Benefit Program (program), which funds health care services for state and local employees, annuitants, continuants, and their eligible dependents:

Statewide/Nationwide Vendor

- Compcare Health Services Insurance Corporation (Anthem Blue Cross Blue Shield)

Regional Vendors

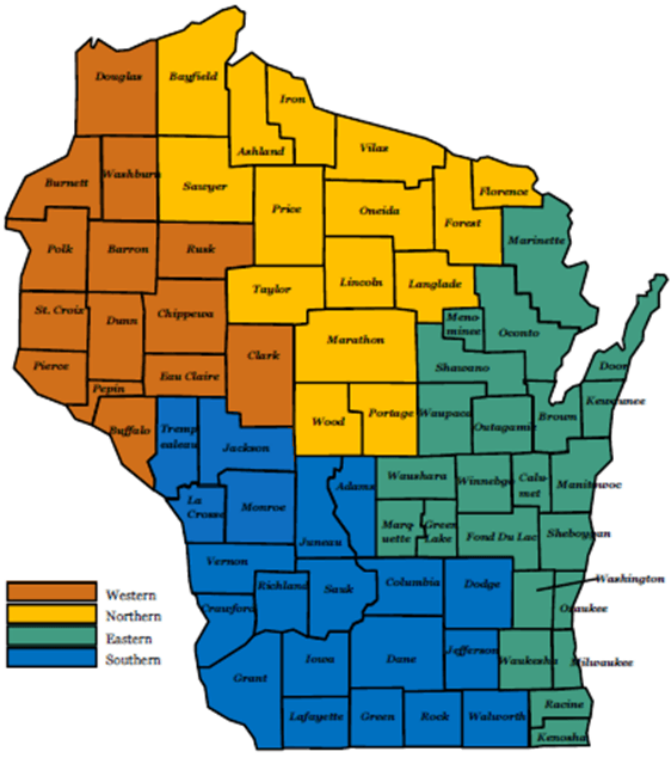
- Compcare Health Services Insurance Corporation (Anthem Blue Cross Blue Shield)
- Dean Health Plan Inc.
- HealthPartners Administrators, Inc.
- Network Health Administrative Services, LLC
- Security Administrative Services
- SPWI TPA, Inc. (Quartz*)

* *Quartz is affiliated with Unity Health Insurance and Gundersen Health Plan.*

New Program Structure
Under the program structure approved by the Board, the Board will contract with one statewide/nationwide vendor on a self-insured basis. The vendor will offer any participant a statewide and nationwide network.

Additionally, the Board will contract with either one or two vendors in each of four regions of the state. These vendors will offer regional networks and will compete for participants with the statewide vendors. The new contracts will be for three years (2018-2020). Below is a map of the regions under the new structure and the vendors that will be available in each region.

Based on the proposals submitted, Segal Consulting (Segal) – the Board's consulting actuary – estimates that taxpayer-funded program costs will be reduced by $60 million over the 2017-2019 biennium. The savings are attributable to reduced administrative and insurer risk fees as well as improved discounts. This new structure could also save an additional $30 million annually in Affordable Care Act (ACA) taxes, recognizing that the future of the ACA and associated taxes and fees is unknown. *None of the anticipated savings will come from reductions in participant benefits.*



Region (% of Program Enrollment)	North (3.9%)	East (30.4%)	South (54.1%)	West (10.0%)
Statewide	Anthem	Anthem	Anthem	Anthem
Regional	Security	Anthem/Network	Dean/Quartz	HealthPartners

The Board made the decision to change from the current fully-insured program structure after a year of review, analysis and consideration of different options to achieve the following goals:

- Quality care
- Maintain benefit levels
- Ensure provider access
- Contain program costs

Key concerns about current program costs were derived from the following research:

- According to the Commonwealth Fund, current program premiums are high relative to other Wisconsin employers, and
- According to the Pew Charitable Trust and Milliman, program premiums are high relative to other states, even after accounting for benefit design differences.

The Board is committed to quality care and participant choice. The following program improvements are expected due to a combination of the strong proposals submitted by the selected vendors and new accountability included in the 2018 contracts:

- Improved provider access – Participants will have access to more Wisconsin providers primarily because the statewide vendor has broader networks than are currently available to most participants. Most Group Health Cooperative – South Central providers will be included via other third party administrators (TPAs) even though GHC did not participate in the RFP. It should also be noted that Physicians Plus, which participated in the RFP but was not selected as a vendor, is publicly exploring a partnership with the Quartz organizations. In addition, the statewide vendor will be available at premium rates competitive with regional plans. Today, the statewide network is only available through the IYC Access Health Plan (formerly Standard Plan), which is a Tier 3 plan and therefore not price competitive with the other regional plans.

- Improved participant choice – In every county, participants will have at least two health plans to choose from. Today, many counties have limited access to health plans. In addition, the statewide/nationwide vendor will be available at premium rates that will be competitive options. As stated above, the current statewide network is a Tier 3 plan.

