State of Wisconsin
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: December 29, 2016

To: Group Insurance Board

From: David H. Nispel, General Counsel

Subject: 2017 Uniform Benefits and Services Related to Gender Reassignment or Sexual Transformation—HHS Nondiscrimination Rule

At the request of a Board Member, the Group Insurance Board (Board) is meeting to discuss and consider the 2017 uniform benefits and services related to gender reassignment or sexual transformation and the federal Department of Health and Human Services (HHS) nondiscrimination rule.

Memoranda on this topic were previously submitted for Board consideration in the August 16 memo, Group Insurance Board Correspondence (Ref. GIB | 8.16.16 | 7A).

- The Department of Justice (DOJ) memorandum (Attachment B) is in regard to the July 12, 2016 motion to approve changes to the Guidelines Contract and Uniform Benefits for 2017 (Ref. GIB | 07.12.16 | 3A).
- ETF reviewed the DOJ memo and provided additional information for Board consideration in its own memorandum (Attachment C). The ETF memorandum provided information concerning the fiduciary duties of Board members.
- At the December 13 Board meeting, a DOJ attorney recommended that the Board follow existing law on this issue. As of this date, ETF is not aware of any changes to the existing law.
- At the December 13 Board meeting, a DOJ attorney stated that DOJ was willing to prepare a legal opinion for the Board that addressed the fiduciary duties of Board members in light of the federal HHS issued final regulations pertaining to Section 1557 of the Affordable Care Act.

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

Attachment A: ETF Memo – Discussion and Consideration of 2017 Uniform Benefits, December 8, 2016
Attachment B: DOJ Memo – ETF's Proposed Revisions to Uniform Benefits Provisions Regarding "Gender Identity" Health Services
Attachment C: ETF Memo – Uniform Benefit Provisions Related to Sex Discrimination

Reviewed and Approved by John Voelker, Deputy Secretary

Electronically Signed: 12/29/16

Board	Mtg Date	Item #
GIB	12.30.16	3

Farrell
EXHIBIT NO. 6
4.11.18 RPTR FC
For the Record, Inc.
(608) 833-0392

State of Wisconsin
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: December 8, 2016

To: Group Insurance Board

From: Sara Brockman, Health Policy Advisor
Office of Strategic Health Policy

Subject: Discussion and Consideration of 2017 Uniform Benefits – HHS Nondiscrimination Rule

This item has been added to the December 13 Group Insurance Board (Board) meeting agenda at the request of a Board member. The Wisconsin Department of Justice has indicated the intent to send representation to the Board meeting to discuss the issue.

Memoranda on this topic were previously submitted for Board consideration as the August 16 memo, Group Insurance Board Correspondence (Ref. GIB | 8.16.16 | 7A).

- The DOJ memorandum (Attachment A) is in regard to the July 12, 2016 motion to approve changes to the Guidelines Contract and Uniform Benefits for 2017 (Ref. GIB | 07.12.16 | 3A).
- ETF reviewed the DOJ memo and provided additional information for Board consideration (Attachment B).

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

Attachment A: DOJ Memo – ETF's Proposed Revisions to Uniform Benefits Provisions Regarding "Gender Identity" Health Services
Attachment B: ETF Memo – Uniform Benefit Provisions Related to Sex Discrimination

Reviewed and Approved by John Voelker, Deputy Secretary

Electronically Signed: 12/9/16

Board	Mtg Date	Item #
GIB	12.13.16	6

Attachment A

WISCONSIN DEPARTMENT OF JUSTICE
MEMORANDUM

Date: August 10, 2016

To: Group Insurance Board

From: Andy Cook, Deputy Attorney General

Subject: ETF's Proposed Revisions to Uniform Benefits Provisions Regarding "Gender Identity" Health Services

Executive Summary

The Department of Justice writes to you regarding proposed revisions to the State of Wisconsin Department of Employee Trust Funds' ("ETF") current Uniform Benefits policy. As you know, the current policy excludes coverage for "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment" and for "sexual counseling services . . . related to sexual transformation." ETF has recommended that the Group Insurance Board ("Board") remove these exclusions in order to comply with rules recently promulgated by the federal Department of Health and Human Services ("HHS"). Those rules purport to implement the Affordable Care Act's anti-discrimination provisions, and they generally ban discrimination based on "gender identity" in the provision of health services. *See* 45 C.F.R. §§ 92.206-207.

To the extent the Board believes that the new HHS rules compel it to accept ETF's recommended changes, it should reconsider for two reasons. First, HHS's rules are unlawful, at least as applied to coverage provisions that classify health services based on "gender identity." The Affordable Care Act's anti-discrimination provisions incorporate Title IX's prohibition against discriminating on the basis of "sex." *See* 42 U.S.C. § 18116; 20 U.S.C. § 1681. But HHS's rules improperly reinterpret Title IX to cover "gender identity" – an expansion Congress has never adopted and that HHS may not effect on its own.

Even if HHS had not misread Title IX, its "gender identity" rules improperly intrude on powers reserved to the State of Wisconsin to administer its own health policy. The United States Constitution prohibits the federal government and HHS from threatening to withhold ETF's receipt of Medicare Part D subsidies if ETF does not comply with the federal mandate. Separately, the Fourteenth Amendment does not authorize HHS to issue these rules, since ETF's policies do not violate that Amendment.

Second, even if HHS's rules were lawful, they do not mandate coverage for any particular procedures – which is effectively what ETF's proposed revisions accomplish. Instead, those rules allow coverage exclusions based on neutral

reasons, such as whether medical necessity demands the services at issue. This allows a narrower revision to the provision regarding gender reassignment services than ETF has proposed. And the Board likely need not revise the provision regarding sexual transformation counseling at all. Since non-transgender patients cannot receive such counseling, no discrimination exists by denying coverage for it. Alternatively, a blanket exclusion for all sexual counseling services would further protect the Uniform Benefits from challenge. Specific alternative proposals are presented at the end of this memorandum.

Analysis

I. HHS's Rules Improperly Require the State of Wisconsin To Enforce A Misreading of the Affordable Care Act and Title IX.

HHS's rules are unlawful because they rest on a misreading of the Affordable Care Act and Title IX. *See* 5 U.S.C. § 706 (agency actions are unlawful if undertaken "in excess of statutory jurisdiction, authority, or limitations"). The Affordable Care Act only prohibits discrimination coextensive with Title IX. But Title IX's prohibition against discrimination on the biological basis of "sex" does not extend to the distinct concept of "gender identity." Since HHS cannot issue rules that amend the Affordable Care Act and Title IX – which is what these rules effectively do – the Board need not conform ETF's Uniform Benefits to them.

First, nothing in Title IX's text suggests that the statute covers "gender identity." The statute's plain language is clear: "No person in the United States shall, ***on the basis of sex***, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance . . . ." 28 U.S.C. § 1681 (emphasis added). Again, "on the basis of ***sex***," not "on the basis of sex ***or gender identity***."

Legislative history confirms that Title IX covers just what it says – "sex," not "gender identity." Nowhere in the Congressional debates over Title IX does the phrase "gender identity" or "transgender" appear. Moreover, Congress has refused to amend Title IX to cover "gender identity."[1] Congress clearly would not have tried to add superfluous new protections for "gender identity" if Title IX already provided them.

Case law affirms Title IX's plain language and legislative history, holding that its protections do not extend to "gender identity." One well-reasoned opinion

[1] *See* H.R. 1652, 113th Cong. (2013); S.439, 114th Cong. (2015).

held, after carefully analyzing Title IX's plain language and its legislative history, that "Title IX's language does not provide a basis for a transgender status claim." *Johnston v. Univ. of Pittsburgh of Com. Sys. of Higher Educ.*, 97 F. Supp. 3d 657, 676 (W.D. Pa. 2015). And *Johnston* is supported by many other cases that reach the same result under Title VII, Title IX's sister anti-discrimination statute in the employment context.

Moreover, the State of Wisconsin has joined 12 other states in challenging another unlawful federal government mandate that rests on an identical misreading of Title IX. *See State of Texas, et al. v. United States, et al.*, No. 16-cv-00054 (N.D. Tex.). There, the federal government improperly demanded, again citing Title IX, that public schools allow students to use the bathrooms, locker rooms, and showers of the students' choosing, regardless of their biological sex. But that overreach must fail for the same reason as here – federal agencies cannot impose their policy preferences on the States by expanding Title IX to cover "gender identity" without Congressional action.

