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Correspondence Memorandum

Date: November 10, 2015

To: Group Insurance Board

From: Lisa Ellinger

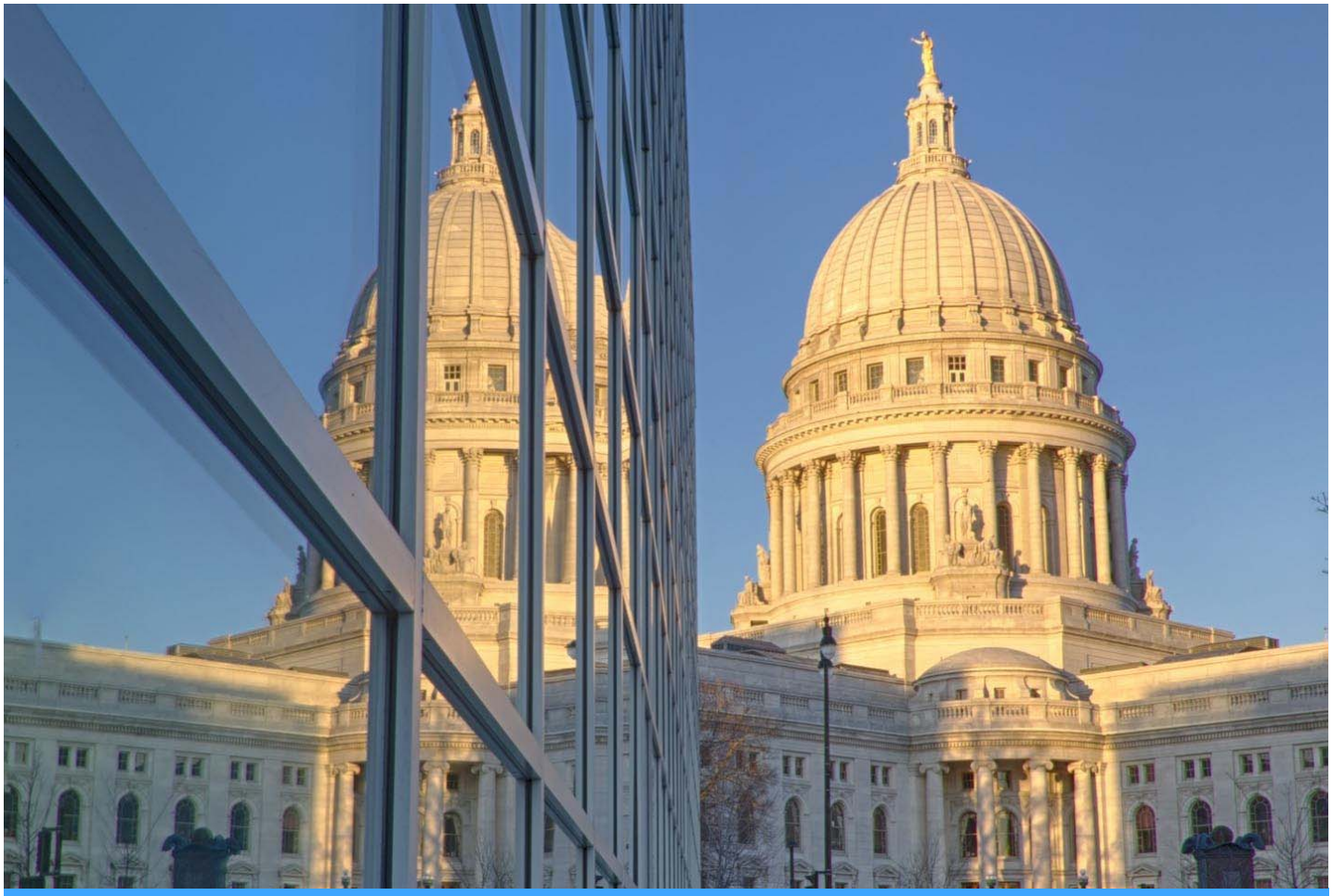
Subject: Health Care Benefits Consultant Second Report

The attached report is the second deliverable from the Benefits Consultant contract with Segal Consulting. This report focuses on long term strategic initiatives for the state employee health plan. Segal will be presenting this report to the Board at the November 17, 2015 meeting.

Please note that there are no Action Items noticed for this presentation on the Board agenda. The purpose of this presentation is to solicit feedback from the Board to guide staff activity in the months ahead to ensure we are bringing actionable recommendations to the Board in 2016 that align with the Board's priorities and expectations.

Some of the concepts presented in the report target 2017 implementation and will require action by staff to bring proposals to the Board at the February 2016 meeting. Other longer term initiatives will require further analysis and development, and target implementation dates of 2018 and beyond. Staff will provide status reports and solicit Board feedback on the development of the longer term initiatives throughout 2016.

Board	Mtg Date	Item #
GIB	11.17.15	3A



Wisconsin Group Insurance Board
Department of Employee Trust Funds

Health Care Benefits Consultant

Second Report—Observations and Recommendations for 2017 and Beyond

November 17, 2015

Segal Consulting

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Second Report—Observations and Recommendations for 2017 and Beyond
November 17, 2015

Executive Summary

Project Overview

The Wisconsin Group Insurance Board (GIB) has authority to retain an actuary and a consultant to support the programs the Board oversees and to make changes to existing health benefit plans, including self-insuring the benefits, provided the changes maintain or reduce premium costs for the State or its employees in the current or any future year. Under this GIB authority, Segal Consulting was retained to perform a full range of services related to the analysis, design, management and communication of the State's health insurance program for employees and retirees.

The primary objective of the project is to analyze data from a variety of sources to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program.

This report is the second of two deliverables anticipated by the contract and includes findings, recommendations and strategies for consideration for 2017 and future years. The first report, presented March 25, 2015, focused on analysis and recommendations for consideration for calendar year 2016.

Segal has agreed to a review of the following components for this second report:

- Total Health Management
- Program Structure
- Pharmacy
- Data Management
- Market Observations
- Self-Insurance
- Retiree Coverage
- Local Government Plan
- ACA Update and Strategies

Segal has completed our review and developed strategic recommendations for consideration, with some initiatives to be considered for possible implementation in 2017 and others to be started in 2016 for longer-term implementation after 2017. We have discussed each component in a separate section of this report, and we have highlighted each section on the following pages.

Summary of First Report

In the first report, we presented our comments and observations on the following topics:

- Benchmarking Comparison
- Total Health Management
- Pharmacy
- Consumer Directed Health (CDH) Care Design
- Private and Public Exchanges
- Affordable Care Act (ACA) 40% Excise Tax
- Market Observations
- Self-Insurance Concepts
- WHIO Database

As a result of our analysis and the discussion that ensued from the first report, the GIB and ETF implemented several changes for 2016:

Benefit Changes

In 2014, the ETF "It's Your Choice Health Plan" (Uniform Benefit Design, UBD) provided one of the highest benefit values in the country (96%), compared to other state employee health benefit programs reviewed in our first report. Note that "benefit value" or "actuarial value" is the percentage of claims paid by the benefit plan. The higher this value, the greater the benefit to the member, resulting in higher costs to the employer. The GIB adjusted medical and pharmacy benefits and still remain competitive in 2016. The GIB approved higher deductibles and out-of-pocket maximums for the UBD and the "It's Your Choice Access Health Plan" (Standard PPO). In the case of the UBD, deductibles were implemented for the first time. Additionally, office visits in the UBD were converted to a copay design (from coinsurance), subject to the out-of-pocket maximum.

The initial enrollment in the It's Your Choice High Deductible Health Plan (HDHP) option was very low (approximately 400 subscribers across all the health plans). We recommended significantly enhancing the State's HSA contribution (to $750 for individual and $1,500 for family) as a measure to help increase the overall value of the HDHP option(s), which would then help to encourage additional enrollment for 2016. The GIB approved this recommendation. Preliminary enrollment shows growth in the program to approximately 1,500 contracts. An improvement over 2015 but still a fairly small percentage of ETF membership.

For 2016, brand and specialty drugs will be covered on a coinsurance basis (with maximums). Generics copays will remain at $5. Out-of-pocket limits will also be increased. This structure should further incent members to utilize lower cost medications. Additional details can be found in the **Introduction** section of this report.

Health Plan Negotiations

During the summer 2015 negotiations and renewal process for the 2016 plan year, some modifications were introduced. Additional data detail, including billed and allowed charges were required, along with an attestation from each plan's CFO or actuary that the data submitted with the proposed premiums was complete and accurate. The additional data provided enhanced clarity and transparency to the process.

2016 Savings

Between the plan changes approved by the GIB for 2016, and the improvements in the renewal and negotiation process, the savings for 2016 was $89 million, slightly higher than the $68 million estimated.

Findings and Recommendations of Second Report

Total Health Management

In our first report, we observed a significant variation in the effectiveness of the health plans' health management programs. Many of the plans appear unable to report basic chronic condition treatment data and therefore are unable to demonstrate their program's effectiveness. However, we do know that ETF's membership has chronic condition rates that exceed national norms (64% vs. 50%), particularly for diabetes, and that significant care gaps exist.

The benefits of the Well Wisconsin program are underutilized, with approximately 17% participation in 2015. Other states report participation in the 70-90% range.

Increasing member engagement in both wellness and disease management programs will improve overall member health and reduce future cost increases to ETF. The programs available to members need to be effective and vendors need to be able to demonstrate their effectiveness.

A combination of incentives for members to engage in health management programs and appropriate required performance metrics with meaningful financial incentives for vendors should accomplish these goals.

The health care market is constantly evolving and additional opportunities for patients to engage with providers are rapidly developing. Telemedicine and employer-sponsored on-site clinics are two primary examples. Both provide additional access to members and present opportunities to improve the efficiency of care.

Recommendations

In the following areas, Segal recommends that ETF:

- **Medical Management:** Integrate disease management and complex case management with the health plans (as is the case currently), but require that vendors meet outcome based performance metrics and attach meaningful financial incentives. For members with a manageable chronic condition, reduce office visit copays and copays for maintenance

medications by $5 or $10 to incent member engagement and reduce barriers to care necessary for condition management.

- **Wellness and Health Promotion:** Utilize a separate vendor and design program to be uniform across the membership. The vendor should be best in class and be able to provide health risk assessments, biometric collection, lifestyle coaching, education, reward tracking, etc. Institute a premium based incentive of $50 per month for completion of designated wellness and health promotion activities. This would apply to both an employee and spouse, as well as non-Medicare retirees.

- **Data Analytics:** Require vendors to provide complete and comprehensive data and engage the technology necessary to perform data analysis and health risk modeling of the covered population.

- **Telemedicine:** Working with the insurers, ETF should develop standards that align with the telehealth services available in the market (that ensure convenience and safety for members).

- **On-site Clinics:** Assess the potential location of on-site clinics that could provide reasonable return for ETF. This is a longer-term initiative designed to integrate clinics into the overall wellness strategy. Collect data at clinics and integrate with the data provided by the plans. As the market matures, we recommend studying how clinics can best support ETF's strategies.

Financial Impact

By our estimation, there is approximately $267 million in unnecessary and avoidable medical services annually in ETF's program. Using the WHIO data, it was estimated that 90% of all claims are due to chronic conditions, slightly higher than 86% CDC reports nationally. Implementing value based incentives to motivate members to engage in medical management and wellness programs should be able to ultimately eliminate approximately $60-$80 million of annual medical expenses. We recognize this will increase gradually and estimate lower first year savings of $10-$30 million, between 1% and 3% of plan costs. Note that THM savings will be cumulative over time.

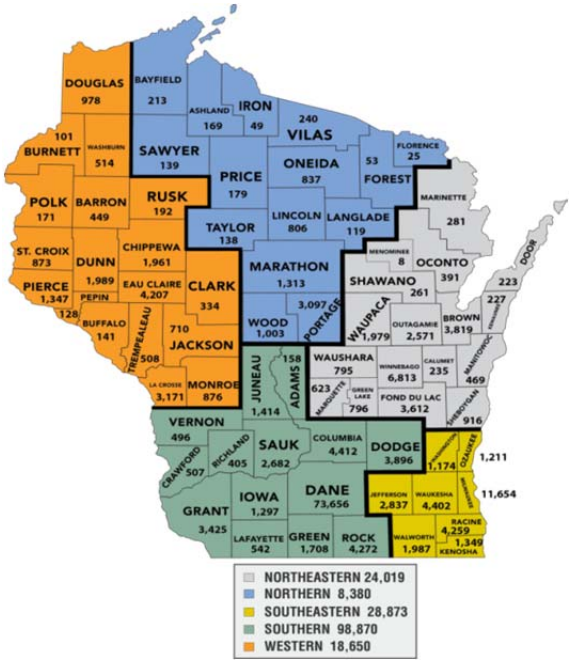
Possible Timing

Given broader changes recommended for 2018, much of the above could be implemented for the 2017 plan year. To get these in place, there will need to be changes to the current plan contracts and initiate a number of possible procurements. It could be beneficial to stagger implementation and allow ETF to focus solely on rolling out a comprehensive initiative for 2018.

ETF may also choose to phase in the Total Health Management components, for example implementing wellness related features in 2017 and then implementing medical management in conjunction with broader recommendations in 2018.

Program Structure

Regions and Contracting



ETF currently works with 17 different health plans throughout the State, with all the plans defining their own service area. Using the current Medicaid regional map, we have completed a detailed analysis of how the Medicaid regions overlap with the current ETF health plan operations. The map summarizes membership in each county and state, as well as the regional structure.

Pricing varies significantly among the plans, with risk-adjusted costs varying by $276 per member per month (PMPM) from the lowest to the highest. Some of this is due to geography, as provider discounts vary significantly across the State, with pricing more favorable in the southern and eastern parts of the State and less favorable in the more rural northern and western region. Differences in pricing are also due to variance the plans' negotiated provider discounts.

In isolation, discounts would not be fully reliable. We then looked at the total per member per month (PMPM) costs as well. The table on below summarizes our analysis, looking regionally.

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

The Discount Only PMPM simply the Statewide PMPM and only adjusting for discounts. So for the Northern Region, the rate would be $416 x (1-0.288)/(1-0.417) or $508. Using the plans' net reported discount does seem to correlate with the resulting costs. Segal has done considerable analysis from the information reports, both specific to plans and within a region. Note that this is self-reported and has **not** been audited.

This detailed data was collected during the negotiations for 2016. However, the information is limited to the currently contracted health plans and to each health plan's current ETF service area and membership. The health plans' full networks generally cover a somewhat broader service area than the area provided to ETF; this data was not collected or necessary when doing 2016 renewals.

In conjunction with ETF, Segal issued a Request for Information (RFI) to receive additional pricing and provider discount information, as well as network and provider access information.

Respondents were not limited to the current health plans contracted with ETF or to their current service areas. Many additional health plan organizations in the market were invited to participate.

Based on our review of the current service areas data, and supported by the discounts and provider access data submitted in response to the RFI, we recommend a structure with three geographic regions:

- In the **Southern Region**, there are many plans with a service area focused in, and around, Madison and Dane County. This region has approximately 99,000 members, which is roughly 50% of the total membership.

- Many plans operate in both the Northeast and Southeast regions, indicating that a combined **Eastern Region** is practical. The combined region would have approximately 53,000 members.

- There are approximately 27,000 members in the Northern and Western regions. There are at least two health plans with an ETF service area currently covering the majority of the combined **Northwestern Region.** Although preliminary results indicate a combined region is feasible, has good access and would be cost effective, there would likely be significant disruption in the Northern region. As ETF moves forward, this region, in particular, may need to remain subdivided initially.

Based on our analysis, we conclude there is an opportunity for ETF to achieve $45-70M in medical claims savings from consolidating the number of health plans and converting to a regional approach with regions determined by ETF and uniform for all health plans. This can be accomplished without sacrificing Provider Access, while improving overall performance of Total Health Management and with a significant Network Match (minimal Disruption).

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

While there are some notable exceptions in the Southern Region, many of the plans' networks overlap to a large degree and consolidation is not likely to result in significant provider disruption for members. If a member utilizes a specific provider on a regular basis and that member's plan's contract is discontinued, then it is very likely that the provider in question is in another plan's network.

Our recommendation would be to contract with up to two health plans per region, alongside a single statewide health plan. This provides a uniform option across the entire membership, while enabling ETF to leverage the very best of the regional health plans. If a single health plan is selected at the regional level, then pricing may be improved without affecting access but there may be some material disruption in selected areas.

We recommend that ETF structure this within a self-insured environment, but the savings detailed above are solely from the regional approach and consolidation and not from self-insurance. There are a tremendous number of advantages to operating in a self-insured environment; these are detailed later in the **Self-Insurance** section of the report.

Benefit Design

Our recommended benefit design incorporates structural features beyond the typical cost-sharing provisions.

- **Tiered Networks:** Providers achieving higher efficiency and/or quality scores are placed in the preferred tier, and patients are given a financial incentive to choose these providers. In the case of physicians, this incentive is typically a moderately lower copayment; for hospitals, it may be a lower coinsurance rate. The ultimate goal is to construct a tiered network to deliver the most efficient care possible and drive utilization to those providers.

- **Reference Based Pricing:** Reference based pricing utilizes an identified network of providers willing to render targeted services at or below a pre-determined price. We recommend working with the contracted plans to develop an array of services subject to reference based pricing. This may initially include hip and knee replacement, colonoscopy, magnetic resonance imaging (MRI) of the spine, computerized tomography (CT) scan of the head or brain, nuclear stress test of the heart, and/or echocardiograms.

- **Centers of Excellence (COE):** All providers are not created equal and outcomes vary widely between providers. The concept of having designated providers, typically hospitals as "centers of excellence" has been around for many years and is being applied to an ever-expanding number of procedures. Typically, the price charged for these services is a bundled price for all associated care. We recommend incorporating an expanded COE component to the program and contract with plans that utilize a comprehensive COE network with demonstrated effectiveness.

Plan Designs

As of 2016, the following plan names have changed and may be referenced differently throughout this document. UBD has become the It's Your Choice (IYC) Health Plan, the HDHP is now the IYC HDHP and the Standard Plan is now the IYC Access Health Plan.

The following recommended designs build off the IYC Access Health Plan, with In-Network benefits similar to the IYC Health Plan. The current In-Network benefit is primarily the Preferred Network Benefit level, with the new In-Network having slightly more cost sharing. The Out-of-Network benefits are similar to current benefits. This should result in the desired steerage towards the higher quality, more efficient providers. Additionally, there is a $5-$10 office visit copay reduction for members engaged in appropriate disease management programs.

RECOMMENDED PLAN OFFERINGS

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

Employee and Non-Medicare Retiree Premiums

We recommend a modified three-tiered approach for determining employee premiums. However, unlike the current structure, we do not expect all our plans in the program to be in Tier 1. In order to be considered Tier 1, the plan must demonstrate a significant financial advantage over the Tier 2 plan. With that in mind, we expect the bulk of the membership to initially be in Tier 2 plans. As plans demonstrate their capabilities, they can migrate to Tier 1.

Another part of the contribution strategy is the integration of the wellness premium credit/penalty. A member that meets his or her wellness requirements would receive a $50 monthly premium reduction ($100 for family coverage). That member would have lower contributions than in Tier 1 in the current program. This reduction would be funded by the additional premiums paid by the members that do not participate in the wellness program. If plans are truly operating at Tier 1 levels, their contributions would be even lower.

2016 ETF PLAN DESIGNS

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

RECOMMENDED PLAN OFFERINGS—ILLUSTRATIVE PREMIUMS

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

The premiums in these tables are for medical and pharmacy coverage only and do not include dental premiums.

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

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

In Summary

We are not anticipating significant savings from this benefit structure alone. Savings are anticipated over time as the reference-based pricing and centers-of-excellence components are implemented and grow towards maturity. The benefit and premium structure is designed to support the recommended THM strategy and is not designed to generate savings to ETF from member cost shifting.

The additional wellness contributions will enable the plan to provide a number of value based benefits, offering plan members reduced cost sharing and lower contributions. The benefit design drives utilization and provider choices that will result in more efficient and higher quality care.

Note that the benefit design is meant to be a greater value than the current program provides. There is no cost-shifting if members engage appropriately and use preferred providers. If members choose non-participating providers and do not engage in their health, they will likely have increased cost sharing and a higher contribution rate (wellness premium).

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

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

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

Pharmacy

Increasingly, pharmaceutical treatments are the most cost effective option to treat illness and disease. Advances in technology and research will continue to present new treatments that keep workers out of the hospital, avoid surgical intervention, reduce complications from disease, reduce the frequency of disability and in some cases offer cures to once life threatening disease.

However, Americans consume roughly 50% more prescription drugs than the average citizen in other developed countries (*source: IMS Health*) without better mortality rates. This situation is partly driven by industry promotion, partly by the practice of defensive medicine by providers, and partly by a lack of price controls on drugs in the United States. Plan sponsors need to take steps to balance the need to provide their members access to the right medication at the right time with the need to combat excessive price inflation and manipulative marketing tactics employed by the pharmaceutical industry.

Strategies that improve the health of the population covered by the employer's plan will reduce waste and the frequency and intensity of polypharmacy patient demands in the future. Improving the health care literacy of plan participants will improve medication adherence results and increase rational consumerism. Finally, tactics that apply new ideas that encourage appropriate utilization of benefit dollars and secure best-in-class pricing terms will be required to get the best economic value for ETF.

ETF's pharmacy benefit expenses as a percentage of overall medical plan costs (medical and drug combined) are reasonable compared to other large plan sponsors. Also, the program already

includes a number of important and effective measures to control costs and manage expenses appropriately.

Overall, the steps ETF has taken for 2016 will mitigate a portion of their future plan cost trends. More steps will need to be taken to continue to manage per capita cost trends to single digits in the years ahead.

Additional strategies include:

- **Generic Dispensing Rate (GDR) Targets** - ETF should encourage the current Pharmacy Benefit Manager (PBM), Navitus, to take an active role in driving utilization toward generics. A future performance guarantee to consider may be to set target GDR increases in some key disease states with pay for performance incentives that the PBM can earn when targets are met. For example, for every 2% increase in the GDR for that disease, the PBM might earn .25% in case management fees to a set maximum dollar amount per year.

- **Limited or Tiered Networks:** Segal's experience suggests that by limiting the retail pharmacy network, additional savings can be realized. Plan sponsors typically can save up to an estimated 1.5% to 3% of retail drug costs.

- **Specialty Drug Network:** Deeper discounts exist for specialty pharmacies by concentrating the volume through fewer providers. However, the true savings and benefits lie in the enhanced clinical outcomes and reduction of waste these specialty pharmacies provide. Savings from use of an exclusive specialty pharmacy manager would require additional study but has been seen in other large employers to reduce both medical and specialty Rx claims by several percentage points over time.

The upcoming PBM RFP should explore the market's ability to support these strategies for ETF.

Long-Term Strategies

A number of longer-term strategies are developing that may be of use to ETF in managing its pharmacy benefit program. Segal highlights five such developments that should be discussed and considered by ETF.

- Prospective Maximum Acquisition Cost (MAC) Price List for Generics
- Targeted Reference Based Pricing for Brand Drugs
- Integration with medical data
- Per Member Per Year (PMPY) cost trend guarantees by class
- Leaner and Rational Plan Design Concepts

These strategies are less evolved but with the size and influence of ETF, we believe you can shape the market during your next PBM procurement.

Summary of Recommendations

In our initial report, Segal made a number of recommendations for specific changes to ETF's pharmacy benefit program for 2016. This report focuses on opportunities for 2017 and beyond.

We are recommending the following changes:

1. **Consider narrow or tiered networks:** Annual savings $3 to $3.5 million per year on retail non-specialty ingredient costs

2. **Move to exclusive contracting for specialty drugs:** Annual savings $2 to $3 million per year in specialty savings from improved pricing and utilization controls

3. **Obtain better Retail 90 pricing either through bids or custom contracting:** Annual savings will vary based on custom contracting and current terms for 90 day retail supply

4. **Tighten up medication management services -** Annual savings of 1% to 2% of program costs. Medication management strategies is the general term that includes clinical programs and member education programs that address both specialty and non-specialty treatments. It includes strategies that support medication adherence, step therapy, prior authorization, quantity limits, patient education around polypharmacy and side effects, etc.

5. **Add a new lower cost Medicare Part D plan option:** This will allow for the offering of substantially lower cost retiree premium option will provide greater choice for retirees

6. **Pursue several new contracting concepts with either the current PBM or through bids**

7. **Adding performance guarantees around clinical outcomes**

Additionally, given the high level of satisfaction with Navitus' service and relatively good financial performance, Segal supports extending the contract through 2017. Extending for another contract year will allow time for the development of a comprehensive PBM RFP and allow for sufficient time for a comprehensive bid process.

With the above we would estimate savings of $10-$20 million could be achieved. Further research will need to be performed to solidify these estimates.

Data Management

ETF participates in the Wisconsin Health Information Organization (WHIO) initiative, which includes access to a statewide, centralized health database consisting of reporting on quality and cost of health insurance experience. WHIO contracts with OptumInsight to provide the platform of its data warehouse through license to an enhanced DataMart.

As noted in our first report, there are limitations within the WHIO DataMart, which in turn limit ETF's ability to analyze opportunities for population health improvement while maintaining costs.

As additional strategic options are considered, including additional value-based elements, ETF needs to be better positioned with comprehensive data to support its ongoing plan management needs.

- **Financial Management:** ETF needs to be able to measure and analyze the aspects of a health plan that are related to budgets, forecasts, rate setting, and reporting.

- **Benefit Design & Network Management:** ETF needs to be able to identify and evaluate services that support design effectiveness, network performance, cost sharing strategies, and vendor management.

- **Medical and Pharmacy Quality Adherence:** ETF needs to have the ability to measure and evaluate preventative services compliance, compliance with standards of care, and prescription drug adherence.

- **Health Management & Wellness Program Design:** ETF needs the ability to perform analyses that support wellness design, including health risk assessment data analysis, chronic conditions profiling and program design modeling.

- **Vendor Performance & Contract Adherence:** ETF needs to have an enhanced ability to evaluate and monitor targeted performance guarantees, conduct discount analysis and review payment accuracy.

- **Provider Quality:** As ETF considers longer term and additional value based components in the program's design and strategy, there needs to be the capability to evaluate and compare quality and efficiency at the provider, or provider group, level.

ETF needs a warehouse option that has rigorous data cleansing processes with comprehensive benchmarking and an ability to go beyond canned reporting. ETF also needs an option to supplement ETF staff capabilities cost effectively (e.g., enhanced analytics assistance).

With a number of structural changes, it is possible that WHIO could be enhanced to meet these needs. Based on our conversations with WHIO, it does not appear likely these changes could be implemented timely. Alternatively, there are a number of vendors in the marketplace that can meet the needs of ETF. In our opinion, a better option for ETF is to competitively bid and contract with an external data warehouse system vendor that could provide a ready-made system tailored to ETF's specific structure and data and functional needs.

It is our recommendation to issue an RFP in 2016 for a 2017 implementation. This will enable ETF to have a data management solution in place as the additional detailed data is provided by the plans during the transition to self-insurance and for ETF to begin to more effectively manage the program in a relatively immediate fashion.

Market Observations

We have reviewed and provide observations on a number of topics of direct relevance to ETF's health benefit plan.

Minnesota State Employees Group Insurance Program

The Minnesota State Employees Group Insurance Program (SEGIP) provides an interesting point of comparison with ETF's program. Not only is this the plan for state employees in a neighboring state, but SEGIP formerly utilized an insured managed competition model similar to ETF's and transitioned some years ago to a self-insured strategy with a more focused number of health plans.

Currently, SEGIP utilizes three statewide plan options and utilizes a tiered provider network approach. Providers are tiered by SEGIP, with tiering uniform across all three plans. Pharmacy is carved out, with the same benefit provided to all members and administered by Navitus.

SEGIP benefits are richer than ETF's. However, the full funding rate for single coverage is approximately $525 per month, which is about 24% less than the average single rate for ETF's UBD, which is $689**.** About 9% of this difference is explainable by geographic cost differentials (Wisconsin is a more expensive market than Minnesota, generally speaking). This leaves approximately 15% remaining unaccounted, some of which could be due to differences in demographic or health risk. In our opinion, the difference between the two memberships' risk is not likely to account for much of this difference. Therefore, there is something about the SEGIP self-insured, three health plan strategy that results in relatively well-managed costs.

National and Regional Market Changes

Regionally, we examined three organizations that are evolving and working to improve efficiency and quality in the Wisconsin marketplace: The Alliance, AboutHealth and the Integrated Health Network. All three are growing, expanding and developing organizations that reported attractive provider pricing and access in some areas of the State. However, at this point, none has evolved to the point of being a health plan and would be most viable to ETF as a partner with an existing health plan.

Nationally, there are a few significant mergers underway, or proposed. Four of the country's largest health plans are involved. Aetna is acquiring Humana and Anthem has proposed to buy Cigna. If both the mergers succeed, they would effectively consolidate the number of large health insurance carriers from five to three. The Anthem-Cigna merger would result in the combined organization being the largest U.S. health insurer by membership. These deals are being reviewed by the Department of Justice and state insurance regulators.

In addition, there has also been activity on the national PBM level. United Health Group has agreed to purchase Catamaran, a large PBM. Catamaran will be folded into United Health's OptumRx pharmacy care services unit. Once combined, OptumRx projects that it will fill over 1 billion prescriptions. As a point of reference, Express Scripts, another large PBM, filled about 1.3 billion prescriptions in 2014.

Observations on Wisconsin State Marketplace/Exchange

Similar to the results in our prior report, in 2016, ETF will offer five UBD options in Madison, with premiums that will range from $576 to $655. By comparison, there will be eleven platinum plans available in Madison on the state marketplace with premiums ranging from $389 to $513. As in 2015, all of the ETF plans are higher cost than the highest cost option on the Exchange.

Plan options and premiums vary on the Exchange by age and location, but if State employees used the Exchange to purchase coverage under Gold Plans, the total plan costs would be 18% to 32% ($207 million to $371 million) lower in 2016. Note that ETF plans are approximately 12% richer than the Gold Plans on the Exchange, providing explanation for some of the difference.

A well-designed state employee health plan like ETF should be able to provide benefits in a more cost efficient manner than those available in the same state's healthcare marketplace. We believe that ETF should continually be addressing the cost efficiency of its programs, and Wisconsin's public Exchange provides a comparison point to measure this efficiency.

Health Care Pricing Transparency Tools

Transparency in health care can be broadly defined as the availability of reliable health information about the cost and quality of health care services. A variety of tools exist in the marketplace and are becoming increasingly sophisticated and are based on an expanding database of provider and pharmacy pricing.

Despite these developments, consumer utilization of transparency tools has not increased significantly. Some plans and employers are including member incentives to increase utilization. However, there is not currently conclusive evidence available to measure and report on the impact increased utilization has on costs and care efficiency.

Consumer Directed Health Update

According to the Kaiser Family Foundation 2015 Employer Health Benefits Survey, almost a quarter, 24 percent, of covered workers are enrolled in an HDHP with a savings option. That percentage is nearly double the enrollment of those plans from just 5 years ago. In addition, in 2015, seven percent of firms providing health benefits offered an HDHP with an HRA and twenty percent offered a qualified HDHP with HSA.

The Kaiser information is consistent with information presented in our first report and provides additional evidence that consumers access healthcare via these plans at a growing rate. For 2016, the State contribution to ETF's HDHP was increased and enrollment is expected to increase from approximately 400 subscribers in 2015 to approximately 1,500.

Self-Insurance

Self-insurance is not a new concept for the State of Wisconsin. ETF has maintained a self-insured pharmacy program since 2004 and results appear to have been successful. With Navitus contracted as the Pharmacy Benefit Manager, ETF has a transparent program providing full access to claims data, a partner that is both flexible and proactive in managing costs on behalf of ETF, and a uniform plan experience for all members wherever their location. For 2016, the dental benefits will migrate to a self-insured approach with Delta Dental contracted as the administrator. The State's Worker's Compensation program is also self-insured.

Large plans generally self-insure the risk and costs for medical and pharmacy benefits. As noted in our first report, the large majority of state health plans self-insure all their health plan options. Some even self-insure their HMO offerings. As noted in the **Market Observations** section in our first report, all but one of the current ETF health plans report the ability to support a self-insurance approach.

What Are the Benefits of Self-Insuring?

There are several reasons why employers choose the self-insurance option. The following are the most common reasons and are primarily financial:

- **Elimination of premium tax:** Wisconsin health plans do not pay a premium tax. However, some ETF plans pay a premium tax in their home state, depending on that state's regulations. Nationally, this rate is approximately 2% of premium. With many ETF plans not subject to premium tax, the aggregate rate is quite low, approximately 0.1% of total ETF premium. This equates to an immediate savings of $0.9 million annually in 2016. There is no premium tax on the current self-insured plans.

- **Elimination of Affordable Care Act (ACA) Market Share Fees:** This fee was introduced with the ACA and applies to all fully insured medical and/or dental business. The fee is to be divided between all health insurance issuers and is expected to increase beyond 2018. The fee allocation is not uniform, with larger plans paying a larger portion and the smallest plans not subject to the fee. This fee is not applicable to self-funded health plans. In aggregate across ETF's health plans, the fee is approximately 2% of health premiums, or $18.3 million annually in 2016.

- **Lower cost of administration:** Employers find that administrative costs for a self-insured program administered through a contracted third party administrator (TPA) – even if that TPA is also a carrier—are generally lower than those included in the fully insured premium by an insurance carrier or health plan. We compared the current ETF administrative fees with those paid by other state plans, other Wisconsin employers, and rates reported in national benefits surveys. It is estimated the current ETF per subscriber per month (PSPM) rate is $44 (reduced from $84 at the beginning of this year's negotiations). The highest rate in the expected range for other state plans is $30 PSPM. This $14 difference equates to $11.2 million annually in 2016.

- **Carrier profit margin and risk charge eliminated:** The profit margin and risk charge of an insurance carrier/health plan are eliminated for the bulk of the plan. Normally these represent 2-4%. However, the loads reported by ETF plans are lower, with the average profit

and risk load in 2016 reported at 1.2% in aggregate. Eliminating this 1.2% load results in an immediate savings of $11.0 million annually in 2016.

- **Cash flow benefit:** The employer does not have to pre-pay for coverage on monthly premium basis, but can fund claims dollars just as they are needed for payment. This can result in improved cash flow. The employer also maintains control over the health plan reserves, enabling maximization of interest income that would otherwise accrue to the insurance carrier through their investment of premium dollars not yet needed for claims payments and other expenses. A typical lag for medical claims is approximately one month, which equates to an estimated $72.1 million in 2016. At a modest investment return of 1.0%, the additional investment income would be approximately $0.7 million annually in 2016.

- **Management of Excise Tax Exposure:** While the regulations have not yet been finalized, it is anticipated that the 40% Excise Tax will be determined for each individual subscriber within assigned groups based on coverage tier and plan groupings. Therefore, employees and retirees in health plans with higher premiums will produce a larger Excise Tax exposure for ETF and the State. It is anticipated that self-insurance will provide more flexibility in establishing rates than available with fully insured premiums. Currently, the Excise Tax exposure is approximately $3-4 million, and the immediate impact of self-insurance is fairly minimal in the short term. However, the impact grows over time and is estimated to be as much as $41 million by 2027.

There are also other non-financial reasons plans choose to self-insure their programs. These include:

- Control of plan design
- Data collection
- National provider network
- Custom Provider Network
- Mandatory benefits are optional
- Cost reporting

Financial Impact

The projected annual savings associated with a conversion of ETF's current plans to self-insurance is $42.1 million and is summarized in the following table.

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

This is an estimate of the impact on fixed dollar costs and does not account for any changes in plans, claims or program structure that could also affect costs. In theory, the current program could be converted to self-insurance and remain otherwise largely unchanged. However, converting 17 fully-insured plans to self-insured is not considered practical, nor feasible, and is not recommended. Our recommendation is to combine a conversion to self-insurance with the regional restructuring and plan designs provided in the **Program Structure** section. This may be best structured through a phased-in approach.

Cash Flow and Reserving

As previously stated, the transition to self-insurance alone is not anticipated to change the underlying claims costs, with savings resulting from a reduction in the fixed, non-claims costs. The conversion will result in a change in the timing of payments made by ETF. Where fully-insured premiums are paid up-front, self-insured claims are paid after the date of service, which results in a run-in period from which both a cash balance and reserve will be built. Therefore, the conversion to self-insurance should produce a month or so of claims cash flow improvement.

The GIB has a policy to maintain cash reserves in a target range of 15-25% of paid claims (including 20% of insured premiums). So overall, the current fully-insured reserve was 3-5% of total annual premiums. A typical reserve for a self-insured medical plan will be 1-2 months of paid claims or 10-15% of total incurred claims. This change in cash flow is similar to what occurred with the transition to self-insuring the pharmacy benefits and what will occur in early 2016 with the dental program. So larger reserve may be necessary, but the cash account will also be higher to compensate for that. We would recommend maintaining the higher 25% first year, to compensate for the run-in and build the reserve needed to fund the IBNR. This should result in a reserve of approximately 10% over the IBNR.

Gain Sharing

In some corners of the industry, there are those that remain skeptical that a health plan will not remain as diligent in managing member utilization and provider costs as it would in a fully-insured arrangement. To mitigate this potential threat, we propose incorporating incentives and penalties for plans as well as for members. The incentives/penalties for members are based on plan design and contribution differentials described in an earlier section. To align incentives for plans, we anticipate incorporating performance metrics with rewards and penalties that are designed to improve member health and manage expenses for ETF. We also recommend that ETF incorporate a gain-sharing component that shares a portion of any financial gains with health plans when they manage costs to be lower than expected for their specific membership.

In Summary

ETF has the opportunity to realize an estimated $42.3 million annually in savings from reductions in fixed costs paid to the health plans by converting to a self-insured model for the plans providing the Uniform Benefit Design. These savings, along with gains associated with the initial lag between service and payment dates should be sufficient to fund the initial reserves for IBNR and solvency needs.

It is worth noting that in the **Self-Insurance Concepts** section of our first report, we estimated that a conversion to self-insurance could result in savings of $50-$70 million. That estimate was

based on a preliminary review of the data and the program and included the expectation that ETF would restructure the program and consolidate health plans. The **Program Structure** section of this report includes our recommendations for health plan consolidation and a regional approach to selecting and contracting vendors. We demonstrated the associated savings for the restructuring and consolidation to be $45-$70 million. Coupled with the savings estimated in this section of the report, the combined annual savings opportunity is $85-120 million, slightly greater than originally estimated.

A self-insured program would provide ETF with significantly improved transparency and access to the detailed data necessary to sufficiently manage the program. ETF and the GIB would also have increased flexibility in benefit design beyond that available through a fully insured plan. Self-insurance may very well provide ETF with additional capabilities to manage exposure to the Excise Tax.

The vast majority of other states utilize self-insurance for their state employee health plans and, in our analysis, there does not appear to be a compelling reason for ETF to remain fully insured over the long-term strategy.

We recommend a phased-in approach to transition to self-insurance. Beginning in 2016, for the 2017 health plan renewal, ETF should require all health plans to provide complete encounter, claims and pricing data at claim level detail. Thereafter, ETF could move toward self-insurance on a timeframe that is most advantageous to the program and also allows ETF staff to manage the transition in a thoughtful manner. Future phases will include the collection of additional data within the new regional structure, the potential inclusion of gain-sharing and a double-sided risk-sharing approach.

Retiree Coverage

In Wisconsin, when state employees retire, they have the option to continue medical, dental and pharmacy benefits at the full cost of coverage. In order to pay for the benefit, retirees use their accrued sick leave. At retirement, unused leave, in conjunction with pay, is converted into a notional account balance that can be used to cover the cost of medical, drug and dental premiums.

Monthly premiums for Pre-Medicare retirees vary by as much as $200. Not surprisingly, the plans with the lowest premiums generally have the highest enrollment. Pre-Medicare retiree premiums are based on experience that is pooled with the active membership. This results in premiums for these retirees being significantly lower than would be the case if they were rated solely on their experience.

In order to reduce costs for the Medicare retirees, we will need to consider some new plan alternatives. We believe additional options exist with lower costs, while maintaining benefit levels. The goal is to contract with Plans to better manage care under group Medicare Advantage programs. Many other states have implemented MA plans with great success. Illinois reduced monthly costs from over $450 to approximately $200 without a reduction in benefits or sacrificing provider access. Actually, group MA PPO plans, meeting the 51% access rule, provide the same provider access as a traditional Medicare Supplement plan and greater access than your HMOs. The 51% rule simply means that the PPO network supporting the plan must cover 51% of the eligible members. If that condition is met, members can use any provider that

accepts Medicare, making the plan a "passive" network, with the same level of benefits in or out of network.

Segal has performed a number of Medicare Advantage opportunity assessments for States. We conducted and Request for Information (RFI) and provided participating organizations summary eligibly and medical claims, as well as detailed pharmacy information. The study included the two largest Group MA Plans – United Healthcare and Humana. We also included one of the largest commercial plans – Anthem.

Below is a summary of the results and the estimated rates provided by the participants:

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

For the Medical Only rates, we would expect to pair the new MA plan with the existing EGWP program. The rates in the Medical & Pharmacy column are for a potential MAPD with both medical and pharmacy benefits that would potentially also replace the current EGWP program. Note that these rates do not include dental.

Recommendations & Timing

The results of the RFI show that a National Passive PPO with the best-in-class plans could produce savings of $50 to $100 per member, a reduction of 10-20% with no benefit changes. This would result in a total premium reduction of $17 to $34 million annually for retirees.

To coordinate with the active recommendations, we would recommend one National (and Statewide) plan. We would enable the plans selected in each region to have a competitive Medicare product, preferably an MA HMO. This will allow retirees a number of options to best meet their needs and budget.

Like the Total Health Management recommendation, we believe this recommendation can be phased-in. The National Passive PPO could be marketed and implemented for 2017 while the Regional plans implemented in conjunction with the 2018 plan and network changes.

Local Government Plan

The current program utilizes 18 health plans to offer 8 benefit options. Enrollment in many of these options is sparse and there is a significant variation in premiums.

Our recommendation is to revise the program to match the state plan, for simplification. This would include the same regional structure and plans in each region and a statewide carrier. Pricing would be based on the regional alignment, as defined for the state plan. The wellness component may need to be handled differently, based on potential difficulty for local governments to administer the contribution differentials while paying full rates to ETF. However, this may not produce an issue as we have seen states that are able to administer a wellness contribution differential similar to this with a separate local plan, successfully.

We also recommend the program transition to self-insurance for the same reasons we recommend self-insurance for the state plan. This would require a similar reserving structure as recommended for the state. If the plans were combined, the WPE program would have no need for reinsurance and plans could still be rated separately. North Carolina is one example of a state plan that allows local governments to enter the state plan. Experience analysis of that plan shows local participants typically cost less than the state employees, primarily due to age differences.

If the programs cannot be combined into one pool due to statutory limitations, ETF could purchase reinsurance, if desired, with amounts determined based on reserve level and risk tolerance. It could also be structured to buy the insurance from the larger State pool, eliminating the unnecessary profits built into that product.

Affordable Care Act (ACA) Update and Strategies

Since Segal's initial report, the Internal Revenue Service and U.S. Treasury have issued two calls for comments on various aspects of the 40% Excise Tax that will become effective in 2018. The report updates our earlier report on these developments.

ETF will continue to face a potential hit from the 40% Excise Tax that goes into effect for 2018. With the current plans just below or already exceeding the benefit value thresholds for 2018, ETF will need to make changes to reduce the value of its plans in order to avoid the tax.

The Excise Tax calculation must take into account all types of health benefit plans offered by the employer, including not just the primary medical benefit plan, but also pharmacy benefits, dental and vision benefits, Medical Flexible Spending Accounts, Health Savings Accounts, Health Reimbursement Arrangements, Archer Medical Savings Accounts, and even Employee Assistance Plans and on-site clinics providing services to employees and their dependents.

With ETF's current structure of separate, fully-insured health plans with widely varying premiums, the calculation and allocation of any Excise Tax to the appropriate plans and participants will be problematic at best, and likely a virtual nightmare to administer.

We recommend that ETF start now reviewing its situation and the major decisions that will need to be made. Those decisions will include at least: which plans must be counted; how the participants enrolled can be aggregated or disaggregated to minimize the possibility of hitting the Excise Tax thresholds; which agencies will have responsibility in the process; which plans may have to be modified or eliminated; and how any tax liability will be allocated across all the contracted vendors.

Segal updated ETF's potential Excise Tax liability using the negotiated 2016 premium rates, assuming no plan changes are made and the Medical Flexible Spending Account continues to be used at about the same level as currently. The projected tax liability has reduced significantly.

ETF Projected Excise Tax
($ Millions)

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

We also included a reminder that the ACA's Employer Shared Responsibility Penalty is now in effect and ETF and the State must continue to monitor eligibility for the plan and the employer subsidy levels to avoid a potential penalty. We understand that the State currently allows employees working at least 1,040 hours per year to join the plan with full employer subsidy, so there is likely little potential for penalty. However, it is important that ETF and the State continue to work together to identify any part-time employees that may be working multiple jobs which together make them a full-time employee under ACA.