- Improved quality – Participants will have access to strong medical management programs with demonstrated success and vendors with experience holding providers financially accountable for cost and quality. The new contracts will include quality-related performance guarantees. Vendors that scored poorly through the RFP evaluation process were eliminated for negotiations.

- Improved customer service – Participants will have access to plans with high quality customer service due to new contract performance guarantees and strong

vendor customer service proposals. Notably, vendors that have historically scored low on ETF customer service metrics have offered enhanced customer service not currently available to program participants.

- Improved data – With a self-insurance approach, the Board owns the detailed claims data which is required to effectively manage the program and make data-driven decisions to improve costs and participant health. Under the current model, each year some of our largest fully-insured health plans contest the state's right to have access to complete claims data for those participants served by the program.

- Simplified administration – the number of vendors will be reduced from eighteen to six, and three-year contracts will allow ETF to focus on managing relationships with our vendor partners rather than focusing on annual negotiations. With fewer vendors and longer-term relationships, ETF and the vendors will be able to focus on developing and implementing strategies designed to improve member health.

Compared with the other options the Board considered, the Board selected a self-insured approach for the following reasons:

- This approach provides concrete savings based on the bids submitted by the vendors themselves, rather than relying on an annual negotiation process where savings are reliant on each insurer's willingness to accept reduced rates;
- A longer-term, more stable relationship with fewer vendors allows the Board and ETF to focus on managing relationships and developing and implementing strategies designed to improve participant health;
- The regional approach ensures that all counties are well served by at least two vendors rather than allowing vendors to self-select which counties they participate in from year-to-year; and
- Under the RFP process used by the Board, the Board selected only those vendors that scored highest on quality measures, had the strongest case management programs with demonstrated return on investment, had strong provider management programs where the plan and the providers collaborate and share data and share risk to improve cost and quality.

Process

The Board's action is based on the results of a Request for Proposal (RFP), which was authorized by the Board at its February 17, 2016 meeting. Attached is a memo prepared by Department of Employee Trust Funds (ETF) staff for the Board's February 2016 meeting that outlines the timeline and steps the Board took leading up to its decision to release an RFP (Attachment A).

The RFP was issued by the ETF on July 22, 2016. Nine vendors responded to the RFP. Many of the plans that have minimal participant enrollment in the current program chose

not respond to the RFP, including Arise, Group Health Cooperative – Eau Claire, MercyCare, and Medical Associates. For these plans, the ETF membership represented a small portion of their business. Some current plans submitted responses under their self-insurance business units, including Unity and Gundersen health plans submitting as Quartz and Health Tradition submitting as Mayo Clinic Health Solutions.

Some current vendors that did not submit a response indicated they did not for two reasons: either they could not meet the requirements to provide sufficient network coverage in the regions established in the RFP or they were unable or unwilling to meet the program requirements, including performance guarantees related to implementation, claims processing, customer service, enrollment, data management, and account management.

The results of the RFP were first presented to the Board at its November 30, 2016 meeting, as well as an overview of the current program, which is also attached (Attachment B). Additional discussions about the RFP results and possible changes to the program's structure continued at the Board's December 13, 2016 and February 8, 2017 meetings.

The Board deliberated for three, mostly full-day meetings to review volumes of information on each of the vendors responding to the RFP and program restructuring options. Information included evaluation committee scoring, cost projections and analysis regarding provider access. The Board also focused on how many participants would likely need to change providers under a new structure. The analysis indicates that only 2% of current providers do not have current contracts with the newly selected vendors, and that number is likely to decrease as new provider contract arrangements evolve.

While a significant portion of the Board meetings were held in Closed Session due to the confidential nature of the RFP content and deliberations, the Board and ETF took great effort to ensure that the options under consideration were publicly available and also presented in Open Session, to ensure that the public had an opportunity to hear what the Board was considering and the pros and cons of each option. An ETF staff memo describing the options presented at the December 13, 2016 meeting during Open Session is attached (Attachment C).

Board Considerations

The Board decided it was important to look at self-insurance as a possible model based on significant evidence that self-insurance is the preferred approach for providing health care benefits for other states and large employers. According to the National Conference of State Legislatures, 46 states fully or partially self-insure their employee health benefit programs. Data from the Kaiser Family Foundation shows that 94% of employees working for large employers (more than 5,000 employees) are in self-insured plans, both before passage of the Affordable Care Act and after.

Large employers self-insure for a variety of reasons, including control over benefit design and data, but primarily because large employers do not want to pay insurers risk premium. Insurers charge a risk premium to cover the additional risk they assume by covering employees' varying health costs. Large employers have relatively stable claims experience and can handle the small cash flow fluctuations that occur in a self-insured model. Conversely, small employers usually cannot handle cash flow variations; one high cost claim can absorb an entire year's health care budget for a small employer.