The United States Constitution also restrains HHS from imposing its view of the Affordable Care Act and Title IX on the State of Wisconsin and ETF. Although the federal government can contribute money to the States to be spent on various programs, that power cannot be used to "undermine the status of the States as independent sovereigns in our federal system." *See* U.S. CONST. art. I, § 8, cl. 1; *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2602 (2012) ("*NFIB*"). Indeed, when federal funding conditions "take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the states to accept policy changes." *Id.* at 2604.

HHS now threatens to withhold federal financial assistance if ETF refuses to implement the federal government's novel interpretation of Title IX. Specifically, HHS's new rules condition federal aid on ETF's "assurances" that its health programs comply with those rules. *See* 45 C.F.R. §§ 92.5-6 (requiring "assurances"); 42 U.S.C. § 18116 (applying Title IX's enforcement mechanisms to the Affordable Care Act); 20 U.S.C. § 1682 (compliance can be enforced by terminating federal assistance). Since ETF partly depends on federal financial assistance in the form of Medicare Part D subsidies, HHS improperly threatens to withhold those subsidies if ETF fails to comply with its novel reading of Title IX. *NFIB*, 132 S. Ct. at 2604. This likely amounts to unconstitutional coercion.

HHS also cannot find authority for its new rules in the Fourteenth Amendment. That Amendment allows Congress to "enforce, by appropriate legislation" its guarantee to "the equal protection of the laws." U.S. CONST. amend.

XIV, §§ 1, 5. But HHS can only issue rules that target a recognized equal protection violation. *See Kimel v. Florida Bd. of Regents*, 528 U.S. 62 (2000). Since many courts have concluded that transgender individuals are not a "suspect class" that triggers heightened constitutional scrutiny, coverage exclusions like ETF's here "need only be rationally related to a legitimate governmental purpose" to be valid under the Fourteenth Amendment.[2]

ETF can easily clear that low bar. For instance, it can point to the high costs the State must bear for covering services and procedures related to gender transition, or to medical research suggesting that such procedures (especially sex transformation surgeries) may in fact harm patients. Even if a heightened level of scrutiny did apply here, these coverage exclusions could for the same reasons pass muster as "substantially related to a sufficiently important governmental interest."[3] Since ETF's coverage provisions at issue here do not violate the Fourteenth Amendment, HHS may not bar them by citing the Fourteenth Amendment.

II. Even If HHS's Rules are Lawful, the Board Need Not Revise the Uniform Benefits As ETF Has Recommended.

Leaving aside the validity of HHS's new rules, ETF's recommended revisions to the Uniform Benefits go beyond what those rules require. Again, ETF has recommended striking entirely two policy exclusions from the Uniform Benefits:

- "Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment." Uniform Benefits § IV.1.a.
- "Sexual counseling services related to . . . sexual transformation." Uniform Benefits § IV.11.ah.

These revisions would arguably mandate that ETF cover ***all*** such procedures, whether medically necessary or not. But HHS expressly noted that its rules "do not . . . affirmatively require covered entities to cover any particular procedure or treatment for transition-related care." 81 Fed. Reg. 31376 at 31429 (May 18, 2016). Likewise, the rules "do not affirmatively require covered entities to cover any

---

[2] *Claussen v. Pence*, - F.3d - , 2016 WL 3213036, at *4 (7th Cir. June 10, 2016) (outlining "rational basis" standard).

[3] *See City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 441 (1985) (establishing "intermediate scrutiny" standard); *Craig v. Boren*, 429 U.S. 190, 199–200 (1976) ("Clearly, the protection of public health and safety represents an important function of state and local governments.").

particular treatment, as long as the basis for exclusion is evidence-based and nondiscriminatory." *Id.* at 31435. And HHS's rules expressly note that they are not "intended to determine, or restrict a covered entity from determining, whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case." 45 C.F.R. § 92.207(d).

Attachment B

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

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: August 11, 2016

To: Group Insurance Board

From: David H. Nispel, General Counsel
Diana M. Felsmann, Attorney

Subject: Uniform Benefits Provisions Related to Sex Discrimination

Information for GIB Consideration

After reviewing the Department of Justice (DOJ) August 10, 2016, memo requesting that the Group Insurance Board (GIB) reconsider its adoption of the Department of Employee Trust Funds' (ETF) recommended changes to the State of Wisconsin Group Health Insurance Program's Uniform Benefits, ETF offers additional information for the GIB's consideration:

- As fiduciaries,[1] GIB Board members must ensure that the Group Health Insurance Program complies with state and federal law. Basic fiduciary principles found in common law include the three "core" fiduciary duties: (1) the duty of loyalty, (2) the duty of impartiality, and (3) the duty of prudence. A fiduciary may rely on the advice and reports of experts (i.e., attorneys, accountants, financial advisors), provided the subject matter is within the expert's area or expertise and the expert is fully informed. Ensuring compliance with state and federal law falls under the duty of prudence.

- The United States Department of Health and Human Services (HHS) final rule implementing the Affordable Care Act's (ACA) nondiscrimination requirements provides that health insurance issuers may not contract away their own nondiscrimination obligations under the rule.[2] As a result, a decision not to comply with the HHS rule would jeopardize ETF's ability to contract with its health insurance issuers as of January 1, 2017.

---

[1] Wis. Stat. §40.03(6)(d).

[2] Moreover, nothing in the rule authorizes qualified health plan issuers or other issuers that are covered entities to contract away their own nondiscrimination obligations. Issuers must ensure that enrollees have equal access to health services provided by their coverage without discrimination on the basis of a prohibited criterion.

81 Federal Register 31376 (May 18, 2016), 31383.

- The cost of removing the Uniform Benefits exclusion related to benefits and services in connection with gender reassignment or sexual transformation is anticipated to be low. Based on a 2014 study Segal Consulting did for the state of Maryland, the highest estimated cost was .01% of the annual cost of Maryland's health insurance program. That study reflected that the annual costs associated with Maryland's health insurance program were approximately $1.3B. The largest estimated cost, $100,000 represents less than a 0.01% increase in annual costs for the cost of the initial procedure(s) and related drug therapy and counseling.

- The Group Health Insurance Program's Uniform Benefits continues to require that services be medically necessary,[3] as determined by the health plan and/or PBM.[4]

Background

The changes to the Group Health Insurance Program recommended in ETF's June 22, 2016, memo entitled *Guidelines Contract and Uniform Benefits Changes for 2017*, and adopted unanimously by the GIB on July 12, 2016, were made after careful research on the application of federal law, specifically the ACA nondiscrimination rule published by HHS on May 18, 2016. ETF's role in relation to the GIB is to make recommendations to assist the GIB in the performance of its fiduciary duties to the insurance programs administered by ETF, including the Group Health Insurance Program, and to provide information so that the Program is properly administered.

The recommended changes to the Program's Uniform Benefits in connection with the HHS rule, and as adopted by the GIB at the July 12, 2016 meeting were as follows:

1. Removing the current exclusion related to benefits and services related to gender reassignment or sexual transformation. Required effective date is January 1, 2017.

2. Including the federally required nondiscrimination notification language on all significant communications related to ETF's health programs. Required effective date is October 16, 2016 (90 days from July 18, 2016).

---

[3] Defined in ETF's Uniform Benefits as a service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care Provider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM:

1. consistent with the symptom(s) or diagnosis and treatment of the Participant's Illness or Injury; and
2. appropriate under the standards of acceptable medical practice to treat that Illness or Injury; and
3. not solely for the convenience of the Participant, physician, Hospital or other health care Provider; and
4. the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner. http://etf.wi.gov/members/IYC2016/IYC_Cert_of_Cov2107.pdf

[4] State of Wisconsin Group Health Insurance Program Uniform Benefits, Section III, Page 4-23.

Summary of August 10, 2016 Department of Justice Memo
In its August 10, 2016, memo to the GIB entitled *ETF's Proposed Revisions to Uniform Benefits Provisions Regarding "Gender Identity" Health Services*, the Department of Justice (DOJ), offers two reasons for the GIB to reconsider the changes to ETF's Uniform Benefits adopted at the July 12, 2016, GIB meeting.

The first reason DOJ provides is that the new HHS rule is unlawful, "at least as applied to coverage provisions that classify health services based on 'gender identity'." Included under that heading, DOJ writes that even if the new HHS rule is not based on a misreading of Title IX, which protects against sex discrimination, the rule "improperly intrude[s] on powers reserved to the State of Wisconsin to administer its own health policy."