In Summary

The report provides specific recommendations for ETF and the GIB to consider for 2017 and beyond, along with our rationale for making these changes. We recognize there are a number of recommendations in this report and have summarized the estimated financial impact for each below, including the timing of the key activities.

Recommendation	Estimated ETF Annual Savings	Potential Timing of Key Activities
Total Health Management	$10 – 30M	• Market wellness vendor for 2017 (RFP in 2016) • Implement wellness and premium surcharges for 2017 • Health management performance initiatives for 2018
Program Structure	$45 – 70M	• Market Statewide Self-Insured PPO/HDHP for 2017 (RFP in 2016) • Market Regional Plans for 2018 • Implement Value-Based Benefit Design with Tiered Provider Networks in 2018 • New employee premium structure in 2018

Recommendation	Estimated ETF Annual Savings	Potential Timing of Key Activities
Pharmacy	$10 – 20M	• Extend Navitus contract for 2017 • Begin implementing strategic changes in 2017 • Conduct pharmacy RFI in 2016 in preparation for RFP • Fully implement changes in 2018 (RFP in 2017)
Data Warehouse	($0.2M) – COST	• Market in 2016 and implement in 2017 (RFP)
Self-Insurance	$40 – 50M	• Expand self-insurance with improved State-wide PPO/HDHP for 2017 • Require collection of detailed claims information for 2017 renewals • Begin transition to self-insurance
Retirees	None[1]	• Statewide MAPD for 2017 (RFP in 2016) • Additional Medicare choices in 2018 in conjunction with regional plans
Local Government	None	• Match changes in State plan (2017-2020)
ACA/Excise Tax	Varies	• Now through 2018

It should be noted that the time and effort required to appropriately plan and implement these changes will be significant. Changes in vendor contracts, benefit design, program structure, budgeting, cash-flow timing, will require extensive communications programs, numerous RFPs, revised vendor contracts, different banking arrangements and potentially additional expertise.

ETF's Office of Strategic Health Policy currently has 14 individuals on staff and the effort required during the multi-year transition will likely tax existing resources and require careful planning, resource allocation and potentially additional resources. Assistance from other state agencies and GIB approval will be required for many of the steps required (such as RFPs and vendor contracting) to implement these recommendations. Given the size of the program and the savings potential, the addition of a few FTEs to staff is a negligible cost.

[1] Savings of $17-34M annually for retirees

Introduction

Segal Consulting was retained by the Group Insurance Board to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program. This report is the second of two and focuses on analysis and recommendations for consideration for the longer-term, with some possibly being implemented as early as 2017. The first report, presented March 25, 2015, focused primarily on opportunities and considerations for 2016.

Background

The State of Wisconsin Employee Trust Fund currently administers retirement, health, life, income continuation, disability, and other insurance programs for 570,000 state and local government employees and annuitants. ETF's Office of Strategic Health Policy administers the state employee health insurance program.

The Group Insurance Board, consisting of 11 members, sets policy and oversees administration of the group health, life insurance, and income continuation insurance plans for state employees and retirees and the group health and life insurance plans for local jurisdictional employers who choose to offer them. The Board also can provide other insurance plans, if employees pay the entire premium.

Membership and Costs

The State and local health insurance programs cover over 245,000 lives. This includes 69,000 active state employees and 26,000 retired state employees and their dependents, and 13,000 active local government employees and 2,000 retired local government employees and their dependents. The program administers nearly $1.41 billion in annual insurance premiums, compared to $1.37 billion projected for 2016.

Based on current premiums, member enrollment, administrative costs and recent claims experience, Segal projects the following costs and expenses for 2016 (amounts in $millions).

	Actives/Non-Medicare Retirees	Medicare Retirees	Total
Total Medical Costs	$896	$84	$980
Total Pharmacy Costs	$176	$69	$245
Total Dental Costs	$44	$8	$52
Total Administrative Fees	$80	$12	$92[1]
Total Annual Costs	**$1,196**	**$173**	**$1,369**
Member Premiums	($204)	($173)	($377)[2]
Net ETF Costs	**$992**	**$0**	**$992**

[1] Note that this is lower than prior report due to discoveries during the annual renewals and is a net post-negotiation effective administrative cost

[2] Retiree Premiums include sick leave funding from the State.

Current Benefits

Most health insurance benefits (98%) are administered through 17 competing, fully insured health plans. Health insurance benefits follow a "uniform benefit" design or "UBD", in that all participating health plans are required to offer the same benefits package. The pharmacy benefit has been administered separately from the insured health plans through a self-insured Pharmacy Benefits Manager (PBM) since 2004.

Also in 2004, the State implemented a three-tier rating system for the health plans that anticipates different levels of employee contribution for each tier. Most plans are offered in Tier 1.

- **Tier 1:** includes the top plans in efficiency and quality, and has the lowest employee contribution.
- **Tier 2:** includes lower ranking plans in efficiency and/or quality, and has a higher employee contribution.
- **Tier 3:** are the lowest ranking plans in efficiency and quality, and highest employee contribution.

The State also administers two self-insured plans—the "Standard Plan" and the "State Maintenance Plan". The Standard Plan is a PPO administered by Wisconsin Physicians Service ("WPS") that provides comprehensive freedom of choice among hospitals and physicians across Wisconsin and nationwide. The Standard Plan is a Tier 3 health plan for employees.

The State Maintenance Plan ("SMP") is available only in counties that lack a qualified Tier 1 Plan. It offers the same UBD benefit design, consistent with the other 17 Health Plans.

For the first time, in 2015 the State is offering employees the option of a high deductible health plan (HDHP). Each participating health plan approved to offer the UBD must also offer the HDHP option. In addition, those participants who enroll in the HDHP will be enrolled in a health savings account (HSA). The HDHP plan option has a minimum annual deductible and maximum out-of-pocket limit. Except as required by federal law, the health plan does not pay any medical, dental or prescription drug costs until the annual deductible has been met. Members must enroll in an HDHP in order to have the state-sponsored HSA. Amounts contributed to the HSA by the state belong to the member and can be used to pay for eligible medical expenses.

Health Management and Wellness

ETF requires the participating health plans to identify members with a moderate or high health risk and have in place a process to enroll them into appropriate health management programs.

Disease Management

ETF has identified five specific areas for disease management, which are covered by the following requirements in the health plan contract:

1. **Low Back Surgery:** Prior authorization for referrals to orthopedists and neurosurgeons for low back pain in members who have not completed an optimal regimen of conservative care. This is not applicable to members who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty referral.

2. **High-Tech Radiology:** Prior authorization for high-tech radiology tests, including MRI, CT scan, and PET scans.

3. **Shared Decision Making (SDM) for Low Back Surgery:** Plans must utilize Patient Decision Aids (PDA) according to International Patient Decision Aids Standards (IPDAS) for members considering low back surgery.

4. **Advance Care Planning (ACP):** Health plans and their contracting providers must provide an ACP program that meet one of the five options outlined in ETF's guidance. Those options include:

    a. Health plan is actively participating in Honoring Choices of Wisconsin, Gundersen's Respecting Choices or the Institute for Healthcare Improvement's The Conversation Project;

    b. Palliative care specialists are added to care teams that commonly care for ETF members with advanced or life-threatening disease;

    c. All ETF members over 60 are offered an opportunity for ACP with a trained facilitator;

    d. All ETF members with a serious disease and a likely survival of less than 1 year will be offered an ACP and/or palliative care consultation; OR,

    e. All ETF members with a likely survival of less than 90 days will be offered hospice services.

    The 2016 contract requires all health plans to offer ACP to the majority of members with a terminal diagnosis.

5. **Coordination of Care (COC)**: With the intent of reducing hospital admissions, health plans (or their contracted hospital/provider groups) must contact members who have been discharged from an in-patient hospital and have a diagnosis of heart failure, myocardial infarction, pneumonia, or any other high-risk health condition within 3 – 5 business days after the initial hospital discharge.

ETF also holds an annual Disease Management Symposium with the contracted health plans as well as meetings with the health plan chief medical officers. These meetings are an opportunity for health plans to share best practices for the areas targeted by ETF and to express challenges that may exist for ETF proposed program expansion.

Wellness

In 2013 the Group Insurance Board (GIB) approved a Uniform Wellness Incentive to begin in plan year 2014. The Uniform Wellness Incentive required all health plans to issue $150 to adult members who completed a biometric screening and a health plan administered health risk assessment (HRA).

Members have the option to complete the biometric screening with their physician or at a worksite biometric screening event. To improve the availability of worksite biometric screenings, the Department of Administration contracted with a single vendor, OptumHealth, in December 2013.

All employers participating in the State of Wisconsin Group Insurance program may access the OptumHealth contract to host worksite biometric screening events. The OptumHealth contract costs for 2016 are covered by a wellness fee of $.40 per contract per month added to the employer health insurance administrative fee paid to ETF. ETF assists with the transfer of screening results from OptumHealth to the health plans. To date in 2015, approximately 17% of eligible members completed the requirements to earn the $150 incentive, compared to 13% in 2014.

WHIO Data Mart

The Wisconsin Health Information Organization (WHIO) is a database resource for health claims information for the state employee health insurance program. WHIO's database is intended to improve health care transparency, quality and efficiency. Fifteen of the state employee health plans currently submit data to WHIO. Beginning in 2015, all ETF health plans are required to submit data to WHIO, and the three plans that have not previously submitted data are being on-boarded this year.

The WHIO Health Analytics Data Mart functions as a data-driven marketplace that enables members to submit information and receive reports that analyze health system and physician performance based on hundreds of variables. The Data Mart is intended for use in identifying gaps in care for treatment of chronic conditions, costs per episode of care, population health, preventable hospital readmissions and variations in generic prescribing.

The Data Mart contains a volume and depth of data on medical services that spans multiple health care systems across the state and multiple service settings, including physician's offices, outpatient services, pharmacy claims, labs, radiology and hospitals.

The Data Mart maintains a rolling 27 months of claims data that comprises the experiences of more than 4 million people and 255 million treatment services. A total of 21.5 million episodes of care are currently in the database and its scope will grow as new members join and contribute to the cooperative effort. An episode of care is defined as the series of treatments and follow-up related to a single medical event, such as a broken leg or heart surgery or the year-long care of a diabetic patient.

Each successive version of the database, refreshed every six months, is intended to capture the most recent health care experiences of additional consumers. The current version of the database contains more than $70 billion of health care expenditures and allows comparisons of those

expenditures by region, county, 3-digit ZIP code and medical system. The WHIO database is Health Insurance Portability and Accessibility Act (HIPAA) compliant.

Benefits Consultant Contract

In May 2014, the State of Wisconsin issued a Request for Proposal (RFP) for a Health Care Benefits Consultant for the Employee Trust Fund (ETF). The RFP stated that the consultant's primary objective is to analyze data from a variety of sources to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program.

Segal Consulting (Segal) was selected for this engagement, with the contract commencing in November 2014. The contract anticipates two main project deliverables:

- Within 6 months of the beginning of the contract, the vendor will provide a documented report ("Report 1") and a presentation to the Group Insurance Board (Board) outlining potential benefit design changes and strategies for the 2016 plan year.

- Within 12 months of the beginning of the contract, the vendor will provide a documented report ("Report 2") and a presentation to the Board outlining potential benefit design changes and strategies for the 2017 plan year.

The RFP also states that the Consultant would receive a large data set from the Wisconsin Health Information Organization (WHIO) immediately once under contract. WHIO provided data to Segal on January 16, 2015.

To fit the timing required for consideration, approval and implementation of changes for 2016, it was agreed that Report 1 would be presented to GIB at a meeting in March 2015. Segal and ETF agreed upon a modified scope for the first report to reflect the delay in receiving usable data from WHIO.

In Report 1, we presented our comments and observations on the following topics:

- **Benchmarking Comparison:** comparison of ETF benefits with regional and national practices, with recommendations for 2016

- **Total Health Management:** review of ETF membership's current health risk and comparison of the health plans' risk and care gaps

- **Pharmacy:** comparison of PBM contract with current market practices and review of current benefits, with recommendations for 2016

- **Consumer Directed Health (CDH) Care Design:** comments and observations on recently implemented CDH options, with recommendations for 2016 to increase enrollment

- **Private and Public Exchanges:** overview of private and public exchanges, and comparison of ETF benefits and costs with those of Gold and Platinum plans available in the Wisconsin Healthcare Marketplace

- **Affordable Care Act (ACA):** review of the Excise Tax due to be implemented in 2018 and ETF's potential exposure
- **Market Observations:** comments and observations on current practices, emerging trends and potential opportunities in the Wisconsin market
- **Self-Insurance Concepts:** summary of the advantages and disadvantages of self-insurance and the feasibility of implementation by ETF
- **WHIO Database:** comparison of WHIO capabilities with best practices for ETF and options for improved ETF data management

As a result of our analysis and the discussion that ensued from the first report, the GIB and ETF implemented several changes for 2016.

Benefit changes

The 2015 UBD provides one of the highest benefit value in the country (96%), presenting an opportunity to adjust benefits and remain competitive. The initial enrollment in the HDHP option was very low (approximately 400 contracts). We recommended enhancing the State's HSA contribution (to $750 for an individual and $1,500 for family) as a measure to help increase the overall value of the CDH option(s), which would then help to encourage additional enrollment for 2016.

Note that some of the plan names have changed and may be referenced differently throughout this document. UBD has become the IYC Health Plan, the HDHP is now the IYC HDHP and the Standard Plan is now the IYC Access Health Plan.

UNIFORM BENEFIT DESIGN
(IYC HEALTH PLAN)

	2015	2016
Annual Deductible		
Single	None	$250
Family	None	$500
Annual Maximum Out-of-Pocket[1]		
Single	$500	$1,250
Family	$1,000	$2,500
Office Visit Copays		
Primary Care Physician	10%	$15
Specialist	10%	$25
Therapy Copays		
Chiropractic Physical Therapy, Speech Therapy and Occupational Therapy	10%	$15
Actuarial Value	**96%**	**92%**

[1] Annual Out-of-Pocket Maximum was increased to include all Copays

The Actuarial Value is the percentage of the total claim paid by the benefit plan. The higher the value, the greater the benefit to the member.

THE STANDARD PLAN
(IYC ACCESS HEALTH PLAN)

	2015 In/Out Network	2016 In/Out Network
Annual Deductible		
Single	$200/$500	$250/$500
Family	$400/$1,000	$500/$1,000
Annual Maximum Out-of-Pocket		
Single	$800/$2,000	$1,000/$2,000
Family	$1,600/$4,000	$2,000/$4,000
Office Visit Copays		
Primary Care Physician	10%/30%	$15/30% after ded
Specialist	10%/30%	$25/30% after ded
Therapy Copays		
Chiropractic Physical Therapy, Speech Therapy and Occupational Therapy	10%/30%	$15/30% after ded
Actuarial Value	**93%**	**91%**

The benefits were changed to be consistent with the UBD benefit design. Note the actuarial value is slightly lower due to the out-of-network provisions.

HIGH DEDUCTIBLE HEALTH PLAN
(IYC HDHP)

	2015	2016
Office visit copays now apply once deductible is met. No other changes to the medical benefit provisions were made.		
Annual State HSA Deposit		
Single	$170	$750
Family	$340	$1,500
Actuarial Value	**83%**	**87%**

The plan changes make the HDHP more competitive, especially with the higher contribution to the HSA.

For 2016, brand and specialty drugs will be covered on a coinsurance basis. Generics will still have a $5 copay. Out of Pocket limits will also be increased. This structure should further incent members to utilize lower cost medications.

PHARMACY—ALL PLANS

		2015	2016
Level 1		$5	$5
Level 2		$15	20% ($50 max)
Level 3		$35	40% ($150 max)
Level 4 – Preferred Level 4 – Non-preferred		$15 $50	$50 40% ($200 max)
Out-of-Pocket Limits	Level 1&2	$410	$600
	Level 4	$1,000	$1,200
ACA MOOP (Medical & Rx)		$6,600	$6,600
Actuarial Value (UBD)		**92%**	**89%**

Note that for the HDHP, the pharmacy benefits apply after meeting the annual deductible.

Health Plan Negotiations

During the summer 2015 negotiations and renewal process for the 2016 plan year, some program and operational modifications were introduced for the participating health plans. Additional data detail, including billed and allowed charges were required, along with an attestation from each plan's CFO or actuary that the data submitted was complete and accurate. The additional data provided enhanced clarity and transparency to the process.

2016 Savings

Between the plan changes approved by the GIB for 2016, and the improvements in the renewal and negotiation process, the realized savings for 2016 are significant and greater than Segal's initial estimates.

SAVINGS/(COSTS) ESTIMATE
(IN $MILLIONS)

	Original Estimate	After Negotiations
Medical Benefit Changes	$50	$46
Pharmacy Benefit Changes	$8	$8
Health Plan Negotiations (Above Typical 2% Year)	$10	$35
Total Calendar 2016	**$68**	**$89**

Observations and Recommendations for 2017 and Beyond

For this Report 2, we present our comments, observations and recommendations on the following topics:

- **Total Health Management:** This section presents our analysis of the WHIO data to identify the most prevalent diseases, health risks and corresponding gaps in care. The report includes recommendations for a value-based incentive structure that includes incentives for members, vendors and providers in a fashion that is aligned to address care gaps and manage the membership's health risk.

- **Program Structure:** This report section includes an illustrative benefit structure to support the value-based benefit design, and is presented along with a recommendation to improve overall provider discounts and pricing while maintaining access and quality health management. Recommendations are supported by market data and analysis.

- **Pharmacy:** In collaboration with Navitus, we examined opportunities to improve net drug costs by reviewing such strategies as tiered networks, specialty drug management, alternative formularies and value-based benefit designs.

- **Data Management:** In the time since the first report, we facilitated ETF discussions with several of the major data management and warehouse vendors. The report identifies several ETF needs and best practices for effectively managing the program, along with a recommendation for meeting those needs and incorporating as many of those best practices as possible.

- **Market Observations:** This section includes our comments and observations regarding the current marketplace in Wisconsin, along with a comparison with the state plan in Minnesota, whose local and state market is similar to that in Wisconsin.

- **Self-Insurance Analysis:** The report analyzes the financial impact of implementing self-insurance, and discusses the advantages and potential disadvantages of self-insurance.

- **Retiree Coverage:** While retirees essentially pay for the full cost of coverage, resulting in virtually no costs to the State, there exist opportunities to improve the efficiencies of the program to benefit both the State and the retirees. In the time since the first report, we worked with the main vendors in the Medicare Advantage (MA) market to assess the potential financial opportunity for an expanded MA presence in the ETF program.

- **Local Government Plan:** Our report includes commentary on implementing many of our recommendations for the State plan, with a discussion on particular issues and considerations specific to the Local Government Plan.

- **Affordable Care Act (ACA) Update:** Since the initial report, the Internal Revenue Service and U.S. Treasury have issued two calls for comments on various aspects of the 40% Excise Tax that will become effective in 2018. The report updates our earlier report on these developments.

- **Recommendations and Next Steps:** The report provides specific recommendations for ETF and the GIB to consider over the longer term, along with our rationale for making these changes to improve the overall program for the State and its active and retired employees. The report addresses necessary steps to implement recommended changes beginning 2016 as well as to begin discussions and planning for changes beginning as early as 2017.

Throughout this report, Segal presents recommendations for consideration by the GIB for future implementation. We present these recommendations as a set of changes that will result in a positive impact to future plan costs and participant health status with the understanding that they may be discussed and implemented in separate actions over time.

Following the main narrative of the report, Segal also provides a number of Appendices that include detailed data tables not included in the main body of the report, as well as a listing of our data sources and methodology.

Total Health Management

In the first Segal report, we indicated that improvements in the health risk profile of ETF's membership could significantly hold down the escalation of plan costs. We estimated that ETF incurs over $267 million annually in unnecessary and avoidable medical services due to the following risk factors - obesity, smoking, non-adherence to drug regimens, alcohol abuse and non-compliance with treatment protocols. That equates to nearly 19% of annual claims saving opportunities if these five risk factors were eliminated. While ETF is not likely to fully eliminate all of these risk factors, the opportunity to achieve savings of $60 - $80 million annually is very achievable (see Report 1 reference to PriceWaterhouse Coopers study). We recognize this will increase gradually and estimate lower first year savings of $10 – $30 million, between 1% and 3% of plan costs. Note that these savings are cumulative.

Unlike traditional medical management and wellness programs offered on a voluntary basis, Total Health Management uses behavior economics to motivate members to make changes in their health habits. Leveraging incentives (rewards and penalties) to create extrinsic motivators, members must be proactive in addressing basic health issues, participate in the programs or contribute more towards the cost of the health benefits. The research shows that using the appropriate rewards and penalties increases engagement in programs like disease management to at least 70%, while voluntary plans achieve engagement rates of less than 20%. We have seen many plans with incentives. With more people engaged in receiving personal health counseling, there are more who make the necessary changes in their health to lower risk factors and reduce their utilization of medical services. The State of Connecticut increased engagement from less than 20% to over 95% using a reward/penalty THM model. We have seen other programs (Alabama, Tennessee, Kansas, North Carolina) with incentives of $50 per month achieve similar results.

With a concerted effort by ETF to reduce health risk factors, plan costs can be reduced well below the current medical trends, typically shaving 1%-3% off current projected trends. The balance of this section of the report will provide a pathway forward for making a meaningful impact on improving the health of ETF's covered membership, which should help to support the reduction in future cost increases.

Total Health Management: A Model for Reducing Health Risk Factors

As stated in our initial report, Total Health Management (THM) is Segal's population health care management methodology model that combines four major plan management components: Vendor and Plan Management; Data Management and Predictive Modeling; Consumer Directed Plan Features; and Patient Outreach and Intervention. The THM model seeks to improve health outcomes through: the use of aggregated patient claim data; the analysis of that data into a single, actionable record; and the creation of access sources for providers to use the information to improve patient interaction both clinically and financially.

THM as a health management model highlights (Fig. 1) the critical components:

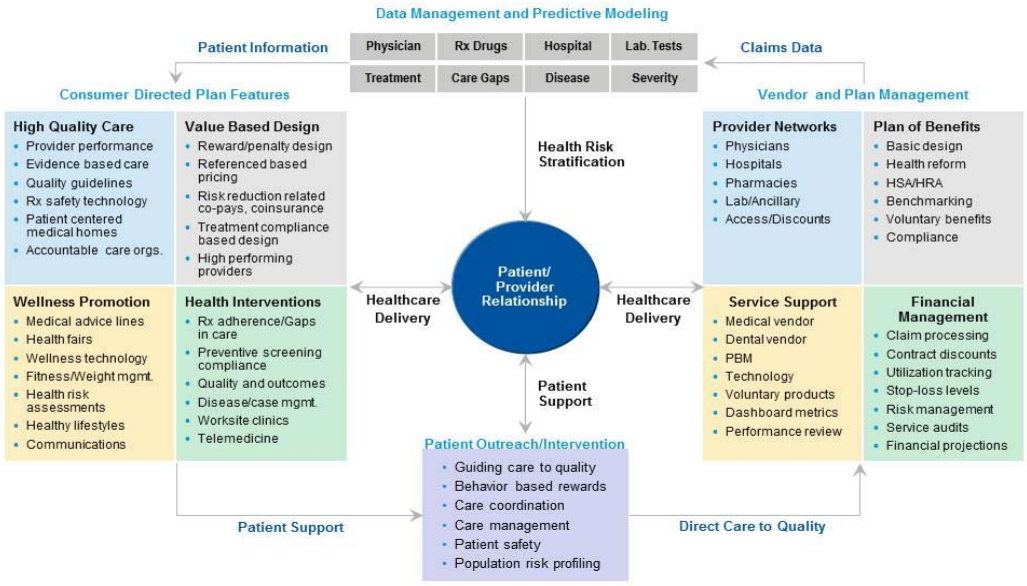
- The coordination of primary care physician access and services;

- A mechanism for patient activation (behavioral changes to improve health through personal responsibility); and

- The coordinated improvement of patient care using wellness, chronic condition management and medical management programs.

The success of a THM model for ETF will be closely aligned with the partnership developed with the operators of the contracted health plans. With a clear vision established by ETF coupled with metrics to measure program improvements linked to the health risk profile of ETF's membership, health plans could be evaluated on key metrics that measure their ability to improve medical outcomes, reduce unnecessary care and produce lower medical utilization.

Figure 1 - **TOTAL HEALTH MANAGEMENT OPERATING MODEL**



A Total Health Management operating model brings together the functions of vendor management, data management, patient directed plan design and patient support. Each aspect is critical to a plan sponsor operating its health care plans in a way that not only effectively manages cost, but assures that the care that is provided to patients is focused on using medical resources efficiently and effectively, while improving the wellbeing of each individual accessing health plan benefits. There have been many studies about the effectiveness of wellness and medical management programs. Each of these studies demonstrates that without a committed plan sponsor, like the state, willing to take responsibility to get those covered by the plans to engage in the programs, the programs will have little impact. It is all about doing what it takes to motivate participation, and not merely making wellness and medical management programs available to members.

Review of Health Plan Performance

As referenced in the first report, ETF needs to contract with health plans that can provide a health care delivery model that supports ETF's efforts to effectively reduce health risk factors in the covered membership. To understand and monitor how the contracted health plans are doing in managing and reducing health risk factors, ETF needs the technology resources to identify patient health risk factors and to analyze and manage coordinated health care through the health plans.

With chronic illness (asthma, diabetes, heart disease, and others) being a primary driver of medical cost for ETF, the data shows that health care delivery of health plans varies significantly. Segal highlighted this in the initial report and pointed out "that there is a significant variance in the quality of health management program, (case management, disease management, and wellness) among the health plans". While the degree of variations may be unclear due to the quality of data currently available, the analysis points towards a significant opportunity for ETF to improve the overall efficiency of care management across all health plans.

What we do know is the following:

- There is a higher than expected prevalence of diabetics.
- Many of the plans were not able to provide basic chronic condition treatment compliance data, while some provided information that was suspect.
- The Health Plans were not able to demonstrate that their medical management programs are having a positive impact on improving the health risk profile of the covered population.
- There is significant opportunity to improve the treatment compliance rates of ETF's covered membership.
- There is a wide variation in the health risk profiles between the covered populations of ETF's health plans.

Because certain medical management programs (e.g. disease management, case management, pre-authorization) are integrated with the medical delivery model of each health plan, there will be some variation in approach. This will require ETF to apply consistent performance metrics to their medical management program to assure that each plan is performing in accordance with ETF objectives.

Ability to Report on Basic Measurements

With clearly defined metrics in place, ETF will be able to monitor performance across a set of common standards and manage the health plans to those standards. The standards will measure improvement in population health that is not impacted by the variations in the specific health risk profile of each plan's current population. Our first report determined that there are plans with serious shortcomings in their risk factor reporting technology. Segal's position would be if the reporting gaps are not remedied, ETF should consider that the health plan is not meeting the established standards in the areas where data is not reported. Continued lack of reporting of this important information should be a factor that weighs into that health plan's contribution tier

rating and that could trigger ETF to consider terminating the plan (or not contracting with them to begin with). Some of the gaps reported in our first report included:

- Six of the plans were not able to provide complete Asthma care compliance information.
- Two plans provided no treatment compliance information related to the diabetes population they covered while four plans provided complete information.
- Three plans provided no treatment compliance information about the covered membership with Coronary Artery Disease, while seven provided complete information.
- Six plans provided no treatment compliance information for the covered population with Congestive Heart Failure, while six provided complete information.

For ETF's Total Health Management strategy to be effective, it will be critical for plans to be able to report these key measures of wellbeing. Cost savings can be realized through improving both treatment compliance and wellbeing (e.g. lab results, biometric measures) related to the specific conditions. The tracking and reporting of health metrics is vital to increasing the success of Total Health Management. If a health plan lacks the ability to track these basic metrics, that plan may lack the ability to be an effective partner for ETF moving forward.

Basic Utilization Reporting

The reduction in unnecessary or avoidable medical care can also be measured. Research shows that when patients are compliant with physician recommended treatment and care, emergency room visits, hospital admissions and ancillary care are reduced. Therefore, ETF will depend on each health plan to be able to report basic metrics on utilization, to measure program impact. In the first report, Segal presented the following findings:

- One of ETF's sponsored plans reported hospital readmission rates of nearly 14%, while the next highest rate was 8%. The health plan with the highest hospital readmission rate also had the second lowest population risk profile reported.
- Seven health plans reported Hospital Admission rates higher than reported for averages in the Midwest, but lower than national average.
- Three plans reported Hospital Days well below the other plans and the average reported for the Midwest. The hospital with the highest risk profile reported the lowest Hospital Days, which indicates effective care coordination.
- Two plans reported Average Length of Stay (ALOS) for hospitals well below the other plans, while four hospitals reported significantly higher ALOS than the plan with the lowest ALOS.
- Emergency room visits in one plan were reported as significantly higher than all of the other plan averages, the Midwest average and national average. That same plan also had very high Ancillary Services utilization.

ETF currently contracts with some health plans that appear to be unable or unwilling to report on basic standards of care management and utilization. These plans will not be able to demonstrate

if their medical care and health management initiatives are having a positive impact on the segment of the ETF population that they cover.

Building Standards to Track Performance Metrics

Prior to building standards for reporting performance metrics, ETF will need to reevaluate the reporting capabilities of every plan. This will result in changes and possibly the termination of some health plan contracts. Once that process is completed, ETF can develop its own customized performance metrics.

It will be necessary for ETF to have a data warehouse in place that can accurately measure each of the key elements. For each plan, there would be a set of baseline metrics established for each of the areas below, with a target to achieve over the next 3-5 years.

- Treatment compliance and medication adherence
- Clinical outcomes and utilization improvement
- Engagement in medical management and wellness programs

Using these metrics, ETF will be able to measure the impact that a specific health plan's medical management programs are having on reducing unnecessary claims, avoidable claims and reducing risk factors in the plan's covered population.

Differentiating between Cost Management and Utilization Management

Cost Management

Vendor and plan management to contain costs has traditionally involved the operational aspects related to addressing:

- **Provider networks:** members access to physicians, hospital, pharmacies, ancillary services, discounts, etc;
- **Design of plans:** co-pays, deductibles, co-insurance, coverage limits, legal compliance, etc;
- **Financial management:** risk management, claim cost projections, medical trend, stop-loss, etc; and
- **Service support:** member services, vendor responsiveness, technology, etc.

For the most part, these are functional components of a health plan that are driven by **price inflation**, the **number of units purchased**, and the **price per unit** that is negotiated.

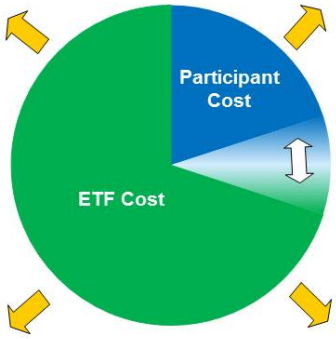
The allocation of these costs are between the plan sponsor and the covered employees through the features of plan design, the member contributions, and the plan sponsor share of the budgeted costs. This is illustrated in Fig. 2 by the divisions in the pie chart. It is more or less a cost accounting process coupled with financial forecasting and risk management. Over time, plan

sponsors have become very efficient at cost management and have driven these costs to a very narrow range of variance.

Figure 2 **- Allocation of ETF Plans Claim Costs**
Balance Cost Management and Utilization Management

Potential Strategies

- **Cost Management:**
  - Change deductibles, copays, coinsurance and employee premium costs
  - Increase network discounts, lower provider fees
  - Eliminate coverage (Shifting 100% of cost to participant); reduce retiree health coverage
  - Negotiate better prices with providers
- **Utilization Management:**
  - Reduce population health risk factors
  - Increase treatment compliance & medication adherence
  - Improve health care coordination
  - Encourage use of quality providers for better outcomes



Successful health care cost management must first identify the health risk factors that drive medical costs and then develop a strategy that addresses each medical cost driver separately.

Utilization Management

Unlike cost management, the factors that drive utilization of medical services involve very complex relationships:

- **The consumer:** age, gender, health risk profile, the state of their health, life-style, treatment compliance, etc; and

- **The health care system:** quality & outcomes variations, poor care coordination, site of care options, evidenced based guidelines, etc.

Utilization of medical services is the portion of medical trend that measures the growth in or expansion of the consumption of medical services. The increasing rate of utilization of medical services adds more to the overall health care costs than does unit cost increases of health care services. This is caused by the aging population, advances in technology, and greater use of diagnostic tools used prior to treatment. This is illustrated in Fig. 2 above by the increase in size of the pie chart.

Utilization management faces the challenge of a very disjointed health care delivery system that is not well coordinated and functions more like a "cottage industry" in terms of integration of services. While efforts have been made over the years to address the shortcoming of the US healthcare delivery system, the system is still very much focused on providing service to people who are sick and not as focused on keeping people healthy.

Plan sponsors like ETF tend to focus very little time and effort on utilization management, even though utilization is a primary driver of cost. The consumer typically accesses care very inefficiently and takes very little responsibility or accountability for the level or number of

services provided. This pattern leaves plan sponsors hoping that their contracted health plans will take responsibility for the proper application of utilization management. That rarely happens unless the health plan is monitored closely.

More recently, population health models like Total Health Management have begun to have an impact on utilization management and plan sponsors are employing behavioral economics, value based plan design, integrated care delivery and other means to more efficiently manage medical care utilization, improve care delivery, improve care quality and slow medical trend. In the next section, we discuss how this can be done.

Overall Strategy and Design

It is clear that any improvements in the health risk profile of ETF's population should help reduce program cost inflation. Our review indicates that there is a wide variation in health plan performance related to patient utilization and coordination of care. ETF has conducted various meetings and seminars with the contracted health plans and have adopted five areas of focus that are part of contract and reporting requirements for the plans. Moving forward it will be important to include a strategic focus on each health plan's ability to improve the health of ETF's covered population under their control. This is best measured using set reporting metrics that measure reductions in health risk factors, show closures in gaps in care, and measure an improvement in the aggregate risk profile.

Any strategy must include the following:

- **Employer Communication and Support:** ETF will need to develop a comprehensive communications package that addresses the new plan initiatives and why they are necessary. Member communication will help to reduce the amount of questions within the employee population. Additionally, the State will need a top-down support structure backing these initiatives.

- **Patient Engagement:** The health plan must be able to work with physicians to deliver appropriate, evidence based care that addresses care gaps even when patients do not come into a physician's office.

- **Patient Behavior:** ETF must create a plan design that motivates employees to take personal responsibility for their health and supports that motivation through appropriate incentives. These design elements will need to be mechanisms that will engage employees in ongoing wellness and medical management activities.

- **Team Based Intervention:** Effective primary care is at the heart of total health management to ensure that patients receive appropriate and coordinated care. In the ideal structure, primary care physicians work with other clinicians in integrated teams to focus the level of needed care. These teams may include mid-level practitioners, nurses, medical assistants, care managers and specialists.

- **Measuring Outcomes:** Health plans must provide comprehensive data that can be used to measure results across each of the factors identified in the strategy. Well-designed tools for

predictive modeling and data analysis are critical to measure treatment compliance, health outcomes, health status, disease severity and patient engagement.

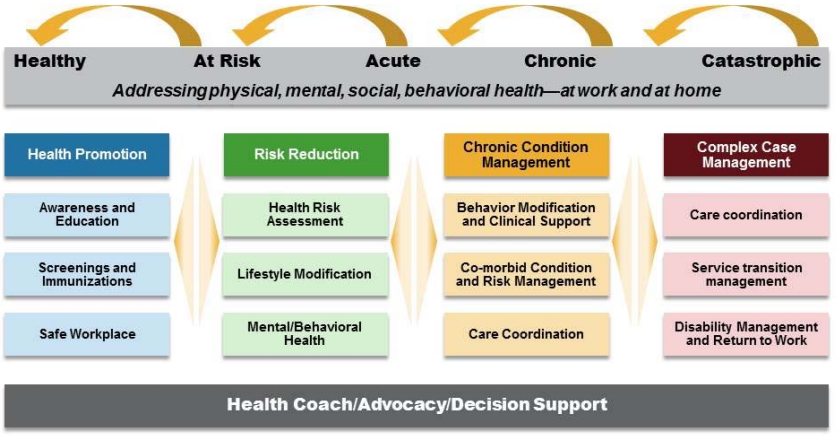
Each of these is a critical component of ETF's strategy going forward. For some of the support required to drive the health improvement initiative, ETF will need to rely on the health plans and their direct services and reporting. ETF will also need to require cooperation between vendors.

To properly manage the health of ETF's membership, health plans will need to have internal systems that allow for the aggregation of member health data (e.g. electronic medical record capabilities). This provides the needed source of patient information for the treating physicians to support the patient/physician relationship and facilitate high quality/efficient patient care.

Medical Management Integration

Segal recommends that medical management services—complex case management, chronic condition management, pre-authorization, and care coordination - be provided through each health plan. Since medical management requires the evaluation of a medical condition, developing and implementing a plan of care, coordinating medical resources, communicating health care needs to patients and promoting cost effective care, we believe that those objectives are best accomplished when integrated. In addition, these services should only be provided to active employees and pre-Medicare retirees, where ETF is the primary insurer.

Figure #3 – **Health Management Across the Spectrum**
Use data to determine programs and services mix



Medical care of patients with acute, chronic and catastrophic treatment needs is identified in the diagnosis that results from episodes of care tracked in each health plan's claims management system. By analyzing the patient claims, each health plan assesses health risk – acute, chronic or catastrophic – triggering the appropriate level of outreach. With medical management services integrated with the health plans, response times to patients needing chronic condition management support or case management is expedited.

Medical management initiatives – case management, disease management, discharge planning, pre-authorization – focus on the needs of those members whose health risks are categorized as – acute, chronic and catastrophic through claims data analysis. On the other hand, wellness and health promotion initiatives – tobacco cessation, weight management, health education – focus

on the needs of those members categorized as healthy or at-risk through direct contact with individuals, where claims data is not sufficient to categorize the individual's health risk. These types of encounters occur during a member's participation in a health risk assessment or some type of wellness coaching session. Coordination of information and referrals between a medical management vendor and a wellness vendor is very useful in leveraging the value of their work to support patient care and patient education. This can be accomplished in a variety of ways – cross referrals, data sharing, and soft transfers during member encounters with a medical management personal health counselor or a wellness coach. In any event, it will be important to have the medical management and wellness vendors working cooperatively and sharing information resources to produce the best outcome for ETF and the members.

Using Data Analytics to Motivate Healthy Behavior

Each participant in an ETF health plan can be categorized in one of five major risk levels – healthy, at risk, acute, chronic, or catastrophic. The data is not used by ETF in any way, but rather is made available by each health plan to network providers to enhance the patient/physician relationship. With that information available, each health plan is able to populate patient health records and make that information available to physicians. With more specific patient information, the provider of care can more effectively treat the specific needs of each individual patient.

The challenge all plan sponsors face is getting individuals to engage in programs designed to support or to improve their health. Since chronic illness is a major source of cost to ETF, incentives will need to be in place for individuals to engage in medical management programs. Plan sponsors in the public sector are turning to value based plan design to motivate engagement in medical management programs. A growing body of evidence supports the notion that people need to be motivated by both extrinsic and intrinsic factors in order to improve their health. This has led many public sector sponsors to include rewards and penalties in their plan design to encourage change of unhealthy behaviors that result in unnecessary and avoidable health care costs. Some of the prominent states that have adopted effective behavior changing plan designs include:

- Alabama
- Connecticut
- Georgia
- Indiana
- Kansas
- Kentucky
- Maryland
- Missouri
- Nebraska
- North Carolina
- Tennessee
- West Virginia

Those states utilizing incentive-based models to motivate positive reductions in health risk factors are seeing progress in reducing waste in health care spending and improvements in the health of the covered population.

Improving treatment compliance of people with chronic conditions should be a high priority for ETF. A plan design should motivate individuals with chronic conditions to engage in a chronic condition management program. While there are a variety of approaches for applying rewards and penalties to motivate program engagement, the two approaches outlined below are quite common, though the dollar amounts used may vary among plan sponsors.

Approach 1: Plan Design Incentives & Premium (Variety of States)

For individuals identified as eligible for disease management

- If they engage in the disease management program they receive co-pays for their condition-related medication that are $5 to $10 less than normal copays. This logic can also be applied for co-pays paid to managing physician.

- If they do not engage in the disease management program, they pay a higher monthly premium contribution ($50-$100).

Approach 2: Plan Design Penalty & Premiums (Connecticut)

For the Connecticut Health Enhancement Plan employees are required to complete three or four healthy activities – wellness exam, early diagnostic screening(s), annual dental cleaning and (for those with a chronic condition) participation in a disease education and counseling program

- If they complete the activities they receive a reduction in their deductible (50% reduction or waived).

- If they do not complete the activities their deductible is increased (100% increase, non-compliance results in double the original deductible) and premium contributions are increased by $100 per month.

These are just a couple of examples to demonstrate how simple designs can be effective. We believe a design incorporating elements in Approach 1 may be the best fit for ETF, but would need to be worked out after going through the strategic planning process for ETF's THM plan design.

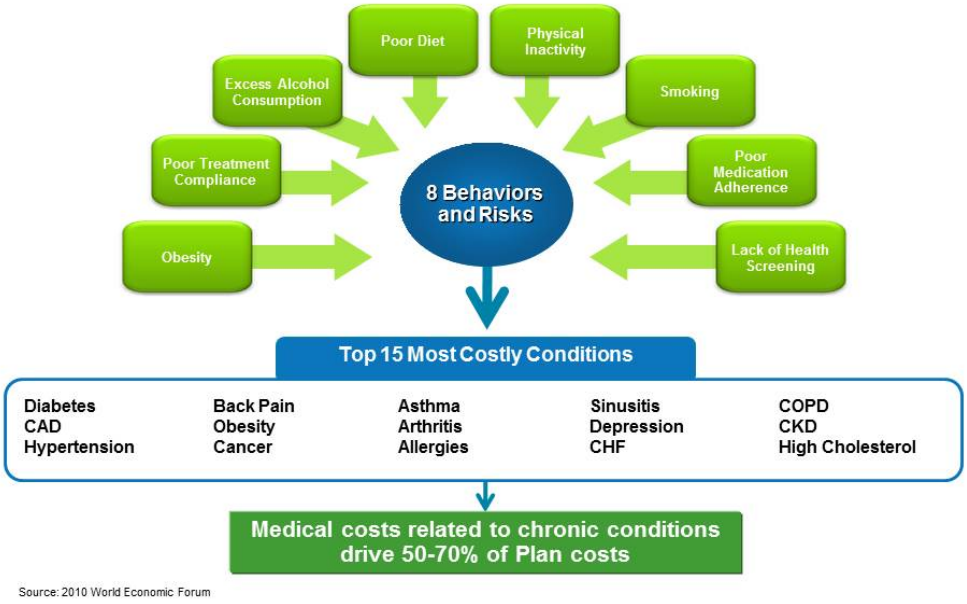
Using a sufficient penalty/reward approach should push engagement in disease management programs to 60%-70% of those eligible. We have recently seen premium-based incentives get participation as high as 90% in Alabama and 95% in Connecticut. This is supported by a 2014 RAND study that showed employers using no incentives reported lower participation, only 20% on average; while those using rewards experienced participation rates on average of 40% and those using penalties experienced participation rates of 73%.With people engaged in a medical management program like disease management, ETF will be in a positon to monitor how effective each health plan is at improving the health of those engaged.

Some of the metrics that should be monitored from a clinical perspective for those with chronic conditions include:

- Reduced use of the E/R
- Lower hospital readmission rates
- Lower hospital admission rates
- Lower Average Length of Stay (ALOS) in hospital
- Reduced use of ancillary services

Figure 4 below identifies the key behaviors we are trying to alter from an incentive based design. All have an impact on the chronic disease prevalence and cost.

Figure 4 – **Identifying the Health Risk Factors Driving Cost**
Behaviors That Can Be Altered



Using behavior based plan design and effective medical management, ETF and its health plans should be successful in modifying the unhealthy behaviors that contribute to unnecessary and avoidable medical care costs. According to the CDC Chronic Disease Prevention and Health Promotion Reports, "*As of 2012, about half of all adults—117 million people—had one or more chronic health conditions. One of four adults had two or more chronic health conditions*" and "*86% percent of all 2010 health care spending was for people with one or more chronic medical conditions*". Using the WHIO data Segal was able to identity that 64% of ETF members had a chronic condition and chronic conditions represented 90% of claims (based on WHIO defined charges). So ETF is slightly higher than the CDC statistics but reasonably consistent. As such, behavior modification resulting in lowering health risk factors of members with chronic conditions, can deliver substantial savings and trend mitigation.

Another way to get the health plans to take an active role in the management of population health is through shared savings arrangements based on plan performance. Health plans are rewarded/penalized based on their success in meeting established performance metrics. Each plan would be tracked and measured on the success of their utilization management programs for ETF participants. This type of arrangement could also encourage health plans to take a more active role in managing the health risk for all of their enrolled population.

Appendix 1 provides an example of the data metrics that ETF may want to track and measure. When the metrics are implemented, a baseline will be created, and then target levels will be set for each component measurement. Health plans can be awarded points on the success of their utilization management programs by measuring the actual result of the improvement on the baseline. This is discussed in more detail in the Gain Sharing model reviewed in the **Self-Insurance** section of the report.