The Board recognizes the unique insurance and provider markets in Wisconsin, which provide our members with an abundance of choice of health plans and providers. However, not all of the current choices are equal in terms of quality. Further, there is ample evidence that despite favorable premium trends under the current program model, the state and local public employers and employees are paying, and will continue to pay, too much for health care.

The Board asked two different health insurance actuaries to identify the potential impact of a move to self-insurance. The two consultants, Deloitte Consulting and Segal, provided a wide range of estimates on the potential financial impact of such a change. Both consultants, however, agreed that the best way to understand the potential financial impact was to issue an RFP to obtain concrete, contractually binding administrative fees and network arrangements. Therefore the Board, at its February 17, 2016 meeting, approved moving ahead with an RFP.

The attachments show the various options the Board reviewed and the factors considered in making our decision. The Board is confident that the approved approach provides the best opportunity to reduce costs for public employers and employees participating in the program and to improve the quality of care and services participants receive without reducing benefits.

Other Options Considered

The other fully-insured options considered by the Board were higher risk in terms of whether savings would be achievable and sustainable. To achieve the same level of program savings would require engaging in annual negotiations where insurance rates would be set significantly lower than today's rates, likely reducing the number of vendors participating. New three-year contract periods eliminate the need for annual negotiations.

Further, under the current approach, vendors selectively participate only in those counties where it is most profitable for them to participate, resulting in some counties that are underserved and year-to-year fluctuations in which plans are available in a given county. The regional approach ensures that vendors serve all counties in a region and eliminate those year-to-year fluctuations, and guarantees high-quality options across the entire state.

It should also be noted that the Board preferred a regional approach rather than pursuing one statewide vendor to administer a self-insured plan since a regional approach maintains participant choice and maximizes the savings available from regional plans, while still providing participant access and choice, which is inconsistent under the current approach.

Next Steps
The Board recognizes that every year when health plans change the counties they serve, ETF and employers have to engage in an aggressive education campaign to make sure participants understand their new choices. The communication strategy for 2018 will be unprecedented in the level of information that needs to be conveyed to members.

Therefore, the Board and ETF are entering contract negotiations immediately, with a targeted completion of March 31, 2017, to ensure that ETF and employers have sufficient time to develop and execute a thoughtful and effective participant education campaign for the 2018 annual enrollment process. The Board will bring contracts ready to execute back to the Committee at that time, as required by law.

We will reach out to the Co-Chairs in the weeks ahead to discuss this initiative in greater detail.

Sincerely,

Michael Farrell, Chair
Group Insurance Board

Stacey Rolston, Deputy Administrator
Division of Personnel Management
Group Insurance Board Member

Attachments:
Attachment A – Agenda Item 5B memo from February 17, 2016 Board meeting
Attachment B – Agenda Item 6 memo from November 30, 2016 Board meeting
Attachment C – Agenda Item 4A memo from December 13, 2016 Board meeting

Attachment A

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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

Reviewed and approved by John Voelker, Deputy Secretary

Electronically Signed 2/11/16

Board	Mtg Date	Item #
GIB	2.17.16	5B

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

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Correspondence Memorandum

Date: November 22, 2016

To: Group Insurance Board

From: Lisa Ellinger, Director
Eileen Mallow, Deputy Director
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