The second reason offered by DOJ was that the HHS nondiscrimination rule does not mandate coverage for any particular procedure.

Benefits Coverage
Specific to the HHS rule and benefits coverage, as noted in ETF's June 22, 2016 memo to the GIB, ETF agrees with DOJ that the rule does not require coverage of specific benefits. However, of note:

- The rule specifies that categorical exclusions in coverage for all health services related to gender transition are facially discriminatory.

- The rule does not explicitly require the coverage of any particular service to treat gender dysphoria, and allows plans to deny services that are not medically necessary. HHS' Office for Civil Rights (OCR) will determine whether certain benefits designs are discriminatory on a fact-specific, case-by-case basis. 81 Fed. Reg. at 31434 & fn. 258.

- Denying coverage for transition-related services on the basis of those services not being medically necessary is anticipated to be subject to careful scrutiny. (Proposed HHS Nondiscrimination Rule) 80 Fed. Reg. 54172, 54190 (Sept. 8, 2015).

- The regulations allow covered entities to use reasonable medical management techniques and apply neutral, nondiscriminatory standards to health-related coverage. Specifically, OCR will consider whether an entity used "a neutral rule or principle when deciding to adopt the design feature or take the challenged action or whether the reason for its coverage decision is pretext for discrimination." 81 Fed. Reg. at 31433.

Penalties for Noncompliance with the HHS Rule
The HHS rule applies the same enforcement mechanisms under Title VI of the Civil Rights Act of 1964 (discrimination on the basis of race, color, and national origin), Title IX of the Education Amendments of 1972 (discrimination on the basis of sex), Section 504 of the Rehabilitation Act of 1973 (discrimination on the basis of disability), or the Age Discrimination Act of 1975. Penalties under Title IX include the termination of federal financial assistance.[5] Thus, one potential impact of a GIB decision to reconsider its adoption of the Uniform Benefits changes would be the Group Health Insurance Program's loss of Medicare Part D subsidies.[6] The Program received approximately $36 million in Medicare Part D subsidies in 2015.

In addition, the HHS rule allows for compensatory damages to be granted if an individual were to successfully litigate a claim that the Group Health Insurance Program was not in compliance with the law.[7]

Current EEOC Complaints Filed Against the GIB
It is important to note that two individual health plan participants have filed complaints with the Equal Employment Opportunity Commission (EEOC) against the GIB on the denial of benefits in relation to transgender services:

- EEOC Charge No. 443-2016-00291—Amended [redacted], Charging Party vs. University of Wisconsin, Respondent, and Department of Employee Trust Funds and Group Insurance Board, Additional Respondents.[8]

- EEOC Charge No. 443-2016-01428—Amended [redacted], Charging Party vs. Department of Employee Trust Funds, Respondent and Group Insurance Board, Additional Respondent.[9]

The EEOC takes the position that Title IX's prohibition against sex discrimination includes discrimination on the basis of gender identity. Compensatory and punitive damages may be awarded in cases involving intentional discrimination based on gender identity.[10]

The HHS Rule references the EEOC's position, and indicates that HHS' Office for Civil Rights (OCR) intends to refer any cases that fall outside of OCR's jurisdiction to the EEOC for investigation.[11] As a result, if the GIB were to reconsider the changes it

---

[5] 45 C.F.R. §92.301(a).
[6] *See* 20 U.S.C. §1682.
[7] 45 C.F.R. §92.301(b).
[8] *See* April 5, 2016, memo to the GIB from ETF General Counsel David H. Nispel.
[9] As of the writing of this memo, ETF has not yet received any details about this EEOC complaint. When ETF receives additional information, ETF will pass that information on to the GIB.
[10] The United States Department of Justice *Title VI Legal Manual*: https://www.justice.gov/crt/title-vi-legal-manual#XII (visited August 11, 2016).

[11] 81 Federal Register at 31432.

adopted to the Uniform Benefits on July 12, ETF anticipates an increase in complaints filed against the GIB.

GIB Authority to Modify Uniform Benefits

State law provides the GIB the authority to modify or expand insurance coverage when that modification or expansion is required by law.[12] The law further provides the GIB the authority to modify or expand benefits as it deems advisable unless the modification or expansion would increase premiums.[13]

The authority to make decisions on insurance coverage is necessary for the GIB, as trustees, to fulfill their fiduciary duties. Based on information provided by Segal Consulting, ETF anticipates the costs of providing the changes to the Uniform Benefits adopted by the GIB in relation to the HHS rule would be extremely low,[14] and would not increase premiums. As a result, whether the HHS rule is found to be invalid, the GIB would still have had the authority under state law to make these changes to the Uniform Benefits.

Recommendations Going Forward

1. ETF does not recommend the GIB reconsider its July 12, 2016, adoption of the changes made to the Group Health Insurance Program's Uniform Benefits in connection with the HHS rule. ETF recommended those changes after careful review of the HHS rule and in consideration of the GIB's fiduciary duties to the Group Health Insurance Program. In particular, the GIB's duty of prudence requires the GIB to ensure the Program is compliant with state and federal law.

   To address DOJ's questions with respect to the validity of the HHS rule, ETF recommends continuing with the changes as adopted at the July 12 GIB meeting, and revisiting that decision in one year. Such a reevaluation could be made in light of any court decisions interpreting the rule. In addition, reevaluation after one year would allow for ETF to present claims data to the GIB, which would provide the Board with insight into the cost of providing these benefits.

2. Important to note is the failure to meet fiduciary obligations may result in severe penalties, including personal liability. The August 10 DOJ memo does not address how the reconsideration of the GIB's adoption of the Uniform Benefits changes on July 12 comports with the GIB's fiduciary duties. As a result, if the GIB were to consider reversing its adoption of the changes to the Uniform Benefits, ETF first recommends the GIB obtain a legal opinion analyzing the Board's fiduciary duties under these specific circumstances.

---

[12] Wis. Stat. §40.03(6)(c).
[13] Wis. Stat. §40.03(6)(c) & (d).
[14] Segal Consulting drafted a report for the State of Maryland in 2014 concluding that the cost of providing initial procedures, drug therapy and counseling would be approximately .01% of the state's total health insurance costs; *See also* page 2.

DRAFT

MINUTES

August 16, 2016

Group Insurance Board
State of Wisconsin

Location:
Lussier Family Heritage Center
3101 Lake Farm Road, Madison, WI 53711

BOARD MEMBERS PRESENT:

Michael Farrell, Chair
Herschel Day, Secretary
Terri Carlson
Chuck Grapentine
Michael Heifetz
Ted Neitzke
Stacey Rolston
Nancy Thompson
JP Wieske
Bob Ziegelbauer

BOARD MEMBERS ABSENT:

Bonnie Cyganek, Vice Chair

PARTICIPATING EMPLOYEE TRUST FUNDS (ETF) STAFF:

Bob Conlin, Secretary
John Voelker, Deputy Secretary
Office of Strategic Health Policy:
Lisa Ellinger, Director
Sara Brockman, Board Liaison
Eileen Mallow, Jeff Bogardus, Sarah Bradley, Rachel Carabell, Tara Pray, Shayna Schomber, Joan Steele
Legal Services:
Daniel Hayes

OTHERS PRESENT:

ETF Department of Trust Finance:
Bob Willett
ETF Information Technology Services:
Ryan Perkins
ETF Legal Services:
David Nispel
ETF Office of Communications:
Nancy Ketterhagen, Mark Lamkins
ETF Office of Internal Audit:
Jacquelyn Van Marter, Yikchau Sze
MacIver Institute:
Chris Rochester
Momentum Insurance:
Stephanie Steel
Navitus:
Tom Pabich, Pam Olson
Network Health:
James Dahlke
Office of the Commissioner of Insurance:
Jennifer Stegall