Wellness and Health Promotion

Segal recommends that wellness and health promotion services – health education, nutrition counseling, coaching, tobacco cessation, and weight management – be carved out of the health plans and offered as a single comprehensive program through a single vendor. Unlike medical management programs, like disease management, the health needs serviced by wellness and health promotion vendors are rarely identifiable through claims data, but rather relate to life-style choices. Wellness programs are less associated with the day-to-day care of an individual and more involved in the dynamic process of improving the state of a person's health physically, socially, and mentally. While the goals of wellness and health promotion are similar, there is enough variation in the approach and the models used that ETF would be best served by having a single wellness vendor managing all of the wellness services. This will enable one consistent message and strategy for your entire population.

We recognize similar options have been considered by the GIB in the past and there was some concern about implementing a strategy that could be limited by the, then new, ACA regulations, or possibly required to be revised or limited by other legislation. The strategies recommended in this report are well within the requirements of the ACA, HIPAA and other related guidelines, including the recently proposed regulations by the Equal Employment Opportunity Commission (EEOC).

Offering Wellness services to employees provides a plan sponsor like ETF the opportunity to build a culture focused on good health. Like medical management programs, getting the covered membership to engage and actively participate is key. A starting list of wellness services includes:

- Health risk assessment
- Lifestyle management and coaching
- Tobacco cessation
- Biometrics screening
- Weight management
- Health Advisor calls
- Goal tracking

Segal recommends that the design of wellness programs should be incentive based, using a design that applies the incentives using a common design or a separate points based model applied to the wellness program.

During the first year, the focus should be on disease management, by identifying risk factors and providing the necessary tools so that employees properly manage their health risks. To support that focus, ETF should require all employees to complete a health risk assessment and also complete basic biometric screening for LDL, HDL, triglycerides, blood pressure, and body mass. In addition, ETF should consider if tobacco use in the population is a pressing enough problem to be addressed in the first year. If it is, most public sector organization are adding tobacco premium surcharges ($40-$50/month) for tobacco users who decline participation in a tobacco cessation program. Other wellness services – weight management, nutrition assistance, health coaching, others - should be incorporated into the Total Health Management plan over time.

The goal is to create program incentives that maximize participation in wellness activities. The most common approaches for an incentive-based wellness plan design follow one of two models:

- ***Wellness incentive integrated with medical management plan (Maryland)***

  Individuals are given a list of activities that must be completed during the plan year to avoid a penalty or to gain program incentives. Participants identified for Disease Management must complete additional activities, failure to complete those activities results in higher participant premiums. Those that are identified as tobacco users must participate in a Tobacco Cessation Program. Please see **Appendix 2** for an example of required program activities.

- ***Wellness incentive is determined by a points based program (Kansas)***

  Individuals are offered a list of wellness activities to choose from, and must complete a minimum number each year to gain points for a plan reward or credit. This allows a tremendous amount of flexibility in plan design. An example of this option can be found in **Appendix 3**.

The Kansas wellness design was cited favorably in a Duke University's Sanford School of Public Policy Study in 2015. The type of wellness design should be determined based on the life-style issues prevalent in ETF's population. For example, if tobacco use is relatively low but obesity rates are high, then the wellness program would likely focus more on weight related life-style awareness. The wellness program should provide an avenue for employees to get the education and support needed to make the right life-style choices. The program should be dynamic and change over time as the needs of ETF's population change and as progress is made in the targeted areas.

Given the culture in Wisconsin, we believe a point-based system would provide the best likelihood of success. This will allow ETF to have a number of targeted programs and can evolve over time.

Measuring Wellness Program Success

As with the medical management components of the Total Health Management program, ETF would set metrics for measuring the success of the wellness services. Of particular interest would be the clinical measures that are indicators of health improvements such as –

- # of people with blood pressures less than 120/80
- # of people with cholesterol total less than 200
- # of people who have achieved a healthy/appropriate BMI
- # of people who have quit smoking
- # of people who completed preventive screening exams
- # of people who have completed a weight management program

We recommend that when ETF establishes metrics, the first year used as a baseline measure from which progress can be tracked. Once the baseline is set, subsequent years are then used to measure progress against the baseline metric.

Expanding Healthcare Access

Access to healthcare is ever more challenging for families where time is limited and working parents are pressed with increasing job demands. As plan sponsors look for ways to provide easier access to medical care, two medical delivery approaches are emerging – telemedicine and worksite clinics. This section provides ETF with some background on each one as it considers its health plan design in the future.

Telemedicine

With rapid advances in telecommunication and smartphone technology, the doctor-patient encounter does not need to happen in person anymore. It is rapidly being enhanced and even replaced by what is called "Telemedicine". At this time, we think that it is premature for ETF to be considering selecting a single telemedicine vendor, but it would be important for ETF to encourage its health plans to incorporate this type of technology to improve member access to medical care. Patients can now connect directly with a doctor from home or other suitable venue using a web cam, and the provider can offer:

- a basic diagnosis
- a referral
- a prescription

Research shows tremendous potential for new models such as telemedicine to emerge and grow in the near future. The global telemedicine market likely to increase to about $4.5 billion by 2018 from about $440 million in 2013, according to a 2014 study from IHS Inc. About three-quarters of large employers plan to offer telemedicine services to their workers next year, up from about half in 2015, according to a National Business Group on Health survey.

The concept is still evolving, but has some appeal to doctors and patients, especially in remote communities where doctors and patients have long distances to cover for short in-person visits. Telemedicine is also becoming very popular with individuals who do not have the time to leave work and get to a face-to-face appointment during regular working hours. For ailments that fit the limitations of telemedicine, they can tap into medical services at any time of the day.

Why Telemedicine

- Adoption will increase as the healthcare model realigns under healthcare reform, where:
  - Payment is value-driven, not volume-driven,
  - Providers (hospitals, physicians, and ancillary caregivers) are paid for results
  - The venue does not matter (for example, where no sophisticated medical testing machinery or x-rays are required)

- Quality is measured and payments made for meeting targets
- There are incentives for preventive care—for keeping participants healthy

- Telemedicine can help meet the increased care demands of an aging population
- Telemedicine offers an approach to overcome provider shortages
- In most cases there is no wait time and almost instant service, which can lead to enhanced patient satisfaction
- Depending on how the program is structured, telemedicine encounter and cost information can be fed back to the employer's primary health benefit plan for payment or simply to capture the utilization information for a data warehouse.

Telemedicine providers can typically diagnose and support the following types of conditions, and can submit prescriptions electronically or by call-in at a nearby pharmacy, if needed:

- Sinus, ear and eye infections
- Cold, cough and flu
- Allergies
- Acne
- Burn and sunburn
- Insect bite
- Urinary tract infection
- Upper respiratory tract infection
- Headaches
- Bronchitis
- Stomach-ache

New innovations in Telemedicine services are also supporting services such as Behavioral Health, EAP, and Dermatology.

Developing the Right Standards

Segal suggests integrating Telemedicine with each of the health plans, assuming each vendor meets ETF defined best practices. Below are some discussion points when developing standards for a telemedicine program:

- Are the physicians in the Telemedicine offering required to complete a credentialing process?
- Is the process of reaching an actual doctor (not a nurse or nurse-practitioner) simple, convenient and fast? ETF should avoid programs that promise that a caller will get a call back "within a few hours".
- Can the doctor write a prescription when appropriate?
- Are their communication channels, information sharing and technology HIPAA compliant?
- Does the program offer a complete survey of the patient's pertinent medical information upon enrollment and forward the information from each call to the employee's PCP?

- Can the program provide full data transfers to the employer's primary health plan or to a data warehouse?

- Does the program have a history of proven success working with employees and helping employers save money?

Working with the insurers, ETF will develop standards that align with the telemedicine services available in the market (that ensure convenience and safety for members). While Telemedicine can provide an additional access point at a low cost point, ETF will need to monitor the utilization to ensure that members are receiving accurate diagnoses, the health plans have the proper technological systems in place, and that members understand when it is appropriate to access Telemedicine and when an in-person evaluation is needed.

Benefits to Employees

Telemedicine provides a subscriber with quick access to a doctor over the phone, email or video call. Unlike a doctor's office, urgent care center, or emergency room, there is no waiting for an appointment in a room full of other sick people. Even if there is a wait during a peak period, the technology usually provides an estimated wait time and offers the opportunity to leave a number and have the doctor call back when you reach the top of the queue.

Telemedicine has been found to be an efficient route to care—97% of patients are treated in their first dial-in attempt with an average response time of eight minutes, according to Teladoc, one of the major telemedicine network providers. When appropriate, the consulting doctor can prescribe a medication and send the prescription to the member's preferred pharmacy.

This program can often eliminate time-consuming visits to a primary care doctor, urgent care center, or emergency room, along with the higher costs associated with those visits. With the right partner in place, we believe ETF should begin to integrate Telemedicine services into your benefit structure and that members should be provided financial incentives to use the program, such as a copayment of $5 to $10 below the PCP level. The final amount will depend on the financial arrangements with the vendor to ensure a win/win for ETF.

Onsite Clinics

With plan sponsors facing persistent growth in health care spending, demand for workplace health clinics has increased. Historically, many manufacturing facilities or plants have had occupational health clinics located in the plant facility. Those clinics usually provide services related directly to the workplace, but some do provide broader services for routine or acute illnesses. While we do not advocate building onsite clinic at this time, at some point we think that ETF should assess the availability of state run medical facilities and explore if there may be some opportunity to leverage those facilities for the ETF covered population. They would never become a substitute for the services offered through the health plan. Most common would be to be the location for a biometric screening program.

The use of onsite clinics is also growing among non-manufacturing employers. About 25% of Fortune 1000 Companies now have some type of onsite clinic capability—occupational or non-occupational. The current trend is to include more primary care in conjunction with health promotion and wellness services, rather than merely occupational health or convenience care.

Indeed, the Affordable Care Act has increased the interest level in onsite clinics that can provide workplace wellness programs.

In general, public sector employers have been lagging the market and very few states have implemented a comprehensive clinic program. The ones who have are typically running a more comprehensive medical management program and using the onsite clinics as a delivery site.

By far the strongest motivation for implementing workplace clinics is to contain direct medical costs. Onsite clinics generate savings from:

- Utilization savings—patient compliance and program participation, over time, leads to decreased:
  - Specialist referrals and visits
  - Discretionary ER visits
  - Inpatient hospitalizations—due to increased compliance with medications and treatment
  - Pharmacy costs (Longer term, through generic and over the counter drugs, and appropriate prescribing.)
- Increased medication compliance
- Improved compliance with preventive screenings
- Increased compliance with evidence-based medicine
- Increased participation in disease management programs
- Increased participation in wellness/health promotion/health coaching programs
- Savings from steerage to high-quality/ high-efficiency health care professionals and facilities

Major features of onsite clinics

- The onsite clinic is typically located on a primary worksite campus or at the "fenceline" surrounding that work location.
- The clinic usually requires a footprint of about 1,000 square feet to start with a minimum group size of about 600 centrally located members. For larger groups, larger, or additional locations are generally utilized.
- Primary care is delivered by a combination of contracted or employed physicians, nurse practitioners, and/or Physicians Assistants. Primary care often includes:
  - Office visits
  - Acute care—ranging from low-acuity episodic care, such as sore throats or sprains, to treatment of more severe symptoms requiring urgent attention, such as exacerbations of chronic conditions
  - Preventive care—physical exams, immunizations and screenings

- Wellness—health risk assessment follow up, biometric screenings, health coaching, lifestyle management programs and educational programs
- Disease management—ongoing care for and management of chronic conditions
- Basic laboratory and radiology
- Physical therapy (customizable)
- Pharmacy—generic drug dispensing
- Often treat members not covered by medical plan for a small fee
- Occupational health—treatment of work-related injuries, employment physicals and screenings, travel medicine, and compliance with federal workplace safety regulations

Clinic can become a "Patient Centered Medical Home"

Beyond a convenient onsite location, workplace clinics aim to transform primary care delivery in several key ways. In contrast to most community-based primary care, the typical workplace clinic model offers much shorter wait times and much longer clinician-patient encounters, resulting in a "trusted clinician" primary care model.

When patients need referrals to specialists or other providers not available within the clinic, referral processes and networks can limit referrals to "high-performance networks".

The clinics need approximately 600 centrally located eligible members to break-even, and about 2,500 eligible members to achieve maximum economies of scale. Ideally, membership should be located at least within a 20-mile radius.

The economics of sponsoring an onsite clinic are also highly sensitive to the local price and ease of access for primary care doctors and specialists. The largest cost for an onsite clinic is staffing.

Benefits to Employees

A majority of employers sponsoring onsite clinics seek to supplement rather than replace community-based care, and they offer a wide variety of cost-sharing arrangements for clinic visits. Many employers waive deductibles or copayments altogether—an approach endorsed by many clinic vendors because it provides a strong incentive to use the clinic. Some employers also provide generic medications free if the prescription is filled through the clinic.

While we do not see the use of Onsite Clinic as the highest priority at this time, there is an opportunity to assess the availability of clinical resources currently in use by the state that at a future time, could be used as an access point for members. This could be to participate in a biometric screening program or be a venue for community health education such as tobacco cessation or nutrition education, for example. Before constructing an onsite clinic, a feasibility study should be undertaken to make sure an appropriate ROI could be achieved for the program.

ACA Considerations

Addition of an onsite clinic would likely add another medical plan to be tracked for purposes of the ACA 40% Excise Tax that becomes effective in 2018. The cost of any onsite clinic program

that provides more than nominal services must be included in determining the value of the plan relative to the statutory thresholds. While an onsite clinic would be expected to help contain or lower overall medical costs in the long run (which would help avoid Excise Tax), there may be net additional costs in the first few years until the clinic's impact begins to show up, which would increase the Excise Tax exposure.

The IRS has not yet provided guidance on how the cost for an onsite clinic must be calculated and allocated to participants. These potential tax implications should be factored into the overall decision to proceed.

Summary of Recommendations

This section of the report provides a framework for developing an ETF Total Health Management strategy. We have suggested ideas and recommendations for the structure of a plan design and the types of reporting needed to operate a successful plan. Assuming that ETF decides to move in the direction of implementing a THM strategy, we would recommend the following:

1. **Medical Management**
    - Allow each plan to administer the medical management component. This would include complex case management, disease management, prior-authorization and care coordination.
    - Assess the capabilities of the health plans individually to determine their ability to support the strategy through medical management, data analysis, data reporting, applying the needed technology, and driving market change. Make this requirement mandatory and only include the higher performing plans.
    - Define the specific metrics necessary to monitor the health plans' effectiveness at medical management and programs designed to improve population health, reduce health risk factors and close gaps care. Put in place performance guarantees that place 20-25% of fees at risk.
    - Have value-based designs for those participants that engage with the medical management program, such as a $5 or $10 reduction for office visit copayments to applicable physician and a $5 or $10 reduction on pharmacy maintenance medications related to those particular diagnoses. Final details would be determined as final decisions are made regarding the program structure.
2. **Wellness and Health Promotion**
    - Carve-out and place wellness and health promotion with a single vendor. The vendor should be best in class and be able to provide health risk assessments, biometric collection, lifestyle coaching, education, etc.
    - Institute a premium based incentive of $50 per month for completion of designated wellness and health promotion activities. This would apply to both an employee and spouse, as well as non-Medicare retirees.

- A point-based system, similar to one utilized by Kansas, is desirable. Various programs within this design would have value-based incentives for participation. The initial requirement should be relatively modest at the outset, ramping up over a few years.

3. **Data Analytics**
   - Collect the data and engage the technology necessary to perform data analysis and health risk modeling of the covered population.
   - Put in place a data management strategy to allow ETF to better manage the financial outcomes and progress of the program. See the Data Management section for a more extensive recommendation.

4. **Telemedicine**
   - Working with the insurers, ETF will develop standards that align with the telemedicine services available in the market (that ensure convenience and safety for members).

5. **On-Site Clinic**
   - Assess the potential location of on-site clinics that could provide reasonable return for ETF. It is likely that ETF could partner with a number of systems to meet this requirement.
   - Integrate clinics into the overall wellness strategy. Reduced copayments and credits toward meeting the annual wellness goals provide good incentives and should result in desired volume.
   - ETF would want to collect data at clinics and integrate with the plans.

Financial Impact of THM

When measuring or evaluating the financial impact of a THM program our experience shows that the program itself produces no measurable financial impact unless a number of conditions are met:

- **Condition 1:** Medical management and wellness programs produce a return on investment (ROI) when designed to target known health risk factors in a covered population. With knowledge about the characteristics of participants, a program can be designed to fit the population's needs.

- **Condition 2:** If those covered by the plan do not participate in a wellness program or make needed lifestyle changes, the program ROI will be negative.

- **Condition 3:** All plan design barriers must be removed and the design of the program aligned with the objective to facilitate participation and reduce targeted health risk factors.

- **Condition 4:** Any program offered on a casual basis without the appropriate design or incentives to reduce health risk factors will fail.

- **Condition 5:** If the leaders of the organization sponsoring the program are not 100% committed to its success, the program's financial impact will be minimal.

With the above conditions assumed met, the financial impact of fully implementing a THM model can affect three major categories of cost: those related to Behaviors of covered members (e.g. treatment compliance, medication adherence, healthy life styles); those related to Administrative complexity of the US healthcare delivery system (e.g. billing, collections, credentialing, oversight, system fragmentation); and those related to Clinical effectiveness (e.g. better preventive care, replacing services with less resource intensive alternatives, variations in practices and standards of care). In total, these three areas offer the opportunity to reduce health care expenditures in the US by 35-40%, over $1.0 trillion.

The initial focus by ETF should be on chronic conditions where changes in behavior can materially affect the health of patients with these conditions, or even prevent members from developing the conditions. These would be the focus of medical management and wellness initiatives, which proactively address the prevalent health risk factors in the covered population. Of principal importance is an intensive effort to reduce the high incidence to chronic illness with its epidemic challenges of motivating patients to comply with treatment and medication protocols related to their conditions.

We discussed earlier in this section that breakdowns in care management are estimated to be costing ETF $267 million in unnecessary and avoidable medical services. Implementing value based incentives to motivate members to engage in medical management and wellness programs should be able to ultimately eliminate at least $60-$80 million of annual unnecessary medical expenses. We recognize this will increase gradually and estimate lower first year savings of $10 – $30 million, between 1% and 3% of plan costs. Note that these savings are cumulative.

Financial impact begins with improving engagement in medical management and wellness initiatives. We know that engagement in ETF's wellness program in 2014 was 12.9% and is projected to be at the 17% level in 2015. For programs to have an impact on population health, the engagement needs to be at least 50% and preferably 70% and higher. With covered members participating actively in medical management and wellness programs, the health plans can be held accountable for managing the care and treatment of those engaged. The role that ETF must play is to create the extrinsic motivators, using tools such as plan design, to get members to engage in the wellness and medical management programs. Once engaged in the programs, it is the job of the wellness or medical management vendors to work with the members to create the intrinsic motivators to take responsibility for their personal wellbeing.

While ETF is in a position to influence the marketplace that delivers care, the opportunities to drive change will likely involve more complexity and will need to be addressed through the State working cooperatively with the healthcare industry and those organizations that support the delivery of care in the state of Wisconsin. At this point in the development of the THM model, these opportunities will require a much longer lead-time and have to be discussed with many stakeholders within the state, many not part of ETF.

Possible Timing

The recommendations in this section can be implemented independently of most other sections of this report. Given broader changes recommended for 2018, much of the above could be implemented for the 2017 plan year. To get these in place, there will need to be changes to the current plan contracts, and number of possible procurements should be initiated. It could be

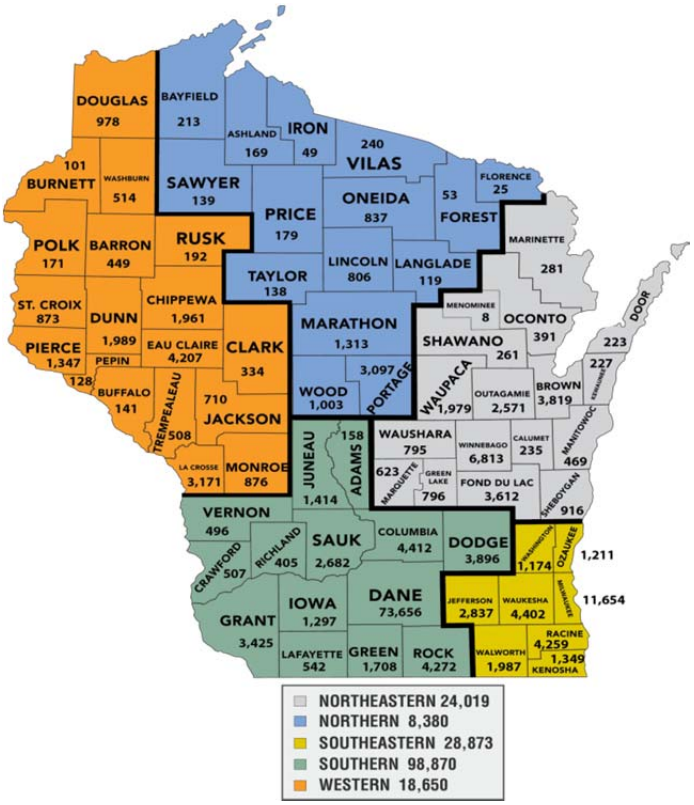
beneficial to stagger implementation and allow ETF to focus solely on rolling out a comprehensive initiative for 2018.

ETF may also choose to phase in the Total Health Management components, for example implementing wellness related features in 2017 and then implementing medical management in conjunction with broader recommendations in 2018.

Program Structure

Review of Current Health Plans

ETF currently works with 17 different health plans throughout the state. All the health plans bid on a self-identified defined service area. Using the current Medicaid regional map, we have completed a detailed analysis of how the Medicaid regions overlap with the current ETF health plan operations. Below is a summary of the non-Medicare membership in the state, as well as the regional structure. We recognize that the plans also have Medicare Retiree and Local plan membership that was not included in any figures in this section. Both of these groups are discussed in later sections, "Retiree Coverage" and "Local Government Plan", of this report.



As indicated in the chart above, we reviewed how the plans fit the five Medicaid regions:

- Northern
- Northeastern
- Southeastern
- Southern
- Western

The Southern Region, which includes Dane County, is the largest region, with nearly 100,000 ETF members. The Northeastern and Southeastern regions are of similar size and combined represent about 53,000 ETF members. These three regions have some of the State's most

populous counties. The Northern and Western regions are smaller in population and more rural, having 27,000 ETF lives combined.

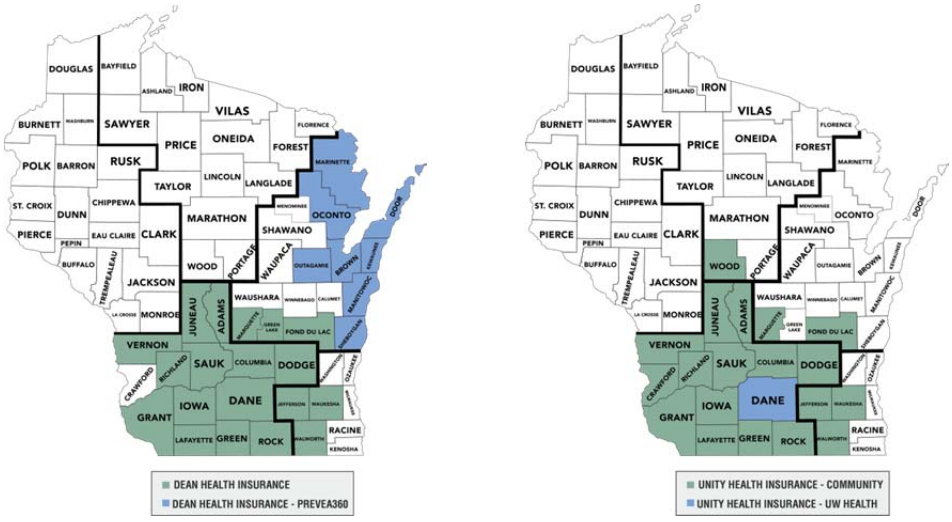
Currently, some ETF health plans fit nicely, having self-defined service areas within a region. Others tend to overlap regions, at least for their current ETF population. Below is a brief summary of ETF plan membership by Medicaid region:

Plan	Northeastern	Northern	Southeastern	Southern	Western	Statewide
Anthem	388	2	2,877	65	2	3,334
Arise	1,586	156	22	4	1	1,769
Dean Prevea	1,427	37	2,818	35,573	43	39,898
Gunderson Health	4	1	—	1,281	2,958	4,244
Health Tradition	3	—	—	749	1,964	2,716
HealthPartners	1	55	4	2	1,783	1,845
Humana	807	4	8,988	112	727	10,638
GHC EC	1	227	—	—	685	913
GHC SCW	25	10	107	9,632	7	9,781
Medical Association	—	—	—	1,066	—	1,066
MercyCare	—	—	402	739	—	1,141
Network Health	8,615	23	20	243	5	8,906
Physician Plus	95	12	151	10,730	8	10,996
Security Health	221	6,209	7	87	1,496	8,020
UHC	5,761	41	4,264	92	—	10,158
Unity	182	23	781	37,571	28	38,585
WEA Trust	4,903	1,580	8,432	924	8,943	24,782
Total	**24,019**	**8,380**	**28,873**	**98,870**	**18,650**	**178,792**

From the table above it is easy to see where plans primarily operate for ETF. This is not to say the plans don't have broader service areas, however, the table captures the areas upon which the plans had bid and been qualified in for ETF.

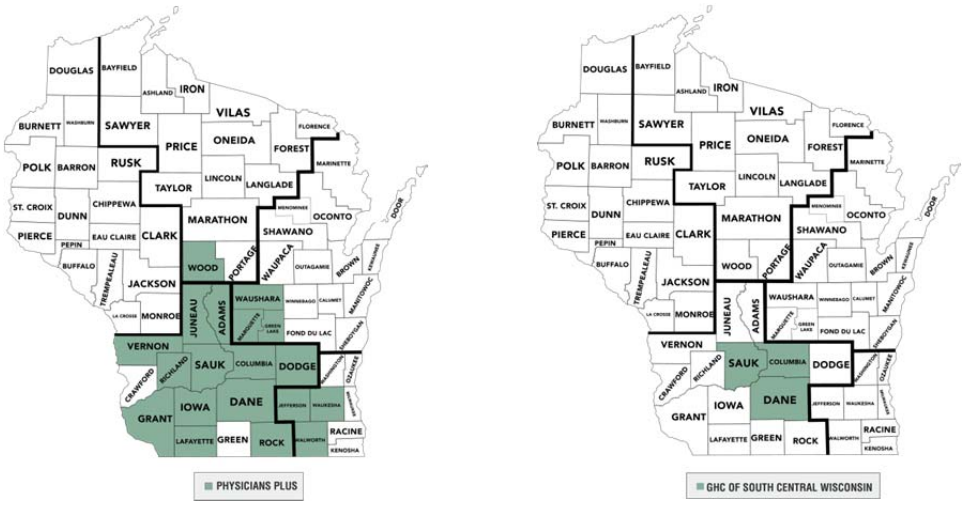
Southern Region

This is the largest region and houses two of the largest plans – Dean Health and Unity. Dean Health has over 35,000 members, while Unity has over 37,000 members. The two combined have 74% of the membership in the Southern region. Dean Health also has membership in the Eastern region through Dean Prevea360, while Unity covers most of region through Unity Community.



By membership alone, it would be difficult to see this region without their representation. That said, there are substantial financial differences between them. The capitation arrangement by Unity needs to be further investigated by ETF since the majority of their premium is based on capitated claims.

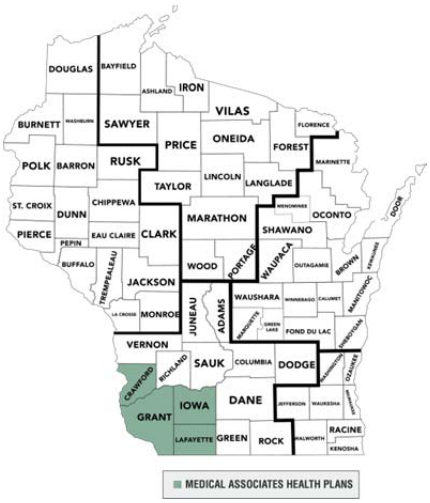
The next two plans, Physicians Plus and GHC-SCW, both have around 10,000 lives in the Southern Region and have total costs that are very competitive within the region. Physicians Plus (10,700) currently covers the entire region but GHC-SCW (9,600) has a narrower focus and only covers Dane and couple of adjacent counties.

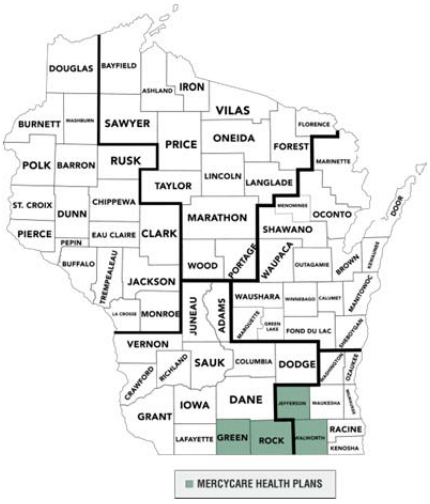


The remaining five plans operate in a subset of the counties in the Southern Region, with some crossing into neighboring regions. They all have around 1,000 lives and are fairly small compared to the previously mentioned plans. Although their membership is small, each offers their own advantages in the market.

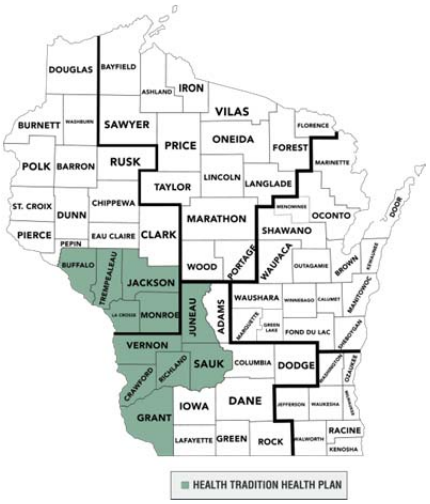
Medical Associates operates exclusively in the region, but only in four southwestern counties. Similarly, MercyCare also covers four counties, but only two of those are in the Southern Region and the other two are in the Southeastern Region.

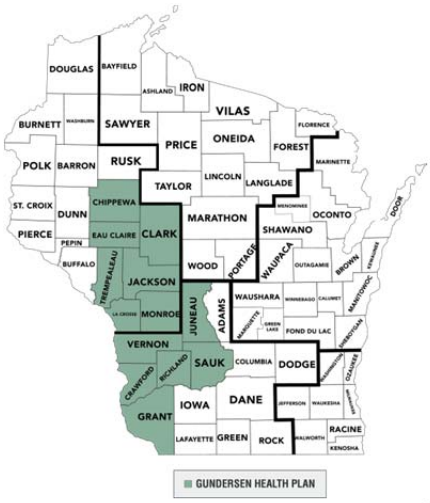
Although focused in those counties, the membership for each plan only represents 12% of the members in their respective service area.



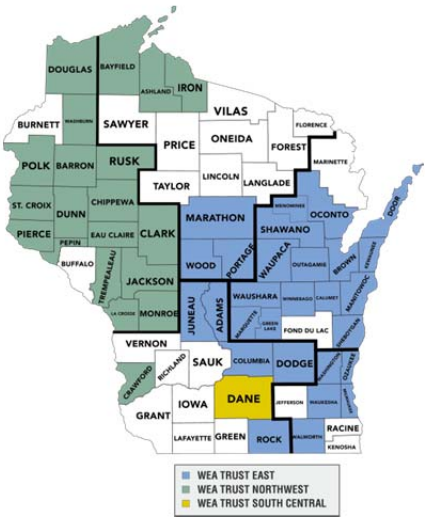


Gundersen Health and Health Tradition have very similar footprints and membership profiles. Each plan's top three counties are identical. Gundersen Health also consistently ranks among the highest quality plans. It is also important to note that they have formed a partnership with Unity Health.





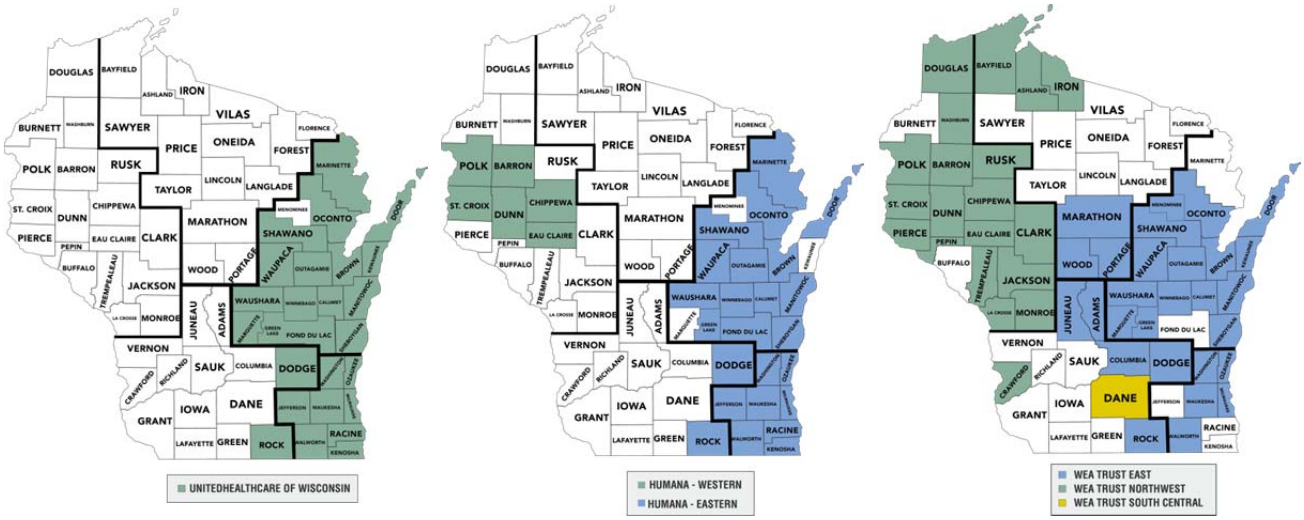
The final plan is WEA Trust. Although their membership is not large in the Southern Region, it is important to recognize that they are the third largest plan by membership statewide, approaching 25,000 lives.



Eastern (Includes Northeastern and Southeastern)

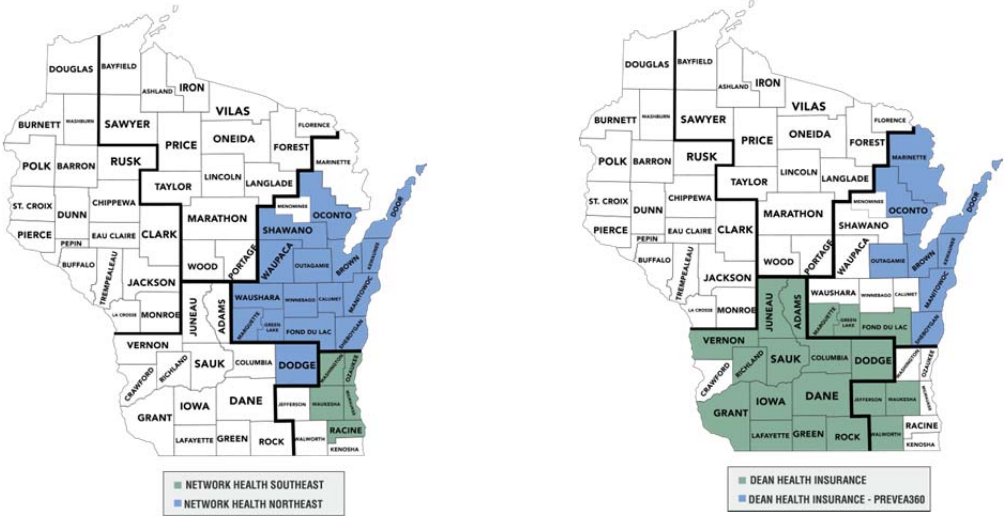
When reviewing ETF enrollment in the Northeastern and Southeastern Medicaid Regions, it becomes obvious that nearly all plans operate in both regions. We believe it is a natural fit to combine these regions into a common "Eastern" Region for this report.

The three largest plans in the region primarily cover the entire combined Eastern Region. The largest membership is WEA Trust, a PPO plan, with 13,300 lives. The other two plans have a national presence – Humana and UnitedHealthcare, each with about 10,000 members.



Network Health is nearly as large as those above, with nearly 9,000 members. They are unique in that their membership is in primarily in the Northeastern Region. They also were approved to operate in some counties in the Southeastern Region for 2016 (in green on map) and should get additional membership after open enrollment.

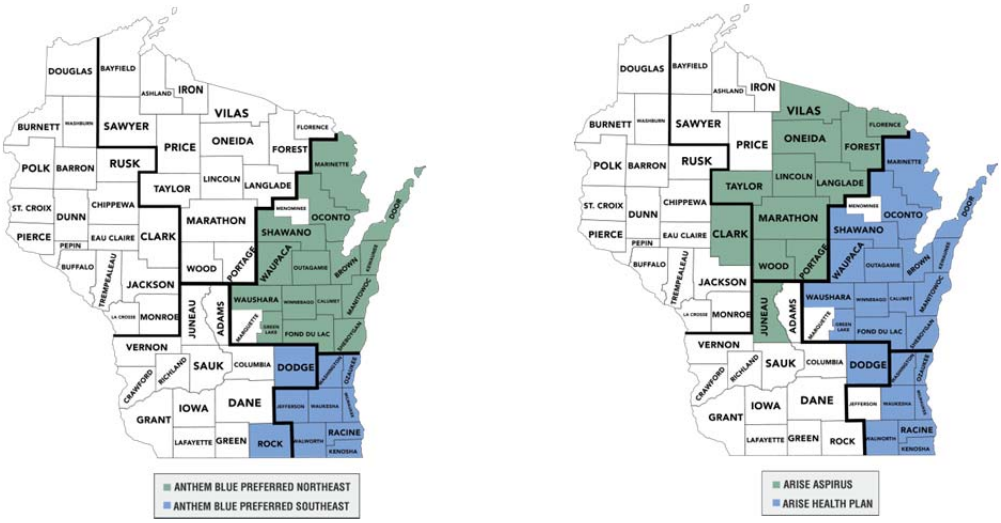
Dean Health is the next largest plan, with 4,200 members split proportionally in both the Northeastern and Southeastern Regions. Members are primarily covered through the Dean Prevea360 Plan.



The last two plans operating in the region primarily have enrollment in either the Northeastern or Southeastern Region. Anthem Blue Preferred is the larger of the two, with 3,200 members, most of which are in the Southeastern Region. Note that Anthem is the third national plan in this region and has a significant block of members within the local program.

Also, Anthem, like many in this region, almost perfectly covers the combined region.

The final plan is Arise Health Plan. They currently have 1,600 members and have recently expanded their service area. The membership may not accurately reflect their new network coverage and might likely expand.



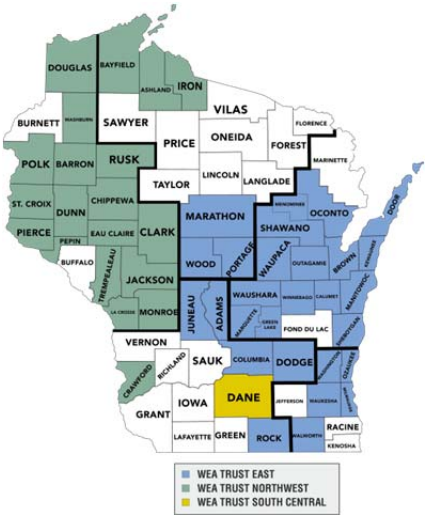
Like the Southern Region, the boundaries for the combined Eastern Region should cause limited network disruption. It is very clear that the Northeastern and Southeastern Regions could be combined into one Eastern Region for ETF purposes.

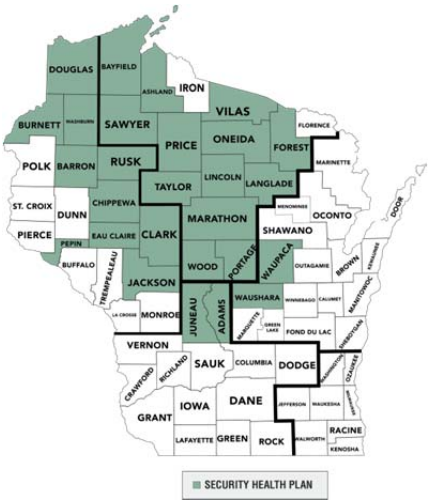
Northwestern (Includes Northern and Western)

This region is slightly more challenging and less obvious than the other regions. The Western Region is nearly the size of each of the Eastern regions, with 18,600 lives. The Northern Region is more rural and by far the smallest region at 8,300 members. Given the level of financial arrangements in these regions, we believe there will be adequate coverage to combine these regions into one "Northwestern" Region.

Unlike the Southern and Eastern Regions, the levels of managed care and provider compensation in the Northern and Western Regions are much less competitive. Their PMPMs are nearly identical to each other and are the highest of all the regions. They appear to be financially similar.

The two largest plans in the region operate across both regions, with each representing the largest membership in each sub-region. We have discussed WEA Trust earlier in this section. They are one of the largest statewide, but also the largest in the Western Region with 8,900 members (10,500 in the combined Northwestern Region). The second largest is Security Health, at 7,700 members. Like WEA Trust, Security Health covers both regions but has more membership (6,200) in the Northern sub-region. Security dominates the north, having over 75% of ETF membership in that region.

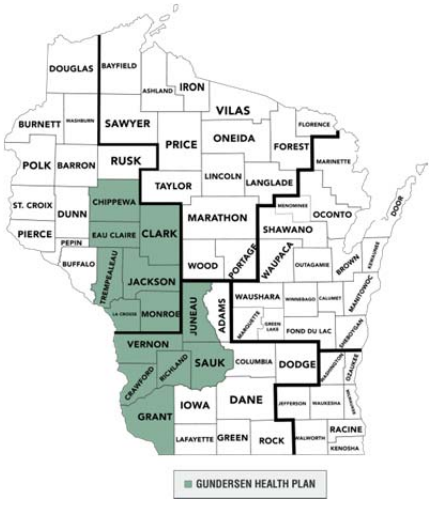


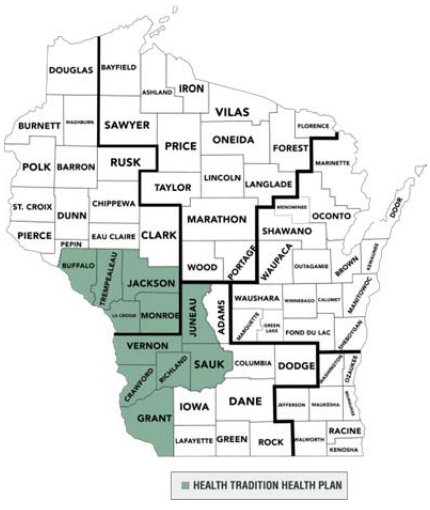


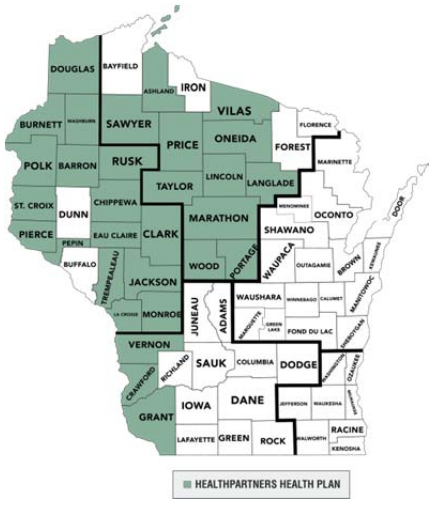
There are no other plans in the Northern Region that have any sizeable membership. The next largest plan is GHC-EC with only 300 members.

The Western Region has a number of plans, in addition to the largest two mentioned above. There are three plans with over 1,000 lives. The largest is Gundersen at 3,000 lives. They have been discussed earlier as being high quality, lower cost and have a new partnership with Unity.

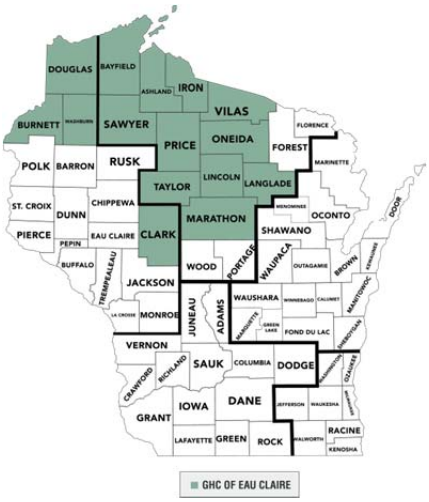
Health Tradition is slightly smaller at 2,000 lives in the region. It is interesting to note that these two plans cover similar counties in the Southern Region as well. The third plan, HealthPartners, provides excellent coverage over the two regions and has 1,800 lives, with very few in the other regions they cover. The majority of their membership is in the Western region.