Lisa Ellinger Electronically Signed 11/22/16

Board	Mtg Date	Item #
GIB	11.30.16	6

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

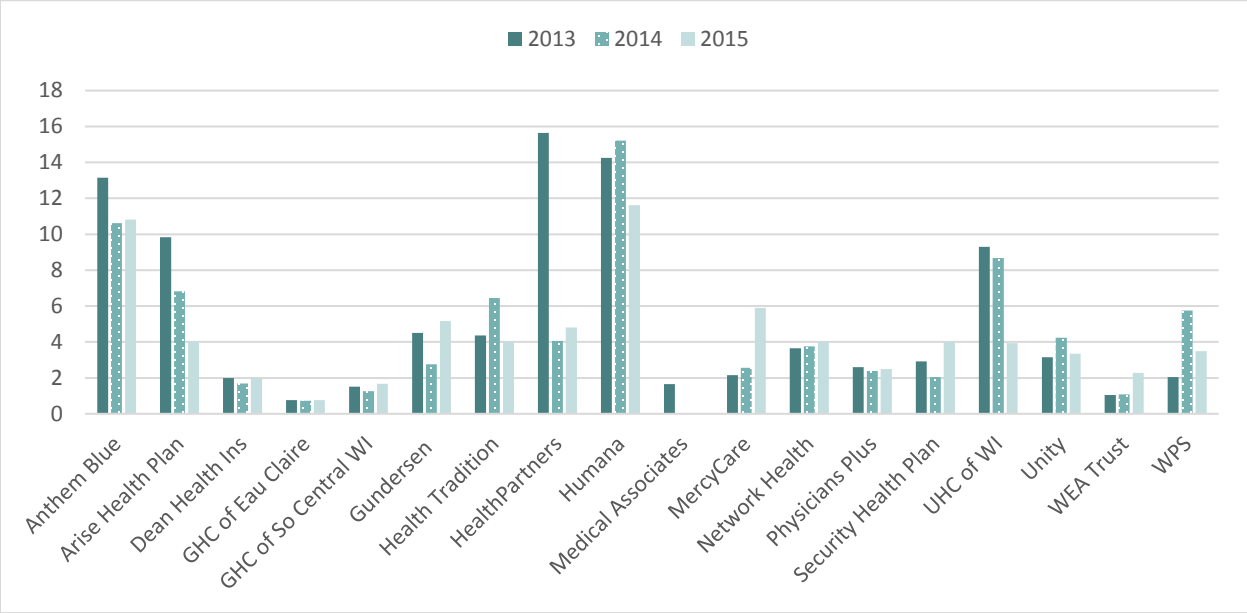
Grievances

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
Robert J. Conlin
SECRETARY

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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

Reviewed and approved by John Voelker, Deputy Secretary

Electronically Signed 2/11/16

Board	Mtg Date	Item #
GIB	2.17.16	5B

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

Attachment C

State of Wisconsin
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Correspondence Memorandum

Date: December 8, 2016

To: Group Insurance Board

From: Lisa Ellinger, Director
Office of Strategic Health Policy

Subject: Request for Proposals for the State of Wisconsin Health Benefit Program: Results and Analysis

This memo presents a variety of options for program structure changes to the State of Wisconsin Group Health Insurance Program (GHIP). The options seek to maintain benefits, contain costs, and improve quality. The Department of Employee Trust Funds (ETF) requests Group Insurance Board (Board) approval of either a preferred option or a combination of strategies from the options presented.

Background

The Request for Proposal (RFP) to evaluate the impact of self-insurance and/or regionalizing the GHIP was issued July 22, 2016. Nine vendors submitted proposals by the due date, September 19, 2016. Vendors could choose to participate in any or all of the regions, as well as the statewide/nationwide service area. Detailed information about the motivation for this evaluation is outlined in the November 22, 2016 Board memo, State of Wisconsin Group Health Insurance Program — Current State & Overview (Ref. GIB | 11.30.16 | 6).

Proposal Scoring

Proposers were required to respond to questions in three sections of the RFP: Section 6, General Questionnaire; Section 7, Technical Questionnaire; and Section 8, Cost, Data, and Network Submission Requirements. A summary of the categories covered follows in Table 1, RFP Scoring Categories. The entire RFP and questions are available at: https://etfonline.wi.gov/etf/internet/RFP/HealthBeneAdminRFP1/index.html

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 teams evaluated the responses, with the assistance of an IT subcommittee. Section 6 and Section 7 (with the exception of section 6.5 Data Security) were scored by a five-member evaluation committee. Section

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

Lisa Ellinger

Electronically Signed 12/9/16

Board	Mtg Date	Item #
GIB	12.13.16	4A

6.5 was scored by a subcommittee of three IT subject matter experts. These two committees were supported by ETF procurement. Section 8 was scored by the Board's consulting actuary, Segal Consulting (Segal).

Table 1. RFP Scoring Categories

RFP Section and Title	Description
Section 6 General Questionnaire	
Experience	Location, types of clients and health insurance business
Staff Qualifications	Account management and key staff
Customer Service	Policies to meet contractual requirements and increase health literacy
Implementation	Submission of implementation plan with detail and key dates
Data Security	Security of hosting environment, application architecture, account and identity management and vulnerability assessment
Section 7 Technical Questionnaire	
Provider Management	Provider steerage, engagement and feedback on initiatives such as evidence-based practices and behavioral health care
Provider Reimbursement	Experience in administering various provider reimbursement methods
Medical Management	Case and disease management (DM), including financial rewards and integration with other wellness or DM vendors
Total Health Management	Experience in administering and facilitating value-based benefit designs, shared savings initiatives and member tools
Data Integration and Technology	Integration of electronic medical records and telehealth
Section 8 Cost, Data, and Network Submission Requirements	
Region Designation	Identification of the region the vendor is bidding on
Network Access	Listing of providers and GeoAccess analysis for member disruption
Network Pricing	Submission of claim repricing files on service categories, providers, and contract types
Administrative Fees	Detailed breakdown of administrative fees
Capitation	Identification of any and all services that would be capitated
Self-Insured Projection	Estimated costs in proposed region including adjustments for utilization and allowed amounts
Data Certification	Signed certification of submission by actuary, CFO or CEO

RFP Results

Results and analysis from the RFP were presented to the Board at its November 30, 2016 meeting. Segal also modeled a variety of scenarios based on the vendor proposals, which included potential cost savings estimates. The meeting was an opportunity for the Board to ask questions about the RFP results and provide feedback on the development of recommendations for the December 13, 2016 Board meeting.