Farrell
EXHIBIT NO. 15
4-11-18 RPTR PC
For the Record, Inc.
(608) 833-0392

Board	Mtg Date	Item #
GIB	11.30.16	1

ETF Office of the Secretary:
Pam Henning, Tarna Hunter, James Kates, Liz Doss-Anderson, Cheryllynn Wilkins
ETF Office of Strategic Health Policy:
James Cooper, Sherry Etes, Arlene Larson, Jessie Rossner, Renee Walk, Wade Whitmus
Anthem:
Brian Martin, Ted Osthelder
Baraboo Ambulance:
Troy Snow
Dean Health Plan:
Katie Beals, Penny Bound
Department of Administration:
Derek Sherwin, Nicole Zimm
Division of Personnel Management:
Peter Flood, Diana McNall, Paul Ostrowski
EPIC Life Insurance Company:
Wendy Hougan
General Public:
Hickory Hurie
Group Health Cooperative – South Central Wisconsin:
Emily Halter
Health Choice:
Cliff Morris, Bob Pearson
Humana:
Rain Buck, Elizabeth Wright
Legislative Audit Bureau:
Lisa Kasel
Legislative Fiscal Bureau:
Paul Onsager
M3 Insurance:
Jeremy Shepherd
Physicians Plus:
Ron Sebranek
Securian:
Hans Larsen, Paul Rudeen, Chris Schmelzer
Segal Consulting:
Patrick Klein, Kirsten Schatten, Ken Vieira
State Engineering Association:
Bob Schaefer
TRICAST:
Stacy Ausbrung, Greg Rucinski
UnitedHealth Group:
Jodie Tierney
Unity Health Insurance:
Cari Alexander
University of Wisconsin – Madison:
Deanne DeSlover, SE Hutchinson
UW Hospital and Clinics:
Anthony Dix, Liz Melin
UW System Administration:
Zoua Vang
WEA Trust:
Greg Cieslewicz
Wisconsin Association of Health Plans:
Phil Dougherty, Nancy Wenzel
Wisconsin Health News:
Tim Stumm
Wisconsin Hospital Association:
Joanne Alig
Wisconsin Medical Society:
Chris Rasch
WPS:
Matt Harty

Michael Farrell, Chair, called the meeting of the Group Insurance Board (Board) to order at 8:31 a.m.

CONSIDERATION OF MAY 18, 2016 OPEN MEETING MINUTES AND JULY 12, 2016 OPEN & CLOSED MEETING MINUTES

MOTION: Ms. Carlson moved to approve the open session meeting minutes of the May 18, 2016 meeting as submitted by the Board Liaison. Mr. Heifetz seconded the motion, which passed unanimously on a voice vote.

MOTION: Mr. Wieske moved to approve the open session meeting minutes of the July 12, 2016, meeting as submitted by the Board Liaison. Ms. Carlson seconded the motion, which passed unanimously on a voice vote.

MOTION: Mr. Grapentine moved to approve the closed session meeting minutes of the July 12, 2016, meeting as submitted by the Board Liaison. Ms. Thompson seconded the motion, which passed unanimously on a voice vote.

ANNOUNCEMENTS

Ms. Ellinger made the following announcements:

- Rachel Carabell has accepted the position of Strategic Health Policy Advisor with the Office of Strategic Health Policy.
- Renee Walk has accepted the position of Strategic Health Policy Advisor with the Office of Strategic Health Policy.
- Wade Whitmus has accepted the position of Health Policy Project Manager with the Office of Strategic Health Policy.
- Sara Brockman has accepted the position of Health Policy Advisor with the Office of Strategic Health Policy. Ms. Brockman will continue her role as the Board Liaison.
- Shayna Schomber assumed management of Optional Plans upon the retirement of Roni Harper. Ms. Schomber will continue to manage the dental benefit contract with Delta Dental and oversight of the self-insured medical benefits with Wisconsin Physicians Service.
- WisconsinEye was not present to record the meeting, due to the short duration of open session.

LIFE INSURANCE

Wisconsin Public Employers Group Life Insurance 2015 Policy Report and Recommendations

Mr. Rudeen with Securian referred the Board to the memo, Wisconsin Public Employers (WPE) Group Life Insurance 2015 Policy Year Report and Recommendations (Ref. GIB | 8.16.16 | 3B). Mr. Rudeen presented 2015 policy year highlights and pricing recommendations for the state and local plans for 2017. Detailed information for the 2015 policy year experience is summarized in the Financial Experience Report (Ref. GIB | 8.16.16 | 3B Attachment A).

All components of the State Plan and Local Government Plan are on track financially. Securian recommended maintaining the existing premium rates and benefits of the state and local plans. In addition, ETF staff recommended accepting the annual report as presented by Securian.

MOTION: Ms. Thompson moved to (1) accept the annual report from Securian Financial Group, and (2) accept the recommendation of no changes to rates under the state and local government portions of the Group Life Insurance Program. Mr. Day seconded the motion, which passed unanimously on a voice vote.

PHARMACY BENEFITS

Audit of Pharmacy Benefit Manager and Employee Group Waiver Plan (Medicare Part D) by TRICAST

Mr. Bogardus referred the Board to the memo, Audit of Pharmacy Benefit Manager (PBM) Services and Medicare Part D Employer Group Waiver Plan (Ref. GIB | 8.16.16 | 4A). Mr. Bogardus provided a summary of the annual audit performed by TRICAST, Inc. of PBM administrative services provided by Navitus Health Solutions, LLC (Navitus).

The audit report covers the following segments:

- 2015 PBM Commercial (non-Medicare) Pricing
- 2014 Pharmacy Network
- 2014 Fourth Quarter Rebates
- 2015 PBM Commercial (non-Medicare) Plan Design
- 2014 Navitus MedicareRx Employer Group Waiver Plan (EGWP)

TRICAST's Executive Summary and Audit Results Report conclude that TRICAST considered this a passing audit. While the audit found some discrepancies in the processing of claims, the volume is quite small, compared to the overall amount of claims processed by Navitus under both the EGWP and commercial plans. TRICAST concludes that overall, the programs are being administered in accordance with the plan designs and contractual provisions.

LONG-TERM CARE INSURANCE

Long-Term Care Insurance Proposal for 2017

Ms. Schomber and Ms. Mallow presented the memo, Long-Term Care (LTC) Insurance Proposal for 2017 (Ref. GIB | 8.16.16 | 5). Mutual of Omaha has been offered to state employees and their families since 2011. A proposal was submitted by Mutual of Omaha to ETF to continue offering LTC insurance in 2017. The Board was reminded that ETF was unable to come to a contractual agreement with Mutual of Omaha for 2016.

Milliman, the Board's actuarial consultant for LTC insurance, reviewed the proposal and found the policy, assumptions, and premium rates reasonable. Milliman verified that the proposal and benefits are in compliance with the Board's *Standards for Proposing and Providing Long-Term Care Insurance* (Standards), including the most recent changes to the Standards, which were updated and approved by the Board in May 2016.

ETF recommended the Board approve the proposal by Mutual of Omaha to offer LTC insurance to State of Wisconsin employees, annuitants, and their families, subject to negotiations between Mutual of Omaha and ETF that results in a signed contract.

The Board requested clarification regarding the lack of agreement between ETF and Mutual of Omaha for 2016. Ms. Mallow stated that 2016 would have been the first plan year with a contract between ETF and Mutual of Omaha, in accordance with the Board's directive for Optional Plan vendors to contract between the Board and individual vendors. Agreements were signed with individual brokers representing Mutual of Omaha. As such, LTC coverage was not impacted for 2016.

The Standards were updated for 2017 in order to clarify that contracts are required between the insurance vendor and the Board. Ms. Mallow also stated that it is ETF's intention to secure a signed contract with Mutual of Omaha as soon as possible.

> ***MOTION: Mr. Wieske moved to approve the proposal by Mutual of Omaha to continue offering long-term care insurance to eligible state employees and annuitants. Mr. Neitzke seconded the motion, which passed unanimously on a voice vote.***

CLEARINGHOUSE RULE # CR 16-034: TECHNICAL AND MINOR SUBSTANTIVE CHANGES TO EXISTING ETF ADMINISTRATIVE RULES

Mr. Hayes referred the Board to the memo, Clearinghouse Rule # 16-034 – Proposed Administrative Rule Making Technical and Minor Substantive Changes to Existing Administrative Rules (Ref. GIB | 8.16.16 | 6). ETF proposed a revision to the existing administrative rules in order to make technical updates to existing ETF rules, delete obsolete language in ETF rules, create consistency with provisions in 2015 Wisconsin Act 55 (2015-17 State Budget) and make other minor substantive changes.

Mr. Hayes provided a brief overview of the administrative rule promulgation process and the proposed changes. Of note, ETF proposed modifying the eligibility requirements for Income Continuation Insurance (ICI) for employees of local units of government in order to make requirements consistent with the 2015 Wisconsin Act 55 ICI changes for state employees.

ETF also proposed making minor changes to the definition of "dependent" for the purposes of life insurance offered to state employees, in order to provide flexibility beneficial to the implementation of ETF's Benefit Administration System (BAS). These

changes included removing the requirement that a dependent be unmarried, removing the requirement that the employee be responsible for at least 50 percent of support and maintenance for the dependent, removing the requirement that the dependent be more than 14 days old, and changing full-time student status from age 25 to 26 in order to match the age limit for health insurance.