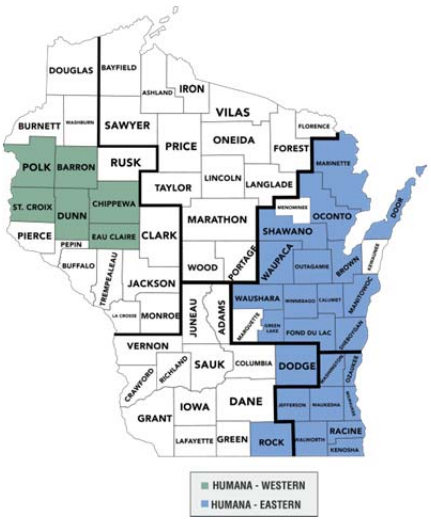




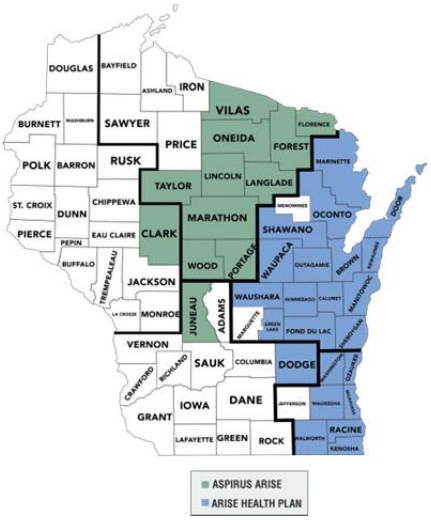


Two other plans with membership are Humana and GHC-EC. Both have around 700 lives in the Western region. Humana is part of a number of regions, having total ETF membership over 10,000 lives. GHC-EC has small additional membership in the Northern Region, making their total membership still less than 1,000.





The final plan is Aspirus Arise. This is also a new service area so the membership representation may not be an accurate assessment of their coverage. What is apparent is that they currently cover virtually no counties in the Western Region and would have challenges in the combined Northwestern Region.



Combining the Northern and Western Medicaid regions into a Northwestern Region is less absolute as the Eastern Region, where a number of vendors cover both geographic sub-regions. There still exists a number of viable options in a combined Northwestern Region that would be very feasible for ETF. To avoid initial disruption in the market, it may be preferable and more practical to have separate Northern and Western regions initially, with a longer term goal to have them combined. This will need to be explored further during a procurement cycle.

Regional Modifications

The analysis in this section was focused on utilizing the Medicaid regions primarily because plans are currently familiar and operate within those boundaries. Our conclusion is that a regional approach, with pre-determined defined counties, can be of great benefit to ETF. We believe there should be three to four regions initially. We also note that the maps will need to be further defined by ETF, where it might make sense to move counties between regions. A good example might be to move those counties in the southern part of the Western Region into the Southern Region, given the geographic footprints of Gundersen and Health Tradition. There may be similar "tweaks" in other regions as well, but we anticipate these changes would be relatively minor and would not materially affect the ultimate recommendation.

Regional Discount Analysis

During the 2016 plan renewal process, Segal received a number of additional exhibits that allowed us to access the financial competitiveness of the various plans. There are obviously a number of elements to consider in the analysis. With the larger picture in mind, Segal requested detailed claims information from the plans. Unfortunately, Plans were not willing to include complete financial information with their data. Only summary level financial data was provided, which was more information than ETF had received from the plans in the past.

Using the best information made available to us, Segal estimated the "net" discounts in each region. To do this we assumed reported discounts for each plan bid were uniformly distributed over their membership. Although not 100% accurate, we believe this method is a reasonable assessment of financial variation between the plans and regions. Below is summary of our results:

Medicaid Region	Hospital Inpatient	Hospital Outpatient	Physician Services	Overall
Northeastern	31%	42%	46%	41%
Northern	19%	27%	34%	29%
Southeastern	35%	44%	49%	44%
Southern	46%	45%	50%	46%
Western	18%	19%	27%	23%
Statewide	38%	41%	46%	42%

In isolation, discounts would not be fully reliable. We then looked at the total per member per month (PMPM) costs as well. The table on the following pages summarizes our analysis, looking regionally. The first column shows overall PMPMs submitted and represent their experience from which rates were built. The second column calculates the relative cost, based on the PMPM, calculated as the region rate divided by the statewide rate. We then took the statewide average and adjusted to the region by using the Statewide PMPM and only adjusting for discounts. So for the Northern Region, the rate would be $416 x (1-0.288)/(1-0.417) or $508.

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

Using the plans' net reported discount does seem to correlate with the resulting costs. Segal has done considerable analysis from the information reports, both specific to plans and within a region.

The combination of the operations of the current plans and their self-reported financials provides further support for the recommendations made later in the section. It also supports the structure of the RFI, also discussed later in this section, and the preliminary results. A summary of the various plans can be found in **Appendix 4**.

Vendors and Contracting

This health-plan-unique service area approach seeks to maximize member choice and access to providers and instill competition among the plans to manage costs. With virtually every healthcare provider in the State participating in at least one of the plans' networks, members certainly have sufficient provider access and most have significant choice when it comes to health plans. Service areas are not necessarily consistent from year to year. From 2015 to 2016, one plan dropped several counties, while others expanded to new counties. Although these changes did not affect many members overall, ETF must deal with a number of service area modifications each year.

Pricing varies greatly among the health plans. In prior years, it was believed that the variation in premiums was largely due to variations in geography and health risk between the plans. This year, plans were required to provide more detailed claims and cost data and this transparency has enabled us to see how the plans' net effective pricing varies. The following table lists the Overall Reported Net Discounts for each of the health plan networks:

Health Plan	Addendum 3a and 3b Overall Reported Net Discounts
Plan Network 1	57.7%
Plan Network 2	51.2%
Plan Network 3	50.4%
Plan Network 4	48.4%
Plan Network 5	47.5%
Plan Network 6	47.1%
Plan Network 7	45.8%
Plan Network 8	45.7%
Plan Network 9	45.3%
Plan Network 10	43.4%

Health Plan	Addendum 3a and 3b Overall Reported Net Discounts
Plan Network 11	40.9%
Plan Network 12	38.7%
Plan Network 13	38.6%
Plan Network 14	37.2%
Plan Network 15	34.9%
Plan Network 16	33.6%
Plan Network 17	32.5%
Plan Network 18	26.2%
Plan Network 19	25.5%
Plan Network 20	25.3%
Plan Network 21	23.0%
Plan Network 22	20.0%
Plan Network 23	15.2%
Plan Network 24	15.2%
Overall Average	**41.7%**

We recognize that discount analysis alone does not provide the complete picture for cost comparisons or financial performance. With that in mind, we reviewed a number of complementary data points, including net cost per service, key utilization components and overall risk adjusted per member monthly costs. This detailed analysis is confidential information to the plans.

The analysis indicates a correlation of discounts to cost per service. Reviewing the four larger plans in Dane County for example, we found that the lowest discount produced the highest cost per day and the highest discounts produced the lowest cost per day. This suggests a correlation between discounts and costs. The prior section also reviewed the markets overall and discussed a similar correlation.

This observation begs the question of how the program could be structured to better utilize the plans with the more effective pricing, but without sacrificing provider access for members. Additionally, in our first report, we presented data showing that there is a significant variation in performance in the current plans' health management programs. The quality of a plan's customer service is also important. All these elements will need to be factored in during a procurement.

A redesigned program should:

- Maximize gains in pricing and provider discounts
- Maintain provider access
- Manage member disruption
- Improve overall performance of the plans' health management
- Provide quality customer service

While additional data was collected during the summer of 2015 for the 2016 health plan negotiations, it was still limited to the currently contracted health plans and to each health plan's

current ETF service area and membership. The health plans' full networks generally cover a broader service area than the area provided to ETF; this data was not collected or necessary when doing 2016 renewals. Also, there are organizations that do not currently contract with ETF. We do not collect cost and access data for those organizations either during the renewal process.

Request for Information

In order to supplement our renewal analysis, Segal, in conjunction with ETF, issued a Request for Information to receive additional pricing and provider discount information, as well as network and provider access information. Respondents were not limited to the current health plans contracted with ETF or to their current service areas. Many additional health plan organizations in the market were invited to participate.

Information was collected on a statewide basis, as well as on a regional basis, with the five regions for this analysis aligned with the regions used by the State's Medicaid agency.

We collected information and analyzed three major network components:

Provider discounts – net effective discounts from billed charges, separately for Inpatient Facility, Outpatient Facility and Professional. Net effective discounts are the allowed costs net of discounts from billed charges and account for value-based, shared risk or other innovative provider payment methods, such as capitated programs, accountable care organizations, patient medical homes, bundled payments, quality bonus payments, etc.

Access to Providers – member access to providers, both professional and facility is measured as the percentage of members with "sufficient access", which was defined to be:

	Urban[1]	Other
Hospital	1 in 20 miles	1 in 35 miles
Primary Care Physician	2 in 10 miles	2 in 20 miles
Pediatrician	2 in 10 miles	2 in 20 miles
Specialist	2 in 10 miles	2 in 35 miles

Member disruption – a list of providers was provided for each participating group in the RFI to indicate network participation. The information was extracted from the WHIO database and

[1] Urban counties are: Brown, Dane, Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha.

represents over 7,000 individual medical providers that together represent over 90% of the claims.

Regions

The ideal regional structure accomplishes the above goals with as few regions as possible. With fewer regions, member communications, vendor contracting and plan administration are simplified. This results in fewer ETF resources necessary to run the program, enabling more resources utilized for strategic planning.

Many states utilize a statewide structure for their primary health benefit plan, which actually requires a national network to accommodate retirees that have moved out-of-state. These states often provide statewide options with multiple vendors. For example, the Minnesota State Employee Group Insurance Plan has three statewide vendors, all with the same plan design. The Wisconsin market, although similar to Minnesota, has several very strong health plans that do not operate on a statewide basis. The regional structure is necessary to accommodate the footprint of the various vendors currently operating in the market. This does not mean that consolidation will not happen, with more statewide vendors, it just means that it may be a phased-in approach to some of the concepts.

As we have previously noted, an inspection of current health plan service areas indicates that many health plans operate in more than one of the five Medicaid regions. This indicates that fewer and larger regions might be considered for ETF.

Based on our review, and supported by the provider access submitted in response to the RFI, we recommend a structure with three geographic regions:

- In the **Southern Region**, there are many plans with a service area focused in, and around, Madison and Dane County. This region has approximately 99,000 members, which is roughly 50% of the total membership.
- Many plans operate in both the Northeast and Southeast regions, indicating that a combined **Eastern Region** may be practical. The combined region would have 53,000 members.
- There are approximately 27,000 members in the Northern and Western regions. There are at least two health plans with an ETF service area currently covering the majority of the combined **Northwestern Region.** Although preliminary results indicate a combined region is feasible, provides good access and would be cost effective, there would likely be significant disruption in the Northern region. As ETF moves forward, this region, in particular, may need to initially remain subdivided.

As we have mentioned earlier, we believe there will need to be some “tweaks” in the regional structure, possibly moving individual counties between regions.

RFI Responses

Each of the current ETF health plans were invited to participate in the RFI, along with additional targeted organizations. While not every organization that received an invitation provided a submission, the overall response was strong, and we believe the data provided is credible and suitable for our analysis. The following is a summary of the requests issued and responses received.

Organization	Discount Data	GeoAccess	Disruption	Declined
Current ETF Plans				
Anthem BCBS	X	X	X	
Arise		X	X	
Dean Health Plan	X	X	X	
GHC – EC				X
GHC – SCW	X	X	X	
Gundersen Health Plan	X	X	X	
Health Tradition Health Plan		X	X	
HealthPartners	X	X	X	
Humana	X	X	X	
Medical Associates Health Plans	X	X	X	
MercyCare Health Plans		X	X	
Network Health	X	X	X	
Physicians Plus				X
Security Health Plan of WI	X	X	X	
UHC	X	X	X	
Unity Health Plan	X	X	X	
WEA Trust	X	X	X	
WPS		X	X	
Prospective Vendors				
AboutHealth	X	X	X	
Aetna				X
CIGNA				X
Integrated Health Network	X	X	X	
The Alliance	X	X	X	

Provider Discounts

Respondents were requested to provide average expected net provider discount levels for their book of business (BOB) for three major categories of services:

- Inpatient Facility;
- Outpatient Facility; and
- Professional.

The provider discount information submitted with the RFI is not ETF specific and results may vary if the analysis were conducted using ETF claims and utilization patterns. However, a comparison with net provider discount data collected during the negotiations for 2016 indicates the BOB data to be largely consistent. Therefore, we consider the information provided in response to the RFI to be sufficient for the purposes of this analysis, which is to identify and analyze the potential opportunity in the market to improve overall pricing for ETF through consolidation. An actual request for proposals (RFP), accompanied with full claims and encounter data, would be necessary to confirm and validate the RFI results.

However, between the data from the RFI and the renewal, it is possible to estimate the opportunity to improve pricing, without sacrificing access, with a regional approach with a more focused health plan contracting approach. Although access should not be affected, there would likely be some initial provider disruption within a region. We would expect this to become less over time, as the market matures and providers alter their contracting strategies to meet ETF needs.

Southern Region

The Southern Region covers the most members and is served by nine (9) health plans which, according to the renewal data, provide an aggregate provider discount of 46.0%. However, discounts vary among the health plans within a range of approximately 38%-49%, which contributes to a spread in risk-adjusted costs of approximately $159.

Some RFI respondents report discounts greater than 50%. But these are BOB figures and may not be realized once the provider contracts are matched with ETF's utilization. There are also capitation arrangements whose encounter data conflict with RFI vendor reported discounts. So looking at a number of data points, it does seem reasonable that pricing could be improved by 2-4% with a more consolidated contracting approach. This would result in the average moving towards the top of the current range. A more competitive environment may also drive additional gains. Claims for the Southern Region are projected to be $405.1M in 2016. Therefore, a 3% midpoint improvement in provider discounts (46% to 49%) produces $22.5M in savings.

All nine (9) current plans, plus three (3) additional respondents reported provider access near 100% based on the GeoAccess standards for the RFI. So, provider access is not an issue under virtually any contracting structure.

The Southern Region is unique in that some of the plans' networks do not significantly overlap, particularly between Dean and Unity. However, per the RFI, providers in both networks do

contract and coexist in other plans' networks. Therefore, it may not be necessary to contract with both plans in order to have access to the various providers. It could also result in not all providers being in the preferred network tier (Tiered networks are discussed later in this section).

Note that Unity is the only health plan with resistance to data sharing and are currently the only plan that has not yet signed the 2016 contract with the GIB.

Eastern Region

The new combined Eastern Region would cover 53,000 members. The area is currently served primarily by four (4) health plans which, according to the renewal data, provide an aggregate provider discount of 42.7%. Reported discounts vary among the health plans within a range of approximately 41-50%, which contributes to a spread in risk-adjusted costs of approximately $167 (similar to the variation in the Southern region). More plans are toward the lower end of the discount range.

Some RFI respondents report discounts in the range of 53-56%. However, these are BOB figures and may not be realized once the provider contracts are matched with ETF's utilization. It does seem reasonable that pricing could be improved by 4-6% with a more consolidated contracting approach. This would result in the average moving towards the top of the current range. Claims for the Eastern Region are projected to be $276.1M in 2016. Therefore, a 5% improvement in provider discounts (42.7% to 47.7%) produces $24.1M in savings to ETF.

All four (4) current plans that primarily serve the region, plus two (2) additional respondents reported provider access near 100% based on the GeoAccess standards for the RFI. So, provider access is not expected to be an issue. Additionally, these plans' networks overlap to a high degree. Therefore, plan consolidation is not anticipated to result in significant disruption at the provider level.

Northwestern Region

The new combined Northwestern Region would cover approximately 27,000 members. The area is currently served primarily by five (5) health plans which, according to the renewal data, provide an aggregate provider discount of 24.7%, much less than the Southern and Eastern Regions. There was a wide variation in this region, with discounts among the health plans having a range of approximately 15-26%, which contributes to a spread in risk-adjusted costs of approximately $272. We do believe some of the variation is from additional risk not fully reflected in the risk adjustment, primarily since many of the plans are much smaller.

Not surprisingly, given the poor discounts, the plans in this region generally have the highest premiums. This is not a unique dynamic to Wisconsin. In many rural areas across the country, health plans often have difficulty negotiating favorable terms with providers who, given the usually limited competition, have less of an incentive, or need, to rely on network steerage for patients.

Some RFI respondents report discounts in excess of 30%. Again, these are BOB figures and may not be realized once the provider contracts are matched with ETF's utilization. It does seem reasonable that pricing could be improved by 4-6% with a more consolidated contracting approach. This would result in the average moving towards the top of the reported range. A more

competitive environment may also drive additional gains. Claims for the Northwestern Region are projected to be $164.4M in 2016. Therefore, a 5% improvement in provider discounts (24.7% to 29.7%) produces $10.9M in savings to ETF.

Four (4) of the current primary plans reported provider access near 100% based on the GeoAccess standards for the RFI. The other plan currently operates primarily in one of the subregions. Nonetheless, provider access is not expected to be an issue. Additionally, these plans' networks overlap to a high degree. Therefore, plan consolidation is not anticipated to result in significant disruption at the provider level.

Statewide Options

Our analysis indicates that there are at least two plans that could provide discounts above the current aggregate average. Both plans also report nearly 100% provider access. Three (3) other plans report nearly 100% access but report discounts below the current average. With the addition of a statewide option we would expect the market to form alliances and partnerships to possibly provide ETF with additional choices than currently available in the market. We have seen this already in certain regions and would expect more over the next few years. Since our approach is primarily regionalized, the savings for the Statewide option, that replaces the current Standard Plan, would produce marginal savings above those already detailed within the State.

The statewide vendor would also be required to provide an out-of-state network. We would expect savings for out-of-state members, primarily retirees, but that was not included in our RFI and doesn't impact the regional structure recommendation.

It is also important to note that we received information from organizations that are not currently health plans. The Alliance, IHN and AboutHealth reported favorable discounts and access in several regions. However, since they are not currently health plans, it is not practical to contract directly with ETF. A partnership of some kind, such as AboutHealth's arrangement with Anthem and Arise or IHN's with Network Health, would be necessary. Therefore we did not include their results directly in our analysis.

Member Disruption

It is important to fully understand the terms "access" and "disruption". We discussed earlier in this report that access is just that, access to necessary healthcare providers that meet the GeoAccess requirements defined. The requirements vary by type of provider and whether the member resides in an urban, suburban or rural location. This is quite different from disruption. Disruption defines whether a member will need to change their current provider(s). Therefore, in Dane County, for example, most members will have 100% access but we would likely expect disruption, since some of the providers are exclusive to a particular plan. This is what we attempted to capture in this section.

A list of currently utilized providers for ETF was provided with the RFI and respondents were requested to indicate which of these providers are in their respective networks. The file contained over 7,000 individual providers and represented more than 90% of claims/encounters. (A file with 100% of all providers and claims/encounters would have been significantly more extensive and more cumbersome for the plans to analyze.)

Currently, very few providers contract with a single, or limited number of, plan(s). The great majority of providers contract with multiple plans. We reviewed the major provider groups and facilities and compared them with what the plans reported as their network providers. Several plans indicate that many or almost all of the hospitals utilized most by ETF members are in their respective networks. There were only a few exceptions to this – primarily in Dane County, where two of the larger plans operate. From a statewide perspective, several plans report that all but a handful of these highly utilized hospitals are in their network. Detail showing network participation by hospital is included in **Appendix 5.**

Note that the statewide model will have all providers in the plan. The delineation will be that the majority of network providers will be In-Network. Some high performing providers will be in the preferred network tier and those not accepting the In-Network pricing will be paid as an Out-of-Network provider. We would expect very few members to use Out-of-Network providers. We also believe some regional plans could operate in a similar structure, but as a minimum, the statewide plan will have this design incorporated (Tiered networks are discussed later in this section).

Summary

Based on our analysis, we conclude there is an opportunity for ETF to ultimately achieve $45-70M in medical claims savings from consolidating the number of health plans and converting to a regional approach with regions ***determined*** by ETF and uniform for all health plans. We believe this can be accomplished without sacrificing Provider Access and with a significant Network Match (minimal Disruption). The approach will also support improving overall performance of Total Health Management, discussed in that section. Below is the midpoint summary:

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

While there are some notable exceptions in the Southern Region, many of the plans' networks overlap to a large degree and consolidation is not likely to result in significant provider disruption for members. If a member utilizes a specific provider on a regular basis and that member's plan's contract is discontinued, then it is very likely that the provider in question is in another plan's network. Also note that further review of the Northwestern region may result in that combined region occurring over time, initially being split up to avoid unnecessary disruption.

Our recommendation would be to contract with up to two health plans per region, alongside a single statewide health plan. This provides a uniform option across the entire membership, while enabling ETF to leverage the very best of the regional health plans. If a single health plan is selected at the regional level, then pricing may be improved without affecting access but there may be some material disruption in selected areas.

We recommend that ETF structure this within a self-insured environment, but the savings detailed above are solely from the regional approach and consolidation and not from self-insurance. There are a tremendous number of advantages to operating in a self-insured environment; these are detailed later in the Self-Insurance section of the report.

Total Health Management capabilities can vary significantly from employer to employer for a single health plan. Depending on the employer's program design and contractual requirements, a particular health plan or wellness vendor may allocate additional and more comprehensive resources and provide better results to a plan sponsor that is more committed to Total Health Management than to a less committed organization. This is best explored and evaluated through a bid and RFP process.

The same can be said of member and customer service capabilities. Member satisfaction can also vary based on contractual requirements and is best explored and evaluated through a bid and RFP process.

Additionally, the local Wisconsin and national health plan markets are in flux, with mergers and acquisitions at both the local and national levels. In Wisconsin, new organizations are evolving and may provide additional health plan choices for ETF in the near future. As the market continues to evolve, we would anticipate changes in health plan capabilities.

Benefit Design

Our last report provided an extensive review of the plan designs. We compared ETF to:

- Wisconsin Exchange
- Federal Employee Benefit Plan
- National Public Sector Plans
- States within your Region (IA, MN, IL, IN, MI)
- Private Sector Plans
- Emerging Trends

The analysis compared plan design structure, elements, pricing, contributions, etc. Further details and analysis can be found at: http://etf.wi.gov/boards/agenda-items-2015/gib0325/item4c1.pdf.

In general, ETF benefits were on the high end of both the cost and benefit value. For 2016, ETF made changes that will move costs closer to regional norms and achieve budget targets. The long-term goal is to develop a sustainable program while maintaining a similar benefit value plan.

We will incorporate a best-in-class design that best fits Wisconsin and ETF's membership. Our goal is to reward those who participate and actively manage their health, while maintaining competitive benefits for all.

Tiered Network

Health plans and large self-insured employers have long attempted to direct patients to certain "preferred" providers. These efforts face a renewed sense of urgency given the escalating pressure to contain health care costs and improve efficiency, coupled with mounting evidence that high prices do not necessarily signal high quality. In contrast to the mid-1990s, however, when HMOs directed patients to particular providers by using closed networks, health plans today are increasingly likely to channel patients through value-based network designs.

Value-based, or tiered, provider networks attempt to engage consumers in making informed decisions about their care, while maintaining consumer choice of provider. This network and benefit design reflects the lessons learned from the managed care backlash against restricted provider choice and has been enabled by improvements in recent years in measuring individual provider performance. In a tiered network, health insurers sort providers into tiers based on cost-efficiency and quality performance measures. Efficiency is typically gauged using case-mix adjusted episode level costs and utilization, while quality is judged through claims-based process measures, external certification, and, in some cases, use of health information technology.

Providers achieving higher efficiency and/or quality scores are placed in the preferred tier, and patients are given a financial incentive to choose these providers. In the case of physicians, this incentive is typically a moderately lower copayment; for hospitals it may be a lower coinsurance rate.

In addition to encouraging individual consumers to seek value in their health care choices, tiered networks also hold the potential to improve the value of the health care system overall as lower-performing providers work to enhance the quality or efficiency of their care in order to improve their ranking, either to recover lost market share or simply to improve their position within the network.

The ultimate goal is to construct a tiered network to deliver the most efficient care possible and drive utilization to those providers.

Commonwealth Study

Commonwealth Fund–supported researchers at Harvard University explored how tiered networks affiliated with Blue Cross Blue Shield of Massachusetts (BCBSMA), the state's largest insurer, affect hospital admission choices. The study used patient-level claims data for 2009-2012 from Blue Cross Blue Shield of Massachusetts (BCBSMA) to analyze the impact of their tiered model within the State.

What the Study Found

BCBSMA's three-tiered hospital network employs large differential cost sharing to encourage patients to seek care at hospitals on the preferred tier. During the study period, 44 percent of

hospitals were moved to a different tier based on changes in cost or quality performance. We relied on this longitudinal variation for identification and specified conditional logic models to estimate the effect of the tiered network (TN) on patients' hospital choices relative to a non-TN comparison group.

The authors predicted that if all BCBSMA members were in a tiered plan instead of a monitored plan, scheduled admissions to hospitals in the nonpreferred tier would drop by 7.6 percentage points, while admissions to middle- and preferred-tier hospitals would rise by 0.9 and 6.6 percentage points, respectively.

Their Conclusion

Tiered-network designs that feature large cost differences between tiers are successful at steering patients toward preferred hospitals—those offering lower costs and higher quality—while preserving a greater degree of provider choice. The authors warn, however, that tiered networks have potential drawbacks. For example, they may transfer risk to patients in the form of higher out-of-pocket payments for lower-tiered providers.

In summary, Tiered Networks:

- Rank providers based on cost and quality and create a plan design with financial incentives to steer members toward lower cost care
- Allow the Member to maintain control of provider decision as well as responsibility to research and understand often complex decisions regarding cost and quality of care
- May include tiering of hospitals only for some plans while others tier primary care physicians and specialists as well
- Vary because each insurer tiers based on a different formula of cost and quality criteria

Discern Health Study

ETF has engaged Discern Health to analyze the possibility of using provider tiers and reference based pricing. In May 2015, they released a report entitled: "***Tiering and Reference Value: Principles and Strategies".*** Discern also conducted a webinar discussing their results and recommendations.

Without going into great detail, Discern had two recommended strategies for ETF:

- ***Physician Tiering***- a program in which individual physicians are evaluated against measures of cost and quality and are then grouped into tiers based on their performance results.
- ***Reference Value for Hospitals***- a program in which a fixed reimbursement level is set for specified services for which there are wide variations in price across a group of hospitals.

The recommendations presented in their report outline a phased framework intended to allow consumers to equilibrate culturally to the idea of seeking out information to make informed health care decisions. The framework also allows time for stakeholder input, review and opportunities to build on previous successes and lessons learned.

By incentivizing consumers to make informed, value-based decisions, they propose that ETF can offer not only more value to its members and Wisconsin taxpayers, but may positively influence overall efforts to improve the experience of care for consumers, improve health outcomes for the population, and lower health care costs overall.

Many of the items we recommend are in sync with this report.

Reference Based Pricing

Going forward, we are likely to see further evolution in how tiered provider networks are utilized. One variant of the concept that has already appeared is the use of reference pricing in combination with an identified network of providers willing to render targeted services at or below the pre-determined price.

For example, in collaboration with CalPERS, Anthem Blue Cross in California launched a program whereby it agreed to pay up to $30,000 for a single hip or knee replacement and identified 47 hospitals across the state willing to provide those services for that "reference" price. Patients using the identified hospitals face only their required cost sharing, but those opting to use a more expensive facility must also pay all allowed charges above $30,000. To the extent that health plans see only muted consumer responses to the relatively modest copayment differences commonly used today, we may start to see more employers and health plans move in the direction of a reference based pricing model, especially for these types of "big ticket" items.

We recommend working with the contracted plans to develop an array of services subject to reference based pricing. This may initially include hip and knee replacement, colonoscopy, magnetic resonance imaging (MRI) of the spine, computerized tomography (CT) scan of the head or brain, nuclear stress test of the heart, and/or echocardiograms. It is desirable to use this strategy for services that have fairly uniform protocols, and that are less likely to experience variation in quality, both of which characteristics make price comparisons easier for patients.

There are, however, pitfalls to any strategy. Some employers that have implemented reference-based pricing plans do not see the desired results because they have not addressed all the related considerations, such as - lack of established markets; safe haven hospitals; and disruption from non-participating providers.

When implementing a referenced-based pricing plan, choose a vendor with experience, as well as clear, transparent processes and safeguards in place to protect patients.

Centers of Excellence

The concept of having designated providers, typically hospitals as "centers of excellence" has been around for many years and had its origins in the notion that for complex medical procedures like heart, kidney, and liver transplants and complex cancer treatment - all providers are not created equal. This notion has been confirmed by the pilots that were initially run and subsequently by research studies. We know that outcomes vary widely and the incidence of unintended consequences like wound inflections, pneumonia rates, kidney inflections, etc. are directly linked to the variations in care delivery and standards of treatment that exist between providers.

Today, the "centers of excellence" concept is being applied to other less complex procedures where variations in outcomes have been measured. The Leap Frog Group and other organizations that measure provider quality and procedure outcomes find there is enough difference among networks to warrant a plan sponsor to implement quality assessments of hospitals and focus care delivery on procedures like – heart by-pass surgery, joint replacement surgery, bariatric surgery along with the traditional complex surgeries referenced above. Typically, the price charged for these services is a bundled price for all associated care.

Recommended Plan Designs

Below is a brief summary of the main plans currently being offered for 2016. As of 2016, the following plan names have changed and may be referenced differently throughout this document. UBD has become the It's Your Choice (IYC) Health Plan, the HDHP is now the IYC HDHP and the Standard Plan is now the IYC Access Health Plan.

2016 ETF PLAN DESIGNS

			IYC Access Health Plan	
	IYC Health Plan	IYC HDHP	In-Network	Out-Network
Annual Deductible				
Individual	$250	$1,500	$250	$500
Family	$500	$3,000	$500	$1,000
HSA Employer Contribution				
Individual	N/A	$750	N/A	N/A
Family	N/A	$1,500	N/A	N/A
Office Visit				
PCP	$15	$15, after deductible	$15	30%, after deductible
Specialist	$25	$25, after deductible	$25	30%, after deductible
Emergency Room	$75	$75, after deductible	$75	$75
Coinsurance	10%	10%	10%	30%
OOP Limits				
Individual	$1,250	$2,500	$1,000	$2,000
Family	$2,500	$5,000	$2,000	$4,000

The following recommended designs build off the IYC Access Health Plan, with In-Network benefits similar to the IYC Health Plan. The current In-Network benefit is primarily the Preferred Network Benefit level, with the new In-Network having slightly more cost sharing. The Out-of-Network benefits are similar to current benefits. This should result in the desired steerage towards the higher quality, more efficient providers. Additionally, there is a $5 office visit copay reduction for members engaged in appropriate disease management programs.

The Preferred Network should only be the high performing hospitals and physicians, a narrower network vs. the current structure. The In-Network would be the remainder of the contracted network and the Out-of-Network would be all other providers. Out-of-Network providers would be paid according to the in-network schedule, with any excess being paid by the member.

Below is a brief summary of the proposed design:

RECOMMENDED PLAN OFFERINGS

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

The copay reduction for disease management would be managed by the plan and would be initiated when members engage in their disease management program. They would also need to provide a feed to the PBM to manage the pharmacy eligibility or possibly use a "coupon" if easier to administer.

As discussed in an earlier section we would anticipate using reference-based pricing as appropriate. We would expect this to be minimal initially but grow over the next 5 years. Hospitals and/or Physicians who accept the pricing will be considered Tier 1 for that procedure.

We recommend integration of Telemedicine at a reduced copayment of $5 to $10, depending on how the contracting is negotiated. Similarly, if ETF moves forward with implementation of an On-Site Clinic, similar financial incentives would be instituted. Note that the HDHP plan would need to be charged the "full cost" while in the deductible, in order to comply with federal regulation.

We also expect to have centers of excellence in place. ETF would need to work with the plans to determine appropriate complex procedures to be placed in this category. Note that ETF already uses centers of excellence for Bariatric Surgery in the Standard Plan. The Standard Plan experience shows costs for patients with surgeries performed in centers of excellence since 2010 are 30-40% less than for patients with surgeries in non-centers of excellence.

Recommended Contribution Rates

Unlike the current structure, we do not expect all our plans in the program to be in Tier 1. In order to be considered Tier 1, the plan must demonstrate a significant financial advantage over the Tier 2 plan. With that in mind, we expect the bulk of the membership to initially be in Tier 2 plans. As plans demonstrate their capabilities, they can migrate to Tier 1.

Another part of the contribution strategy is the integration of the wellness premium credit/penalty discussed in the **Total Health Management** section earlier in this report. A member that meets his or her wellness requirements would receive a $50 monthly premium reduction ($100 for family coverage). That member would have lower contributions than those currently in Tier 1. This reduction would be funded by the additional premiums paid by the members that do not participate in the wellness program. For the subset of plans operating at Tier 1 levels, their contributions would be even lower.

2016 ETF PLAN DESIGNS

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

RECOMMENDED PLAN OFFERINGS—ILLUSTRATIVE PREMIUMS

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

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

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

The numbers above are illustrative and would need to be finalized during the rate development cycle. These numbers may need to be adjusted to meet any regulatory requirements in place.

Note that the premiums in these tables are for medical and pharmacy coverage only and do not include dental premiums.

In Summary

We are not anticipating significant savings from this benefit structure alone. Savings are anticipated over time as the reference-based pricing and centers-of-excellence components are implemented and grow towards maturity. The benefit and premium structure is designed to support the recommended THM strategy and is not designed to generate savings to ETF from member cost shifting.

The additional wellness contributions will enable the plan to provide a number of value based benefits, offering plan members reduced cost sharing and lower contributions. The benefit design drives utilization and provider choices that will result in more efficient and higher quality care.

Note that the benefit design is meant to be a greater value than the current program provides. There is no cost-shifting if members engage appropriately and use preferred providers. If members choose non-participating providers and do not engage in their health, they will likely have increased cost sharing and a higher contribution rate (wellness premium).

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

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

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

Pharmacy

The Value of Pharmaceutical Treatment

Increasingly, pharmaceutical treatments are the most cost effective option to treat illness and disease. Advances in technology and research will continue to present new treatments that keep workers out of the hospital, avoid surgical intervention, reduce complications from disease, reduce the frequency of disability and in some cases offer cures to once life threatening disease.

However, Americans consume roughly 50% more prescription drugs than the average citizen in other developed countries (*source: IMS Health*) without better mortality rates. This situation is partly driven by industry promotion, partly by the practice of defensive medicine by providers, and partly by a lack of price controls on drugs in the United States. Plan sponsors need to take steps to balance the need to provide their members access to the right medication at the right time with the need to combat excessive price inflation and manipulative marketing tactics employed by the pharmaceutical industry.

Strategies that improve the health of the population covered by the employer's plan will reduce waste and the frequency and intensity of polypharmacy patient demands in the future. Improving the health care literacy of plan participants will improve medication adherence results and increase rational consumerism. Finally, tactics that apply new ideas to better ration benefit dollars and secure best-in-class pricing terms will be required to get the best economic value for ETF.

Current State of Wisconsin's Pharmacy Benefit Program

ETF's pharmacy benefit expenses as a percentage of overall medical plan costs (medical and drug combined) are reasonable compared to other large plan sponsors. Also, the program already includes a number of important and effective measures to control costs and manage expenses appropriately.

The following are selected financial highlights about ETF's current pharmacy benefit plan in comparison to other large programs:

- Active and Non-Medicare Retiree prescription drug costs represent about 12% of total medical and Rx program spend. This is lower than the typical large employer range of 15% to 18% Rx spend.

- Medicare Retiree Rx costs are about 38% of total medical and Rx spend. This is lower than the national average range of 45% to 55% of Medicare total per capita spending.

- ETF's pharmacy per capita claim cost trend rates are running around 9%. This compares favorably to Segal's book of business norms of 11% to 13% per capita. Additional efforts will be needed to keep trend increases in the single digits the next few years.

- ETF's generic dispensing rate (GDR) is also higher than observed norms for a number of therapy classes.

Overall, the steps ETF has taken for 2016 will mitigate a portion of the future plan cost trends. More steps will need to be taken to continue to manage per capita cost trends to single digits in the years ahead. We will discuss some of these concepts and strategies in the pages that follow.

Changes in the pharmacy benefit plan to percentage copays for brand drugs will impact utilization to a modest degree. Some patients will become more prudent consumers of their prescription options and request lower cost brands or generics as a result of higher copays for level 2 and level 3 drugs.

Generic Dispensing Rate Targets

Greater use of generics means lower costs and lower future price inflation. Even with the continued rise in use of generic drugs instead of brand drugs, there is still more room for plan savings. ETF should encourage its PBM to take an active role in driving utilization further toward generics.

Segal reviewed ETF's current generic dispensing rate (GDR) for a variety of diseases against commercial averages and against other similar state employee health plans in our book of business. ETF is doing well compared to the GDR averages for the following disease states:

SELECT DISEASE STATE WHERE THE GDRS ARE HIGHER THAN NORMS*

Disease Indication	Wisconsin ETF GDR	PBM GDR (Commercial Average)	Difference from PBM	Similar State Plan GDR
Diabetes	58.9%	45.9%	13.0%	57.1%
Oncology	91.4%	90.1%	1.3%	87.7%
Depression	97.2%	95.5%	1.7%	95.9%
Skin Disorders	85.2%	84.6%	0.6%	77.5%
Pain Management	92.5%	90.7%	1.8%	91.3%
Contraceptives	78.3%	74.7%	3.6%	74.0%
Cardiovascular/Hypertension	94.8%	93.4%	1.4%	90.8%
Mental Health/Neurological Disorders	72.9%	65.7%	7.2%	69.9%

* Results are unadjusted for differences in demographics or plan features.

The following disease states are examples of ones where ETF has room for improvement in its GDR:

DISEASE STATES WHERE GREATER FOCUS BY NAVITUS SHOULD BE EXPLORED

Disease Indication	Wisconsin ETF GDR	PBM GDR (Commercial Average)	Difference from PBM	Similar State Plan GDR
Autoimmune Disease	19.2%	25.8%	-6.6%	14.4%
ADHD	45.9%	67.1%	-21.2%	60.7%
Asthma/COPD	26.2%	42.8%	-16.6%	37.9%

A future performance guarantee to consider may to be set target GDR increases in some key disease states with pay for performance incentives that the PBM can earn when targets are met. For every 2% increase in the GDR for that disease, the PBM might earn .25% in case management fees, to a set maximum dollar amount per year.

Design of a GDR target should be a joint discussion with the PBM to assure that realistic levels are set to have the desired impact. We recommend that ETF engage Navitus in discussion of adding a GDR target for one or more disease states where ETF is lagging the general market. This will offer an opportunity to focus efforts on utilization of lower cost drugs to help hold down the overall trend increase.

Limited or Tiered Networks

One method of garnering additional savings in a pharmacy benefit plan is by limiting or tiering the retail pharmacy choices. By eliminating or restricting the pharmacies covered under the program, deeper discounts may be negotiated with the remaining pharmacy groups.

Segal's experience suggests that by restricting the retail pharmacy network, additional plan savings can be realized. Plan sponsors typically can save up to an estimated 1.5% to 3% of retail drug costs. However, to capture meaningful savings from deeper discounts, ETF would have to make substantial moves to remove some participant choice of retail pharmacy and steer market share for savings.

Segal has helped implement several custom and limited pharmacy networks that remove one or more competing national or regional retail pharmacy chains. By eliminating one or more major competitors the plan can then negotiate more favorable discount pricing with the remaining pharmacy groups. This type of arrangement can reduce costs for plan sponsors and still maintain adequate market access for participants with minimal disruption. For example, a Food workers multiemployer health plan worked with their PBM to create a custom network that excludes Walmart, Walgreens, Price Chopper and Big Y pharmacies in New England. The remaining network continued to provide adequate participant access and improved retail discounts by 2.5%.

ETF data suggests a natural concentration of members using Walgreens retail pharmacies (50% of retail use). If a custom retail network is considered, Segal would recommend first approaching Walgreens to determine what concessions would need to be made from improved pricing for this

chain. Would ETF be able to negotiate close to mail order level discounts from Walgreen's for exclusive access to 90-day retail maintenance fills? Only if Walgreens is willing to offer near mail service pricing would such a move produce value to both ETF and participants.

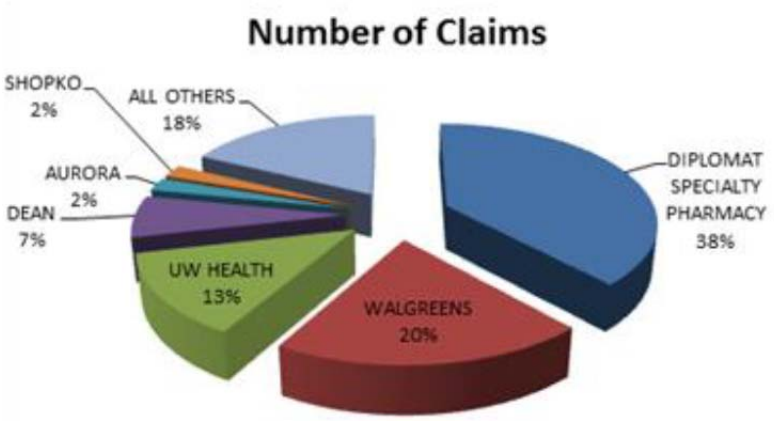
Some plan sponsors are not prepared to completely eliminate access for major pharmacy chains. It is also possible to create a tiered network where pharmacy groups that provide the best discounts and fee arrangements are preferred and those that don't are in a non-preferred tier. Members could be rewarded for using the preferred pharmacy groups by paying lower copayments or lower maximum coinsurance. This plan design approach to steering members toward low cost pharmacies would also mean less disruption, since all pharmacies would still be available; some would just cost more. Prior to implementation of either approach, a member disruption report and a savings estimate with the consolidated network would need to be completed. In some cases and in some geographical areas, the savings potential for the more limited pharmacy network may not outweigh the member disruption and potential political fallout from local providers.

Navitus is currently in negotiations with the retail pharmacies serving ETF. They have estimated that ETF could see an additional $2 million in network savings by remaining with the current pharmacy network. However, additional savings from creating a narrow network could be expected, possibly up to 1% to 3% of retail pharmacy claims. A 2% savings from creation of a narrow retail pharmacy network would equate to between $2 million and $2.5 million per year.

Optimized Specialty Drug Distribution Network

Specialty drug utilization continues to grow and is expected to represent 50% of the spend for most plan sponsors by 2018. ETF's Commercial Plan specialty drug utilization represented 28.6% of spend in the 2nd quarter of 2014 and increased to 33% by 2nd quarter of 2015. While ETF has put in good clinical management programs (e.g. split fill program, prior authorizations), more can be done to control the rising costs of specialty drugs for ETF and to better manage the utilization. One such approach ETF may consider is optimizing the specialty pharmacy network by limiting the dispensing to certain select pharmacy vendors.

Currently, ETF's plan design provides incentives for using a preferred specialty pharmacy network but still allows specialty drugs to be dispensed by any participating network pharmacy. The specialty drug distribution for the 1st and 2nd quarters of 2015 in displayed in the chart below.



Diplomat Specialty Pharmacy dispenses the majority of ETF's specialty drugs at 38% followed by Walgreens Specialty Pharmacy and UW Health Pharmacy at 20% and 13%, respectively. The remaining 29% of the specialty claims are dispensed by other retail pharmacies. It is important to note that this 29% includes other specialty pharmacies where the patient has been directed by the doctor.

To illustrate the impact of careful specialty pharmacy selection and management, Segal analyzed the potential savings that could be achieved if members moved from retail Walgreens pharmacies to either Lumicera or Diplomat (two different specialty pharmacies) based on current contract terms. Although the savings are modest, carving out all specialty drugs from Walgreens, including tablets that are now dispensed at retail pharmacies, will produce savings and create a consistent clinical point of contact for all specialty drugs.

The first table presents the potential savings for the first two quarters of 2015 that could result from moving specialty drugs for active and non-Medicare members for a number of health conditions from retail to specialty pharmacy.

COMMERCIAL (NVTETF) Q1 & Q2 2015: POTENTIAL LUMICERA AND DIPLOMAT SAVINGS VS. WALGREENS RETAIL

Health Condition	Total Approved Ingredient Cost (Walgreens Retail)	Total Claims	Total Potential Lumicera Savings	Total Potential Diplomat Savings
Anemia	$8,877	4	$67	$126
Chronic Hepatitis Infection	$29,945	5	$1,508	$482
Chronic Inflammatory Disease	$3,198,824	945	$98,640	$65,277
Cystic Fibrosis	$95,563	25	$5,738	$668
Growth Hormone	$5,883	6	-$240	$170
Hyperparathyroidism	$19,010	21	-$828	$155
Multiple Sclerosis	$424,578	79	$16,579	$9,801
Neutropenia	$39,276	7	$1,556	$581
Oral Chemotherapy	$104,946	15	$7,779	$2,236
Osteoporosis	$10,861	6	-$51	$217
Pulmonary Arterial Hypertension (PAH)	$14,524	6	$319	$115
Grand Total	**$3,952,286**	**1,119**	**$131,066**	**$79,827**
Grand Total (%)			**3.32%**	**2.02%**

The following table presents results for a similar selection of health conditions for Medicare eligible retirees for the first two quarters of 2015, assuming those specialty drugs are dispensed by one of two different specialty pharmacies.