The RFP was informative on several fronts: It provided the Board with an indication of the number of vendors, and which vendors, would participate in a restructured program. This aspect of the analysis revealed that there are multiple vendors available in every region and at the statewide level that provide broad access to providers. The RFP also indicated that vendors with a history of demonstrated quality in the GHIP would be available in a new program structure.

The cost analysis also indicated that there is the potential for significant savings in a new program structure. This memo outlines various options for achieving equivalent future costs under different program structures.

Considerations

A “decision matrix” was used to outline priority criteria to consider in deliberating potential changes to the program structure (see Table 2).

Based on these priorities, scenarios for the Board to consider were built, with the following objectives in mind:

- Achieve program cost savings
- Meet access standards
- Maintain/improve quality options
- Minimize disruption
- Maintain benefit levels
- Understand capacity concerns
- Highlight vendor proposal scores
- Delineate risks
- Consider the timing of other ongoing Board initiatives
- Highlight prior experience with vendors
- Maximize use of tools currently available to the Board
- Maintain competition

Table 2. Decision Matrix

Consideration	Description
Cost	How do claims and administrative costs under the scenario compare with the projections under the current model?
Access	Do members have sufficient access to primary and specialty care as well as facilities?
Quality	How do the vendors in the scenario currently perform on quality measures and what is the potential to improve performance over time?
Disruption/ Capacity	How does access to primary and specialty care providers and facilities compare to the access members have today? Is there sufficient capacity in the available network(s) to absorb the disruption?
RFP Score	Does the scenario include only the top scoring vendors?
Risk	How significant/likely are the risks associated with the scenario and do they outweigh the potential improvements?
Timing	What is the appropriate implementation timeline, given other ongoing Board priorities?
Tools	Does the Board have other mechanisms available to effectively achieve the same goal in more efficient manner?
Partnerships	Have the vendors included in the scenario demonstrated that they understand Board/ETF program needs well and are poised to be strong partners with the Board/ETF?
Competition	Are there sufficient vendors available to provide negotiation leverage/options?
Program Control	Does the scenario maintain control of the program with the Board or give the Legislature's Joint Committee on Finance an opportunity to determine next steps?
Opportunity to Try Different Models	Does the scenario give the Board/ETF the opportunity to try different models: fully-insured vs. self-insured, narrow vs. broad networks?
Impact on Markets	Does the scenario include the maximum number of vendors participating to minimize disruption in the Wisconsin insurance market? Does it reflect provider systems' service areas and their referral patterns?

Based on the Board priorities and RFP results, the scenarios listed in Table 3 were developed for the Board's consideration. All scenarios were developed to produce equivalent future costs, in order to allow the Board to focus equally on the non-financial merits and concerns of each scenario. The scenarios are listed from those that represent the least change from current structure (Option 1), to those that are the most transformative (Option 7).

Table 3. Program Structure Scenarios

Scenario	Funding Structure*	Level of Program Change
Scenario 1: Current Program Structure Up to 16 Vendors	**Fully-Insured**	**Minimal**
Scenario 2: Regionalized 7-11 Total Vendors	**Fully-Insured**	**Moderate**
Scenario 3: Regionalized 6-10 Total Vendors	**Fully-Insured**	**Moderate**
Scenario 4: Regionalized 6-8 Total Vendors	**Hybrid**	**Significant**
Scenario 5: Regionalized 6 Total Vendors	**Hybrid**	**Significant**
Scenario 6: Regionalized 6 Total Vendors	**Self-Insured**	**Major**
Scenario 7: Statewide 1-2 Total Vendors	**Self-Insured**	**Major**

**IYC Access Plan (formerly Standard Plan) remains self-insured in all options.*

Scenarios: Risks and Benefits

The following is a brief description of each scenario, along with key considerations for the Board.

Scenario 1: Current Program Structure, Up to 16 Vendors

The "Current Program Structure" scenario does not represent the status quo, but includes program improvements to achieve competitive premium rates and improve quality. Many of these changes are related to Board initiatives already underway that pertain to wellness and data warehousing:

- Non-negotiable data warehousing requirements
- Increased member incentives for wellness participation
- Improved quality through performance measurement benchmarks/thresholds

Other proposed changes are new concepts and are intended to ease program administration, contain costs and maintain employee benefits:

- Minimize cost shift to members / minimize reduction in benefits
- 3-year contracts with health plans
- Fully insured premium rates established/capped in order to achieve program costs comparable to other program restructure options

All of the scenarios presented in this memo assume implementation of these provisions.