Mr. Farrell noted the Patient Protection and Affordable Care Act (ACA) does not require dependents between the ages of 19 and 26 years to also be a full-time student, and asked if there was a reason why ETF's definition would be inconsistent with the ACA definition. Mr. Hayes stated that he would seek clarification.

Ms. Rolston also requested additional rationale to support removing the 50 percent support requirement and the requirement that a dependent be unmarried. Mr. Hayes stated that these items were both related to system specifications and functionality, and that he would seek clarification.

The Board did not take a motion on the item. The Board requested that additional information and justifications regarding the proposed administrative rule changes be presented at the November 30 Board meeting.

OPERATIONAL UPDATES

Mr. Farrell referred the Board to the Operational updates in the Board Packets (Ref. GIB | 8.16.16 | 7) and offered that staff were available if the Board had questions.

Mr. Farrell noted the inclusion of a Department of Justice (DOJ) memorandum (Ref. GIB | 8.16.16 | 7A Attachment A) regarding the July 12, 2016 Board action to approve changes to the Guidelines Contract and Uniform Benefits for 2017 (Ref. GIB | 7.12.16 | 3A). ETF reviewed the DOJ memo and provided additional information for Board consideration (Ref. GIB | 8.16.16 | 7A Attachment B).

The Board requested clarification regarding the timing of the DOJ memo in relation to ETF's contracting process for the 2017 plan year, specifically if the Board would be able to revisit the Guidelines Contract and Uniform Benefits for 2017 at a future meeting. Ms. Ellinger stated that 2017 contracts will be signed prior to the November 30 Board meeting. However, the contract clearly states that plan design is based on Board decisions and contracted vendors must implement any Board-directed changes.

HEALTH INSURANCE

Wisconsin Health Insurance Market: Review and Update of Developments
Ms. Carabell referred the Board to the memo, Wisconsin Health Insurance Market: Review and Update of Developments (Ref. GIB | 8.16.16 | 8A). Ms. Carabell provided a brief overview of health plan mergers and partnerships announced since 2013, and

noted developments in the Wisconsin health plan and provider markets that are relevant to the state group health insurance program.

Ms. Carabell noted that several themes have emerged from the developments. National insurers are getting larger and regional insurers are expanding into new regions, including continued movement into Dane County; while local providers are being acquired. Several provider systems from Iowa, Minnesota, and Missouri have purchased formerly Wisconsin-based provider systems and insurance plans in recent years. However, Dane County-based plans continue to grow.

Ms. Carabell stated that most carriers participating in the state group health insurance program have been involved in some new partnership arrangement since 2013, including network expansions and collaborating with new insurance companies. Driving factors behind these changes include the Affordable Care Act, Board discussions around self-insurance and regionalization of health plans and normal market competitive pressures.

ETF will continue to monitor changes within the Wisconsin health plan and provider markets and provide updates to the Board as necessary.

Request for Proposals Implementation Plan Update

Ms. Ellinger referred the Board to the Requests for Proposals (RFP) Implementation Plan Update memo (Ref. GIB | 8.16.16 | 8B) and provided a brief update on the development and distribution of various RFPs.

At the July 12, 2016 Board meeting, the Board approved the staff recommendation to issue a letter of intent to award the contract for Wellness and Disease Management to The StayWell Company LLC (StayWell). The original contract start date target was August 15, 2016. The contract start date will be delayed, due to a vendor appeal (Ref. GIB | 8.16.16 | 12).

The RFP for a Data Warehousing/Visual Business Intelligence vendor was released on August 5, 2016. Vendor questions and letters of intent to bid are due August 17, 2016. Vendor selection is scheduled to occur at the November Board meeting.

The RFP for the Pharmacy Benefit Manager is on schedule to be released in November 2016.

The RFP to Evaluate Self Insurance and Regional/Statewide Program Structure was released on July 22, 2016. Vendor questions and letters of intent to bid were due August 5, 2016. Ms. Ellinger noted the complexity of the RFP and suggested delaying the November Board meeting by two weeks, in order to allow vendors an additional week to submit responses and provide the evaluation team an extra week to review and prepare for the November Board meeting.

The Board agreed with Ms. Ellinger's proposed timeline adjustment and the Board meeting was rescheduled for November 30, 2016.

2018 Contract Changes

Ms. Pray and Ms. Steele referred the Board to the memo, Potential 2018 Health Benefit Program Contract Changes (Ref. GIB | 8.16.16 | 8C). The required specifications released with the RFP to Evaluate Self Insurance and Regional/Statewide Program Structure were included in a new State of Wisconsin Health Benefit Program Agreement (Agreement). The Agreement was based largely on the current contract between the Board and the health plans, with modifications included to insure the potential accommodation of a self-insurance model. Ms. Pray and Ms. Steele provided an overview of key components of the new Agreement.

Minimal changes were made to enrollment and eligibility specifications, Uniform Benefits, contract requirements and administrative processes, the participant grievance process, and Medicare requirements. Ms. Steele noted that if a Medicare Advantage procurement is executed for 2018, as recommended by Segal, certain Medicare provisions may be removed.

Ms. Pray noted two minor benefit changes that would be necessary under a potential self-insurance model, relating to mid-year plan transfers and the organ retransplantation benefit. No other benefit changes would be required to implement a self-insurance model.

Ms. Steele highlighted several contractual and administrative changes that would be required in a self-insured model. Of note, each participant would be required to select (or be assigned) a Primary Care Provider (PCP). This change is related to the data warehouse and strategic goals related to population health.

Ms. Pray highlighted new provisions that were added to the Agreement, including:

- Objectives, outlining areas of importance to the Board
- Expectations related to data sharing and integration
- Implementation plan requirements
- Administrative fee and financial administration guidelines
- Information technology protocols and technical requirements
- Requirements for continued provider negotiations to strategically realize cost savings to the benefit program and reporting the results annually
- Provider review requirements regarding fraud and abuse
- Reporting and deliverable requirements
- Performance standards and penalties
- Hospital bill audits
- Federally required nondiscrimination testing
- Plan outlining transition to a succeeding vendor

Ms. Pray stated that the Agreement includes provisions that are independent from a decision on self-insurance, such as plan design options, wellness incentives, premium tiering structure, provider networks, out-of-network benefit allowances, pharmacy networks, local provider options, and Medicare program offerings.

Staff noted that regardless of whether the Board moves forward with a self-insured model, stays with a fully-insured model or chooses a hybrid approach, the Agreement is intended to ensure consistent contract requirements for all selected vendors so that participants receive the same level of service irrespective of their benefit plan choice. The flexibility of the new Agreement will allow for the implementation of various other considerations depending upon future Board action.

Update on Guidelines Contract and Uniform Benefit Changes for 2017 and Current Change for the It's Your Choice Access High Deductible Health Plan

Ms. Pray and Ms. Schomber referred the Board to the memo, Update on Guidelines Contract and Uniform Benefit Changes for the It's Your Choice (IYC) Access High Deductible Health Plan (Ref. GIB | 8.16.16 | 8D).

At the May 18 and July 12, 2016 meetings, the Board approved initial Guidelines and Uniform Benefit change recommendations as presented, and granted the staff the authority to make additional technical changes as necessary. Additional updates have been made since the July Board meeting.

ETF recommended no change to the non-High Deductible Health Plan (HDHP) Maximum Out-of-Pocket Limits (MOOP) for 2017. Although the federal maximum MOOP for 2017 for non-HDHPs has increased for 2017, ETF recommended maintaining the current MOOP, in keeping with the Board-approved decision of no benefit changes for 2017. Ms. Pray noted that very few people reach the MOOP levels, and the vast majority of benefits covered under the plan accumulate to a much lower out-of-pocket limit (OOPL).

Ms. Pray highlighted new clarification language, including additional clarification on Board authority related to incomplete data submissions by health plans, revised non-discrimination notices for use by health plans on all significant benefit communications, and a minor clarification on exclusion to residential and transitional care regarding compliance with the Mental Health Parity and Addiction Equity Act.

ETF recommended the family OOPL for the IYC Access HDHP be reduced to $6,550, effective immediately. Ms. Schomber explained that the current OOPL of $6,750 does not meet the Internal Revenue Service (IRS) requirements related to Health Savings Account-qualified HDHPs. Participants will be notified of the change upon Board approval. Ms. Schomber stated that no participants have met this OOPL for 2016.