MEDICARERX (MRXWIE) Q1 & Q2 2015: POTENTIAL LUMICERA AND DIPLOMAT SAVINGS VS. WALGREENS RETAIL

Health Condition	Total Approved Ingredient Cost (Walgreens Retail)	Total Claims	Total Potential Lumicera Savings	Total Potential Diplomat Savings
Acromegaly	$111	1	-$135	-$92
Chronic Hepatitis Infection	$6,241	7	-$95	$0
Chronic Inflammatory Disease	$488,233	137	$15,523	$9,489
Growth Hormone	$489	1	-$71	$13
Hyperparathyroidism	$25,434	26	-$1,559	-$480
Multiple Sclerosis	$104,119	21	$3,841	$2,435
Neutropenia	$14,246	3	$517	$340
Osteoporosis	$71,923	39	-$278	$1,411
Pulmonary Arterial Hypertension (PAH)	$24,133	10	$530	$196
Grand Total	**$734,930**	**245**	**$18,274**	**$13,313**
Grand Total (%)			**2.49%**	**1.81%**

While the analysis above may not appear to show significant financial savings for moving to a more consolidated network for specialty medications, the true benefit of driving utilization to specialty pharmacies can be seen from the better clinical outcomes a specialized pharmacy can provide.

Some key clinical differentiators of pharmacies that specialize in dispensing specialty medications include the following:

- Enhanced patient monitoring
  - A patient is monitored throughout the course of their therapy to ensure they are adhering to approved FDA treatment protocols as well as evidence-based clinical pathways/guidelines. These guidelines are subject to change as new research emerges and pharmacies that do not specifically specialize in specialty medications may not be aware of new research that could impact the members clinical therapy trajectory.
  - This enhanced patient monitoring to measure adherence to prescribed therapy is key in achieving optimal clinical outcomes. This monitoring can help reduce duration of therapy by preventing relapses in certain disease states that can occur from breaks in therapy. Also, certain specialty drug therapies (e.g., Hepatitis C) have a predisposition to developing resistance if therapy is stopped and then restarted. The close monitoring by a specialty pharmacy helps to reduce the need to extend therapy beyond what was originally prescribed and thereby helps to contain the total cost of these usually very expensive therapies.

- Pharmacy personnel
  - The pharmacist and pharmacy technicians that staff these specialty pharmacies are dedicated to these specific specialty medications (and not supporting all prescription drugs) and therefore have gained greater insight on the manner in which these drugs need to be handled as compared to a general pharmacist or pharmacy technician at a retail location.
  - Additionally, the pharmacists at these specialty pharmacies often are required to obtain additional training and are specialized in specific disease states and therefore are able to offer a higher level of care to the member.

Segal recommends that ETF consider optimizing the specialty drug dispensing network to include only pharmacies that can offer specialty drug dispensing expertise and clinical management for these expensive and complex drugs. While deeper discounts do exist for these specialty pharmacies by concentrating the volume through fewer providers, the true savings and benefit lie in the enhanced clinical outcomes and reduction of waste these specialized pharmacies provide.

Savings from use of an exclusive specialty pharmacy manager would require additional study but has been seen in other large employers to reduce both medical and specialty Rx claims by several percentage points over time.

Clinical Program Strategies

ETF could also benefit from more tightly focused efforts on specific disease states.

With regard to clinical pharmacy program strategies, the two most impacted disease states over the last couple of years have been Hepatitis C (with the introduction of Sovaldi, Harvoni, Olysio, and Vikera Pak) and Cholesterol lowering agents (with the introduction of Praluent and Repatha).

The following represents Segal's analysis of these two disease states based on the data available.

Hepatitis C

Hepatitis C treatment is ranked in the top five disease states by utilization cost to ETF for Q1 and Q2 of 2015. For this time period ETF has spent $3.5 million in plan paid costs for 74 utilizing members for the commercial prescription benefit plan and $2.5 million in plan paid costs for 26 utilizing members for the MedicareRx plan. Currently a prior authorization coverage review is mandated by ETF and the plan maintains a 46% approval rate for the commercial plan and a 65% approval rate for the MedicareRx plan. These approval rates are consistent with Segal's expectations for a large plan similar to ETF.

Hepatitis C also consistently ranks among the top five disease states by cost for many of Segal's plan sponsors. While the high price tag for this medication is often seen as the only cause for this, there are also other factors that have resulted in the appearance of this medication in the top five disease states. One of the primary drivers has been an apparent "warehousing" effect by physicians.

The anticipation of the new release of these cures resulted in greater utilization in the first years of the launch 2014-2015). Due to the detrimental side effects that older traditional Hepatitis C therapies would cause many patients, many prescribers delayed treatment of these patients until these more effective medications with reduced side effects were available. Essentially patients were "warehoused" until the launch of these medications.

Segal expects there to be continued utilization of these medications in years to come; however we expect a gradual drop off in utilization rates of these expensive Hepatitis-C treatments. We also expect to see prices stabilize as additional new drugs in this therapeutic category enter the market, resulting in potential cost savings to ETF's pharmacy benefit plan in the coming years.

PCSK9 Inhibitors

PCSK9 (proprotein convertase subtilisin/kexin type 9) inhibitors are a new generation of specialty cholesterol-lowering drugs. On July 24, 2015, the U.S. Food and Drug Administration (FDA) approved Praluent (alirocumab), the first cholesterol-lowering treatment approved in this new class of drugs. Praluent is approved for use in addition to diet and maximally tolerated statin or traditional cholesterol lowering therapy in adult patients with genetic condition known as Heterozygous Familial Hypercholesterolemia (HeFH) or patients with clinical atherosclerotic cardiovascular disease such as heart attacks or strokes, who require additional lowering of cholesterol. This was a more stringent indication than expected by many in the industry and has contributed to the slower than expected uptake of these medications.

Repatha (evolocumab; Amgen) was the second medication in this drug class approved by the FDA on August 27, 2015. In addition to the indications that Praluent carries, Repatha also was approved to treat the genetic condition known as Homozygous Familial Hypercholesterolemia (HoFH). Prior to Repatha's approval, the medications available to treat HoFH cost roughly $1.2 million a year per patient. The cost of the new therapies is approximately $12,000 annually per patient.

The introduction of high-cost specialty brand medications in a predominantly maintenance drug category, such as high cholesterol (which could be lifelong treatments), has the potential to expose plan sponsors to significant increases in pharmacy costs if the appropriate utilization management techniques are not employed. Currently ETF does not allow for "new to market" medications to be covered unless they have been on the market for at least 180 days.

The Navitus P&T Committee, on which ETF has a representative, will not add either of these PCSK9 drugs to its formulary until additional clinical outcome data is available. Evaluations of the clinical efficacy of the drugs are expected in late 2016. The drugs could still be covered on an exception basis.

This recommendation is consistent with Segal's view on the management of these medications. Segal has recommended this approach due to a variety of factors, predominately being that this disease state already contains widely available medications that are clinically appropriate and very successful in lowering cholesterol for the vast majority of patients. The circumstances in which Segal would currently recommend coverage for these medications would be for those members who have a diagnosis of HoFH, as mentioned above. While the PCSK9 inhibitor (Repatha) has significant cost implications, it is significantly more cost effective than alternative therapy (Juxtapid or Kynamro). Segal asked for a review of the ETF's claims utilization and it

was determined that the ETF does not currently have any members utilizing Juxtapid or Kynamro.

Segal's national pharmacy team clinicians monitor closely the utilization of this drug class and the clinical endpoints after the new drugs are launched. Segal will work with ETF and its pharmacy benefit manager to discuss the latest developments for this drug class, provide industry standard best practices once coverage is allowed, and design protocols for these medications to control for the right balance of coverage.

From our review of the results and utilization of the ETF prescription drug program, we believe that the ETF has a very solid grasp on their active clinical programs. In addition, we conclude that there are no other clinical programs that will generate significant savings for the plan. At this point we would recommend that ETF focus on optimizing its pharmacy network and move forward with the already selected clinical programs.

Long-Term Strategies

A number of longer-term strategies are developing that may be of use to ETF in managing its pharmacy benefit program. The following describes five such developments that should be discussed and considered by ETF.

Prospective MAC Price List for Generics

The current process to set pricing terms as a discount off of Average Wholesale Price (AWP) for generic drugs with multiple suppliers can leave clients open to inflationary manipulation of generic drug prices. It is possible that a PBM or pharmacy chain can manipulate the use of the AWP source to demonstrate that it meets the agreed percentage discount guarantees, yet still have higher actual drug pricing than another PBM with the same discount percentage guarantees calculated based on a more cost-effective starting AWP.

Given the need for buyers to contain the price increases of established and well supplied generic pricing, Segal proposes that large employer plans push the market in attempt to secure prospective price ceilings for future generic drugs. By working with the PBM to set a cap on next year pricing per unit of generic therapy, a client can effectively transfer some of the price increase risk to the PBM and supplier to keep their increases in generic prices closer to overall CPI or some multiple of CPI. This process can start most easily with pricing caps for generic drugs at mail service where the PBM is the buyer and has a relationship with wholesalers. Rules can be imposed that exclude new generic entrants or drugs with limited suppliers to help PBMs engage in potential contracting. Instead of comparing discount percentages off of a moving and potentially manipulated AWP target, the plan can compare pricing offers for generic drugs in a more effective way to contract for generic drugs that caps price inflation. Today price inflation, not increased utilization, is a major driver of plan cost trends.

Although Navitus currently offers a pass-through pricing arrangement to ETF, it is no longer enough to simply pass through excessive price increases and take no responsibility to manage these increases. To that end, ETF should expect its PBM to begin to negotiate prospective price increases from generic drug wholesalers and retailers. ETF requirements should now include commitments from Navitus or any other PBM to find ways to control supplier price increases for

generic drugs where multiple suppliers exist. It should be possible to use market competition and auctions from generic suppliers, wholesalers or retailers to include caps on product price increases. This approach should not impact the current pass through retail arrangement.

Targeted Reference Based Pricing for Brand Drugs

Borrowing from the medical community, a prescription drug plan sponsor could set a reference based maximum reimbursement (per day of therapy or per 30-day supply) within a therapy class where there are many interchangeable competing products.

For example, in the cholesterol lowering class, the plan can set a maximum allowance for reimbursement equal to 80% of some fair cost-per-day metric (median or 80th percentile price of all brand products on the formulary that treat hyper-lipidemia). The member would pay 100% of the excess price per day or per 30-day supply. This approach could be implemented for several high cost therapy classes and could dramatically change market share as consumer behavior gradually changes away from higher couponed or rebated drugs to the most cost effective options. In effect, the plan would give the member a nudge to pay attention to the cost of the drug being purchased and to ask tough questions about the available options, whether brand or generic, that would keep the participant's cost below the subsidized threshold.

Of course, this concept requires not only plan design changes, but also a significant and ongoing investment in systems support and member education and communications. Such a plan design change could reverse the pharmaceutical pricing logic to begin to put downward pressure on brand pricing for drugs in crowded therapy classes to make sure their drugs doesn't lose market share. At the same time, this protocol would begin to generate significant savings to ETF.

This approach could also be considered for certain specialty drug classes where interchangeable therapies are available. Finally, such a strategy will likely reduce rebate revenue as a percent of total plan expenses; however, with proper design, overall net plan cost could be lowered.

Integration with Medical Data

When provided with participant medical data, specialty pharmacies can use specific medical data, such as lab test results, to ensure the medication that is being dispensed does not pose significant health risk to the member. This coordination of medical data across employer sponsored programs can result in both pharmacy savings and medical plan savings.

Laboratory tests to monitor toxicity versus effectiveness are important parameters to consider with specialty medications as many are very potent and can potentially carry significant side effects. In the future genetic testing for key markers will also allow plans to avoid the cost of wasted supplies and treatments. We encourage ETF to begin to look at adopting more clinically intense protocols for select therapies by providing the vendors with requisite data to allow them to help manage the program.

PMPY Cost Trend Guarantees by Class

In addition to securing discounts and rebates in the traditional PBM contracting manner, ETF can explore implementation of cost guarantees by patient that will incorporate all elements of discounts, rebates, generic dispensing rates, and dispensing fees. For example, assuming the

current industry trend for prescription drug treatment of diabetes patients is 15%, the PBM would be asked to place a per member per year (PMPY) cap on the next year costs to treat those same diabetics at a price increase less than 15%. Simply demanding a pass through contract is no longer adequate as it allows the PBM to sit on the sidelines when suppliers, wholesalers and retailers do nothing to limit the spiraling cost inflation of some drugs and therapies.

Creating a new financial arrangement that shares the risk of cost trends with the PBM should be the next step in the evolution of PBM contracting. Excess PMPY cost trends would need to be returned as PBM refunds to ETF if the PBM misses the target. The PBM will likely require several rules and pre-established metrics in order to create a fair risk-sharing contract that the PBM can help control. The PBM will need to be able to propose clinical management programs that would be attached to the trend guarantees, and possibly the inclusion of some gain sharing with the PBM should they reduce the PMPY trend rates below an agreed threshold.

Segal recommends starting with a discussion with Navitus and establishment of an initial pilot program for a few important but manageable therapy classes. This would allow the PBM to take on manageable risk and allow ETF to limit the exposure of new plan management rules to a controlled number of patients before wider scale use is pursued.

Leaner and Rational Plan Design Concepts

Not all therapies are equal in value. Consider a plan design that provides higher levels of coverage for lifesaving or life-sustaining drug therapies and lower coverage for treatments of minor illnesses.

In most cases, conditions like cough and cold, allergies acid indigestion, minor pain (treatable with NSAIDs) or lifestyle needs like contraceptives and erectile dysfunction may require only modest “monthly maximum allowances” rather than an across the board 80% reimbursement. For example, a plan could design coverage for such less serious treatments that include a maximum monthly allowance of $25 to $35 with patients paying 100% of any excess charges above the allowance. Such a design would limit the plan sponsor’s exposure to inflation for these therapies and reduce the impact of manufacturer coupons and other promotional activity that increase plan costs and utilization. The program could also result in some patients moving from prescription medications to over the counter (OTC) products, increase generic drug use where applicable, and potentially remove some excess utilization, allowing the plan to maintain a high level of coverage for more costly but serious conditions.

We recommend that ETF discuss this type of approach as part of its ongoing prescription drug design planning each year.

Retiree Drug Plan Design Issues

In addition to changes for the overall pharmacy benefit program, ETF should consider changes that help to contain and reduce cost for the retiree prescription drug program.

The current per member per month (PMPM) cost for the Medicare retiree prescription drug plan is over $200 for Rx coverage alone. Adding a lower value plan will allow the State to offer a plan with much lower premiums.

The dollars coming from the CMS reinsurance payments for catastrophic claimants and the manufacturer discounts on brand drugs in the coverage gap have become and will continue to be a bigger source of funding over time for plans. This is because a growing portion of drug plan expenses are coming from high cost specialty brand drugs which can largely be funded by the 80% reinsurance payments from CMS. At the same time, the direct payments to PBMs from CMS for the initial tier coverage are stagnant or even reduced year over year.

This situation of decreased initial tier Medicare subsidies and increased coverage gap and catastrophic claims subsidies is in part driven by the national bids submitted by the commercial Medicare Prescription Drug Plans and health insurers (MAPDs) that are trying to keep overall plan costs down by leveraging savings from the narrow pharmacy networks, more restricted formularies covering fewer drugs, and use of maximum available member out-of-pocket annual maximums. Unless ETF can follow and adopt these cost containment elements, there will be continued pressure on the standard part D subsidy as it becomes a smaller and smaller portion of the overall plan costs.

We offer the following recommendations as a starting place to lower retiree drug premiums in the future:

- To take advantage of these shifts in Medicare funding, ETF may actually want to increase the amount of retiree out of pocket costs selectively to get those members into the catastrophic level sooner. More claims would then be reimbursed by the CMS 80% reinsurance payment source. By doing so, the value of premium savings will more than outweigh the benefit cuts required to be made. This approach is, of course, counterintuitive to most retirees' sense of purchasing insurance. They believe they should buy the greatest level of coverage available or that they can afford. In this case, the Medicare Part D catastrophic coverage provides a better benefit for those retirees with very high annual drug costs.

- The changes being made for 2016 will help move in this direction and lower future premium rates. ETF should plan on making changes to the retiree prescription coverage every year to maximize the potential for Medicare reimbursements.

- We know from extensive analysis of retiree buying decisions that retirees often cite affordable premium as the most important feature when selecting a Part D plan. We also know that retirees want some choice (but not too many choices) in benefit selection. To address these factors, we suggest ETF create multiple prescription drug options for Medicare retirees. A starting point would be to keep the current plan as a high value plan and add another lower premium cost option. That plan would need to have perhaps 25% brand copays, higher annual member out of pocket maximums and even tiered generic copays (e.g. $3 for low cost generics and $10 for higher cost generics). Such a design could help ETF encourage retiree self-management of their prescription drug benefits by being able to trade premiums cost for point-of-sale costs.

  An example of a plan design for a lower premium Medicare Part D design would have the following benefit provisions. Apply a 25% coinsurance to all preferred brand and generic drugs with per Rx copay maximums

  - Apply a 35% coinsurance to all non-preferred brand drugs with no per Rx copay maximums

- Exclude all non-covered Part D drugs
- Consider annual deductibles

➢ Adverse Selection is a factor to address when multiple plan options are offered among a population. Such selection will need to be addressed and accounted for when pricing out the retiree annual cost to enroll in each option. While adverse selection can certainly affect the cost and success of a second plan, Segal's experience with retiree selection and the relative lack of mass migration tendency among retirees to change health plan options will enable us to adequately account for adverse selection over time to create stable pricing options and minimize cross subsidies between groups.

Formulary Concepts to Consider

Another concept to consider is limiting ETF's formulary to help lower pharmacy spending. ETF currently operates a broad and open formulary, where most drugs are covered. A limited formulary would have only a selected few drug choices in each therapeutic category. The choices would be limited to proven drugs with an attractive price point. Drugs not on the limited formulary could be covered, but not at the same level of cost sharing.

Adopting more aggressive formulary strategies, as is observed with some other buyers such as Medicaid state agencies and even commercial insurers offering coverage on the public health marketplaces, requires investment in clinical expertise and a willingness to take on greater risk. The potential return is significant, with lowered overall pharmacy benefit costs of possibly 5% to 10%

It should be noted there is a legal risk associated with potential negative clinical results from the use of chosen formulary products. All plans have some modest fiduciary risk already with respect to the formulary that is adopted or selected. However, to date we are not aware of any plan sponsor suffering major losses as a result of the formulary they offer or support. Moving to a more aggressive and restrictive formulary could increase that exposure. Having a qualified P and T committee and independent experts to help validate the steps taken would be an important requirement of adopting a more narrow formulary.

Restrictive formularies have been in place for years and the track record of plans to lower pharmacy spending with restrictive formularies has been good. Plans can lower overall pharmacy benefit claim costs by 5% to 10% by adopting a restrictive but still effective formulary. The ability to appeal to get non-formulary coverage must be managed appropriately to limit the potential liability to the plan. ETF will need to weigh the cost savings benefits against the risks and effort to properly support a restricted lower-cost formulary.

Summary of Recommendations

In our initial report, Segal made a number of recommendations for specific changes to ETF's pharmacy benefit program for 2016. This report focuses on opportunities for 2017 and beyond.

We are recommending the following:

1. **Consider narrow or tiered networks:** Annual savings $3 to $3.5 million per year on retail non-specialty ingredient costs

2. **Move to exclusive contracting for specialty drugs:** Annual savings $2 to $3 million per year in specialty savings from improved pricing and utilization controls

3. **Obtain better Retail 90 pricing either through bids or custom contracting:** Annual savings will vary based on custom contracting and current terms for 90 day retail supply

4. **Tighten up medication management services -** Annual savings of 1% to 2% of program costs. Medication management strategies is the general term that includes clinical programs and member education programs that address both specialty and non-specialty treatments. It includes strategies that support medication adherence, step therapy, prior authorization, quantity limits, patient education around polypharmacy and side effects, etc.

5. **Add a new lower cost Medicare Part D plan option:** This will allow for the offering of substantially lower cost retiree premium option and will provide greater choice for retirees

6. **Pursue several new contracting concepts with either the current PBM or through bids**

7. **Add performance guarantees around clinical outcomes**

Additionally, given the high level of satisfaction with Navitus's service and relatively good financial performance, Segal supports extending the contract through 2017. Extending for another contract year will allow time for the development of a comprehensive PBM RFP and allow for sufficient time for a comprehensive bid process.

With the above, we would estimate savings of $10-$20 million in total could be achieved. Further research will need to be performed to solidify these estimates.

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Data Management

In our initial report, we presented a model of the features and functions that would be present in a current best practice claims data warehouse and how those features would allow a large health benefit plan like ETF to more closely manage its costs, utilization, health risk, provider quality and plan performance. We also discussed our preliminary findings on the Wisconsin Health Information Organization (WHIO) initiative as a possible vehicle to provide that best practice data warehouse for ETF.

As part of that report, we identified four possible approaches for ETF to consider with regard to WHIO as a health plan management warehouse, including:

- Working with WHIO and Optum to expand the current WHIO capabilities;
- Using WHIO for the clinical and enrollment factors and developing plan financial information separately;
- Bidding and contracting a new data warehouse system specifically for ETF; or
- Building your own data warehouse.

This report picks up from that initial analysis and looks in more detail at ETF's particular needs ETF for health plan data management. We review ETF's current data mining status, identify the long-term needs for the program, present potential approaches to achieve that desired level of data accessibility and recommend next steps for ETF action.

Current State

ETF is a leading purchaser of healthcare in the State of Wisconsin, with an increasing focus on value based purchasing. The objective is to attain the best cost value for employees and improve efficiency and quality within the health care system. Access to the plan's data and the ability to perform analysis is crucial to ETF's ability to effectively manage the program to maximum efficiency and to support, develop and monitor achievement of its strategic and tactical objectives.

Currently, ETF does not have the ability to evaluate and analyze costs, utilization, health risk, provider quality and plan performance from a single data source. It is unclear whether ETF even has access to all of this data from all its health plans and vendors. In addition, the data that is available is housed in multiple locations, covering different historical periods and in varying formats and quality.

WHIO Access

ETF participates in the Wisconsin Health Information Organization (WHIO) initiative, which includes access to a statewide, centralized health database consisting of reporting on quality and cost of health insurance experience. WHIO contracts with OptumInsight to provide the platform of its data warehouse through license to an enhanced DataMart.

As noted in our first report, there are limitations within the WHIO DataMart, which in turn limit ETF's ability to analyze opportunities for population health improvement while maintaining costs. Care gap levels and utilization patterns do not necessarily correspond to health risk levels between the health plans. Financial information is limited and there are inconsistencies in reporting of key metrics across plans. In addition, until recently not all of ETF's contracted health plans provided data to WHIO, which has resulted in gaps in the data. Even with the remaining non-submitter plans now being incorporated into the WHIO database, it will be another year or two before the DataMart includes a comprehensive history for the entire ETF membership. Finally, the reporting package provided by WHIO is targeted more for carriers who submit data to WHIO, not for plan sponsors trying to manage a complex employer health benefit program.

After further evaluation of the capabilities and potentials of the current WHIO database, we believe it will not constitute a long-term solution for ETF's data-focused management of its benefit programs. While WHIO provides some of the features needed, it lacks crucial data elements and functions, such as the actual reported cost and allowed cost of services reported, and ad hoc data access for detailed analyses of selected procedures, providers or effective discounts.

While ETF has continued involvement with WHIO, it does not control the mission or contracting of WHIO, so will not have full influence over the data or services that will be available in the future. We believe that full control over ETF's plan data is important for successful ongoing management of the program.

ETF Needs

As additional strategic options are considered, including additional value-based elements, ETF needs to be better positioned with comprehensive data to support its ongoing plan management needs. For example, ETF needs to be able to analyze and manage targeted interventions; improvement in participant compliance; outcomes-based payments; and quality at the individual provider level.

The following provides a summary of features we believe ETF needs for best practice ongoing management of its program. These features also support ETF's ability to develop supportable strategies for improving efficiency in delivery of health care, and for managing cost and pricing for long-term plan sustainability.

- **Financial Management**: ETF needs to be able to measure and analyze the aspects of a health plan that are related to budgets, forecasts, rate setting, and reporting.

For 2016, ETF improved the health plan renewal process with a goal of more accurate assessment of costs and efficiencies of competing health plans utilizing detailed claims and encounter data. It is expected that additional information and enhanced transparency will be achieved in subsequent renewals and negotiations. More comprehensive data management capabilities are essential to manage and effectively analyze this data.

- **Benefit Design & Network Management**: ETF needs to be able to identify and evaluate services that support design effectiveness, network performance, cost sharing strategies, and vendor management.

  ETF continues to analyze data and investigate market options for 2017 to improve the health management and wellness programs. The Plan is in the process of designing effective cost sharing strategies that steer patients away from overpriced hospitals, physicians or drugs for specific procedures or conditions, where the higher cost is not justified by demonstration of better outcomes. The Plan is also reviewing the feasibility of implementing tiered networks.

  Data warehousing is frequently used to monitor high-quality/high-performance providers and to tie those providers to their underlying cost. ETF can also utilize data warehousing to evaluate provider reimbursement arrangements as you consider a shift from the fee-for-service model to alternative payment models, such as bundled payments, which are designed to encourage providers to coordinate care and reward efficiency.

- **Medical and Pharmacy Quality Adherence**: ETF needs to have the ability to measure and evaluate preventative services compliance, compliance with standards of care, and prescription drug adherence.

  An integrated data warehouse is key to monitoring quality of care compliance with evidence-based medicine for programs such as cancer screenings, diabetes treatment, flu shots, and hypertension control.

- **Medical Management & Wellness Program Design**: ETF needs the ability to perform analyses that support wellness design, including health risk assessment data analysis, chronic conditions profiling and track the metrics developed to measure the progress of the Total Health Management program design.

  There are additional needs as ETF continues to require tools though use of data mining to support health management and wellness design efforts:

  - ETF's use of risk modeling to support and enhance the three-tier premium program to and negotiate with providers to price plans within Tier 1 (plans with top efficiency and quality). The current risk modeling and adjustments are performed utilizing pharmacy data. A comprehensive data warehouse will provide the ability to incorporate medical data, which provides a more comprehensive member risk profile and therefore a better basis for comparing performance and quality between plans and providers.

- ETF's requirement of health plans to identify members with moderate or high health risk and enroll them into appropriate health management programs. Data mining is used to determine members who currently are driving a high percentage of costs as well as those projected to drive costs in the future. Those members could benefit from targeted, clinical intervention that aims to reduce future costs that may result from hospital readmissions for the same illness, or early detection of disease that can be treated with less invasive and less costly treatment options. Reviewing the severity of employees' diseases and conditions will help ETF identify those who have complex needs and require significant care management and verify that the health plans are utilizing appropriate outreach
- Evaluate the Uniform Wellness Incentives required of all health plans to issue $150 to adjust members who complete biometric screenings and a health plan administered HRA. Correlation of biometric screening results and intent to change behaviors collected from the Health Risk Assessments can be evaluated to monitor improvement to health risk and costs.

➢ **Vendor Performance & Contract Adherence**: ETF needs to have an enhanced ability to evaluate and monitor targeted performance guarantees, conduct discount analysis and review payment accuracy.

Through the program's coordination of care, health plans (or their contracted hospital / physician groups) must contact a member who has been discharged from an inpatient hospital with a diagnosis of heart failure, myocardial infarction, pneumonia, or any other high-risk health condition, within 3-5 business days with the intent of reducing hospital admissions. ETF can utilize data mining to independently monitor vendor performance related to reduction in hospital readmissions. ETF can also utilize data mining in support of to proactively detect fraud and abuse (e.g., identify ineligible dependents and excessive or unnecessary prescriptions).

➢ **Provider Quality:** As ETF considers longer term and additional value based components in the program's design and strategy, there needs to be the capability to evaluate and compare quality and efficiency at the provider, or provider group, level.

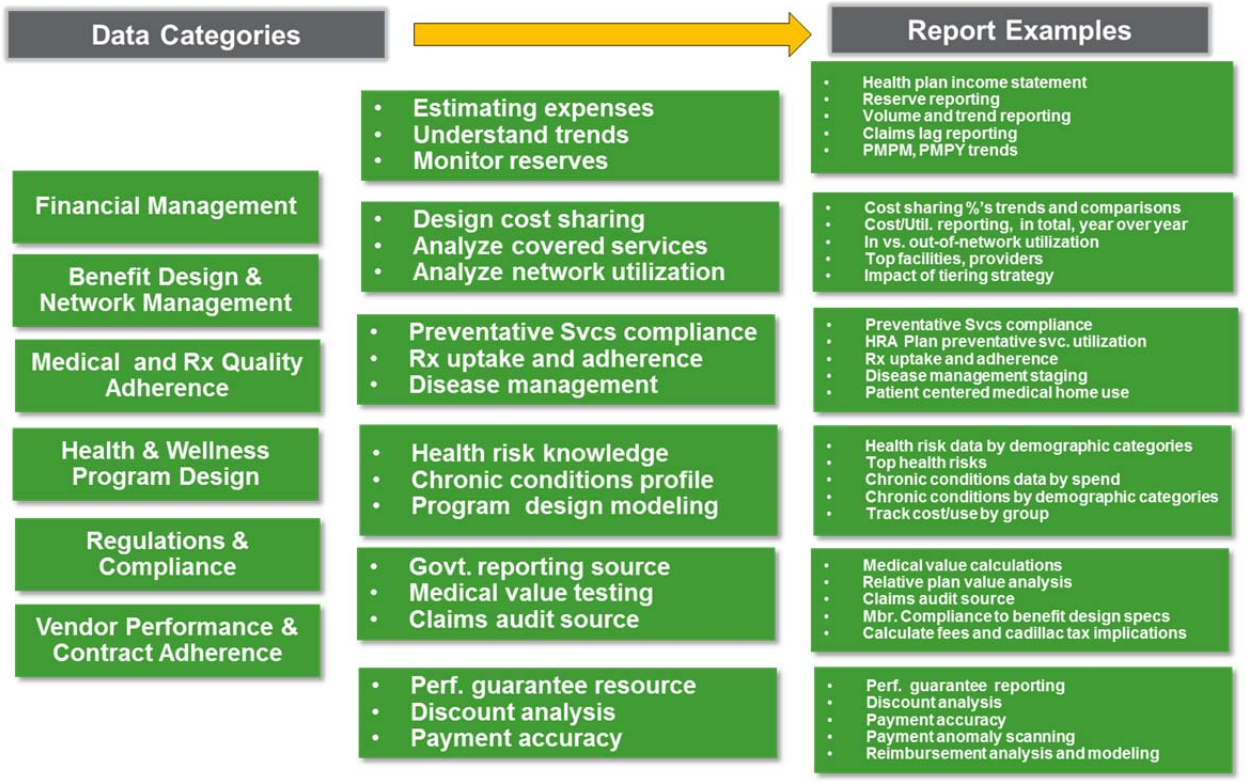
An integrated data warehouse specifically designed for ETF's structure and needs can also be valuable in analyzing provider quality. This would allow ETF to make determinations on how to encourage employee and retiree use of the highest quality and most reasonable cost providers.

ETF needs a warehouse option that has rigorous data cleansing processes with comprehensive benchmarking and an ability to go beyond canned reporting. ETF also needs an option to supplement ETF staff capabilities cost effectively (e.g., enhanced analytics assistance).

In summary, the objective is to have the ability to analyze data from a variety of sources on a fully consistent and continuing basis. This will allow ETF to develop and monitor strategies for improving health outcomes and for increasing the outcome-efficient and cost-efficient delivery of quality health care to ETF participants.

Data Warehouse Architecture

The most efficient data warehouse installations are those specifically designed for the health plan's needs. While numbers of different health data warehouse structures exist, all typically include the following major categories of data, functionality and reporting:



ETF needs its own comprehensive health plan data warehouse. With such a data warehouse, ETF will be able to convert health utilization data into actionable information and make well-informed decisions that improve the value of the plan.

Data Warehouses Among State and Local Government Health Plans

The world of health plan data warehousing has developed enormously over recent years. Most state plans now employ data warehousing to identify and support strategies that reduce waste, mitigate cost increases and improve the overall health and well-being of their participants. As an example, every other Segal state-level client has a comprehensive data management and warehousing system, with many having been in place for more than 10 years.

In addition, many of our larger local government, multi-employer and private sector clients utilize a customized data warehousing system as well. Even smaller local government entities now have access to low-cost, standardized data warehouse platforms that capture key data from their health plan carrier or administrator and provide standardized and some ad hoc reporting functions for many of the important management factors.

Typical data housed in the data warehouse includes complete medical and pharmacy claims data (encounter, diagnosis, costs, etc), biometric screening results, laboratory results, health risk assessments, disease management program participation and wellness program participation.

Some plans have state sponsored clinics and they track encounters. Additional elements sometimes include dental and vision experience, as well as disability and worker's compensation program related data.

A small number of states have developed and now maintain their own data warehouse systems; however, it is far more common for state plans to license access to a highly sophisticated data warehouse system managed by an external vendor. For almost all states, the significant cost and staff time and effort required to design, build, operate and maintain a home-built system, plus the specialized expertise required on staff to support the system, have encouraged them to bid and contract use of a ready-made warehouse.

Additionally, state health plans typically rely on their actuaries and consultants for technical and analytical assistance. These outside professionals are given access to the data warehouse and help develop specialized reports and analyses using the system functions and data. Some of those reports are designed to allow the Plan's staff to update and run regular reports needed for day-to-day operation. In addition, the data can be used to develop highly customized analyses such as dashboards. For example, Segal has worked with a number of large state plans to develop a sophisticated dashboard of key management and utilization factors specifically targeted for the plan's needs. These dashboard can provide perspectives on emerging trends (e.g., forecast to pharmacy trend with the introduction of PCSK9 in the marketplace) as well as ongoing measures of important plan performance.

Marketplace Capabilities

There are a number of data mining firms in the marketplace with significant years of experience (20+ years) that have capabilities and experience aligned with ETF's needs. Major data warehouse players operating efficiently at the state health plan level include: HDMS; Optum; Truven; and Verisk Health. In late summer 2015, Segal conducted market educational webinars for ETF with each of these vendors to have them demonstrate the depth of their capabilities in the marketplace.

These firms demonstrated processes to perform extensive data quality validation, including: unique member ID matching; link to enrollment records; financial reconciliation; population of fields with expected results; review of key dates; and custom fields. Application functionality for these systems include dynamic dashboard reporting; scorecards; automated reporting; trend analysis; comparison to comprehensive benchmarks; risk profiling / predictive modeling; analysis of disease severity; analysis of episodes of care; HRA and biometric data integration; provider profiling; and cohorts / population segmentation.

Each vendor in the market also provides rigorous safeguards to protect and secure all data to meet all applicable Federal and State standards, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. On each of the systems, data can be stored with each member's sensitive personal information (SSN, names, etc) redacted for reporting purposes, to keep reports on an "anonymous" basis. Reporting and analysis is generally performed in aggregate, and under no circumstances would an individual's personal information become available to the State or ETF.

Each of the firms that participated in the webinar demonstration has experience with large public sector plans and we expect could provide an effective warehouse solution to support ETF's plan management and strategic needs.

Additional Cost

Currently, ETFs annual direct cost for use of WHIO is $50,000.

As part of our market survey, Segal received ballpark estimates of implementing a data warehouse solution from the firms discussed above assuming 4-8 medical carriers (along with Rx and eligibility feeds). One-time, up-front, implementation fees ranged between $75,000 - $155,000. Ongoing maintenance fees ranged between $200,000 - $260,000 annually for quarterly updates and $220,000 - $330,000 annually for monthly updates. These should be taken only as market estimates, but are generally in line with our experience with other state and large government plans. Actual pricing would be subject to negotiation based on the actual specifications and requirements of the contract.

While these data warehouse and data mining fees are greater than ETF's current cost for WHIO, the capabilities and flexibility of these systems are far superior than the current WHIO structure. The investment in a customized data warehouse is likely to be offset by the plan savings that should result from the enhanced analytic capabilities and the ability for ETF to identify and quantify opportunities to improve efficiencies within the program. Relative to the current annual program cost of $1.4B, fees for a customized data warehouse would be less than 0.02% and additionally, there generally is room to negotiate costs and potentially reduce implementation fees with a multi-year agreement.

Recommendations and Next Steps

Our first report commented that augmenting WHIO could be a possible approach to meeting ETF's program management needs. However, to accomplish this, it would be necessary to make a number of structural changes to the current WHIO architecture, including:

- Incorporating additional charge fields, many of which are sensitive to plans and providers
- Increasing the frequency of data updates and reduce the time necessary for each update
- Enhancing access for ETF, and others working on behalf of ETF, directly into the system to run reports and conduct analyses on the all the data available, including cost and charge fields
- Increasing the amount of historical data maintained in the DataMart

This last item may be achievable, but in our opinion, based on conversations with WHIO and ETF, the other three items pose significantly greater challenges.

In our opinion, a better option for ETF is to competitively bid and contract with an external data warehouse system vendor that could provide a ready-made system tailored to ETF's specific structure and data and functional needs.

We recommend bidding the data warehouse system in early 2016, with a decision target of mid-2016. Initial implementation of a warehouse solution typically takes four to six months, so with such a bid schedule, ETF's data warehouse vendor could be operational as early as January 2017.

It is our recommendation to issue an RFP in 2016 for a 2017 implementation. This will enable ETF to have a data management solution in place as the additional detailed data is provided by the plans during the transition to self-insurance and for ETF to begin to more effectively manage the program in a relatively immediate fashion.

A rough proposed timeline is as follows:

Task	Timing
Draft RFP	January-February, 2016
RFP Release	March 1, 2016
Intent to Bid	March 15, 2016
Deadline to Submit Questions	March 15, 2016
RFP Deadline	March 31, 2016
Evaluation of Proposals	April, 2016
Interviews and Demos	May, 2016
Final Selection & Award	May 31, 2016
Contract Execution	June, 2016
Contract Effective Date	July 1, 2016
Implementation	July to December, 2016
Operational Date	January 1, 2017

ETF would need procurement assistance from the Department of Administration to meet the above timeline. We also believe it may be necessary to expand ETF staff (currently 2) to focus on data management initiatives.

Segal also recommends that ETF continue its participation in and support of the WHIO data system. While that system will not provide the full data solution for management of ETF plans, the breadth of utilization and provider information collected by WHIO may continue to provide a useful enhancement and broader statewide health benefit perspective. In addition, with its own data warehouse, ETF's data feed to WHIO could be accomplished on a consolidated and regularly scheduled basis from a single data source, which over time should help reduce WHIO's reconciliation and data scrubbing efforts.

Market Observations

This section presents Segal's review and observations on a number of topics of direct relevance to ETF's health benefit plan. These descriptions help to provide a broader perspective of current developments across a variety of state health benefit programs.

Minnesota State Employees Group Insurance Program

The Minnesota State Employees Group Insurance Program (SEGIP) provides an interesting point of comparison with ETF's program. Not only is this the plan for state employees in a neighboring state, but SEGIP formerly utilized an insured managed competition model similar to ETF's and transitioned some years ago to a self-insured strategy with a more focused number of health plans. While the Minnesota and Wisconsin healthcare markets are unique relative to one another in many ways, there are some interesting observations regarding SEGIP's current program and its recent history that may help inform ETF as it considers future plan and program changes.

Current Program

SEGIP provides coverage to approximately 54,000 active and retired State employees, plus their eligible dependents for a total membership covering about 127,000 members. Medical coverage is provided on a statewide and national basis by three claims administrators:

- Blue Cross Blue Shield of Minnesota
- Health Partners
- PreferredOne

Pharmacy benefits are provided by Navitus, Both medical and pharmacy benefits are self-insured. SEGIP purchases an aggregate stop loss insurance policy with a 125% attachment point (this is apparently primarily for political reasons, to provide an additional measure of protection against unexpected spikes in plan cost).

Most employees have coverage via the Advantage Health Plan, which provides coverage at one of four levels, or Tiers. See the benefit details in the following table.

Benefit Provision	Tier 1	Tier 2	Tier 3	Tier 4
Preventive Care Services	No cost to member	No cost to member	No cost to member	No cost to member
Deductible (single/family)	$75/$150	$180/$360	$400/$800	$1,000/$2,000
Max Out of Pocket (single/family)	$1,100/$2,200	$1,100/ $2,200	$1,500/ $3,000	$2,500/$5,000
Office Visits[1]	$18/$23	$23/$28	$36/$41	$55/$60
Emergency Care	$100 copay after Ded.	$100 copay after Ded.	$100 copay after Ded.	25% coinsurance after Ded.
Inpatient Hospital	$100 copay after Ded.	$200 copay after Ded.	$500 copay after Ded.	25% coinsurance after Ded.
Outpatient Surgery	$60 copay after Ded.	$120 copay after Ded.	$250 copay after Ded.	25% coinsurance after Ded.

Members that complete a Health Risk Assessment and agree to take a phone call from a health coach or nurse have their physician office visit copays reduced by $5.

Each member is required to select a Primary Care Clinic (PCC), which is essentially a provider practice that acts like a Primary Care Physician in a traditional HMO model. Each PCC is evaluated annually on risk-adjusted cost only, assuming quality and efficiency result in lower costs. The PCCs are grouped into one of four tiers. A member's PCC tiering determines the benefits and cost sharing for the member for all medical services. Most members (50%) utilize a Tier 2 PCC, with about 20% in Tier 1. The remaining 30% are in Tiers 3 & 4.

Rigorous utilization management protocols are in place, requiring referrals or prior authorizations for most services provided by providers not within the member's PCC. Since the tiering is on a total cost basis, the assumption is that PCCs have an incentive to treat and refer members in most efficient and high-quality fashion possible.

Pharmacy benefits are uniform across all tiers. The pharmacy data is not utilized in the PCC tiering.

Benefit Provision	Generic Copay	Preferred Brand Copay	Non-Preferred Brand Copay
Prescription Drugs	$12	$18	$38

A Consumer Directed Health Plan is also offered to management and employees that are not collectively bargained, but only about 50 employees are enrolled. The plan is an HDHP with an accompanying Health Savings Account (HSA). It is called the Advantage Consumer Directed Health Plan (ACDHP). The premium for the ACDHP is based on the Advantage Plan. The employer contributes to the premium on the same basis as it contributes to Advantage (e.g., 95% of single premium, 85% for dependent premium). The employer contributes $500 (single)/ $1,000 (family) to the HSA. Employees that participate in the Biometric Health Screening had who complete the Health Assessment and agree to accept a coaching call can earn additional employer contributions into their HSA.

[1] Copay level dependent upon whether the employee has completed the Health Assessment.

Most active employees do not pay a monthly premium. However, much like in Wisconsin, retirees pay the full cost of coverage. Medicare retirees have a choice between Advantage plans that coordinate with Medicare and a Medicare Advantage option.

Background

Prior to 2002, SEGIP utilized a managed competition model similar to ETF's model. At one time 12 plans competed to provide coverage on an insured basis with member choices varying by county. Market consolidation and volatility (significant premium increases) led the State to determine that converting to a self-funded approach, with limited plans, was the best strategy to take control of the situation and reduce, or at least manage, the volatility.

The conversion to self-insurance was also driven by a desire to "own" its own healthcare claims data and have the ability to utilize the data as necessary to manage the program. They had a number of issues collecting data from their insured vendors and the state was pushing for full transparency in their contracting. After three years, it was determined there was sufficient data to compare providers and the current PCC tiering approach was implemented.

SEGIP reports that annual trends have been low or manageable, but that is at least in part due to the State implementing and adhering to a reserving policy that has enabled SEGIP to manage annual claims volatility.

Comments and Observations

The PCC tiering approach is interesting as a value-based provider payment strategy to incent high quality, efficient care. However, this may be of interest mostly at a theoretical level, as SEGIP has not conducted a thorough study to examine and verify the impact of this approach.

Virtually all providers are in each of the claims administrators' network. With this lack of differentiation between the networks, it is unclear how each administrator has the leverage to negotiate as effectively as possible with the providers. Also, SEGIP has not analyzed the data to determine if, and to what degree, each of the administrators is providing different levels of provider pricing and health management. There is no difference in the full funding rates by claims administrator.

However, it should be noted that the full funding rate for single coverage is approximately $525 per month, which is about 24% less than the average single rate for ETF's UBD, which is $689**.** It is important to note that the benefit levels in Minnesota are higher than ETF, making the above even more perplexing. The data utilized by our manual health premium rating model indicates that, on average, healthcare in Wisconsin is approximately 9% more expensive than in Minnesota. This leaves approximately 15% remaining unaccounted, some of which could be due to differences in demographic or health risk. In our opinion, the difference between the two memberships' risk is not likely to account for much of this difference. Therefore, there is something about the SEGIP self-insured, three health plan strategy that results in relatively well-managed costs.