Scenario 1 would allow all existing health plans to continue to participate in the program under the conditions specified above. The most controversial of the changes is the final bullet point – fixed premium rates. This would reverse the current dynamic, wherein health plans submit preliminary bids and negotiate with ETF to reach the desired Tier 1 premium threshold. In this scenario, ETF would establish fully insured premium levels for each of the three program tiers, and health plans would opt in at the selected premium rate and tier level where they choose to participate. Premium levels would be established to match estimated program costs under a restructured program.

The Board could direct ETF to initially pursue a fully insured strategy, but also authorize ETF to move to a self-insured approach if premium negotiations on a fully insured basis do not progress toward signed contracts within a reasonable time frame.

A significant unknown in this scenario is whether all health plans would continue to participate under the established premium structure, given the requirements noted above. An additional unknown is the future of fees associated with the Affordable Care Act (ACA). In the event that ACA fees remain, a fully insured model would include additional costs related to the ACA.

This scenario would also select a new self-insured statewide/nationwide vendor to administer the IYC Access Plan (formerly Standard Plan), as the current self-insured statewide/nationwide vendor contract ends December 31, 2017.

Table 4. Scenario 1: Current Program Structure, Up to 16 Vendors

Program Structure:	
Self-Insured Plan	**Fully-Insured Plans**
• *Statewide/Nationwide*: One Plan	• Up to 16 current plans willing to meet program requirements; plans define service area

Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Insurer financial responsibility for claims costs • Insurer incentive to focus on medical management and utilization • Maintain competitive insurer environment • Legislative approval required for statewide vendor only • Public/member positive perception • Ability to administer with current ETF staff capacity	• Missed opportunity to eliminate lower quality vendors • Complex administration	• Which health plans will continue to participate -- impacts access and provider disruption

Scenario 2: Regionalized, 7 to 11 Total Vendors

This scenario would adopt the regional structure outlined in the RFP, establishing regional service areas in the North, South, East and West. Table 5 provides a breakdown of group health insurance program members for each region. The majority of members reside in the South and East regions.

Table 5. ETF Regional Membership

Region	NORTH	SOUTH	EAST	WEST
% of membership	**4%**	**54%**	**30%**	**10%**

This scenario maintains a fully insured program structure, with the exception of the statewide/nationwide vendor, which will be self-insured (as noted in Scenario 1). The requirements noted in Scenario 1 would apply in this scenario as well, including the fixed premium approach.

Participating insurers in Scenario 2 would be required to provide coverage to the entire region where they participate. This is a reversal from current practice, wherein health plans determine the service area on a county-by-county basis. In addition to moving toward a regional structure, ETF would limit Tier 1 status to the most efficient and highest quality health plans in each region. These structural changes would likely reduce the number of health plans participating in the GHIP.

The only exception to the regionalization approach outlined above is in the Southern region, where the Board may determine that it is in the program's best interest to allow additional insurers to compete.

Table 6. Scenario 2: Regionalized, 7–11 Total Vendors

Program Structure:		
Self-Insured Plan	**Fully-Insured Plans**	
• *Statewide/Nationwide*: One Plan	• *North*: Multiple Plans • *East*: Multiple Plans • *West*: Multiple Plans • *South*: Current plans willing to meet program requirements; plans define service area	
Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Insurer financial responsibility for claims costs • Insurer incentive to focus on medical management and utilization • Maintain competitive insurer environment, but with fewer insurers • Legislative approval required for statewide vendor only • Public/member positive perception • Ability to administer with current ETF staff capacity	• Missed opportunity to eliminate lower quality vendors • Complex administration	• Which health plans will continue to participate -- impacts access and provider disruption

Scenario 3: Regionalized, 6 to 10 Total Vendors

This scenario is very similar to Scenario 2, with two key changes:

- Addition of a second statewide/nationwide vendor
- Contracting with fewer insurers in each region

The addition of a second statewide vendor adds competition to the IYC Access Plan administration, which could result in lower negotiated administrative fees and the ability to compare cost and performance across vendors. This model also ensures additional member options in every region. Moving to fewer regional insurers steers more members to the most efficient and highest quality health plans, provides those plans with additional market leverage, and eases program administration.

Again, the only exception to the regionalization approach outlined in Scenario 3 is in the Southern region, where the Board may determine that it is in the program's best interest to allow additional insurers to compete.

Table 7. Scenario 3: Regionalized, 6–10 Total Vendors

Program Structure:		
Self-Insured Plans	**Fully-Insured Plans**	
• *Statewide/Nationwide*: Two Plans	• *North*: Fewer Plans • *East*: Fewer Plans • *West*: Fewer Plans • *South*: Current plans willing to meet program requirements; plans define service area	
Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Insurer financial responsibility for claims costs • Insurer incentive to focus on medical management and utilization • Maintain competitive insurer environment, but with fewer insurers • Legislative approval required for statewide vendors only • Public/member positive perception • Ability to administer with current ETF staff capacity • Improved ease of administration	• Missed opportunity to eliminate lower quality vendors	• Which health plans will continue to participate -- impacts access, disruption

Scenario 4: Regionalized, 6 to 8 Total Vendors

This scenario is very similar to Scenario 3, with one key change:

- Self-insuring regions where the greatest cost saving are anticipated

In the RFP, regional bidders submitted varying administrative fees and reported different levels of discounts. In this scenario, ETF would attempt to negotiate comparable net program costs, or tier insurers accordingly if negotiations do not result in lower projected program costs.