In addition, the IRS issued the limits for 2017, and there was no change to the family OOPL. ETF recommended that the revised $6,550 family OOPL remain in place for 2017.

Final change recommendations will be presented at the November 30, 2016 Board meeting.

MOTION: Mr. Neitzke moved to (1) approve the 2017 changes to the Guidelines Contract and Uniform Benefits as presented and grant ETF staff the authority to make additional technical changes as necessary, as well as (2) approve the recommended change to the out-of-pocket limit for the It's Your Choice Access High Deductible Health Plan, effective immediately. Ms. Carlson seconded the motion, which passed unanimously on a voice vote.

The Chair announced the Board would convene in closed session.

MOTION: Ms. Thompson moved to convene in closed session, pursuant to the exemptions contained in Wis. Stats. § 19.85(1) (a), (g) and (e), respectively, for the purposes of deliberating or negotiating the investing of public funds or to conduct other specified public business, whenever competitive or bargaining reasons require a closed session; confer with legal counsel for the Board who is rendering oral or written advice concerning strategy to be adopted by the Board with respect to litigation to which it is or is likely to become involved; and, for quasi-judicial deliberations concerning a case before the Board. Ms. Rolston seconded the motion, which passed on the following roll call vote:

Members Voting Aye: Carlson, Day, Farrell, Heifetz, Grapentine, Neitzke, Rolston, Thompson, Wieske, Ziegelbauer

Members Absent: Cyganek

The Board convened in closed session at 10:38 a.m. and reconvened in open session at 12:40 p.m..

ANNOUNCEMENT OF ACTION TAKEN ON BUSINESS DELIBERATED DURING CLOSED SESSION

Health Insurance

Mr. Farrell announced the Board took the following action during closed session:

- Approved a motion to accept the recommended Alternate Plan Service Area Qualifications for 2017 as proposed by ETF staff.
- Approved a motion to accept the Financial Review of Alternate Health Providers for 2017.

- Approved a motion to approve the 2017 Tier assignments.
- Approved a motion to accept the 2017 state rates for self-insured plans, including the Standard Plan, State Maintenance Plan (SMP), Medicare Plus, Pharmacy, and Dental.
- Approved a motion to accept the 2017 local rates for self-insured plans, including the Standard Plan, State Maintenance Plan (SMP), Medicare Plus, Pharmacy, and Dental.

Appeal 2015-020-GIB
During closed session, the Board moved to adopt the hearing examiner's proposed decision with modifications in regard to Appeal 2015-020-GIB.

Wellness Program Vendor Appeal
Mr. Farrell announced the Board reviewed and deliberated the vendor appeal on the Request for Proposal for the Third Party Administration of Wellness and Disease Management Programs (RFP#ETG0005).

MOTION: Mr. Day moved to accept the recommendation to deny the appeal filed by Limeade for the reasons set forth by ETF legal counsel. Mr. Wieske seconded the motion, which passed unanimously on a voice vote.

FUTURE ITEMS FOR DISCUSSION

Ms. Ellinger requested Board feedback regarding expectations for the November 30 Board meeting, in light of the considerable amount of information set to be presented to the Board pertaining to the RFP for a Data Warehousing/Visual Business Intelligence Vendor and the RFP to Evaluate Self Insurance and Regional/Statewide Program Structure.

Given the number of significant decisions associated with the RFP to Evaluate Self Insurance and Regional/Statewide Program Structure, Ms. Ellinger proposed that Segal and ETF staff present a series of different health plan options based on the data and information collected in the RFP. The Board would be able to provide feedback and direction during the November meeting, as well as request additional information to be presented at an additional special Board meeting.

The special Board meeting would provide the Board with a dedicated session for further discussion and deliberation and the opportunity to act on staff recommendations pertaining to self-insurance and regional/statewide program structure

The Board requested clarification on the role of the Joint Finance Committee (JFC) in regard to self-insurance. Mr. Conlin stated that should the Board ultimately decide to purse a self-funded plan, the contract must be sent to the JFC for review and approval. Mr. Conlin also noted that only decisions pertaining self-funding are subject to JFC

review. The Board has the authority to make other plan design changes, such as regionalization, without further review or approval.

The Board supported the addition of a special meeting and expressed a preference to meet in December 2016 instead of January 2017. The additional special Board meeting was scheduled for December 13, 2016.

ADJOURNMENT

MOTION: Ms. Thompson moved to adjourn the meeting. Mr. Heifetz seconded the motion, which passed unanimously on a voice vote.

The meeting adjourned at 1:01 p.m.

Date Approved: _____

Signed: _____
Herschel Day, Secretary
Group Insurance Board

State of Wisconsin
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: August 12, 2016

To: Group Insurance Board

From: Sara Brockman, Health Policy Advisor
Office of Strategic Health Policy

Subject: Group Insurance Board Correspondence

On occasion, the Department of Employee Trust Funds (ETF) receives correspondence on behalf of the Group Insurance Board (Board) regarding proposed or recent changes to the state health insurance program.

Since the July 12, 2016 Board meeting, the following communications have been submitted for the Board's consideration:

1. August 10, 2016 Correspondence – Wisconsin Department of Justice (DOJ)

The attached DOJ memorandum (Attachment A) is in regard to the July 12, 2016 motion to approve changes to the Guidelines Contract and Uniform Benefits for 2017 (Ref. GIB | 07.12.16 | 3A). ETF has reviewed the DOJ memo and provided additional information for Board consideration (Attachment B).

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

Attachment A: DOJ Memo – ETF's Proposed Revisions to Uniform Benefits Provisions Regarding "Gender Identity" Health Services
Attachment B: ETF Memo – Uniform Benefit Provisions Related to Sex Discrimination

Reviewed and Approved by John Voelker, Deputy Secretary
Electronically Signed: 8/12/16

Board	Mtg Date	Item #
GIB	8.16.16	7A

ETF00091

Roth Decl. Ex. K

Attachment A

WISCONSIN DEPARTMENT OF JUSTICE
MEMORANDUM

Date: August 10, 2016

To: Group Insurance Board

From: Andy Cook, Deputy Attorney General

Subject: ETF's Proposed Revisions to Uniform Benefits Provisions Regarding "Gender Identity" Health Services

Executive Summary

The Department of Justice writes to you regarding proposed revisions to the State of Wisconsin Department of Employee Trust Funds' ("ETF") current Uniform Benefits policy. As you know, the current policy excludes coverage for "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment" and for "sexual counseling services . . . related to sexual transformation." ETF has recommended that the Group Insurance Board ("Board") remove these exclusions in order to comply with rules recently promulgated by the federal Department of Health and Human Services ("HHS"). Those rules purport to implement the Affordable Care Act's anti-discrimination provisions, and they generally ban discrimination based on "gender identity" in the provision of health services. *See* 45 C.F.R. §§ 92.206-207.

To the extent the Board believes that the new HHS rules compel it to accept ETF's recommended changes, it should reconsider for two reasons. First, HHS's rules are unlawful, at least as applied to coverage provisions that classify health services based on "gender identity." The Affordable Care Act's anti-discrimination provisions incorporate Title IX's prohibition against discriminating on the basis of "sex." *See* 42 U.S.C. § 18116; 20 U.S.C. § 1681. But HHS's rules improperly reinterpret Title IX to cover "gender identity" – an expansion Congress has never adopted and that HHS may not effect on its own.

Even if HHS had not misread Title IX, its "gender identity" rules improperly intrude on powers reserved to the State of Wisconsin to administer its own health policy. The United States Constitution prohibits the federal government and HHS from threatening to withhold ETF's receipt of Medicare Part D subsidies if ETF does not comply with the federal mandate. Separately, the Fourteenth Amendment does not authorize HHS to issue these rules, since ETF's policies do not violate that Amendment.

Second, even if HHS's rules were lawful, they do not mandate coverage for any particular procedures – which is effectively what ETF's proposed revisions accomplish. Instead, those rules allow coverage exclusions based on neutral

reasons, such as whether medical necessity demands the services at issue. This allows a narrower revision to the provision regarding gender reassignment services than ETF has proposed. And the Board likely need not revise the provision regarding sexual transformation counseling at all. Since non-transgender patients cannot receive such counseling, no discrimination exists by denying coverage for it. Alternatively, a blanket exclusion for all sexual counseling services would further protect the Uniform Benefits from challenge. Specific alternative proposals are presented at the end of this memorandum.