National and Regional Market Changes

Health care is a fluid and ever-changing marketplace. Staying abreast of new developments in the health care landscape is important for plan sponsors. Significant regional vendor alliances and consolidations are underway in Wisconsin and major national level mergers are also currently in process. Below is a brief review of some of the more notable events influencing and modifying today's health care market.

Local and Regional

In addition to ETF's current health plans, we reviewed three local/ regional organizations of note that may impact health care in Wisconsin. One is an organization called The Alliance. Founded in 1990 by seven Madison-area employers, the Alliance is a cooperative of employers that self-fund their health benefits and claim to be "moving health care forward by controlling costs, improving quality, and engaging individuals in their health."

Currently, this organization includes over 240 self-funded employers and insurance trusts that cover more than 100,000 individuals. The Alliance negotiates directly with providers, evaluating both quality outcomes and service costs. They also provide data management services and claims reporting detail allowing their members to better understand the factors driving their costs. In addition, the Alliance provides education and resources to help members design benefit plans and implement employee wellness and prevention programs.

Their service area includes providers in Wisconsin, Illinois and Iowa. The Alliance contracts with 80 participating hospitals, over 7,000 physicians, 13,500 professional service providers and 4,400 medical, chiropractic and mental health clinic sites. A transparency tool is provided to their employers' plan participants to encourage informed decision-making and health care consumerism among their in-network providers.

While they may offer attractive provider discounts and their focus on quality outcomes and efficient care is in-line with ETF's mission, utilizing The Alliance would likely require special procurement and contracting consideration. The Alliance does not process claims; all of its employer partners (who are also part owners) utilize a separate Third Party Administrator under their own separate contract. Also, a portion of the provider discounts are retained by The Alliance.

Originally launched in 2010 as Quality Health Solutions, Integrated Health Network (IHN) of Wisconsin is a relative newcomer to the local health care market. IHN is an Accountable Care network and the first clinically integrated Accountable Care Organization (ACO) in the state. This consortium of independent health systems, hospitals and physicians have come together voluntarily, intent on providing coordinated care to improve the quality, efficiency and value of health care.

IHN has more than 5,700 physicians and participating providers, 550 clinics and 45 hospitals in their network. IHN delivers care to Wisconsinites across 44 counties. IHN's network members include:

- Agnesian HealthCare
- Columbia St. Mary's

- Froedtert Health
- Hospital Sisters Health System
- The Medical College of Wisconsin
- Ministry Health Care
- SSM Health
- Wheaton Franciscan Healthcare

IHN, in its current configuration is not likely a viable vendor for ETF. If IHN evolves into a full service health plan, that may very well change. However, IHN may be an attractive component within a larger network and full-service contract between a health plan and ETF. For example, Froedtert Health and Ministry Health Care, have partnered to pursue co-ownership of Network Health. This transaction will expand the Network Health service area into southeastern Wisconsin and enable Network Health to offer IHN within its provider network in SE Wisconsin.

AboutHealth is another ACO new to the Wisconsin area. AboutHealth is a strategic partnership formed in the summer of 2014 and includes eight Wisconsin health systems and provider groups. These are:

- Aspirus
- Aurora Health Care
- Bellin Health
- Gundersen Health System
- Marshfield Clinic Health System (MCHS)
- ProHealth Care
- ThedaCareACO

AboutHealth is focused on improving overall population health for the communities they serve while working together to advance clinical quality, efficiency and the customer experience. The provider organizations that make up AboutHealth are recognized as leaders in delivering high quality, low cost care. Members have the same electronic health record platforms across provider groups and patients have access to 48 hospitals and over 8,000 providers.

Over 90% of Wisconsin's population resides within the AboutHealth network. An initial commercial insurance plan featuring the AboutHealth's organizations is currently being offered through Anthem Blue Cross Blue Shield's Blue Priority network. In addition, AboutHealth and Arise Health Plan announced an agreement in the summer of 2015 to offer co-branded individual and group coverage products with AboutHealth providers for 2016, and will have individual and small-group plans on the Wisconsin State Marketplace, or Exchange.

AboutHealth, in its current configuration also is not likely a viable vendor for ETF. If it evolves into a full service health plan, that may very well change. However, as demonstrated in the recent relationship with Arise, AboutHealth may become more attractive if it continues to partner

with health plans within a larger network and full-service contract between a health plan and ETF.

In addition to the presence of the three organizations above, there has also been a recent local merger of two of ETF's health plans. Unity Health Insurance, an affiliate of UW Health and Gundersen Health Plan, a subsidiary of Gundersen Health System, are making their partnership official. The resulting merger will represent a combined 250,000 patients. The goal of the partnership is to facilitate access to local health care and more effectively manage the health of the combined plans' population.

National

At a national level, news headlines report on the planned mergers of four major health insurers – namely, Aetna's acquisition of Humana and Anthem's proposal to buy Cigna. If both the mergers succeed, they would effectively consolidate the number of large health insurance carriers from five to three. The Anthem-Cigna merger would result in the combined organization being the largest U.S. health insurer by membership. These deals are being reviewed by the Department of Justice and state insurance regulators.

In addition, there has also been activity on the national PBM level. United Health Group has agreed to purchase Catamaran, a large PBM. Catamaran will be folded into United Health's OptumRx pharmacy care services unit. Once combined, OptumRx projects that it will fill over 1 billion prescriptions. As a point of reference, Express Scripts, another large PBM, filled about 1.3 billion prescriptions in 2014.

As the local and national health care marketplace evolves, ETF can monitor the developments of the changing environment. With respect to ACOs for example, large provider communities may yield significant influence that can affect change. Insurer consolidations may drive additional competition. With such a rapidly changing landscape, today's health care environment will likely be very different from the environment one year, five years and a decade from now. Remaining informed on current health care events affords ETF the ability to evaluate such changes prospectively and properly assess what potential impact market changes may have on ETF and its health plans.

Observations on Wisconsin State Marketplace/Exchange

In the first report to the GIB in March of 2015, we compared ETF premiums with premiums on the State Exchange for plans of similar value. For example, for people in one of the UBD options or Standard Plan, we compared their current 2015 premiums with premiums for Platinum Plans available on the Exchange. For members in the HDHP, premiums for Gold Plans were utilized. We excluded Medicare-eligible retirees since the State Exchange does not provide coverage for those retirees. In 2015, with the exception of about 2,000 members, all members in Wisconsin would have at least one Platinum Plan option on the Exchange.

According to the database released by the Federal Government on October 30, 2015, the number of rating areas with Platinum Plan options will be reduced in 2016 in Wisconsin. The result is that approximately 40,000 ETF members would not have a Platinum Plan option, if they were to be eligible for the Exchange. However, all members would have a Gold Plan option. Therefore, we compared 2016 ETF premiums, without dental coverage, with 2016 premiums for Gold Plans

on the State Exchange. Some of the plans on the Exchange include dental coverage; no adjustment was made to the Exchange plans' premiums.

As in our first report, we conducted the analysis under three scenarios:

1. Each member would choose the plan with the highest premium available;
2. Members would choose plans resulting in an average premium in aggregate;
3. Each member would choose the plan with the lower premium available.

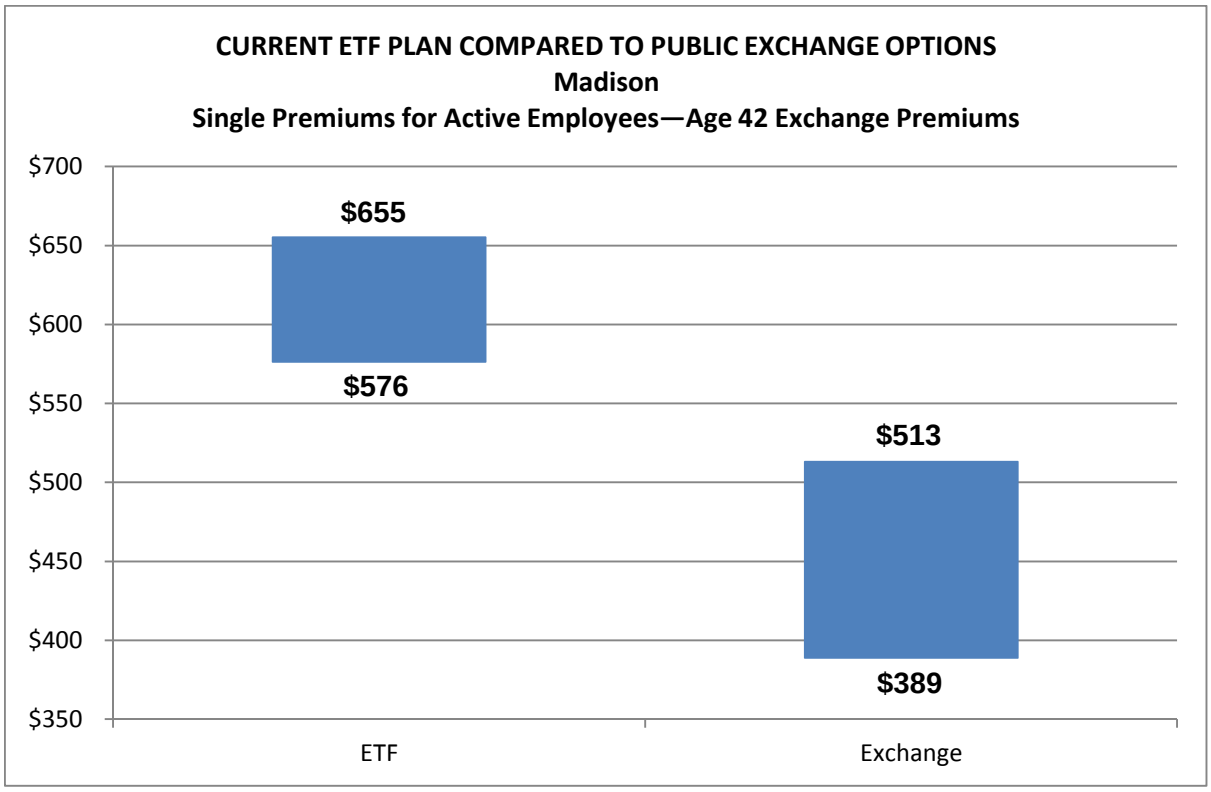
Based on projected ETF costs for 2016 of $1.152 billion for medical, pharmacy, and related administration costs (no dental) for non-Medicare ETF members, the three scenarios produce the following results:

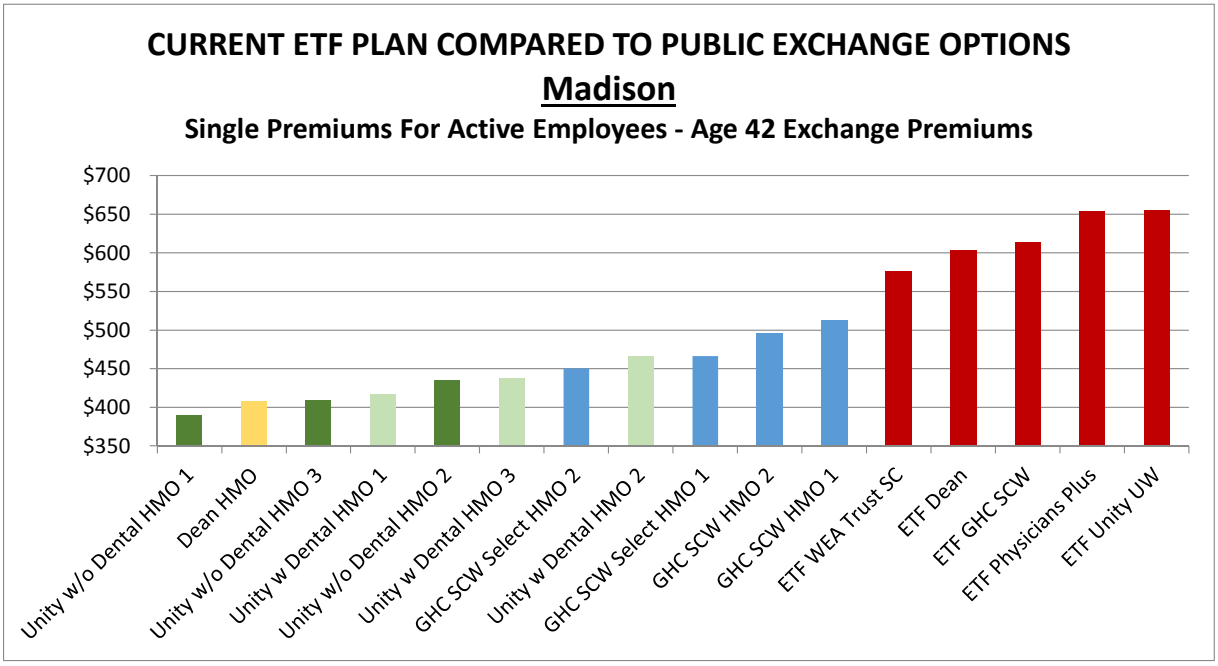
Scenario	2016 Projected Costs	Difference
Baseline/ETF	$1.152 B	
Choose Highest Gold Plans	$1.164 B	$12 M (1.0%)
Choose Average Gold Plans	$0.945 B	-$207 M (-18.0%)
Choose Lowest Gold Plans	$0.781 B	-$371 M (-32.2%)

It is somewhat expected that the plans on the Exchange would generally have lower premiums, due to the Gold Plans having an actuarial value of 80%, which is lower than that for the UBD (92%), Standard (91%) and HDHP (86%). We would expect the difference to be approximately 13% when comparing an average plan, since 98% of members are in the UBD, but the analysis shows an 18% difference, leaving 5% unaccounted. In the comparison of the most competitive plans, we see a difference of 32%, leaving 19% unaccounted.

Similar to the analysis in the first report, Segal compared the 2016 UBD premiums, without dental, with Age 42 Platinum Plan premiums available in Madison. Platinum Plans have a 90% actuarial value, which means they cover 90% of covered expenses on average. Some of the plans on the Exchange include dental coverage. In the first report, we provided this for Madison and Milwaukee. However, for 2016, Milwaukee is in one of the rating areas without Platinum Plans. Therefore, we have provided the results for only Madison below.

In 2016, ETF will offer five UBD options in Madison, with premiums that will range from $576 to $655. By comparison, there will be eleven platinum plans available in Madison on the state marketplace with premiums ranging from $389 to $513. On average, Platinum Plan premiums in Madison increased by 2.5% since 2015. As in 2015, all of the ETF plans are higher cost than the highest cost option on the Exchange.





All of these comparisons against the State Exchange options suggest there is room for improvement in ETF's cost efficiency in delivering benefits. In short, the plans on the Exchange are delivering, on average, a comparably-rich benefit plan design at a lower cost for an individual. A well-designed state employee health plan like ETF should be able to provide group benefits in a more cost-effective manner than those available in the same state's healthcare market place, which is populated with individual policies.

During the transition to self-insurance, while plans are fully-insured, it may be advisable to have the State Exchange plan bids provide a cap on the premium rates to ETF. This could easily be done, adjusting for appropriate demographics and geography.

Health Care Pricing Transparency Tools

Transparency in health care can be broadly defined as the availability of reliable health information about the cost and quality of health care services. Accessing this information empowers the consumer to make educated decisions about a needed service based upon the expected out of pocket cost of that service, the quality of the provider or facility, clinical outcomes, patient satisfaction and other pertinent data. The information can be utilized to facilitate more informed, responsible discussions to further the patient/ provider relationship. And it can serve as an avenue to make health plans more accountable with respect to the quality of the providers with whom they are contracting. While information is more readily available, the public lacks the understanding that such information is necessary in order to navigate the health care system in the United States. Too many consumers are unaware of the wide variations in the cost of medical services, the capabilities of medical service providers and the outcomes of the services provided.

As costs for physician services, hospitals and prescription drugs have escalated and continued to outpace Consumer Price Inflation (CPI), and as health plan sponsors shift more of the cost of these plans to their employees, patients are becoming increasingly aware of the price they pay for their health care as well as variability in cost among providers. This awareness coupled with the need to understand more about provider quality provides an impetus for the health care transparency movement. In addition, the introduction of consumer driven health plans to the health care benefits landscape marked a true shift in how patients view their health care. The patient is becoming more of an informed, price sensitive "consumer" wanting to learn more about the cost and quality associated with medical tests and procedures. Cost shifting designed into consumer driven health plans is driving consumers to have a vested interest in controlling higher out of pocket costs due to increased deductibles and larger out of pocket maximums.

In 2009, a national, independent, nonprofit corporation named FAIR Health was established to "bring transparency to healthcare costs and health insurance information through comprehensive data products, consumer resources and the support of health services research." FAIR Health created a database of claims data for health care procedures as an avenue for consumers to better estimate their out of pocket expenses. Supporting this trend, certain states including Washington and Massachusetts passed laws requiring insurance companies to provide pricing transparency directly to patients. Because of these and other developments, the health care marketplace responded to meet the growing demand.

Insurance companies and PBMs have developed their own transparency pricing tools and data analytics services for their members. Third party cost and quality transparency intermediaries have created technological platforms and tools that compare actual costs for medical procedures and prescription drugs and offer other services such as providing benefits information, quality metrics about providers performing specific tests and procedures and utilization data. Organizations that work on behalf of employers and other health care purchasers further the transparency effort by offering specifications for evaluating transparency tools, promoting open dialogue between providers and their patients, and advocating payment model reforms.

Large insurers like Aetna, Blue Cross, and United Healthcare offer their own individual transparency tools through their member web sites. The sites include cost estimator tools that typically address total estimated costs, detailed breakdowns by cost, and variations in price for the same treatment. The tools also identify specific providers or facilities as top quality and efficiency performers and display which providers or facilities participate in select performance networks. The breadth and depth of the data available, technological advancements, and overall transparency continue to improve.

Transparency information educates the consumer, acts as a springboard for conversations between patients and their doctors, and promotes better health care. In fact, when searching for providers, many of the large insurers' web sites list their top performing providers and facilities first and then display providers by the prices they charge per treatment. The focus on quality data, clinical outcomes, designated specialists, and tiered networks are a reminder that transparency tools are more than an online price shopping mechanism, but are truly meant to improve the entire health care experience.

The Market

Some of the largest insurers have agreed to contribute data to the Health Care Cost Institute (HCCI), a research facility and data repository. HCCI has developed a secure, online, and free transparency tool that gives consumers timely and accurate information about the price and quality of health care procedures.

Other proponents of health care transparency have created initiatives to aid in transparency. The American Board of Internal Medicine Foundation advises providers and patients to select treatment plans based on evidence-based guidelines that are not duplicative of other tests and procedures already received. The Emergency Care Research Institute is dedicated to discovering which medical procedures, devices, drugs, and processes that best further improved patient care. Healthcare Bluebook provides free online tools to help consumers find fair 'fair market cash prices' for medical care.

There are also a number of third party vendors that work towards improving patient care through transparency tools and benefits solutions such as Castlight Health, Change Healthcare, Vitals and the Leapfrog Group, to name a few. There are also firms that provide transparency information specific to prescription drugs and allow consumers to compare drug prices across therapeutic categories, delivery channels and retailers. These include Castlight Pharmacy, BidRx, and DestinationRx (DRX).

Qualities and Capabilities

As transparency tools evolve in the marketplace, plan sponsors should assess the vendors and tools that best fit their organizational needs. While there is much competition and differentiation among the solutions available, many tools often have common features. Third party tools are typically available to consumers through their employer who has subscribed to the service. Information is available via a secure web application. The application includes cost data for health related treatments and procedures from the subscribers' health insurers and often other sources, clinical outcomes and quality data, utilization information, provider and facility contact information and membership satisfaction rates and reviews. Many tools also include vehicles to help consumers take the full advantage of their health care benefits coverage. The process and

available information allow the consumers to understand the overall value of a test, service, or procedure as well as the value of their employer provided benefits.

While there are many aspects to consider when evaluating transparency tools, the group, Catalyst for Payment Reform, a nonprofit firm that works on behalf of large employers to initiative improvements in how health services are paid for, has developed a comprehensive list of specifications that optimal tools should possess. The specifications fall into five categories:

- **Scope:** the comprehensiveness of the provider network and information on price quality and consumer rating
- **Utility:** the capability of the tool to facilitate consumer decision making through comparative data
- **Accuracy:** the extent to which consumers can rely on the provider, service and benefit information
- **Consumer Experience:** The user-friendly nature of the tool and the intuitive ability to find information. The availability of a mobile application
- **Data Exchange, Reporting and Evaluation:** the extent to which claims data is exchanged with purchasers and the ability of purchasers to use the data with third party vendors in a private secure manner as well as ongoing tool improvements and the ability of users to rate the tool

The tools can empower consumers to choose lower cost, high quality providers, and they can help plans manage trend and reduce unnecessary utilization. As the movement towards transparency matures, tools and platforms available are constantly upgraded, becoming more sophisticated. Transparency technology is more comprehensive and precise, incorporating actual data in real time and using data that is updated more frequently than the technology from several years ago.

Consumer Utilization

As transparency tools have become more robust and more accessible, usage of the tools, however, have not kept pace. According to a Consumer Survey from FAIR Health, most consumers reported that they do not use the Internet to comparison shop for medical services. In fact, Millennials, a generation known for its technological savvy, do not use the Internet any more than older generations as it relates to searching online for medical services, the survey reports. In addition, research shows that consumers often incorrectly associate more tests and services and higher costs with better quality health care. These cultural trends raise questions about how we educate consumers on how to shop for cost and quality and how we teach plan participants to be better consumers.

Health plan sponsors can design benefit plans to promote consumer engagement and responsibility. Health care insurers can be held accountable for how they use quality information in transparency tools to improve the quality measures of their contracted providers, manage care, influence referral patterns and educate providers on how to advise their patents to make the best use of the data available in the tools. Plan sponsors also can incent their members to utilize the

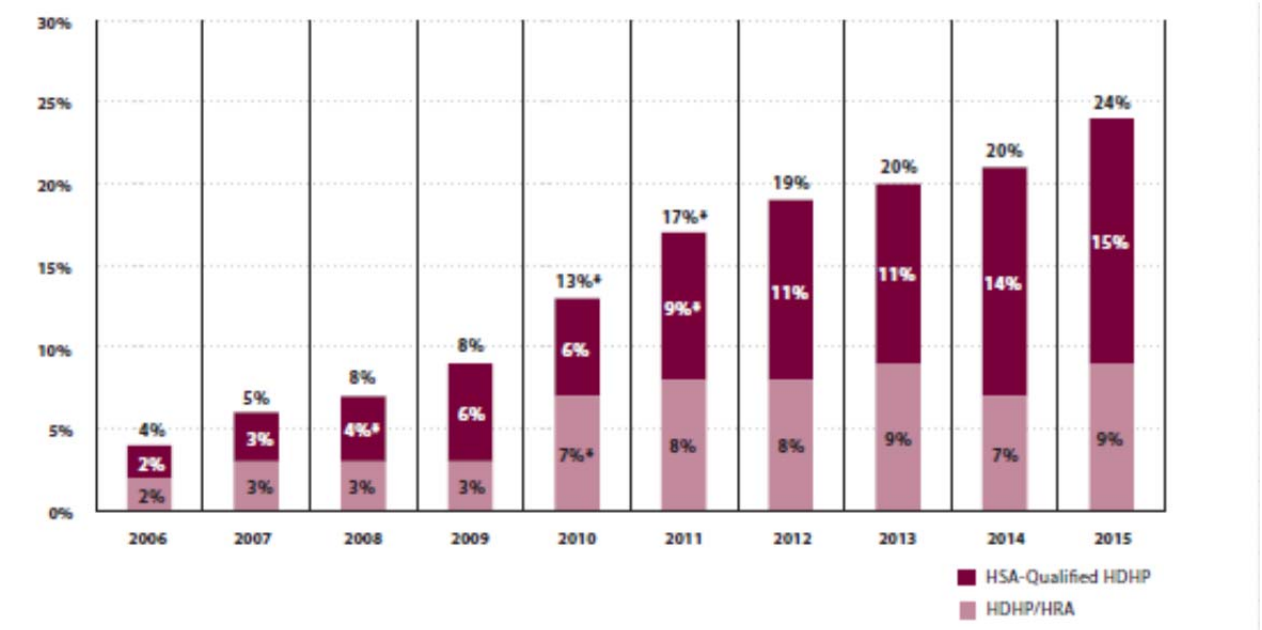
tools to gain a better understanding of the true value of their health benefits. As consumers become more aware of the variations in cost and quality, the use of transparency tools will increase. Transparency tools are available to support those consumers who are ready to become more engaged in making medical choices

Consumer Directed Health Update

Consumer driven health plans provide a financial incentive for consumers to make informed health care decisions based on cost and quality. With low monthly premiums and high deductibles and out of pocket costs characteristic of CDH plans, consumers carry a greater financial risk than participants in a typical managed care plan. As a result, they are usually more motivated to shop for health care services providing the greatest value.

With the health care industry placing such an emphasis on consumer accountability, it is not surprising that enrollment in consumer driven plans is on the rise. According to the Kaiser Family Foundation 2015 Employer Health Benefits Survey, almost a quarter, 24 percent, of covered workers are enrolled in an HDHP with a savings option. That percentage is nearly double the enrollment of those plans from just 5 years ago. In addition, in 2015, seven percent of firms providing health benefits offered an HDHP with an HRA and twenty percent offered a qualified HDHP with HSA.

PERCENTAGE OF COVERED WORKERS ENROLLED IN A HDHP/HRA OR HSA-QUALIFIED HDHP, 2006–2015



*Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: Covered Workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. For more information see the Survey Methodology Section. The percentages of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-Qualified HDHP enrollment estimates due to rounding.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.

Although PPO plans are still the most prevalent plan type offered by employers sponsoring health care benefits, CDH plans continue to generate interest. It is likely that enrollment in such

plans will continue to increase in the future. These plans are a viable and robust component in a list of employer strategies and well-designed benefits packages.

The Kaiser information is consistent with information presented in our first report and provides additional evidence that consumers access healthcare via these plans at a growing rate. For 2016, the State contribution to the ETF HDHP was increased and enrollment increased from approximately 400 subscribers in 2015 to approximately 1,500.

Self-Insurance

Current State

Self-insurance is not a new concept for the State of Wisconsin. ETF has had a self-insured pharmacy program since 2004 and results appear to have been successful. With Navitus contracted as the Pharmacy Benefit Manager, ETF has a transparent program providing full access to claims data, a partner that is both flexible and proactive in managing costs on behalf of ETF, and a uniform plan experience for all members wherever their location. For 2016, the dental benefits will migrate to a self-insured approach with Delta Dental contracted as the administrator. The State's Worker's Compensation program is also self-insured.

Additionally, two medical plans are currently self-insured, the Standard Plan and State Maintenance Plan. Enrollment in these plans is less than 5% of the total membership, with many of the members in these being out-of-state retirees. The remainder of the membership is covered in one of 17 fully insured HMO or PPO plans offering the Uniform Benefit Design.

With the above in mind, our review concentrates on the fully-insured managed competition health plan model ETF has had in place since 2004. The model was designed to encourage competition among the health plans and, in theory, to reduce the corresponding premium rates charged to ETF. Recent annual trends have been low. However, during negotiations the plans' premiums are tiered based on an internal comparison among the group of bidders and, without an external benchmark, the plans have little incentive as a group to manage overall cost levels. As shown in our first report, full premiums for single and family coverage are high within the region when compared with other state plans, even when adjusted for benefit levels.

Large employers generally self-insure the risk and costs for medical and pharmacy benefits. As noted in our first report, the large majority of state health plans self-insure all their health plan options. Some even self-insure their HMO offerings. As noted in the Market Observations section in our first report, all but one of the current ETF health plans report the ability to support a self-insurance approach.

California is an example of a state that utilizes a blended approach between self-insurance and fully-insured contracts. Large portions of the membership are in plan options that are self-insured and equally sizeable portions of the membership are in plan options that are fully-insured. The fully-insured options largely utilize a staff-model HMO, where the providers are directly employed and compensated by the health plan. Most members choose between fully-insured or self-insured options, although the members are likely unaware of this distinction. Kaiser is primarily the fully-insured plan and will not/cannot operate in a self-insured environment.

The staff-model HMO type does not have a significant presence in Wisconsin, although Dane county has similar attributes. The market favors more traditional group-model HMOs, where provider payment structures that are transferrable between self-insured or fully-insured. Therefore in the Wisconsin market, a conversion from fully-insured to self-insured is expected to provide the plan sponsor access to the same provider contract terms and pricing negotiated by the health plan that is utilized for its fully insured business. In other words, the providers are

typically neutral as to which approach is utilized and likely are not even aware of who holds the risk for the employer's plan.

What Are the Benefits of Self-Insuring?

There are several reasons why employers choose the self-insurance option. The following are the most common reasons and are primarily financial:

- **Elimination of premium tax:** Wisconsin health plans do not pay a premium tax. However, some ETF plans pay a premium tax in their home state, depending on that state's regulations. Nationally, this rate is approximately 2% of premium. With many ETF plans not subject to premium tax, the aggregate rate is quite low, approximately 0.1% of total ETF premium. There is no premium tax on the current self-insured plans.

- **Elimination of Affordable Care Act (ACA) Market Share Fees:** This fee was introduced with the ACA and applies to all fully insured medical and/or dental business. The fee is to be divided between all health insurance issuers and is expected to increase beyond 2018. The fee allocation is not uniform, with larger plans paying a larger portion and the smallest plans not subject to the fee. This fee is not applicable to self-funded health plans. In aggregate across ETF's health plans, the fee is approximately 2% of health premiums.

- **Lower cost of administration:** Employers find that administrative costs for a self-insured program administered through a contracted third party administrator (TPA) – even if that TPA is also a carrier – are generally lower than those included in the fully insured premium by an insurance carrier or health plan.

- **Carrier profit margin and risk charge eliminated:** The profit margin and risk charge of an insurance carrier/health plan are eliminated for the bulk of the plan. Normally these represent 2-4% but upon our review of various Health Plan Market Reports, it appears to be lower in Wisconsin. These reports are somewhat suspect, since in many occasions they own the hospitals and their margins are well over norms.

- **Cash flow benefit:** The employer does not have to pre-pay for coverage on monthly premium basis, but can fund claims dollars just as they are needed for payment. ETF now pays at the end of the month but the concept remains the same. Not requiring the employer to pre-fund the full incurred amount can result in improved cash flow. The employer also maintains control over the health plan reserves, enabling maximization of interest income that would otherwise accrue to the insurance carrier through their investment of premium dollars not yet needed for claims payments and other expenses.

- **Management of Excise Tax Exposure:** While the regulations have not yet been finalized, it is anticipated that the 40% Excise Tax will be determined for each individual subscriber within assigned groups based on coverage tier and plan groupings. Therefore, employees and retirees in health plans with higher premiums will produce a larger Excise Tax exposure for ETF and the State. It is anticipated that self-insurance will provide more flexibility in establishing rates than available with fully insured premiums.

There are also other non-financial reasons plans choose to self-insure their programs. These include:

- **Control of plan design:** The employer has complete flexibility in determining the appropriate plan design to meet the needs of the employer and employees. The employer can redesign the plan at any time.

- **Data collection:** In a self-insured program, ETF would receive and own detailed claims and encounter data. This would allow more efficient management of the plan's financials. Availability of fully detailed data about members and their claims is a major problem for the program right now, with the plans often claiming that confidentiality issues prevent them from providing ETF full data about its own plans. This lack of detailed data was addressed with the health plans with partial success this past summer during the 2016 health plan negotiations.

- **National provider network:** The third party administrator for a self-insured plan should be able to offer a national integrated program of networks for retirees and out-of-state workers. While some out-of-area coverage is available now, a self-insured program essentially has no arbitrary plan or network boundaries.

- **Custom Provider Network:** Under a self-insured plan, the employer is free to contract with the providers or provider networks best suited to meet the health care needs of its employees. Self-insured plans can easily design and initiate pilot programs or value based initiatives for all or portions of their covered membership. These types of initiatives are difficult, if not impossible, to implement under a fully-insured plan structure.

- **Mandatory benefits are optional:** State regulations mandating costly benefits are usually optional because self-funding is regulated by federal legislation only. *(Note: mandated benefits would typically not apply to ETF, although ETF may be included in the scope of state legislation.)*

- **Cost reporting:** Under a self-insured arrangement, the TPA can provide detailed reporting of costs by month or other desired cycle, by department or location, and by type of medical service. Utilization and lag reports would also be available. In addition, since the self-insured employer owns the detailed data for the plan, that data can be captured and loaded on a frequent basis to a data warehouse, where it can be combined and analyzed with similar data from the employer's other self-insured plans.

Financial Impact

Based on the information from the 2016 negotiations and renewal, the average monthly per subscriber premium for the insured non-Medicare UBD portion of the program is $1,143.

Premium Tax

Health plans domiciled in Wisconsin do not pay a premium tax. However, some of the ETF health plans pay a premium tax, depending upon the rules and regulations in their home state. For the 2016 renewals Segal requested a detailed breakdown of each plan's administrative

expenses. Premium tax was a required line item and detailed the amount currently paid or charged to the ETF plans. Overall, the average premium tax was only 0.1%, as most of the plans are domiciled in Wisconsin. This equates to an immediate savings of $1.14 per subscriber per month, or $0.9 million annually in 2016.

ACA Market Share Fees

In aggregate, the ACA Market Share Fees are approximately 2% of premium and are only paid by insured plans that have written over $25 million in net premium during the year. This fee is only paid by insured plans, with the fee allocation larger for the largest health plans and the smallest plans not assessed the fee. Based on the information provided by the health plans in the negotiations for 2016, moving to self-insurance would result in an immediate savings of $22.86 per subscriber per month, or $18.3 million annually in 2016, for ACA Market Share Fees alone.

Administrative Costs

The health plans provided a detailed breakdown of their administration costs in the required addendum submission during the 2016 renewal cycle. The net administrative costs component averaged approximately $84 per subscriber per month (PSPM). Although this was the amount reported and anticipated to have been put in the rate development, we believe it is overstated and not an accurate assessment of the true administrative costs.

Due to the negotiation and renewal process it was necessary to estimate the final net administrative costs. Subsequent submissions focused on only the total premium. As the total premiums were reduced during the negotiations, it is not known for certain exactly how each of the individual premium components were adjusted. Our estimate is derived from a comparison between the final aggregate premium and aggregate claims projected at 3%. Based on the information provided by the health plans in the negotiations for 2016, the current net administrative cost per subscriber per month (PSPM) is estimated to be approximately $44**.**

This $44 PSPM (and $84 PSPM) figure is net of ACA fees, profit, and contingency loads. What remains is a rate that covers administrative-only services (ASO), including claims processing, member services, network contracting and maintenance, reporting, as well as wellness, health management and the administration of health savings accounts (HSAs) and health reimbursement arrangements (HRAs). In our experience, ETF's administrative cost rate is significantly higher than rates for other similarly situated employers regionally and nationally.

Segal collected per subscriber per month rates from a variety of sources:

- **Other state health plans** – Segal surveyed several state-level health plans, receiving data from Illinois, Minnesota, Colorado, Alaska, New Mexico, Hawaii, Tennessee, North Carolina, Alabama, Georgia, New Hampshire, West Virginia, Maryland, Delaware and Kentucky

- **Other Wisconsin employers –** Segal collected administrative fee information from several private sector entities whose primary operations are in Wisconsin

- **National survey data –** The 2014 Mercer Health Benefits Survey includes administrative fee data

Information from these sources was utilized to develop the following expected administrative fee range for each group:

Group	Per Subscriber Per Month ASO Rate
Wisconsin ETF	$44
Other States	$15 to $30
Other Wisconsin Employers	$20 to $30
Other Regional Employers	$30 to $40
Other Government Plans Nationally	$25 to $35
Other Large Employers Nationally (5K+)	$25 to $35

The large majority of the plans represented in the data for other states are self-insured. In our opinion, the most appropriate comparison is to other states. The rates for other regional and Wisconsin employers, as well as for other governments nationally are similar. However, other states are, in general, more similar in size and composition than the organizations in the other groups. That said, taking the conservative approach and comparing the 2016 ETF PSPM rate ($44) with the highest rate in the expected range for other state plans ($30) still shows a savings opportunity. This $14 difference equates to $11.2 million annually in 2016.

Profit Margin and Risk Charge

While it may be perfectly understandable and a standard practice for health plans to include profit and risk loads in an insured premium, there is no reason to do so in a self-funded arrangement. In these instances, the health plan or administrator includes the profit in the ASO fee.

Typically, a profit and risk load is in the 2-4% range. However, the loads reported by ETF plans are lower, with the average profit and risk load in 2016 reported at 1.2% in aggregate. It should be noted that hospitals show net income over industry norms, with some greater than 10%. So although provider owned HMOs may show a low profit, their owned providers show a higher profit.

Eliminating this 1.2% load results in an immediate savings of $13.72 per subscriber per month, or $11.0 million annually in 2016.

Cash Flow Benefit

For self-insured programs, claims are paid as they are invoiced, which includes an inherent lag between service and paid dates. ETF would retain the associated assets and have the ability to earn investment income for the time it holds the assets before they are actually paid out for claims. A typical lag for medical claims is approximately one month, which equates to an estimated $72.1 million in 2016. At a modest investment return of 1.0%, the additional investment income would be approximately $0.7 million annually in 2016.

Managing Excise Tax Exposure

The 40% Excise Tax goes into effect for 2018. While final regulations are yet to be provided by the Federal government, it appears the Excise Tax will have to be calculated based on the actual plan elections for each individual subscriber. In a self-insured plan, the plan sponsor has more flexibility in developing rates for each plan option and in adjusting specific benefit features to help hold costs down. Pooling may also be utilized between active and retiree rates. For insured plans, the current expectation is that the specific premiums must be used.

Single premiums in the UBD vary by as much as $250, and even more for family coverage. If the average cost per member could be utilized across the membership groups that must be aggregated for Excise Tax purposes, the State's Excise Tax exposure would be managed to a lower level. Currently, the Excise Tax exposure is approximately $3-4 million, and the immediate impact of self-insurance is fairly minimal in the short term. However, the impact grows over time and is estimated to be as much as $41 million by 2027.

Note that these figures measure the impact of the reduction on the fixed costs and the effect of utilizing a more aggregate rating structure to calculate the Excise Tax exposure. The impact of other strategic initiatives, such as health plan consolidation and an enhanced approach to total health management would further reduce the exposure.

ETF PROJECTED EXCISE TAX IMPACT OF SELF-INSURANCE ($ MILLIONS)

	Projected with Current 2016 Premiums		Projected with Aggregate Rates and Fee Reductions from Self-Insurance	
Year	Tax with 4% Trend	Tax with 6% Trend	Tax with 4% Trend	Tax with 6% Trend
2018	$3	$5	$3	$3
2019	$4	$7	$3	$4
2020	$4	$11	$3	$4
2021	$5	$17	$3	$5
2022	$6	$28	$4	$6
2023	$7	$40	$4	$9
2024	$9	$55	$4	$14
2025	$11	$71	$5	$25
2026	$14	$93	$5	$49
2027	$18	$118	$5	$75

Savings Summary

The projected annual savings associated with a conversion of ETF's current plans to self-insurance is $42.1 million and is summarized in the following table.

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

This is an estimate of the impact on fixed dollar costs and does not account for any changes in plans, claims or program structure that could also affect costs. In theory, the current program could be converted to self-insurance and remain otherwise largely unchanged. However, converting 17 fully-insured plans to self-insurance is not considered practical, nor feasible and is not recommended. Our recommendation is to combine a conversion to self-insurance with the regional restructuring provided in the **Program Structure** section. This may be best structured through a phase-in approach.

Cash Flow and Reserving

As previously stated, the transition to self-insurance alone is not anticipated to change the underlying claims costs, with savings resulting from a reduction in the fixed, non-claims costs. The conversion will result in a change in the timing of payments made by ETF. Where fully-insured premiums are paid up-front, self-insured claims are paid after the date of service, which results in a run-in period from which both a cash balance and reserve will be built. Therefore, the conversion to self-insurance should produce a month or so of claims cash flow improvement.

Incurred But Not Reported Reserve

Claims in a self-insured plan have a "lag" between the date of service and the date the claim is paid. There may also be a lag from the date the health plan pays the claims and the date ETF pays the health plan. Claims for services already provided, but not yet settled, are often referred to as Incurred But Not Reported (IBNR) or Incurred But not Paid (IBNP) claims. In this discussion, we will not draw a distinction between IBNR and IBNP and simply use IBNR to refer to claims incurred but not fully settled.

Generally speaking, medical claims have an average lag of one month. Some claims, like office visits that are adjudicated at the point-of-sale are generally settled sooner while inpatient hospital claims, or other more complicated situations, may take months or even years to be completely settled and paid.

At any given time, there is a liability for these unresolved claims and it is common to estimate and book an IBNR Reserve. ETF already follows this practice for the self-insured pharmacy program and for the Standard and State Maintenance Plans.

When a program first transitions to self-insurance, there is a drop in expenses for about 4-8 weeks. Assuming a transition on January 1 (of any year), the premiums paid prior to changeover will cover all claims incurred until December 31, but claims in January will need some time to work their way through the health plans claims submittal and processing system before assets are transferred from ETF to cover the expenses. During this lag time, ETF should be able to accumulate enough assets to fund the IBNR. In other words, the gains during this "run-in" period should cover the liability of the "run-out" period on the other end. This is what will happen for the dental plan at the start of 2016.

Solvency Reserve

In a self-funded approach, ETF will be exposed to the natural, and expected, claim and expense volatility. Utilization and expenses will inevitably vary from month-to-month and from year-to-year and many self-funded plans maintain an asset reserve above the IBNR to provide protection against this volatility and to smooth out funding requirements for the State and the members.

For the Pharmacy program, as well as for the Standard and State Maintenance plans, ETF currently has a formal reserving policy that seeks to maintain assets at a level above the IBNR. More accurately, ETF seeks to maintain assets within a range where there are sufficient assets to fund the IBNR with additional assets to fund a solvency reserve. The expense lag will fund the IBNR, but additional assets will be required to provide the initial funding for the solvency reserve.

The GIB has a policy to maintain cash reserves in a target range of 15-25% of paid claims (including 20% of insured premiums). So overall, the current fully-insured reserve was 3-5% of total annual premiums. A typical reserve for a self-insured medical plan will be 1-2 months of paid claims or 10-15% of total incurred claims. This change in cash flow is the same as what was experienced when the plan converted on the pharmacy side and more recently the dental program. So you will need a larger reserve but the cash account will be higher to compensate for that. We would recommend maintaining the higher 25% first year, to compensate for the run-in and build the reserve needed to fund the IBNR. This should result in a reserve of approximately 10% over the IBNR.

The additional funding for the solvency or claims fluctuation reserve in the first year could be sourced from the savings from the reduction in administrative fees and other fixed costs. The amount needed will be included in the premium rate development, consistent with current processes.

Gain Sharing

In some corners of the industry, there are those that remain skeptical that a health plan will not remain as diligent in managing member utilization and provider costs as it would in a fully-insured arrangement. To mitigate this potential threat, we propose incorporating incentives and penalties for plans as well as for members. The incentives/penalties for members are based on plan design and contribution differentials described in an earlier section. To align incentives for plans, we anticipate incorporating performance metrics with rewards and penalties that are designed to improve member health and manage expenses for ETF. We also recommend that ETF incorporate a gain-sharing component that shares a portion of any financial gains with health plans when they manage costs to be lower than expected for their specific membership.

Gain-sharing is a methodology in which cost savings compared to a targeted cost are shared between ETF and the plans. Cost savings are defined as performing better than a benchmark cost target. To share in cost savings, the plans will need to demonstrate quality and reduce spending below targets. Quality requirements are needed to ensure quality is not compromised as providers reduce services. This type of arrangement helps align financial and quality of care initiatives and can be used by ETF to encourage plans to use lower-cost or higher-quality providers as well as to work with providers to coordinate care for members. This approach works well in a model where medical management is integrated with the plan, and eliminates the difficulty of trying to quantify a return on investment (ROI) from a medical management vendor.

The ACA defined several approaches for new models of payment to be tested. The Medicare Share Savings Program (MSSP) was the first model for which rules were issued. The MSSP is a two-sided risk model where payment can be either received based on cost being lower than the benchmark or paid based on cost being higher than the benchmark. The gain-sharing methodology outlined here is similar to the MSSP approach but with a one-sided risk model which only seeks to reward a plan when savings are achieved. Any amounts paid to the plans would result in a bonus payment to the plans based on savings to ETF. This type of methodology provides funding for bonus payments without the need for ETF to separately fund a bonus pool.

Plans that meet specified quality performance standards are eligible to receive payments for savings if they can reduce spending growth below cost target amounts. Quality performance will be measured based on metrics related to care coordination and patient safety, preventive health, and caring for at-risk populations. Performance on these measures will affect the amount of shared savings for a plan. Cost performance compared against benchmarks will determine whether or not the plan is eligible to receive an additional bonus from savings.