The only exception to the regionalization approach is in the Southern region, where the Board may determine that it is in the program's best interest to allow additional insurers to compete.

Table 8. Scenario 4: Regionalized, 6–8 Total Vendors

Program Structure:	
Self-Insured Plans	**Fully-Insured Plans**
• *Statewide/Nationwide*: Two Plans • *Regions selected by Board*	• *Regions selected by Board* • *South*: Current plans willing to meet program requirements; plans define service area

Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Maintain competitive insurer environment, but with fewer insurers • Steer membership toward highest quality insurers • Improved ease of administration	• Legislative approval required • Shared financial responsibility for claims costs • Public/member perception	• Which health plans will continue to participate -- impacts access, disruption

Scenario 5: Regionalized, 6 Total Vendors

This scenario is very similar to Scenario 4, with one key change:

- Only negotiate with the top two vendors in the Southern region

Table 9. Scenario 5: Regionalized, 6 Total Vendors

Program Structure:		
Self-Insured Plans	**Fully-Insured Plans**	
• *Statewide/Nationwide*: Two Plans • *Regions selected by Board*	• *Regions selected by Board* • *South*: Two Plans	
Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Maintain competitive insurer environment, but with fewer insurers • Steer membership toward highest quality insurers • Improved ease of administration	• Legislative approval required • Public/member perception • Health plan capacity • Shared financial responsibility for claims costs	• Which health plans will continue to participate -- impacts access, disruption

Scenario 6: Regionalized, 6 Total Vendors

This scenario is very similar to Scenario 5, with one key change:

- Self-insure the entire program

Table 10. Scenario 6: Self-Insured/Regionalized, 6 Total Vendors

Program Structure:		
Self-Insured Plans	**Fully-Insured Plans**	
• *Statewide/Nationwide*: Two Plans • *Regions*	• None	
Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Cost savings • Maintain competitive insurer environment, but with fewer insurers • Steer membership toward highest quality insurers • Improved ease of administration	• Legislative approval required • Public/member perception • Health plan capacity • Shared financial responsibility for claims costs plan capacity	• Which health plans will continue to participate -- impacts access, disruption

Scenario 7: Self-Insured, 1-2 Total Vendors

This scenario is very similar to Scenario 6, but would only contract with one or two statewide vendors. The Board should note that this scenario does not achieve the same level of cost containment available in the previous scenarios. ETF and Segal do not recommend this option.

Table 11. Scenario 7: Self-Insured, 1–2 Total Vendors

Program Structure:		
Self-Insured Plan(s)	**Fully-Insured Plans**	
• *Statewide/Nationwide*: One - Two Plans	• None	
Benefits, Risks and Unknowns with This Scenario:		
Benefits	**Risks**	**Unknowns**
• Improved ease of administration	• Missed opportunity for cost savings • Legislative approval required • Public/member perception • Health plan capacity • Full financial responsibility for claims costs	

All options presented in this memo are summarized in Table 12.

Table 12. All Scenarios

Scenario	Self-Insured	Fully-Insured
Scenario 1: Current Program Structure Up to 16 Vendors	• *Statewide:* 1 plan	• *Maintain current structure* • *Up to 16 plans* • *Plans define service area*
Scenario 2: Regionalized 7-11 Total Vendors	• *Statewide:* 1 plan	• *East:* Multiple plans • *West:* Multiple plans • *North:* Multiple plans • *South:* Current plans that define service area
Scenario 3: Regionalized 6-10 Total Vendors	• *Statewide:* 2 plans	• *East:* Fewer plans • *West:* Fewer plans • *North:* Fewer plans • *South:* Current plans that define service area
Scenario 4: Regionalized 6-8 Total Vendors	• *Statewide:* 2 plans • *Regions selected by Board*	• *Regions selected by Board* • *South:* Current plans that define service area
Scenario 5: Regionalized 6 Total Vendors	• *Statewide:* 2 plans • *Regions selected by Board*	• *Regions selected by Board* • *South:* 2 plans
Scenario 6: Regionalized 6 Total Vendors	• *Statewide:* 2 plans • *Regions selected by the Board*	• *None*
Scenario 7: Statewide 1-2 Total Vendors	• *Statewide:* 1-2 plans	• *None*

Delayed/Phased Implementation
The Board could delay or phase-in the implementation of self-insuring and/or regionalizing to allow adequate transition time for contracting and member communication. The public discussion around implementation has generally focused on January 1, 2018; however, the Board could opt for a mid-2018 implementation (which would align the GHIP with the state budget cycle) or aim for 2019 or beyond.