Analysis

I. HHS's Rules Improperly Require the State of Wisconsin To Enforce A Misreading of the Affordable Care Act and Title IX.

HHS's rules are unlawful because they rest on a misreading of the Affordable Care Act and Title IX. *See* 5 U.S.C. § 706 (agency actions are unlawful if undertaken "in excess of statutory jurisdiction, authority, or limitations"). The Affordable Care Act only prohibits discrimination coextensive with Title IX. But Title IX's prohibition against discrimination on the biological basis of "sex" does not extend to the distinct concept of "gender identity." Since HHS cannot issue rules that amend the Affordable Care Act and Title IX – which is what these rules effectively do – the Board need not conform ETF's Uniform Benefits to them.

First, nothing in Title IX's text suggests that the statute covers "gender identity." The statute's plain language is clear: "No person in the United States shall, ***on the basis of sex***, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance . . . ." 28 U.S.C. § 1681 (emphasis added). Again, "on the basis of ***sex***," not "on the basis of sex ***or gender identity***."

Legislative history confirms that Title IX covers just what it says – "sex," not "gender identity." Nowhere in the Congressional debates over Title IX does the phrase "gender identity" or "transgender" appear. Moreover, Congress has refused to amend Title IX to cover "gender identity."[1] Congress clearly would not have tried to add superfluous new protections for "gender identity" if Title IX already provided them.

Case law affirms Title IX's plain language and legislative history, holding that its protections do not extend to "gender identity." One well-reasoned opinion

[1] *See* H.R. 1652, 113th Cong. (2013); S.439, 114th Cong. (2015).

held, after carefully analyzing Title IX's plain language and its legislative history, that "Title IX's language does not provide a basis for a transgender status claim." *Johnston v. Univ. of Pittsburgh of Com. Sys. of Higher Educ.*, 97 F. Supp. 3d 657, 676 (W.D. Pa. 2015). And *Johnston* is supported by many other cases that reach the same result under Title VII, Title IX's sister anti-discrimination statute in the employment context.

Moreover, the State of Wisconsin has joined 12 other states in challenging another unlawful federal government mandate that rests on an identical misreading of Title IX. *See State of Texas, et al. v. United States, et al.*, No. 16-cv-00054 (N.D. Tex.). There, the federal government improperly demanded, again citing Title IX, that public schools allow students to use the bathrooms, locker rooms, and showers of the students' choosing, regardless of their biological sex. But that overreach must fail for the same reason as here – federal agencies cannot impose their policy preferences on the States by expanding Title IX to cover "gender identity" without Congressional action.

The United States Constitution also restrains HHS from imposing its view of the Affordable Care Act and Title IX on the State of Wisconsin and ETF. Although the federal government can contribute money to the States to be spent on various programs, that power cannot be used to "undermine the status of the States as independent sovereigns in our federal system." *See* U.S. CONST. art. I, § 8, cl. 1; *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2602 (2012) ("*NFIB*"). Indeed, when federal funding conditions "take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the states to accept policy changes." *Id.* at 2604.

HHS now threatens to withhold federal financial assistance if ETF refuses to implement the federal government's novel interpretation of Title IX. Specifically, HHS's new rules condition federal aid on ETF's "assurances" that its health programs comply with those rules. *See* 45 C.F.R. §§ 92.5-6 (requiring "assurances"); 42 U.S.C. § 18116 (applying Title IX's enforcement mechanisms to the Affordable Care Act); 20 U.S.C. § 1682 (compliance can be enforced by terminating federal assistance). Since ETF partly depends on federal financial assistance in the form of Medicare Part D subsidies, HHS improperly threatens to withhold those subsidies if ETF fails to comply with its novel reading of Title IX. *NFIB*, 132 S. Ct. at 2604. This likely amounts to unconstitutional coercion.

HHS also cannot find authority for its new rules in the Fourteenth Amendment. That Amendment allows Congress to "enforce, by appropriate legislation" its guarantee to "the equal protection of the laws." U.S. CONST. amend.

XIV, §§ 1, 5. But HHS can only issue rules that target a recognized equal protection violation. *See Kimel v. Florida Bd. of Regents*, 528 U.S. 62 (2000). Since many courts have concluded that transgender individuals are not a "suspect class" that triggers heightened constitutional scrutiny, coverage exclusions like ETF's here "need only be rationally related to a legitimate governmental purpose" to be valid under the Fourteenth Amendment.[2]

ETF can easily clear that low bar. For instance, it can point to the high costs the State must bear for covering services and procedures related to gender transition, or to medical research suggesting that such procedures (especially sex transformation surgeries) may in fact harm patients. Even if a heightened level of scrutiny did apply here, these coverage exclusions could for the same reasons pass muster as "substantially related to a sufficiently important governmental interest."[3] Since ETF's coverage provisions at issue here do not violate the Fourteenth Amendment, HHS may not bar them by citing the Fourteenth Amendment.

II. Even If HHS's Rules are Lawful, the Board Need Not Revise the Uniform Benefits As ETF Has Recommended.

Leaving aside the validity of HHS's new rules, ETF's recommended revisions to the Uniform Benefits go beyond what those rules require. Again, ETF has recommended striking entirely two policy exclusions from the Uniform Benefits:

- "Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment." Uniform Benefits § IV.1.a.
- "Sexual counseling services related to . . . sexual transformation." Uniform Benefits § IV.11.ah.

These revisions would arguably mandate that ETF cover ***all*** such procedures, whether medically necessary or not. But HHS expressly noted that its rules "do not . . . affirmatively require covered entities to cover any particular procedure or treatment for transition-related care." 81 Fed. Reg. 31376 at 31429 (May 18, 2016). Likewise, the rules "do not affirmatively require covered entities to cover any

---

[2] *Claussen v. Pence*, - F.3d - , 2016 WL 3213036, at *4 (7th Cir. June 10, 2016) (outlining "rational basis" standard).

[3] *See City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 441 (1985) (establishing "intermediate scrutiny" standard); *Craig v. Boren*, 429 U.S. 190, 199–200 (1976) ("Clearly, the protection of public health and safety represents an important function of state and local governments.").

particular treatment, as long as the basis for exclusion is evidence-based and nondiscriminatory." *Id.* at 31435. And HHS's rules expressly note that they are not "intended to determine, or restrict a covered entity from determining, whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case." 45 C.F.R. § 92.207(d).

Attachment B

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

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: August 11, 2016

To: Group Insurance Board

From: David H. Nispel, General Counsel
Diana M. Felsmann, Attorney

Subject: Uniform Benefits Provisions Related to Sex Discrimination

Information for GIB Consideration
After reviewing the Department of Justice (DOJ) August 10, 2016, memo requesting that the Group Insurance Board (GIB) reconsider its adoption of the Department of Employee Trust Funds' (ETF) recommended changes to the State of Wisconsin Group Health Insurance Program's Uniform Benefits, ETF offers additional information for the GIB's consideration:

- As fiduciaries,[1] GIB Board members must ensure that the Group Health Insurance Program complies with state and federal law. Basic fiduciary principles found in common law include the three "core" fiduciary duties: (1) the duty of loyalty, (2) the duty of impartiality, and (3) the duty of prudence. A fiduciary may rely on the advice and reports of experts (i.e., attorneys, accountants, financial advisors), provided the subject matter is within the expert's area or expertise and the expert is fully informed. Ensuring compliance with state and federal law falls under the duty of prudence.

- The United States Department of Health and Human Services (HHS) final rule implementing the Affordable Care Act's (ACA) nondiscrimination requirements provides that health insurance issuers may not contract away their own nondiscrimination obligations under the rule.[2] As a result, a decision not to comply with the HHS rule would jeopardize ETF's ability to contract with its health insurance issuers as of January 1, 2017.

---

[1] Wis. Stat. §40.03(6)(d).

[2] Moreover, nothing in the rule authorizes qualified health plan issuers or other issuers that are covered entities to contract away their own nondiscrimination obligations. Issuers must ensure that enrollees have equal access to health services provided by their coverage without discrimination on the basis of a prohibited criterion.

81 Federal Register 31376 (May 18, 2016), 31383.

- The cost of removing the Uniform Benefits exclusion related to benefits and services in connection with gender reassignment or sexual transformation is anticipated to be low. Based on a 2014 study Segal Consulting did for the state of Maryland, the highest estimated cost was .01% of the annual cost of Maryland's health insurance program. That study reflected that the annual costs associated with Maryland's health insurance program were approximately $1.3B. The largest estimated cost, $100,000 represents less than a 0.01% increase in annual costs for the cost of the initial procedure(s) and related drug therapy and counseling.