To calculate a payment methodology, a baseline expenditure estimate will be developed in order to project cost benchmarks that will be used to determine cost savings. The baseline will be based on cost data and trended to the benchmark year. Benchmarks will be calculated separately for each region and adjusted for health status for each plan. To generate savings, plans must reduce spending below their benchmark amounts. To help ensure that payments are based on true savings below the benchmark rather than simply random fluctuations, plans must reduce spending by more than a minimum percentage (e.g. 2%) in order to receive any savings. However, once the minimum percentage is met, all savings (even the amount that is less than the minimum percentage) are eligible. Final expenditures will be calculated after the end of the plan year using a 3-month run-out of claims to determine the final amount of savings to be shared. Note that reduction in the number of plans is an essential component of this methodology since it would be difficult to determine the minimum percentage for random fluctuations for plans with low membership.

Plans that meet the minimum percentage of savings and become eligible for payment will share in up to a certain percentage (e.g. 50%) of their achieved savings, depending on how well they exceed minimum quality performance standards.

The gain-sharing model will require plans to report on quality performance measures. The measures will be developed as described in the Total Health Management section of this report and similar to the measures shown in **Appendix 1,** with some measures based on processes and other measures based on outcomes. The first year of the program will be a pay-for-reporting system where plans will be eligible for shared savings if they report accurately on 100% of the measures, regardless of their actual performance. This will determine baselines on the measures. In the second year, process measures will be based on actual performance and outcome measures

will continue to be based on a pay-for-reporting basis. Year 3 and beyond will be based on actual performance of all measures. A scoring system will be implemented to calculate the percentage of performance measures achieved. The percentage of performance measures achieved will be multiplied by the financial percentage (e.g. 50%) of savings to determine final payment to the plans.

For plans to be successful in this type of arrangement, they will be required to become accountable to and report on quality, cost, and overall care of the beneficiaries. In a procurement, the plans will be required to describe its plans to promote evidence-based medicine, promote beneficiary engagement, coordinate care and report on quality and cost metrics. They will be required to have systems to identify high-risk individuals and develop individualized care plans for targeted populations. They will also need to be able to communicate clinical knowledge to beneficiaries in an understandable way to allow for shared decision making. These processes for measuring clinical and/or service performance will be critical for them to use these results to improve care and service.

Health status adjustments for gain-sharing will be determined through a diagnoses based risk model. This type of model will be useful to incentivize plans to incentivize providers to use correct coding as it will improve the risk scores of their populations.

One downside of the CMS MSSP model is the concern of whether plans already operating with high efficiency have a reasonable chance of meeting target reductions. The model we are recommending would have targets based on a regional benchmark with cost levels adjusted to a plan specific benchmark based on health status adjustments. This would allow the plans operating better in a region the ability to be rewarded.

In Summary

ETF has the opportunity to realize an estimated $42.3 million annually in savings from reductions in fixed costs paid to the health plans by converting to a self-insured model for the plans providing the Uniform Benefit Design. These savings, along with gains associated with the initial lag between service and payment dates should be sufficient to fund the initial reserves for IBNR and solvency needs.

It is worth noting that in the **Self-Insurance Concepts** section of our first report, we estimated that a conversion to self-insurance could result in savings of $50-70 million. That estimate was based on a preliminary review of the data and the program and included the expectation that ETF would restructure the program and consolidate health plans. The Program Structure section of this report includes our recommendations for health plan consolidation and a regional approach to selecting and contracting vendors. We believe the associated savings for the restructuring and consolidation is $45-70 million. Coupled with the $40-50 million savings estimated in this section of the report, the combined annual savings opportunity is approximately $85-120 million.

A self-insured program would provide ETF with significantly improved transparency and access to the detailed data necessary to sufficiently manage the program. ETF and the GIB would also have increased flexibility in benefit design beyond that available through a fully insured plan. Self-insurance may very well provide ETF with additional capabilities to manage exposure to the Excise Tax.

The vast majority of other states utilize self-insurance for their state employee health plans and, in our analysis, there does not appear to be a compelling reason for ETF to remain fully insured over the long-term strategy.

We recommend a phased-in approach to transition to self-insurance. Beginning in 2016, for the 2017 health plan renewal, ETF should require all health plans to provide complete encounter, claims and pricing data at claim level detail. Thereafter, ETF could move toward self-insurance on a timeframe that is most advantageous to the program and also allows ETF staff to manage the transition in a thoughtful manner. Future phases will include the collection of additional data within the new regional structure, the potential inclusion of gain-sharing and a double-sided risk-sharing approach.

Retiree Coverage

Program Structure

In Wisconsin, when State employees retire they are given the option to continue medical, dental and pharmacy benefits at the full cost of coverage. Those not yet eligible for Medicare are given the same plan options as active employees, but at the total rate of the combined non-Medicare group (active and retirees). This rate has an implicit subsidy for the retiree, since non-Medicare retirees are much older and would have experience 150% to 200%, or more, of an active employee.

Benefits for Medicare retirees are slightly different. All of the current plans provide a Medicare option for retirees. There is no implied subsidy in these rates, since the Medicare rate is meant to cover the full cost of that population only. There are some issues with the rate setting that tends to make these rates higher than what we believe a reasonable cost to be.

In order to pay for the benefit, retirees use their accrued sick leave. At retirement, unused leave, in conjunction with pay, is converted into a notional account balance that can be used to cover the cost of medical, drug and dental premiums. This can be a sizeable amount and will typically last 6-10 years into retirement. So, the goal of this section is to provide more cost effective options for retirees, allowing their sick leave balance to last longer into retirement.

Plan Options

As mentioned earlier the non-Medicare retirees get the same benefit options as active employees, details can be found in the **Program Structure** section of the report. When retirees become Medicare eligible they would have a somewhat different set of options.

All health plans have coverage options which are coordinated with Medicare, except the HDHP.

- Members in an alternate health plan who become Medicare eligible transition into the Medicare Traditional Uniform Benefits plan.
- Members enrolled in the Standard Plan or the SMP transition to the Medicare Plus Plan on the member's Medicare effective date.
- Members enrolled in Humana will be enrolled in Humana's Medicare Advantage Preferred Provider Organization (MA-PPO) after enrolling in Medicare Parts A and B.

Medicare Plus is a fee-for-service Medicare supplement plan administered by WPS. This plan is available to eligible annuitants enrolled in Medicare Parts A and B. Medicare Plus permits eligible members to receive care from any qualified health care provider anywhere in the world for treatment covered by the plan.

Medicare Advantage Preferred Provider Organization (MA-PPO) allows members to use any health care provider accepting Medicare; however, they will not have greater out-of-pocket

expenses when using out-of-network providers. The in-network MA-PPO benefit is modeled to replicate the Uniform Benefits package.

Pre-Medicare Retiree Risk Pool

Most state government health plans include both active employees and non-Medicare eligible retirees in the primary rating pool. For self-insured plans, this typically takes the form of a single rating pool for all participant experience, where everyone in the plan pays the same rate for their respective coverage level (single, family, etc.) and there is no differential in premium made for age or other factors. The same rating approach is used for most fully-insured plans, where a single rate structure applies to all participants, except for Medicare eligible employees still employed where a reduced rate may apply to reflect the fact that Medicare is a secondary insurance while those eligible persons are still working.

This "one for all" traditional rating approach contributes to the stability of the health benefit program, and helps to build confidence among older employees that when they retire, they will not be charged any different premium base than what they paid during their employment.

However, there is a direct relationship between age and illness. The older a person, the more likely he or she is to have one or more serious conditions. More conditions generally correlate to greater medical cost, and increased medical cost results in higher premiums required to fund those medical costs. In effect, the older and sicker persons covered in the plan will drive up the required premium cost for younger and healthier members, so with a broad based employer health plan covering active employees and non-Medicare retirees, premium cost will be higher per person than in a plan that does not cover the non-Medicare retirees.

We estimate on the following page that approximately $62 million in premiums are paid by pre-Medicare retirees, primarily through their accrued sick-leave. The average premium rate paid is approximately $700 per member per month. If the retirees were rated separately, we would expect this rate to go up 50-100%, $30-$60 million in aggregate.

Many other states with an implied pre-Medicare subsidy have reviewed strategies and approaches towards addressing the associated costs and liability. These strategies incorporate grandfathering or incremental changes phased in over time, such as service based contributions. However, Wisconsin is fairly unique in that retirees pay 100% of the premium. Therefore, a significant change in premium structure could significantly affect the cost to retirees. Generally speaking, in other states that have addressed the implicit subsidy, retirees pay a portion of the premium and therefore, the financial impact to those states' retirees is less.

Given that this is a limited benefit for retirees, who in total are much smaller than the group, we would recommend no changes to the pooling methodology at this point in time.

Pricing and Enrollment

During the annual renewal cycle, Plans are asked to separately bid a Medicare only rate. This rate is limited to a maximum of 50% of the non-Medicare rate. The Medicare Plus plan is self-insured and rates are developed by the actuaries, in consultation with WPS.

Note that the full rate would involve adding components for pharmacy, dental and administrative costs. Pharmacy is fully transparent and self-insured, as is the dental plan. The costs are rated separately for the Medicare Plus and Medicare Traditional Uniform Benefit Plan. With total costs being paid by the retiree, enrollment is highly dependent on premiums.

Below is summary of the enrollment by plan and the single premium rates. The non-Medicare rates vary by nearly $200 for the Plans, with the Standard Plan over $1,300. The enrollment tracks fairly close to the active enrollment. The recommendations being made for actives will be beneficial to holding these costs down.

For Medicare retirees, enrollment tends to follow the premiums to a greater extent. Plans with lower premiums have higher membership. Note also that since a number of retirees travel and leave the state, the Medicare Plus plan has the greatest enrollment. The plan changes addressed earlier have limited impact on the Medicare eligible retirees.

	Non-Medicare				Medicare			
Plan	**Rank**	**Single Rate**	**Contract**	**Members**	**Rank**	**Single Rate**	**Contract**	**Members**
Anthem Northeast	12	$744	25	39	24	$520	18	32
Anthem Southeast	18	$767	74	107	27	$532	171	253
Arise Health Plan	13	$747	65	106	25	$521	214	309
Aspirus Arise	10	$728	0	0	23	$512	1	2
Dean Health Plan	2	$603	1,275	1,896	10	$423	3,830	5,728
Dean Prevea 360	7	$659	2	2	19	$471	2	3
GHC EC	20	$780	52	86	21	$493	106	151
GHC SC	3	$614	317	435	16	$455	648	958
Gundersen Lutheran	19	$772	117	186	9	$421	488	761
Health Tradition	15	$749	56	83	8	$410	146	216
HealthPartners	9	$692	117	194	22	$494	94	160
Humana Eastern/MA-PPO	21	$781	228	315	3	$396	1,124	1,659
Humana Western/MA-PPO	27	$836	32	46	3	$396	289	444
Medical Associates	8	$661	23	34	2	$379	89	142
Mercycare	4	$614	28	38	7	$408	60	88
Network Northeast	14	$749	279	410	17	$462	554	860
Network Southeast	22	$785	2	5	12	$435	0	0
Physicians Plus	5	$653	394	560	18	$462	1,850	2,690
Security	26	$809	326	495	28	$553	552	875
Standard Plan/Medicare Plus	28	$1,305	146	186	5	$400	6,269	8,534
State Maintenance Plan (SMP)	25	$808	3	3	5	$400	11	15
UnitedHealthcare	17	$758	297	437	26	$527	603	941
Unity Community	11	$743	30	50	20	$488	57	83
Unity UW	6	$655	653	955	15	$449	2,425	3,769
WEA Trust East	16	$757	194	302	11	$431	230	402
WEA Trust NW – Chippewa	23	$797	70	104	13	$445	135	211
WEA Trust NW – Mayo	23	$797	156	227	13	$445	339	541
WEA Trust Southcentral	1	$576	3	7	1	$367	3	4
Total		**$707**	**4,964**	**7,308**		**$433**	**20,308**	**29,831**
Total Cost	**$62.0 million**				**$154.9 million**			

In order to reduce costs for the Medicare retirees, we will need to consider some new plan alternatives. We believe additional options exist with lower costs and with comparable benefit levels. The goal is to contract with Plans to better manage care under group Medicare Advantage programs.

Experience of Other States

All states are struggling to cost-effectively manage their Medicare retirees. The vast majority of States have converted their Part D program into an Employer Group Waiver Plan (EGWP). States make this transition to best maximize federal subsidies and offset net costs. Where the logic is pretty straightforward for this program, similar logic could be applied to the medical program as well.

Under a Medicare Supplement arrangement, which is the primary ETF structure, a claim is paid by Medicare first and then the remaining benefit is shared by the member and ETF. If a Medicare Supplement plan has great success managing the Medicare members, the cost savings primarily goes to Medicare, which pays 85%+ of the claim. With Medicare Advantage plans, CMS pays the plan the average of what a Medicare member costs. There are number of complexities in the calculation but payment of the average risk adjusted cost is the primary method. Plans with higher quality get more money as well.

A number of states, including Illinois, have implemented Medicare Advantage plans to maximize the federal money and minimize their premiums. Illinois saw their rates drop from over $450 PMPM to around $200 PMPM in the first year. This spread has been maintained over the first three years. The typical design is to have a Passive PPO, where the in/out of network benefits are the same and care is provided at the in network schedule of benefits when a provider that accepts Medicare is utilized. This important feature of a Passive PPO results in no difference in access between the MA plan and Medicare Supplement plan. As long as 51% of members are within their network, Per CMS regulations, as long as 51% of ETF's Medicare retirees enroll in an MA plan in a particular service area, this type of plan can be provided. This is very different that an individual MA-HMO, where the network is a closed panel. The only requirement would be that the provider accepts Medicare.

If Wisconsin could get pricing similar to what we have seen in other states, the rates for Medicare retirees would be much less and their paid sick leave account will last much longer.

RFI – Medicare Advantage Passive PPO

Segal has performed a number of Medicare Advantage opportunity assessments for States. We conducted and Request for Information (RFI) and provided participating organizations summary eligibly and medical claims, as well as detailed pharmacy information. The study included the two largest Group MA Plans – United Healthcare and Humana. We also included one of the largest commercial plans – Anthem.

With the passive PPO product, it is not necessary to do a detailed network analysis. As long as they meet the 51% rule, the network will be virtually identical for each health plan. During a procurement we will do some network analysis to determine long term sustainability of the program but it was not necessary for this assessment.

There is sometimes additional savings on the pharmacy side, where the integration and coding can influence reimbursement and CMS subsidies as well. With that in mind we requested estimated rates for medical only (MA), as well as combined medical and pharmacy (MA-PDP).

Below is a summary of the results and the estimated rates provided by the participants:

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

For the Medical Only rates, we would expect to pair the new MA plan with the existing EGWP program. The rates in the Medical & Pharmacy column are for a potential MAPD with both medical and pharmacy benefits that would potentially also replace the current EGWP program. None of these rates include dental premiums.

Recommendations & Timing

The results of the RFI show that a National Passive PPO with the best-in-class plans could produce savings of $50 to $100 per member, a reduction of 10-20% with no benefit changes. This would result in a total premium reduction of $17 to $34 million annually for retirees.

To coordinate with the active recommendations, we would recommend one National (and Statewide) plan. We would enable the plans selected in each region to have a competitive Medicare product, preferably an MA HMO. This will allow retirees a number of options to best meet their needs and budget.

Like the Total Health Management recommendation, we believe this recommendation can be phased- in. The National Passive PPO could be marketed and implemented for 2017 while the Regional plans are implemented in conjunction with the 2018 plan and network changes.

It is expected this would have a positive impact on the State's liability for Other Post Employment Benefits (OPEB). While the retirees' sick leave accounts would not be affected, with lower premiums, the pay-out would take place over a longer period of time, which would result in a reduction of the expected present value of those premium payments. This change may be minimal and estimating the impact is beyond the scope of this report.

Local Government Plan

Program Structure

The current local government plan, Wisconsin Public Employers' Group Health Insurance Program (WPE), is similar to the state plan in that it offers benefits through the same 17 fully-insured HMOs and a self-insured PPO. Coverage is available for active employees, non-Medicare retirees and Medicare retirees.

Employer groups apply for entry into the WPE on a quarterly basis. Groups undergo risk evaluation, based on general group and individual underwriting principles, according to the number of eligible employees. Historical experience and the overall health risk of the group will dictate whether a surcharge may need to be assessed during the first 24 months of program membership. Other pool stabilization techniques are employed such as employer cost-share/contribution requirements, minimum participation requirements, and a lock-out period, for groups that withdraw from participation in the program.

The WPE program is different from the State plan in that Locals have multiple options from which to choose. There are currently four program options. Each program option offers two plans—one fully-insured HMO benefit design and one self-insured PPO benefit design. In total, there are eight plan options—four HMO plans and four PPO plans. Many of these plans were created in response to requests for certain designs; however, there is not much difference in benefit value for three of the programs, with the fourth program being an HDHP. The three non-HDHP programs each have an actuarial value that is at or above the Uniform Benefits design offered to state employees.

Enrollment and Costs

While the WPE program offers more choice in terms of number of plan options, enrollment in the WPE program is currently less than 20% of the state enrollment figure. With 18 vendors and 8 benefit plan options, enrollment is sparse in most plans—particularly in the self-insured plans. WPE enrollment, as of January 2015, is shown below, by vendor. Note that only seven vendors have enrollment of at least 5%, Eighty percent of WPE enrollment is spread across these 7 vendors, with 50% in Unity, alone. These vendors are highlighted in red.

Plan	Number of Contracts	Number of Members	Percent of Contracts
Standard - Dane	1	1	0%
Standard – Milwaukee	6	9	0%
Standard – Waukesha	0	0	0%
Standard - Balance of State	6	7	0%
SMP	24	63	0%
Anthem Northeast	698	1,965	5%
Anthem Southeast	754	2,217	5%

Plan	Number of Contracts	Number of Members	Percent of Contracts
Arise Health Plan	4	11	0%
Arise Aspirus	0	0	0%
Dean Health Plan	1,387	3,479	10%
Dean Prevea 360	0	0	0%
GHC EC	2	6	0%
GHC SC	1,007	2,750	7%
Gundersen Lutheran	421	1,172	3%
HealthPartners	82	241	1%
Health Tradition	832	2,354	6%
Humana Eastern	3	5	0%
Humana Western	0	0	0%
Medical Associates	222	664	2%
Mercycare	558	1,646	4%
Network Northeast	368	991	3%
Network Southeast	0	0	0%
Physicians Plus	244	543	2%
Security	0	0	0%
UnitedHealthcare	313	753	2%
Unity Community	3,531	9,854	25%
Unity UW	2,950	7,877	21%
WEA Trust East	344	924	2%
WEA Trust NW - Chippewa	70	171	1%
WEA Trust NW - Mayo	55	118	0%
WEA Trust Southcentral	0	0	0%
TOTAL	**13,882**	**37,821**	**100%**

To compare costs between the state members and the WPE members, we compared the 2016 premiums. Premiums in the state program are set through the managed competition model, based on a tiering structure. WPE premiums do not go through the same process, as it would be difficult to apply the model to a structure with so few members in each plan. When comparing the WPE rates to the state rates by HMO, the rate differences vary greatly among the vendors. Computing a straight average of both programs produces a WPE rate that is 17.7% higher than the average state rate. However, the higher WPE premiums appear to be in the plans with no or low membership. Computing a weighted average of both, based on enrollment, produces a WPE rate that is 1.5% lower than the average state rate. This indicates that there is no selection issue under the current WPE underwriting process. The 2016 premium rates for WPE and state plans are shown below, with these calculated percentages.

PLAN	Percent Of Contracts	Local 2016 Premiums	State 2016 Premiums	Local % Above/ Below State
State Standard			$1,305	
Local Standard - Dane	0%	$1,130		
Local Standard – Milwaukee	0%	$1,320		
Local Standard – Waukesha	0%	$1,219		
Local Standard - Balance of State	0%	$1,219		
SMP	0%	$811	$808	0.4%
Anthem Northeast	5%	$740	$771	-4.0%
Anthem Southeast	5%	$824	$794	3.8%
Arise Health Plan	0%	$1,088	$773	40.7%
Arise Aspirus	0%	$1,041	$755	37.9%
Dean Health Plan	10%	$737	$629	17.1%
Dean Prevea 360	0%	$713	$686	4.0%
GHC EC	0%	$1,028	$806	27.5%
GHC SC	7%	$684	$641	6.8%
Gundersen Lutheran	3%	$831	$799	4.0%
HealthPartners	1%	$912	$718	27.0%
Health Tradition	6%	$729	$776	-6.0%
Humana Eastern	0%	$1,218	$807	50.9%
Humana Western	0%	$1,273	$862	47.7%
Medical Associates	2%	$689	$688	0.1%
Mercycare	4%	$695	$641	8.5%
Network Northeast	3%	$786	$775	1.4%
Network Southeast	0%	$838	$812	3.2%
Physicians Plus	2%	$715	$680	5.3%
Security	0%	$1,064	$836	27.3%
UnitedHealthcare	2%	$934	$784	19.1%
Unity Community	25%	$679	$769	-11.7%
Unity UW	21%	$620	$681	-9.0%
WEA Trust East	2%	$844	$784	7.7%
WEA Trust NW – Chippewa	1%	$1,069	$823	30.0%
WEA Trust NW – Mayo	0%	$1,069	$823	30.0%
WEA Trust Southcentral	0%	$650	$603	7.8%
Average		**$909**	**$772**	**17.7%**
Weighted Average		**$715**	**$726**	**-1.5%**

Recommendations

Based on the observations noted above, we recommend revising the WPE program to match the state plan, for simplification. This would include the same regional structure with plans in each region and a statewide carrier. This would also include the same benefit design options with benefits based on provider tiers and separate contribution tiers. Pricing would be based on the regions as defined for the state plan. The wellness component may need to be handled differently, based on potential difficulty for local governments to administer the contribution differentials while paying full rates to ETF. However, this may not produce an issue as we have seen states that are able to administer a wellness contribution differential similar to this with a separate local plan, successfully. Tennessee is an example.

We also recommend the WPE program transition to self-insurance for the same reasons we recommend self-insurance for the state plan. A similar phase-in approach would be practical and allow appropriate data to be collected and monitored. This would require a similar reserving structure as recommended for the state. If the plans were combined, the WPE program would have no need for reinsurance and plans could still be rated separately. North Carolina is one example of a state plan that allows local governments to enter the state plan. Experience analysis of that plan shows local participants typically cost less than the state employees, primarily due to age differences.

If the programs cannot be combined into one pool due to statutory limitations, ETF could purchase reinsurance, if desired, with amounts determined based on reserve level and risk tolerance. It could also be structured to buy the insurance from the larger State pool, eliminating the unnecessary profits built into that product.

ACA Update and Strategies

With the implementation of the Patient Protection and Affordable Care Act (ACA) of 2010 well under way, ETF has already been moving into compliance with the various coverage, benefit and reporting mandates and requirements of the Act. This second report provides an update on the next major coming concern – the 40% Excise Tax that will become effective in 2018. We also provide a reminder about another of the key ACA requirements – the Employer Shared Responsibility Penalty.

40% Excise Tax—Update

In Segal's initial study, we reported on the 40% Excise Tax that will be in effect starting in 2018. Our report described how the tax works in general terms prior to issuance of any regulatory guidance. We also provided preliminary calculations of how the Excise Tax could affect ETF's health benefit programs and illustrations of the amount of Excise Tax that might be payable if no changes are made to the program.

The ACA provides that an employer must consider those covered for self-only coverage separately from those covered for other tiers of coverage (such as family coverage, employee plus spouse, etc.). Different threshold values apply based on whether a person is covered for self-only coverage, or another tier of coverage.

Since the initial report in March 2015, the Internal Revenue Service and U.S. Treasury have issued two separate requests for comments from the employer community on various aspects of the 40% Excise Tax and how it should be regulated. Each of these requests for comments included questions relating to how an employer must or should aggregate (or disaggregate) employees or participants for purposes of calculating the Excise Tax. Comments on the initial request (Notice 2015-16) were due by May 15, 2015 and on the second request (Notice 2015-52) by October 1, 2015. As of this writing, IRS has not issued any response to the comments.

While these calculation methods will likely end up very complicated and conditional, they are nevertheless important for ETF to monitor, since the flexibility that may be granted to aggregate or disaggregate groups may make the difference between owing the Excise Tax or not.

Impact of Medical Flexible Spending Account and Other Plans

The Excise Tax must take into account not only the primary health benefit plan (medical and prescription drug), but also other health benefit programs offered by the employer. Such plans include dental and vision plans that are part of the medical benefit, Health Flexible Spending Accounts (FSAs) under a cafeteria plan, Health Reimbursement Arrangements (HRAs) Health Savings Accounts (HSAs), Archer Medical Savings Accounts (MSAs), and onsite medical clinics.

As illustrated in our original report, the largest single variable in the Excise Tax calculation for ETF will likely be the availability of employee salary reductions through a Health Flexible Spending Account (FSA) under a cafeteria plan. Having the ability for an employee to reduce pay by up to $2,550 per year can immediately create an Excise Tax situation for the plan.

The IRS and Treasury requests for comments also included questions and preliminary positions on whether other types of health benefit plans should be included in the Excise Tax threshold calculation and the appropriate cost basis. For example:

- Dental and vision benefits that are under a separate contract from the medical plan or that a participant can decline would be excluded from the calculation.

- Health Flexible Spending Accounts (FSA) would be counted and would include the amount of the employee's salary reduction plus any employer reimbursement in excess of the salary reduction amount.

- Archer Medical Savings Accounts (MSAs) and Health Savings Accounts (HSAs) would include only employer contributions, not after-tax employee contributions.

- Health Reimbursement Arrangements (HRAs) would be counted and include the applicable premium for health coverage provided through the HRA.

- Employee Assistance Programs (EAPs) might be deemed by the IRS to be an excepted benefit and would be excluded from the calculation, provided they met all four of the following requirements:
  - Not provide significant medical care benefits
  - Not be coordinated with benefits under another group health plan or contingent upon participation in another group health plan
  - Not require participant premiums or contributions to participate in the EAP
  - Not have cost sharing

- On-site medical clinics would generally be included in the cost of health coverage, although IRS is considering excluding on-site clinics that offer only *de minimis* medical care, such as first aid, immunizations, allergy shots, pain relievers, or treatment of workplace accidents. There are also questions about how the cost for on-site medical clinics would be established and allocated across the covered participants.

Other programs would need to be reviewed by legal counsel to determine whether they must be included in the Excise Tax calculation. For example, there is no federal guidance yet on whether an Opt-Out program that pays cash or alternate benefit credits under a cafeteria plan would have to be counted as a health plan. ETF should monitor the regulatory process closely as guidance is forthcoming.

Significant questions are also under consideration about which employees and retirees actually qualify for the higher thresholds for high-risk professions and retirees. While the State will have some employees that work in high-risk positions (law enforcement officers, fire protection employees, emergency medical technicians, paramedics, first responders, etc.), there is as yet no guidance regarding the additional requirement that the majority of employees covered by the plan be in high-risk positions to qualify for the higher thresholds.

The IRS and Treasury Notices have been clear that the cost of coverage would be determined under rules similar to calculating COBRA premiums for continuation of coverage. Also, the

calculation must be made based on the plan in which the employee is enrolled, not coverage offered to the employee in which they do not enroll. This differs from the new health plan and employer reporting under Sections 6055 and 6056 of the Internal Revenue Code, where the employer must report the lowest value plan offered to the employee, whether that employee enrolled in that plan or not. We anticipate considerable confusion among employers as these filing and Excise Tax calculation processes move into full operation.

Who Calculates? Who Files? Who Pays?

The 40% Excise Tax is to be paid by the "coverage provider". For an insured plan (such as ETF's current insured health plans) the insurer would be the coverage provider. For a self-insured group health plan, Health FSA or HRA, the coverage provider is the "Plan Administrator", which in many cases will be the Plan or the employer. For other self-insured benefits, the coverage provider is the person that administers the benefits. The IRS/Treasury have sought input on how to define "coverage provider", recognizing that, like the State, many employers will have multiple plans cutting across all different types, so there could be multiple parties responsible for paying the tax.

Also, a big area of concern raised by the IRS and Treasury is how to calculate the Excise Tax values when an employee has self-only coverage for one plan, but other than self-only coverage in another plan. For example, if the employee has self-only coverage for the medical plan (because his or her spouse is covered under another employer's plan), but also has family coverage under an includable dental plan. Again, there is no guidance published yet and whatever guidance is published will likely be highly complex.

To calculate the Excise Tax values, the employer must combine the cost of the different included benefits and calculate the amount of the excess benefit over the applicable statutory threshold. The employer then must determine the pro rata share of the excess benefit attributable to each "coverage provider" and report the taxable excess benefit share to each coverage provider and to the IRS. If the employer or plan sponsor does not accurately perform the required calculations, the coverage provider must pay any additional tax due, but the employer is subject to a penalty of 100% of the amount of the additional tax, plus interest based on the IRS underpayment of taxes rates.

ETF Strategy Recommendations

While the Excise Tax will not be applicable until 2018, there will be considerable work to be accomplished by that date and we recommend that ETF start now. Major decisions will need to made on a variety of key issues, including, for example:

- Which plans must be counted and which can be excluded;
- How to aggregate or disaggregate participants counted under each plan to minimize the possibility of hitting the Excise Tax thresholds;
- Identification of the appropriate coverage provider for each plan or contract and determination of that provider's role in the process – what data is needed, etc.;

- Negotiation across organizational lines within the State as to which entity does which calculations, particularly where plans may be administered by different agencies;

- Establishing how the cost for each plan will be determined and setting up processes to support that determination on an annual basis;

- Determining how to allocate any excess cost across the various health plans, administrators or the State as the Plan Administrator; and/or

- Setting up the reporting process for coverage providers and the IRS.

We recommend that ETF initiate the process by establishing a working group composed of representatives from any State agency that may sponsor or administer a plan that might be covered, along with legal counsel and actuarial firm representation for cost calculation methodology. After an initial survey of plans, that group could become the core for coordinating the data flow and calculations necessary to the annual process.

We also remind the Board that as long as health benefit cost trends continue at a higher rate than general inflation, at some point every health plan will hit the Excise Tax threshold. ETF should continue to monitor the projections of cost carefully and take progressive steps to reduce the total cost of the program and hold it below the tax threshold. This process will require ETF to manage the cost of the program in a corridor between the floor of mandates, plan coverage and employer subsidy requirements and the ceiling of the Excise Tax thresholds.

As of this writing, there are four bills pending in Congress that would change or repeal the 40% Excise Tax. Changes among these bills would include delaying the effective date for two to five years, increasing the statutory thresholds, pegging the tax to be triggered at the 90% or 85% actuarial value level, exempting retiree-only plans, allowing geographic adjustments to the thresholds, improving adjustments for age/gender, exempting various plans (such as FSAs, HSAs or HRAs) from the calculation, and providing broader language to cover more workers as high-risk positions. Under the Congress' own rules, any changes involving reduction of revenue would need to have offsetting provisions to increase revenue, so the way forward for any changes will be complicated. ETF should continue to monitor these potential changes as they may have a significant effect on future plan design and maximum benefit limitations.

ETF Excise Tax Exposure

In our prior report, we estimated the following potential Excise Tax assessments:

ETF PROJECTED EXCISE TAX
($ Millions)

Year	Tax with 4% Trend	Tax with 6% Trend
2018	$7	$13
2019	$7	$20
2020	$8	$31
2021	$11	$43
2022	$14	$58
2023	$17	$76
2024	$21	$99
2025	$26	$127
2026	$32	$158
2027	$39	$193

The health plan negotiations, along with some benefit changes for 2016 improved ETF's Excise Tax exposure:

ETF PROJECTED EXCISE TAX – UPDATED FOR 2016 PREMIUMS
($ Millions)

Year	Tax with 4% Trend	Tax with 6% Trend
2018	$3	$5
2019	$4	$7
2020	$4	$11
2021	$5	$17
2022	$6	$28
2023	$7	$40
2024	$9	$55
2025	$11	$71
2026	$14	$93
2027	$18	$118

Implementing the full array of recommendations presented in this report will further mitigate the Excise Tax exposure. Please see the Executive Summary.

Shared Responsibility Penalty

Under the ACA, employers must provide minimum essential health benefit coverage to at least 95% their full-time employees and subsidize that coverage at the minimum required employer contribution level of 60% of the cost, or face a Shared Responsibility Penalty. Employees working 30 hours per week or equivalent are considered full-time employees for ACA purposes.

ETF has not had difficulty meeting these requirements as they have phased in because state employees working at least 1,040 hours per year are eligible to participate in the health plan at the full subsidy levels. That level roughly equates to 20 hours per week, which is well below the minimum requirement to cover employees working 30 hours per week.

Recommendations for Shared Responsibility Penalty Management

We recommend that ETF continue discussions with the Department of Administration Division of Personnel Management to ensure there are no groups of employees hired by any agency that would be excluded from the eligibility for the plan even if working more than the equivalent of 30 hours per week. Diligence is needed to check all persons receiving a W-2 from the State to avoid missing pockets of employees that might be considered full-time. We have worked with state health plans where their penalty situation was triggered by numbers of rehired annuitants, short-term employees who keep working, part-time employees with two or three part-time job positions with the same employer, or specifically excluded groups like Adjunct Professors or Teaching Assistants at the university.

In addition, for local participating government entities where ETF does not have control over employment policies, there may be employees working well over the 30 hour ACA rule that are excluded from coverage because they are not considered permanent employees or budgeted employees and that are never reported to ETF. We recommend that ETF initiate and maintain a dialogue with participating local governments to help understand whether there are such groups of employees. While the Shared Responsibility Penalty for those groups would generally fall on employer, the Plan will need to know about those non-covered groups and individuals and help the local employers take appropriate steps to deal with them.

Appendices

1. Performance Metrics
2. Sample—Medical Management and Wellness Health Plan
3. Sample—Goal for Plan Year 2016 Premium Incentive Discount
4. Plan Regional Analysis
5. Network Participation by Hospital

Appendix 1: Performance Metrics

Shared savings will be based on the 100 point performance metric scale. Each metric has a target goal based on NCQA guidelines. The vendor's baseline for each metric will be determined by self-reported 2015 data. Carriers will achieve points based on increases in these metrics for 2016, 2017, 2018, 2019, and 2020. Need to address if baseline is higher than target for any year, should the incentive be for improving on baseline data? Each vendor will be required to reach the compliance level each year beginning 2016. The target levels and available points are as follows:

Clinical Compliance Metric	Available Points	Target Level	Compliance (Percent of Target)				
			2016	2017	2018	2019	2020
			50%	65%	80%	90%	100%
Diabetes							
Patient(s) that had 1 Hb A1c tests in last 12 reported month	3	90%	45%	59%	72%	81%	90%
Increase participants with HbA1c tests of < 8.0% (target < 7.0%)	6	75%	38%	49%	60%	68%	75%
Patient(s) that had an annual screening test for diabetic nephropathy.	3	80%	40%	52%	64%	72%	80%
Increase percentage of participants with BP control of <140/90	5	75%	38%	49%	60%	68%	75%
Increase the percentage of participants with HbA1c < 9%	5	90%	45%	59%	72%	81%	90%
Hypertension							
Patient(s) on anti-hypertensives that had a serum potassium in last 12 reported months.	6	80%	40%	52%	64%	72%	80%
Patient(s) that had a serum creatinine in last 12 reported months.	6	80%	40%	52%	64%	72%	80%
Increase percentage of participants with BP control of <140/90	10	70%	35%	46%	56%	63%	70%
Hyperlipidemia							
Patient(s) with a LDL/HDL cholesterol test in last 12 reported months.	6	85%	43%	55%	68%	77%	85%
Patient(s) with a triglyceride test in the last 12 reported months.	6	85%	43%	55%	68%	77%	85%
Increase the percentage of participants with cholesterol level below the high range	10	70%	35%	46%	56%	63%	70%

Clinical Compliance Metric	Available Points	Target Level	Compliance (Percent of Target)				
			2016	2017	2018	2019	2020
			50%	65%	80%	90%	100%
Preventive Screening							
Increase percentage of women age 40-69 who have had at least 1 mammogram in last 24 months to screen for breast cancer	3	75%	38%	49%	60%	68%	75%
Increase percentage of participants age 50-75 who have had appropriate colorectal cancer screening	3	75%	38%	49%	60%	68%	75%
% of population with attestation of HRA discussion with PCP	6	100%	50%	65%	80%	90%	100%
Utilization Rates							
Increase the number of participants with major cardiac events, COPD, asthma, or congested heart failure that do not require readmission within 6 months of discharge.	11	80%	40%	52%	64%	72%	80%
Increase the percentage of participants with asthma/COPD and diabetes that do not have a disease related ER visit	11	90%	45%	59%	72%	81%	90%

Appendix 2: Sample - Medical Management and Wellness Health Plan

SAMPLE

Sample—Medical Management and Wellness Health Plan
Healthy Activity Requirements

All Employees & Covered Spouses	Additional Requirements for Participants with a Chronic Condition & Eligible for the Disease Management Program
1/1/2016 – 7/1/2016: Health Activity Requirements – Surcharge Applies for 2017 Plan Year	
• Complete the online Personal Health Assessment, give a copy to your physician and discuss results with your PCP • Designate a Primary Care Physician • Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program	
7/1/2016 – 6/30/2017: Health Activity Requirements – Surcharge Applies for 2018 Plan Year	
• Complete all recommended age/gender specific biometric screenings & discuss with your PCP	• Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program
• Complete the online Personal Health Assessment, give copy to your PCP & discuss findings with your PCP	• Set a health related goal with your personal nurse advisor that will be helpful in better managing your chronic condition
• Complete a Nutrition Education, Weight Management, or other health related educational program sponsored by your health plan	• Complete all chronic condition related medical testing and follow medical guidelines prescribed by the treating physician
7/1/2017 – 6/30/2018: Healthy Activity Requirements – Surcharge Applies for 2019 Plan Year	
• Complete all recommended age/gender specific biometric screening & discuss with your PCP	• Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program
• Complete the online Personal Health Assessment (PHA), including your current blood pressure, BMI, cholesterol levels and take a copy of the PHA to your physician & discuss results with your PCP	• Set a health related goal with your personal nurse advisor that will be helpful in better managing your chronic condition
• Document the achievement of a personal health improvement goal in consultation with your PCP through your health plan's health tracker	• Complete all chronic condition related medical testing and follow medical guidelines prescribed by the treating physician in consultation with your D/M care manager

Note: Participants with a chronic condition who are notified as eligible for the disease management program before July 1 of 2016 must meet the disease mangement related healthy activities requirements to be eligible for the rewards and avoid the penalty for 2017

Segal Consulting 1

Sample—Medical Management and Wellness Plan *continued*
Healthy Activity Requirements

All Employees & Covered Spouses	Additional Requirements for Participants with a Chronic Condition & Eligible for the Disease Management Program
7/1/2018 – 6/30/2019: Health Activity Requirements – Surcharge Applies for the 2020 Plan Year	
• Complete all recommended age/gender specific biometric screening & complete a physical exam showing blood pressure, and cholesterol in the normal range, & discuss with your PCP. Document testing results in your health plan's online Personal Health Assessment (PHA)	• Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program
• Complete a Nutrition Education, Weight Management, or other health education program sponsored by your health plan (i.e. online or class setting)	• Set a health related goal with your personal nurse advisor that will be helpful in better managing your chronic condition
• Document the achievement of a personal health improvement goal in consultation with your PCP through your health plan's health tracker	• Complete all chronic condition related medical testing and follow medical guidelines prescribed by the treating physician
7/1/2019 – 6/30/2020: Healthy Activity Requirements – Surcharge Applies for the 2021 Plan Year	
• Complete a Nutrition Education, Weight Management, or health education program sponsored by your health plan (i.e. online or class setting)	• Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program
• Complete all recommended age/gender specific biometric screening, maintain blood pressure and cholesterol in the normal ranges, & discuss with your PCP	• Set a health related goal with your personal nurse advisor that will be helpful in better managing your chronic condition
• Complete all recommended age/gender specific biometric screening, maintain blood pressure and cholesterol in the normal ranges, & discuss with your PCP	• Complete all chronic condition related medical testing and follow medical guidelines prescribed by the treating physician
• Document the achievement of a personal health improvement goal in consultation with your PCP through your health plan's health tracker	
7/1/2020 – 6/30/2021: Healthy Activity Requirements – Surcharge Applies for the 2022 Plan Year	
• Complete all recommended age/gender specific biometric screening, maintain blood pressure and cholesterol in the normal ranges, & discuss with your PCP	• Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program
• Document the achievement of a personal health improvement goal in consultation with your PCP through your health plan's health tracker	• Set a health related goal with your personal nurse advisor that will be helpful in better managing your chronic condition
• Complete the online Personal Health Assessment (PHA), including your current blood pressure, BMI, cholesterol levels and take a copy of the PHA to your physician & discuss results with your PCP	• Complete all chronic condition related medical testing and follow medical guidelines prescribed by the treating physician

Segal Consulting 2

Sample—Medical Management and Wellness Plan *continued*
Requirements for Tobacco users

Employees who are Tobacco Users*
7/1/2015 – 6/30/2016(Year 1): Healthy Activity Requirements – Surcharge Applies for the 2017 Plan Year
• Participate in a Tobacco Cessation program sponsored by your health plan (i.e. online or class setting)
• Complete a Nutrition Education or Weight Management program sponsored by your health plan (i.e. online or class setting)
• In consultation with your PCP and Tobacco Cessation coach, develop a plan to achieve the goal to reduce your tobacco use by 25%
7/1/2016 – 6/30/2017(Year 2): Healthy Activity Requirements – Surcharge Applies for the 2018 Plan Year
• Participate in a Tobacco Cessation program sponsored by your health plan (i.e. online or class setting)
• Complete a Nutrition Education or Weight Management program sponsored by your health plan (i.e. online or class setting)
• In consultation with your PCP, achieve the goal to reduce your tobacco use by 25%
7/1 – 6/30 (Year 3+) Going Forward: Healthy Activity Requirements – Surcharge Applies Next Year
• Stop the use of tobacco products
• Provide an alternative tobacco cessation approach as documented by physician

Note: Participants will be required to attest to not using tobacco to avoid having to complete the additional healthy activity requirements related to tobacco use

* New employees must complete the healthy activities during the following qualification period beginning with Year 1 requirements and going forward.