Likewise the Board could assume a phased-in approach and move forward with certain structural changes for 2018 (e.g. regionalization), and delay other significant changes such as self-insuring. This would provide the Board with an opportunity to evaluate the impact of a more aggressive tiering strategy, as well as other program changes already targeted for 2018 implementation.

The Board has also expressed an interest in coordinating long-term program strategies with the Board initiatives already underway, particularly the activities of the new wellness and disease management vendor and new data warehousing vendor. Attachment A provides a timeline of these initiatives for the Board's reference.

Key benefits and risks associated with these options include:

Benefits

- Allow sufficient time for successful transition
- Allow sufficient time to complete contracting and provider network arrangements
- Allow sufficient time for member communication
- Allow for implementation of the data warehousing vendor and improved access to program data
- Allow for the evaluation of incremental strategies

Risks

- Potential missed opportunity to reduce costs in the short term

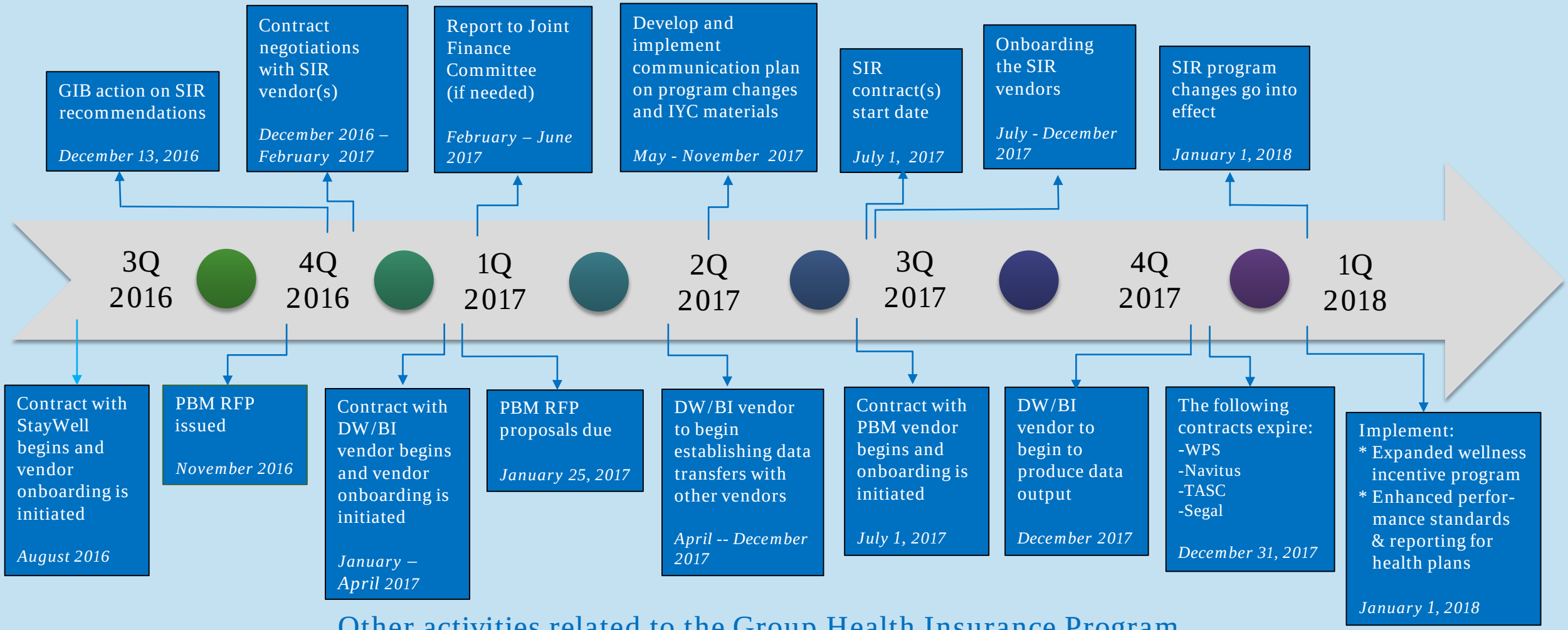
Staff and Segal will be at the Board meeting to answer any questions, and model the cost and member impacts of the scenarios outlined above. In closed session, staff and Segal will further detail the scenarios, including the number of vendors and which vendors would be included in each option.

Attachment A: Group Insurance Board Initiatives Timeline

Attachment A

Group Insurance Board Initiatives Timeline

Activities related to the self-insurance and/or regionalization (SIR) RFP



Other activities related to the Group Health Insurance Program