Segal Consulting 3

Sample—Qualification Period Explained *continued*

Enrolled in Plan on January 1st 2016

All Employees & Covered Spouses

- Must complete designated healthy activities in Qualification Period beginning January 1, 2016 through June 30, 2016
- $50 monthly premium surcharge in 2017 for non-compliance
- Surcharge increase in 2018 to $75 and 2019+ to $100
- Must complete designated healthy activities in Qualification Period 2016 to avoid $50 surcharge in 2017 for non-compliance

Join During Calendar Plan Year 2016

All Employees & Covered Spouses:

- Requirement of healthy activities begins the following Qualification Period of July 1, 2017 to June 30, 2017
- Surcharge not applicable in 2017
- Eligible for higher surcharge beginning 2018

Identified for Disease Management:

- Those identified through carrier outreach are subject to healthy activity requirements during following Qualification Period
- Ex. Join in October 2016; surcharge not applicable in 2018. Participate in Qualification Period beginning July 1, 2017; surcharge in 2019

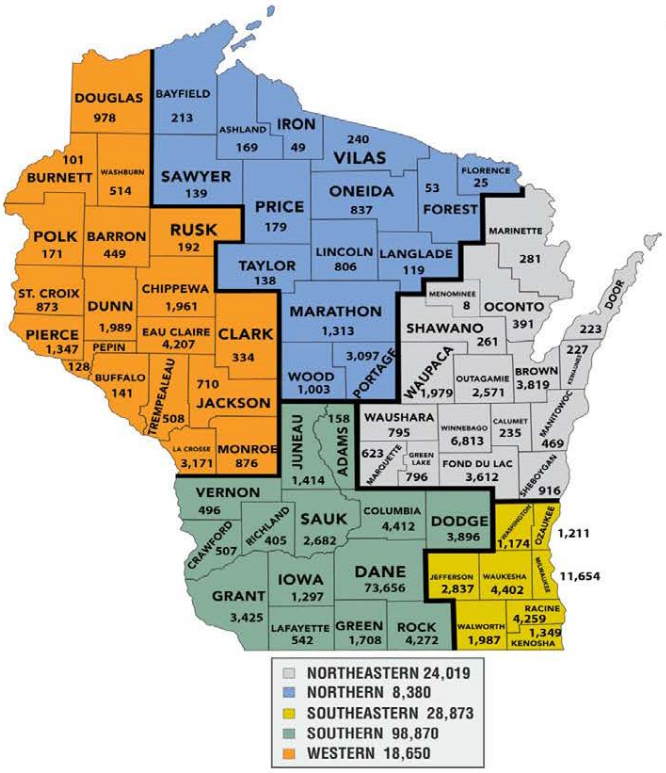
Segal Consulting 4

Appendix 3: Sample - Premium Incentive Discount Using Points Based Activities

Earning Period: November 16, 2014 – November 15, 2015 **Goal for Plan Year 2016 Premium Incentive Discount:** **1) Complete the Health Assessment Questionnaire (worth 10 credits) AND** **2) Earn 20 additional credits for a total of 30 credits by November 15, 2015**	**Credit Value**	**Credit Max**
Health Assessment Questionnaire - REQUIRED (online/paper)	10	10
Lifestyle Coaching - 6 interactions + Survey (telephonic, email)	10	10
Tobacco Cessation Program Completion (telephonic)	10	10
Condition Management - Enrollment + 3 calls (telephonic)	10	10
Health Advisor Call (telephonic)	5	5
Virtual Coaching (online)	5	15
Non-Tobacco User Declaration (online)	5	5
Wellness Challenges (online)	5	20
Preventive Exam - Well Woman/Well Man (in-person/self-reported)	5	5
Preventive Exams - 2 Dental/Year (in-person/self-reported)	5	10
Preventive Exam - 1 Vision/Year (in-person/self-reported)	5	5
Agency Training Classes (in-person/self-reported)	3	6
Agency Wellness Programs (in-person/self-reported)	5	10
Monthly Seminars (online)	1	3
Conversations (online)	1	3
Health & Fitness Activities (in-person, online, telephonic/self-reported)	1	3
Blood Pressure Less Than 120/80	2	2
Total Cholesterol Less Than 200	2	2
Glucose Less Than 100	2	2
Kansas Financial Learning Center Modules	1	5
Register for Castlight Health	3	3
Castlight Health - Complete Quiz and Video	2	2
EAP Webinars (telephonic)	1	3
Total Credits Possible = 149		
Total Credits Required = 30		

Appendix 4: Plan Regional Analysis

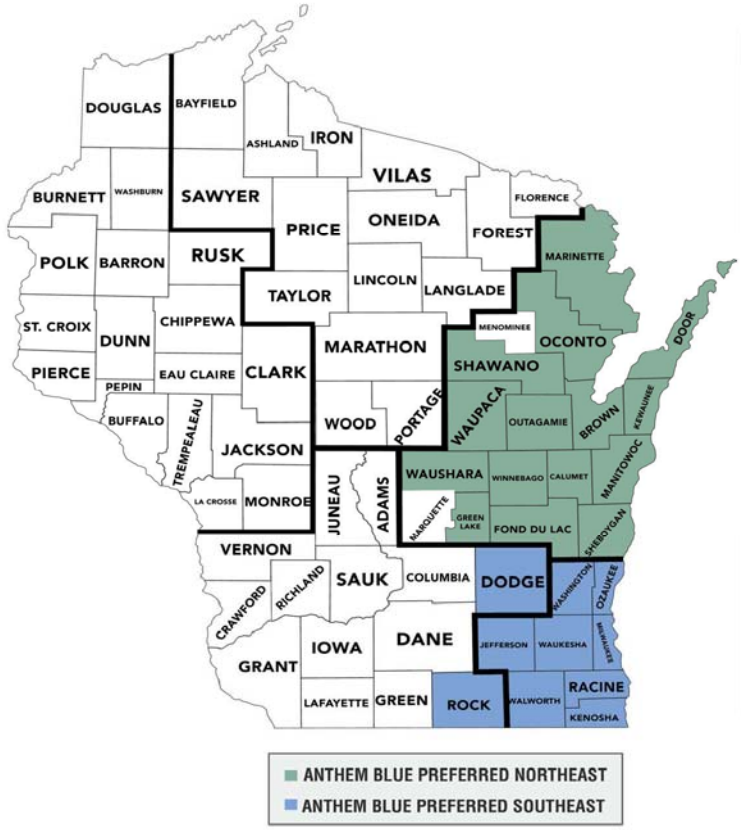
Wisconsin ETF Membership By Region



Top 5 Plans By Region	
Northeastern	
Network Health	8,615
UHC Northeast	5,761
WEA Trust East	4,901
Arise	1,586
Dean Health	1,331
Northern	
Security Health	6,209
WEA Trust East	1,438
GHC EC	227
Arise	156
WEA Trust NW Chippewa	134
Southeastern	
Humana Eastern	8,988
WEA Trust East	8,422
UHC Northeast	4,264
Anthem Southeast	2,872
Dean Health	2,818
Southern	
Dean Health	35,573
Unity (Dane)	35,043
Physician Plus	10,730
GHC SCW	9,632
Unity Community	2,528
Western	
WEA Trust NW Mayo	5,250
WEA Trust NW Chippewa	3,684
Gunderson Health	2,958
Health Tradition	1,964
HealthPartners	1,783

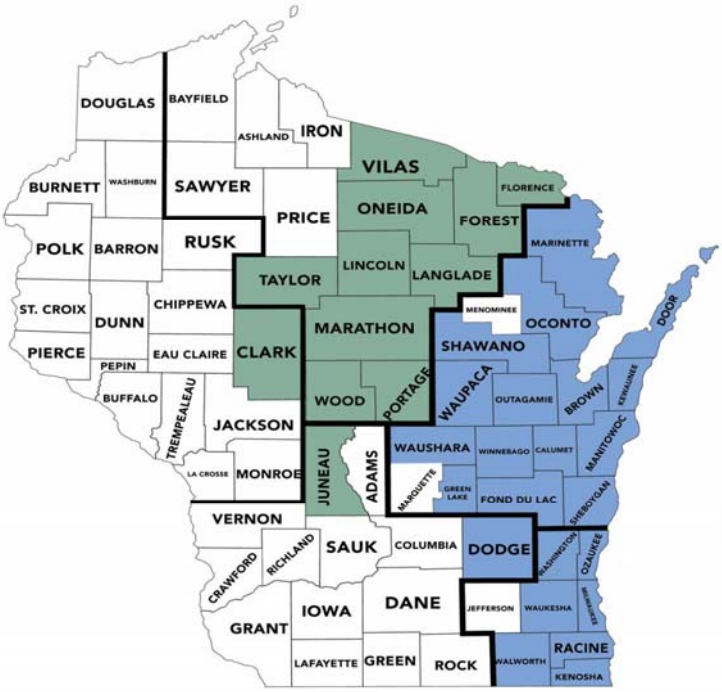
Discounts	Northeastern	Northern	Southeastern	Southern	Western	Statewide
IP	31.0%	19.2%	35.4%	45.5%	18.5%	38.2%
OP	41.9%	26.9%	43.9%	44.8%	18.7%	41.5%
Prof	45.9%	33.9%	48.9%	50.3%	26.9%	45.8%
Total	40.9%	28.8%	44.0%	46.0%	22.8%	41.7%

ANTHEM BLUE PREFERRED



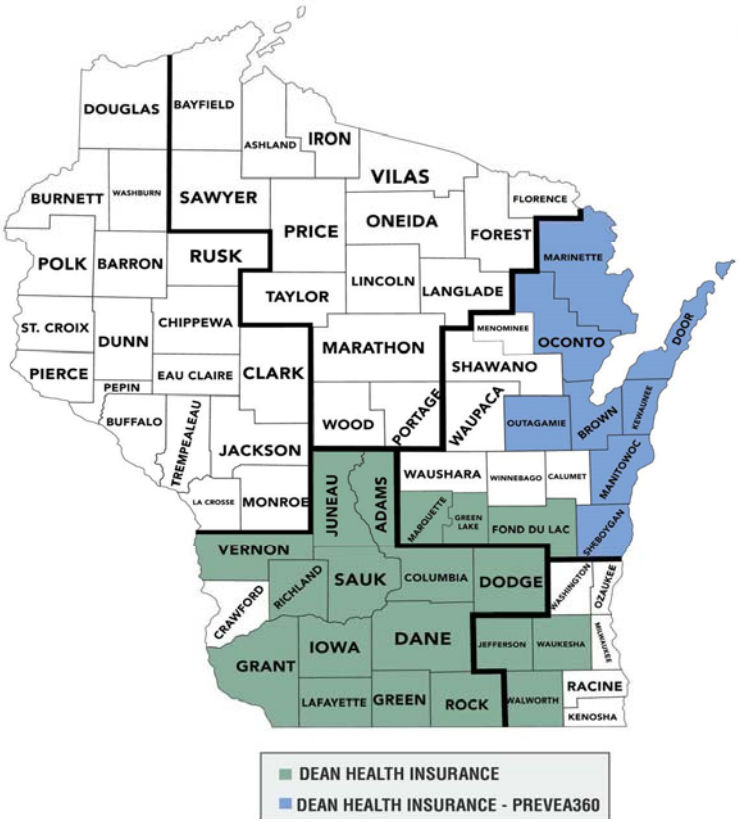
Members	
By Plan:	
Northeast	379
Southeast	2,955
Total	3,334
By Region:	
Northeastern	388
Northern	2
Southeastern	2,877
Southern	65
Western	2
Total	3,334
Top 5 Counties	
Southeast	
Milwaukee	1,497
Waukesha	478
Racine	394
Kenosha	154
Washington	133
Northeast	
Winnebago	88
Brown	82
Outagamie	38
Waupaca	32
Fond Du Lac	29

ARISE HEALTH PLAN



Members	
By Plan:	
Arise	1,753
Arise SE	16
Total	1,769
By Region:	
Northeastern	1,586
Northern	156
Southeastern	22
Southern	4
Western	1
Total	1,769
Top 5 Counties	
Arise	
Brown	858
Outagamie	120
Oconto	107
Manitowoc	102
Marinette	100

DEAN HEALTH INSURANCE



Members	
By Plan:	
Dean	39,799
Prevea360	99
Total	39,898
By Region:	
Northeastern	1,427
Northern	37
Southeastern	2,818
Southern	35,573
Western	43
Total	39,898
Top 5 Counties	
Dean	
Dane	22,484
Dodge	2,495
Columbia	2,413
Rock	2,380
Grant	1,814
Prevea360	
Brown	70
Kewaunee	8
Oconto	6
Sheboygan	6
Ashland	3

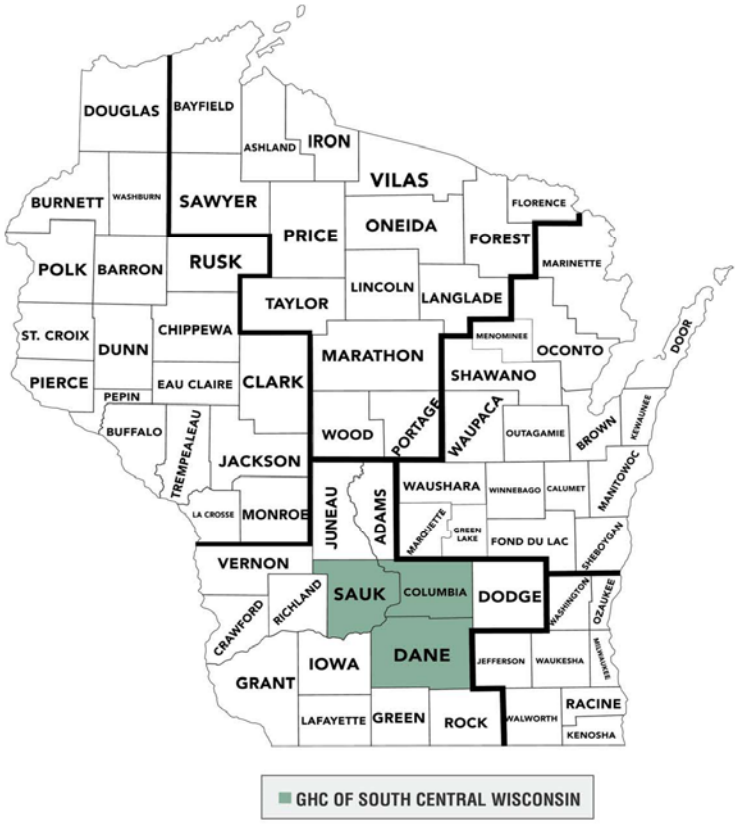
DEAN HEALTH INSURANCE
DEAN HEALTH INSURANCE - PREVEA360

GHC OF EAU CLAIRE

Members	
By Plan:	
GHC of EC	913
Total	913
By Region:	
Northeastern	1
Northern	227
Southeastern	-
Southern	-
Western	685
Total	913
Top 5 Counties	
GHC of EC	
Douglas	586
Bayfield	108
Washburn	80
Ashland	76
Sawyer	31

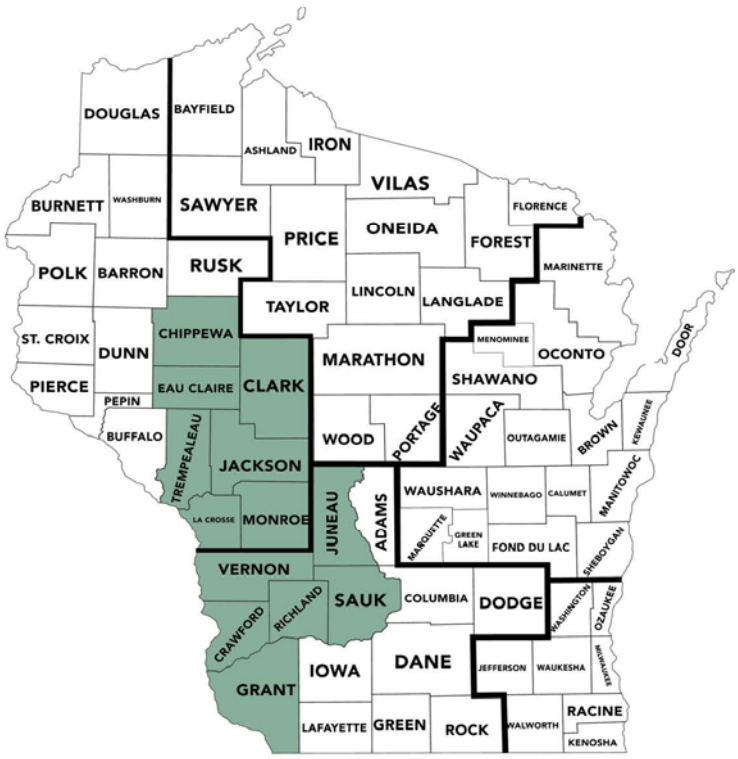
GHC OF EAU CLAIRE

GHC OF SOUTH CENTRAL WISCONSIN



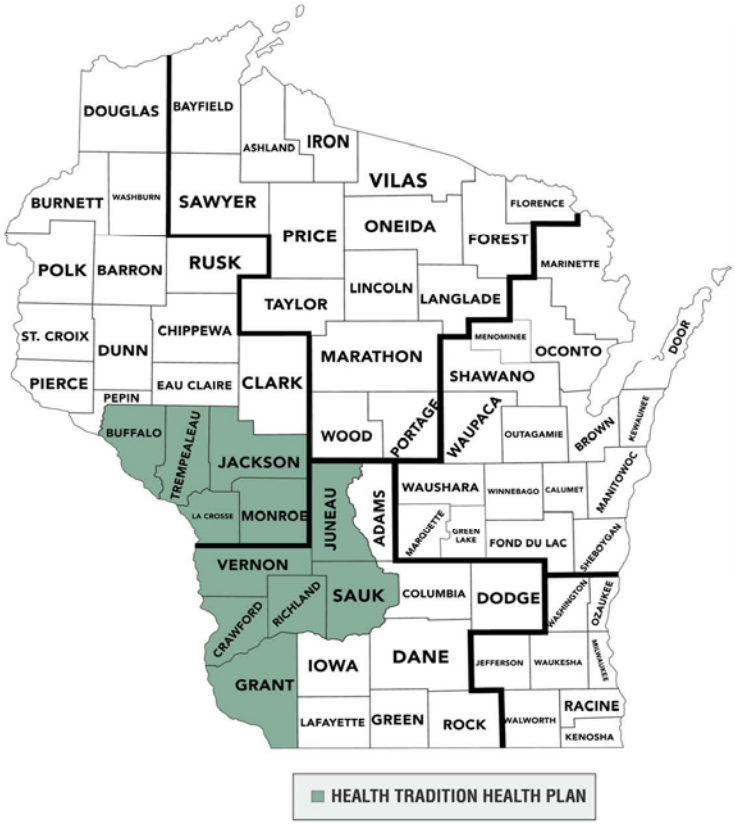
Members	
By Plan:	
GHC of SCW	9,781
Total	9,781
By Region:	
Northeastern	25
Northern	10
Southeastern	107
Southern	9,632
Western	7
Total	9,781
Top 5 Counties GHC of SCW	
Dane	9,060
Columbia	208
Rock	122
Green	103
Jefferson	71

GUNDERSEN HEALTH PLAN



Members	
By Plan:	
Gundersen	4,244
Total	4,244
By Region:	
Northeastern	4
Northern	1
Southeastern	-
Southern	1,281
Western	2,958
Total	4,244
Top 5 Counties Gundersen	
La Crosse	2,005
Juneau	429
Monroe	409
Vernon	343
Crawford	281

HEALTH TRADITION HEALTH PLAN

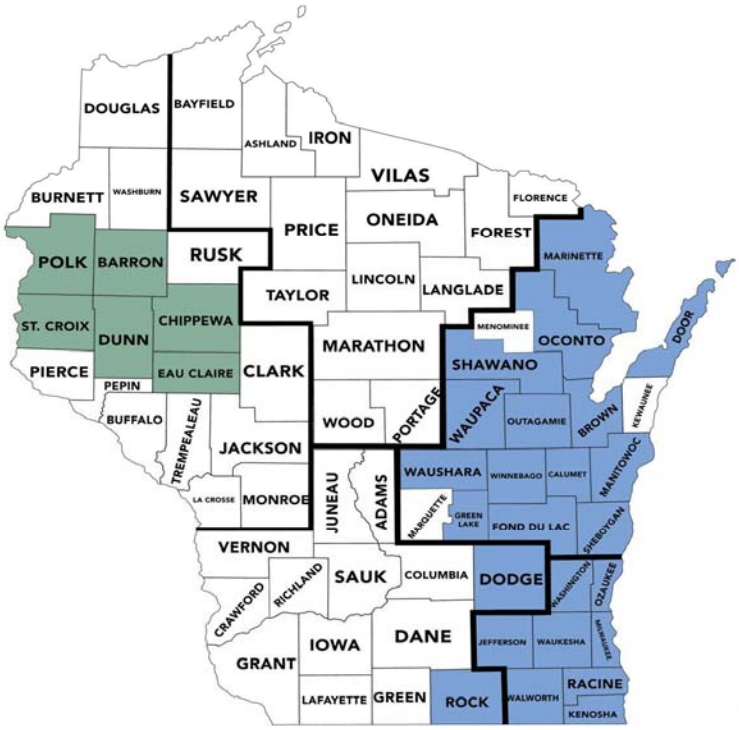


Members	
By Plan:	
Health Tradition	2,716
Total	2,716
By Region:	
Northeastern	3
Northern	-
Southeastern	-
Southern	749
Western	1,964
Total	2,716
Top 5 Counties Health Tradition	
La Crosse	1,140
Juneau	448
Monroe	435
Jackson	290
Crawford	135

HEALTHPARTNERS HEALTH PLAN

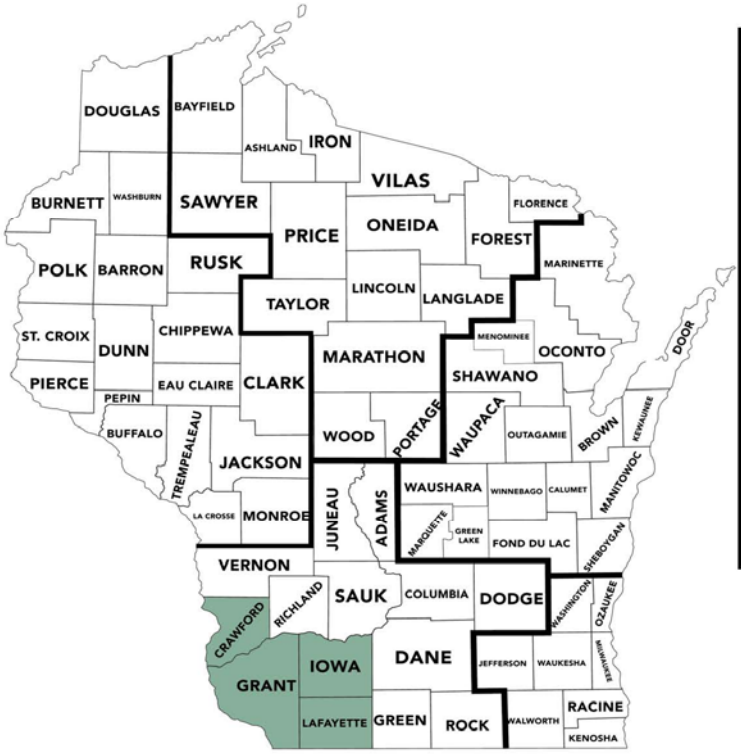
Members	
By Plan:	
Healthpartners	1,845
Total	1,845
By Region:	
Northeastern	1
Northern	55
Southeastern	4
Southern	2
Western	1,783
Total	1,845
Top 5 Counties Healthpartners	
Pierce	884
ST. Croix	504
Douglas	94
Polk	94
Eau Claire	55

HUMANA



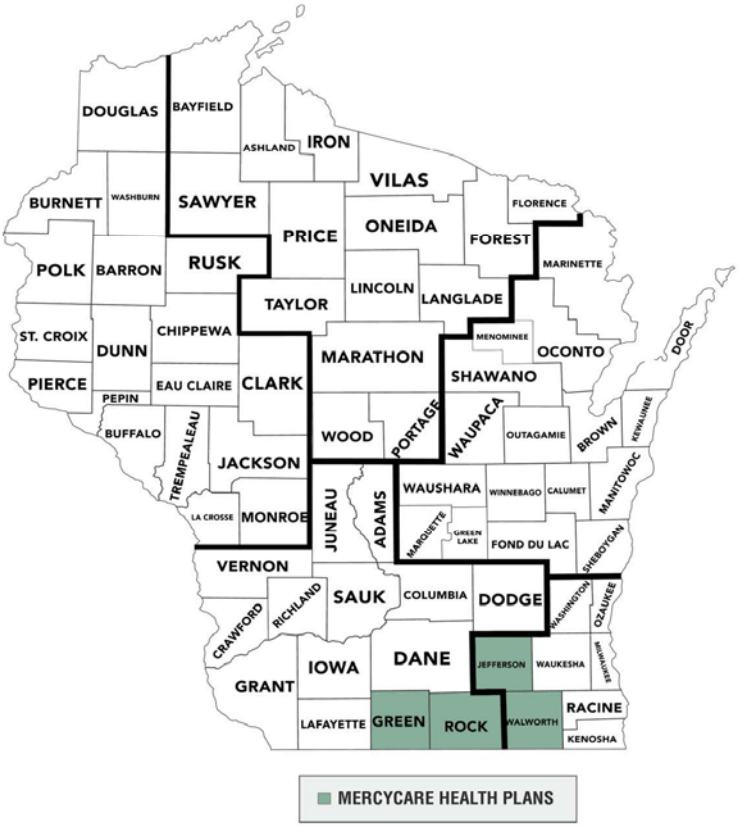
Members	
By Plan:	
East	9,916
West	722
Total	10,638
By Region:	
Northeastern	807
Northern	4
Southeastern	8,988
Southern	112
Western	727
Total	10,638
Top 5 Counties	
East	
Milwaukee	3,974
Racine	1,688
Waukesha	1,543
Ozaukee	545
Kenosha	498
West	
Eau Claire	182
Pierce	163
Dunn	143
ST. Croix	90
Chippewa	80

MEDICAL ASSOCIATES HEALTH PLANS



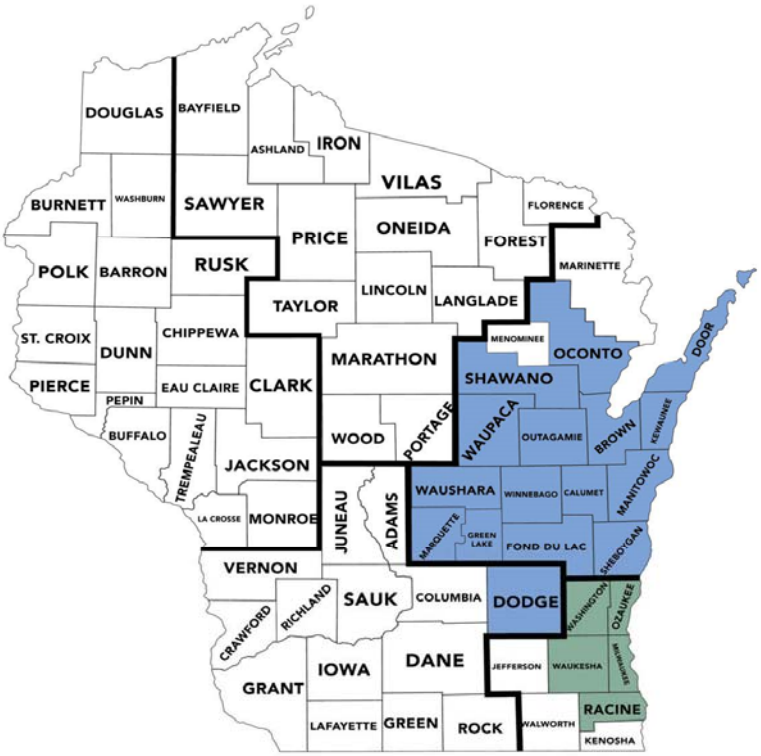
Members	
By Plan:	
Med Associates	1,066
Total	1,066
By Region:	
Northeastern	-
Northern	-
Southeastern	-
Southern	1,066
Western	-
Total	1,066
Top 5 Counties	
Med Associates	
Grant	969
Lafayette	57
Crawford	24
Iowa	12
Dane	4

MERCYCARE HEALTH PLANS



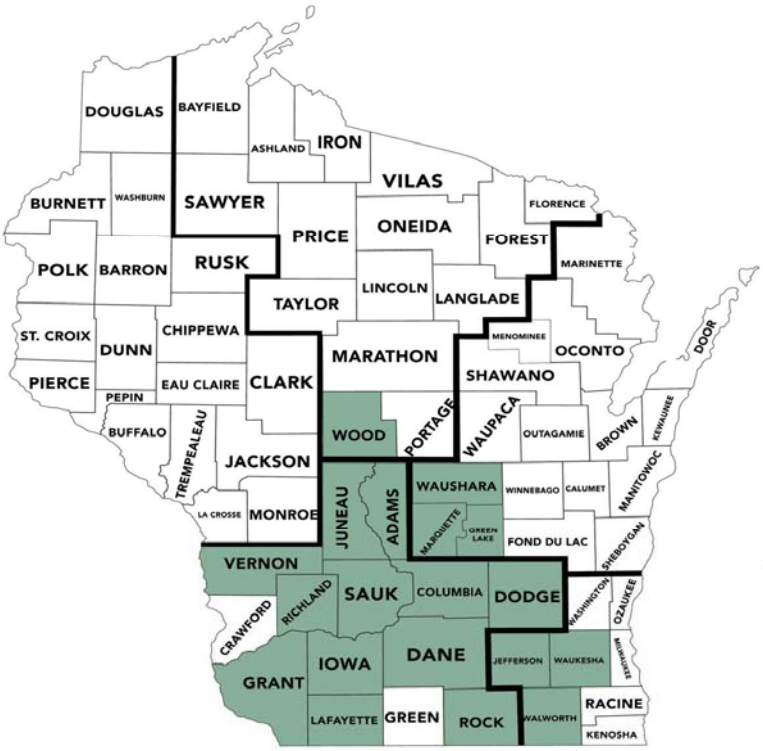
Members	
By Plan:	
MercyCare	1,141
Total	1,141
By Region:	
Northeastern	-
Northern	-
Southeastern	402
Southern	739
Western	-
Total	1,141
Top 5 Counties	
MercyCare	
Rock	690
Walworth	284
Jefferson	108
Green	23
Dane	14

NETWORK HEALTH



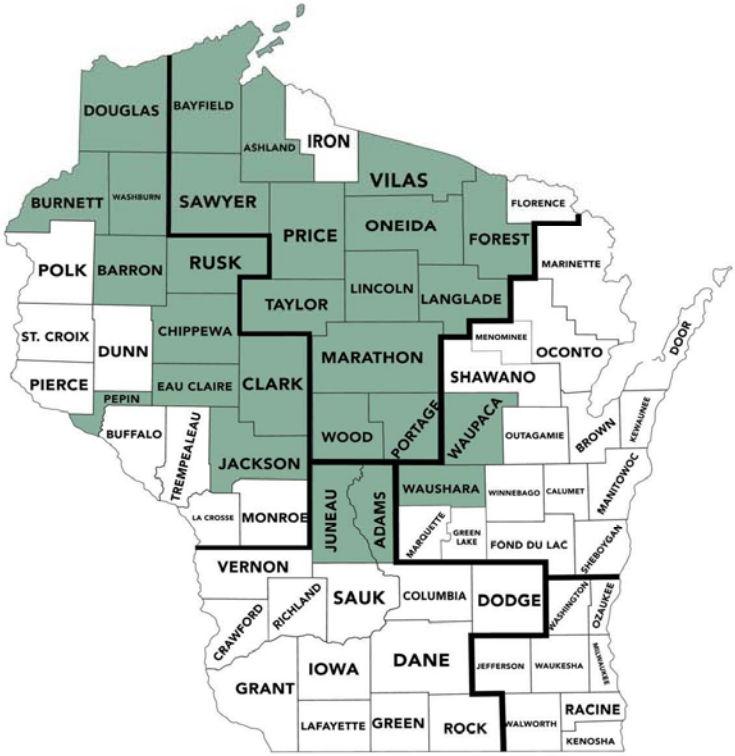
Members	
By Plan:	
Network	8,906
Total	8,906
By Region:	
Northeastern	8,615
Northern	23
Southeastern	20
Southern	243
Western	5
Total	8,906
Top 5 Counties	
Network	
Winnebago	3,693
Fond Du Lac	1,550
Outagamie	1,256
Waupaca	634
Waushara	433

PHYSICIANS PLUS



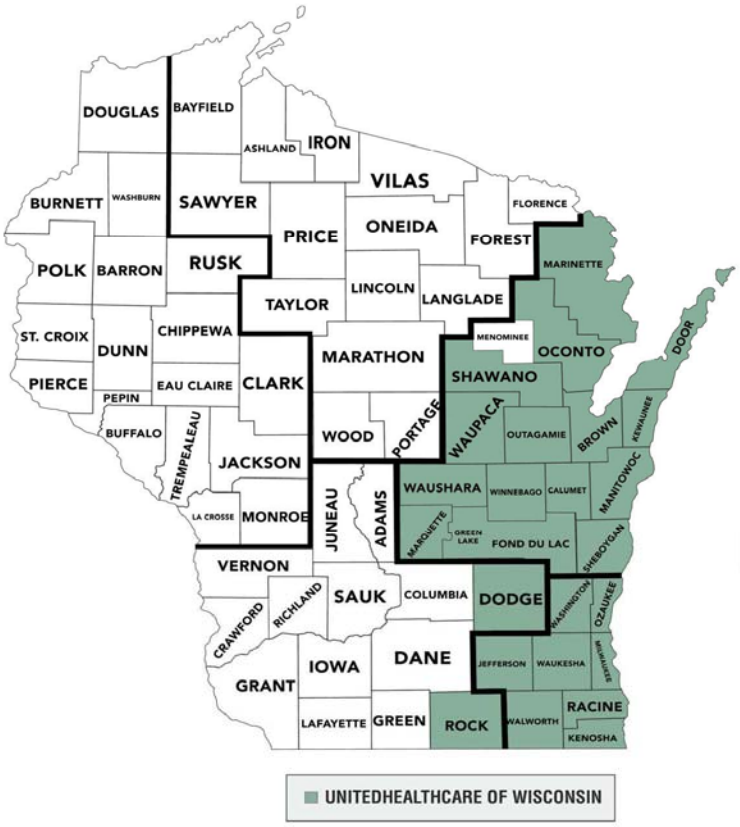
Members	
By Plan:	
Physicians Plus	10,996
Total	10,996
By Region:	
Northeastern	95
Northern	12
Southeastern	151
Southern	10,730
Western	8
Total	10,996
Top 5 Counties Physicians Plus	
Dane	9,134
Columbia	665
Sauk	261
Rock	166
Green	149

SECURITY HEALTH PLAN



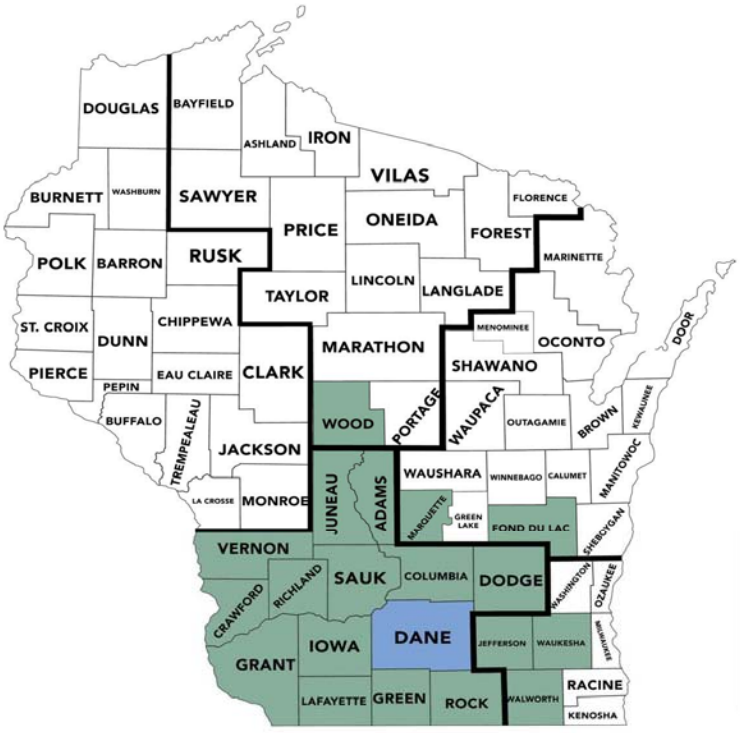
Members	
By Plan:	
Security	8,020
Total	8,020
By Region:	
Northeastern	221
Northern	6,209
Southeastern	7
Southern	87
Western	1,496
Total	8,020
Top 5 Counties Security	
Portage	2,166
Marathon	1,031
Oneida	791
Wood	749
Lincoln	674

UNITEDHEALTHCARE OF WISCONSIN



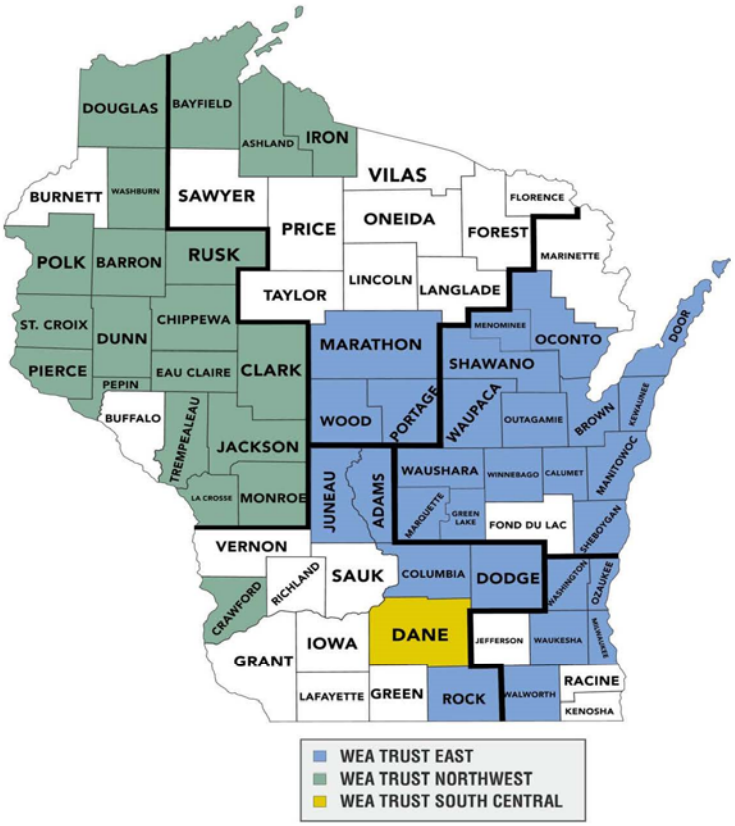
Members	
By Plan:	
UHC	10,158
Total	10,158
By Region:	
Northeastern	5,761
Northern	41
Southeastern	4,264
Southern	92
Western	-
Total	10,158
Top 5 Counties	
UHC	
Milwaukee	2,116
Winnebago	1,954
Brown	1,415
Waukesha	768
Outagamie	736

UNITY HEALTH INSURANCE



Members	
By Plan:	
UW Health	35,465
Community	3,120
Total	38,585
By Region:	
Northeastern	182
Northern	23
Southeastern	781
Southern	37,571
Western	28
Total	38,585
Top 5 Counties	
UW Health	
Dane	32,676
Columbia	747
Green	514
Rock	432
Sauk	286
Community	
Sauk	403
Grant	385
Jefferson	329
Dodge	308
Columbia	299

WEA TRUST



Members	
By Plan:	
East	15,612
NW Chippewa	3,819
NW Mayo	5,263
South Central	88
Total	24,782
By Region:	
Northeastern	4,903
Northern	1,580
Southeastern	8,432
Southern	924
Western	8,943
Total	24,782
Top 5 Counties	
East	
Milwaukee	3,972
Racine	1,499
Waukesha	1,274
Brown	965
Winnebago	860
NW Chippewa	
Eau Claire	1,142
Chippewa	865
Pierce	254
Washburn	247
ST. Croix	218
NW Mayo	
Eau Claire	2,396
Dunn	1,643
Chippewa	591
Trempealeau	194
Barron	104
South Central	
Dane	67
Rock	10
Walworth	8

Other Specifics

Appendix 5: Network Participation by Hospital

	Provider Name	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Southern	UW Hospital and Clinics	◆	◆	◆						◆	
	Meriter Hospital		◆					◆		◆	
	St. Mary's Hospital		◆		◆						◆
	Beaver Dam Community Hospitals		◆		◆			◆	◆	◆	
	Divine Savior Healthcare		◆		◆	◆		◆		◆	
	Mile Bluff Medical Center		◆				◆				
	Watertown Regional Medical Center	◆	◆		◆			◆		◆	
	Stoughton Hospital Association		◆		◆			◆		◆	
	Mercy Hospital and Trauma Center		◆					◆		◆	
	Sauk Prairie Memorial Hospital		◆		◆	◆				◆	
	Monroe Clinic		◆		◆	◆		◆		◆	
	St. Clare Hospital & Health Services		◆		◆				◆	◆	◆
	Upland Hills Health		◆		◆			◆		◆	
	Richland Hospital		◆		◆						
	Columbus Community Hospital		◆		◆			◆	◆	◆	
	Southwest Health Center		◆		◆		◆			◆	
	Reedsburg Area Medical Center		◆		◆	◆	◆			◆	
	St. Mary's Surgery and Care Center				◆	◆					◆
	Grant Regional Health Center		◆		◆		◆	◆		◆	
	St. Mary's Janesville Hospital		◆		◆	◆					◆
	Beloit Health System		◆		◆			◆	◆	◆	
	Memorial Hospital of Lafayette Co.		◆		◆				◆	◆	
	Prairie Du Chien Memorial Hospital	◆	◆				◆		◆	◆	
Northeastern & Southeastern	St. Elizabeth Hospital		◆					◆		◆	◆
	Fort Healthcare		◆		◆			◆		◆	
	St. Agnes Hospital		◆	◆	◆			◆		◆	◆
	Mercy Medical Center		◆					◆		◆	◆
	Froedtert Memorial Lutheran Hospital		◆					◆		◆	◆
	Waupun Memorial Hospital		◆	◆	◆			◆		◆	◆
	Wheaton Franciscan Healthcare-All Saints		◆					◆		◆	◆
	Columbia St. Mary's Hospital Milwaukee		◆					◆		◆	◆
	Aurora Medical Center in Oshkosh	◆	◆	◆				◆		◆	
	Aurora St. Luke's Medical Center	◆	◆	◆				◆		◆	
	Berlin Memorial Hospital	◆	◆	◆				◆		◆	
	Waukesha Memorial Hospital	◆	◆	◆	◆			◆		◆	
	Theda Clark Medical Center	◆	◆	◆				◆		◆	
	Appleton Medical Center	◆	◆	◆				◆		◆	
	Aurora Baycare Medical Center in Green Bay	◆	◆	◆				◆		◆	
	Mercy Walworth Hospital and Medical Center		◆					◆		◆	
	Aurora Sinai Medical Center	◆	◆	◆				◆		◆	
	Riverside Medical Center	◆	◆	◆				◆		◆	
	Oconomowoc Memorial Hospital	◆	◆	◆	◆			◆		◆	
Northern & Western	Gundersen Lutheran Medical Center	◆	◆	◆			◆	◆	◆	◆	
	Mayo Clinic Health System - Franciscan Healthcare		◆						◆	◆	
	Marshfield Clinic	◆	◆					◆		◆	
	Ministry Saint Michael's Hospital		◆					◆		◆	◆
	Aspirus Wausau Hospital	◆	◆	◆				◆		◆	
	Black River Memorial Hospital	◆	◆				◆	◆		◆	
	Tomah Memorial Hospital	◆	◆				◆	◆		◆	
	Ministry Saint Mary's Hospital		◆					◆		◆	◆

	Provider Name	Plan K	Plan L	Plan M	Plan N	Plan O	Plan P	Plan Q	Plan R	Plan S
Southern	UW Hospital and Clinics					◆	◆	◆	◆	◆
	Meriter Hospital					◆		◆	◆	◆
	St. Mary's Hospital					◆	◆		◆	◆
	Beaver Dam Community Hospitals			◆		◆	◆	◆	◆	◆
	Divine Savior Healthcare					◆	◆	◆	◆	◆
	Mile Bluff Medical Center				◆	◆		◆	◆	◆
	Watertown Regional Medical Center		◆			◆	◆	◆	◆	◆
	Stoughton Hospital Association					◆	◆	◆	◆	◆
	Mercy Hospital and Trauma Center		◆			◆	◆	◆	◆	◆
	Sauk Prairie Memorial Hospital					◆	◆	◆	◆	◆
	Monroe Clinic					◆	◆	◆	◆	◆
	St. Clare Hospital & Health Services					◆	◆	◆	◆	◆
	Upland Hills Health	◆				◆	◆	◆	◆	◆
	Richland Hospital					◆		◆	◆	
	Columbus Community Hospital					◆		◆	◆	
	Southwest Health Center					◆	◆	◆	◆	◆
	Reedsburg Area Medical Center					◆	◆	◆	◆	◆
	St. Mary's Surgery and Care Center					◆	◆		◆	◆
	Grant Regional Health Center	◆				◆	◆	◆	◆	◆
	St. Mary's Janesville Hospital					◆	◆		◆	◆
	Beloit Health System					◆	◆		◆	
	Memorial Hospital of Lafayette Co.					◆	◆	◆	◆	◆
	Prairie Du Chien Memorial Hospital	◆				◆		◆	◆	◆
Northeastern & Southeastern	St. Elizabeth Hospital			◆			◆		◆	◆
	Fort Healthcare		◆			◆	◆	◆	◆	◆
	St. Agnes Hospital			◆		◆	◆	◆	◆	◆
	Mercy Medical Center			◆			◆		◆	◆
	Froedtert Memorial Lutheran Hospital			◆			◆		◆	
	Waupun Memorial Hospital			◆		◆	◆	◆	◆	◆
	Wheaton Franciscan Healthcare-All Saints			◆			◆		◆	
	Columbia St. Mary's Hospital Milwaukee			◆			◆		◆	◆
	Aurora Medical Center in Oshkosh						◆		◆	◆
	Aurora St. Luke's Medical Center						◆		◆	◆
	Berlin Memorial Hospital			◆	◆	◆	◆	◆	◆	◆
	Waukesha Memorial Hospital					◆	◆	◆	◆	◆
	Theda Clark Medical Center			◆			◆		◆	
	Appleton Medical Center			◆			◆		◆	◆
	Aurora Baycare Medical Center in Green Bay						◆		◆	◆
	Mercy Walworth Hospital and Medical Center		◆			◆	◆	◆	◆	◆
	Aurora Sinai Medical Center					◆	◆		◆	
	Riverside Medical Center			◆	◆		◆		◆	◆
	Oconomowoc Memorial Hospital					◆	◆		◆	◆
Northern & Western	Gundersen Lutheran Medical Center					◆	◆		◆	◆
	Mayo Clinic Health System - Franciscan Healthcare						◆		◆	◆
	Marshfield Clinic				◆		◆	◆	◆	◆
	Ministry Saint Michael's Hospital			◆	◆		◆		◆	◆
	Aspirus Wausau Hospital				◆	◆	◆		◆	◆
	Black River Memorial Hospital				◆	◆			◆	◆
	Tomah Memorial Hospital					◆	◆		◆	◆
	Ministry Saint Mary's Hospital			◆	◆		◆		◆	◆