- The Group Health Insurance Program's Uniform Benefits continues to require that services be medically necessary,[3] as determined by the health plan and/or PBM.[4]

Background

The changes to the Group Health Insurance Program recommended in ETF's June 22, 2016, memo entitled *Guidelines Contract and Uniform Benefits Changes for 2017*, and adopted unanimously by the GIB on July 12, 2016, were made after careful research on the application of federal law, specifically the ACA nondiscrimination rule published by HHS on May 18, 2016. ETF's role in relation to the GIB is to make recommendations to assist the GIB in the performance of its fiduciary duties to the insurance programs administered by ETF, including the Group Health Insurance Program, and to provide information so that the Program is properly administered.

The recommended changes to the Program's Uniform Benefits in connection with the HHS rule, and as adopted by the GIB at the July 12, 2016 meeting were as follows:

1. Removing the current exclusion related to benefits and services related to gender reassignment or sexual transformation. Required effective date is January 1, 2017.

2. Including the federally required nondiscrimination notification language on all significant communications related to ETF's health programs. Required effective date is October 16, 2016 (90 days from July 18, 2016).

---

[3] Defined in ETF's Uniform Benefits as a service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care Provider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM:

1. consistent with the symptom(s) or diagnosis and treatment of the Participant's Illness or Injury; and
2. appropriate under the standards of acceptable medical practice to treat that Illness or Injury; and
3. not solely for the convenience of the Participant, physician, Hospital or other health care Provider; and
4. the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner. http://etf.wi.gov/members/IYC2016/IYC_Cert_of_Cov2107.pdf

[4] State of Wisconsin Group Health Insurance Program Uniform Benefits, Section III, Page 4-23.

Summary of August 10, 2016 Department of Justice Memo
In its August 10, 2016, memo to the GIB entitled *ETF's Proposed Revisions to Uniform Benefits Provisions Regarding "Gender Identity" Health Services*, the Department of Justice (DOJ), offers two reasons for the GIB to reconsider the changes to ETF's Uniform Benefits adopted at the July 12, 2016, GIB meeting.

The first reason DOJ provides is that the new HHS rule is unlawful, "at least as applied to coverage provisions that classify health services based on 'gender identity'." Included under that heading, DOJ writes that even if the new HHS rule is not based on a misreading of Title IX, which protects against sex discrimination, the rule "improperly intrude[s] on powers reserved to the State of Wisconsin to administer its own health policy."

The second reason offered by DOJ was that the HHS nondiscrimination rule does not mandate coverage for any particular procedure.

Benefits Coverage
Specific to the HHS rule and benefits coverage, as noted in ETF's June 22, 2016 memo to the GIB, ETF agrees with DOJ that the rule does not require coverage of specific benefits. However, of note:

- The rule specifies that categorical exclusions in coverage for all health services related to gender transition are facially discriminatory.

- The rule does not explicitly require the coverage of any particular service to treat gender dysphoria, and allows plans to deny services that are not medically necessary. HHS' Office for Civil Rights (OCR) will determine whether certain benefits designs are discriminatory on a fact-specific, case-by-case basis. 81 Fed. Reg. at 31434 & fn. 258.

- Denying coverage for transition-related services on the basis of those services not being medically necessary is anticipated to be subject to careful scrutiny. (Proposed HHS Nondiscrimination Rule) 80 Fed. Reg. 54172, 54190 (Sept. 8, 2015).

- The regulations allow covered entities to use reasonable medical management techniques and apply neutral, nondiscriminatory standards to health-related coverage. Specifically, OCR will consider whether an entity used "a neutral rule or principle when deciding to adopt the design feature or take the challenged action or whether the reason for its coverage decision is pretext for discrimination." 81 Fed. Reg. at 31433.

Penalties for Noncompliance with the HHS Rule
The HHS rule applies the same enforcement mechanisms under Title VI of the Civil Rights Act of 1964 (discrimination on the basis of race, color, and national origin), Title IX of the Education Amendments of 1972 (discrimination on the basis of sex), Section 504 of the Rehabilitation Act of 1973 (discrimination on the basis of disability), or the Age Discrimination Act of 1975. Penalties under Title IX include the termination of federal financial assistance.[5] Thus, one potential impact of a GIB decision to reconsider its adoption of the Uniform Benefits changes would be the Group Health Insurance Program's loss of Medicare Part D subsidies.[6] The Program received approximately $36 million in Medicare Part D subsidies in 2015.

In addition, the HHS rule allows for compensatory damages to be granted if an individual were to successfully litigate a claim that the Group Health Insurance Program was not in compliance with the law.[7]

Current EEOC Complaints Filed Against the GIB
It is important to note that two individual health plan participants have filed complaints with the Equal Employment Opportunity Commission (EEOC) against the GIB on the denial of benefits in relation to transgender services:

- EEOC Charge No. 443-2016-00291—Amended [redacted], Charging Party vs. University of Wisconsin, Respondent, and Department of Employee Trust Funds and Group Insurance Board, Additional Respondents.[8]

- EEOC Charge No. 443-2016-01428—Amended [redacted], Charging Party vs. Department of Employee Trust Funds, Respondent and Group Insurance Board, Additional Respondent.[9]

The EEOC takes the position that Title IX's prohibition against sex discrimination includes discrimination on the basis of gender identity. Compensatory and punitive damages may be awarded in cases involving intentional discrimination based on gender identity.[10]

The HHS Rule references the EEOC's position, and indicates that HHS' Office for Civil Rights (OCR) intends to refer any cases that fall outside of OCR's jurisdiction to the EEOC for investigation.[11] As a result, if the GIB were to reconsider the changes it

---

[5] 45 C.F.R. §92.301(a).
[6] *See* 20 U.S.C. §1682.
[7] 45 C.F.R. §92.301(b).
[8] *See* April 5, 2016, memo to the GIB from ETF General Counsel David H. Nispel.
[9] As of the writing of this memo, ETF has not yet received any details about this EEOC complaint. When ETF receives additional information, ETF will pass that information on to the GIB.
[10] The United States Department of Justice *Title VI Legal Manual*: https://www.justice.gov/crt/title-vi-legal-manual#XII (visited August 11, 2016).

[11] 81 Federal Register at 31432.

adopted to the Uniform Benefits on July 12, ETF anticipates an increase in complaints filed against the GIB.

GIB Authority to Modify Uniform Benefits

State law provides the GIB the authority to modify or expand insurance coverage when that modification or expansion is required by law.[12] The law further provides the GIB the authority to modify or expand benefits as it deems advisable unless the modification or expansion would increase premiums.[13]

The authority to make decisions on insurance coverage is necessary for the GIB, as trustees, to fulfill their fiduciary duties. Based on information provided by Segal Consulting, ETF anticipates the costs of providing the changes to the Uniform Benefits adopted by the GIB in relation to the HHS rule would be extremely low,[14] and would not increase premiums. As a result, whether the HHS rule is found to be invalid, the GIB would still have had the authority under state law to make these changes to the Uniform Benefits.

Recommendations Going Forward

1. ETF does not recommend the GIB reconsider its July 12, 2016, adoption of the changes made to the Group Health Insurance Program's Uniform Benefits in connection with the HHS rule. ETF recommended those changes after careful review of the HHS rule and in consideration of the GIB's fiduciary duties to the Group Health Insurance Program. In particular, the GIB's duty of prudence requires the GIB to ensure the Program is compliant with state and federal law.

   To address DOJ's questions with respect to the validity of the HHS rule, ETF recommends continuing with the changes as adopted at the July 12 GIB meeting, and revisiting that decision in one year. Such a reevaluation could be made in light of any court decisions interpreting the rule. In addition, reevaluation after one year would allow for ETF to present claims data to the GIB, which would provide the Board with insight into the cost of providing these benefits.

2. Important to note is the failure to meet fiduciary obligations may result in severe penalties, including personal liability. The August 10 DOJ memo does not address how the reconsideration of the GIB's adoption of the Uniform Benefits changes on July 12 comports with the GIB's fiduciary duties. As a result, if the GIB were to consider reversing its adoption of the changes to the Uniform Benefits, ETF first recommends the GIB obtain a legal opinion analyzing the Board's fiduciary duties under these specific circumstances.

---

[12] Wis. Stat. §40.03(6)(c).
[13] Wis. Stat. §40.03(6)(c) & (d).
[14] Segal Consulting drafted a report for the State of Maryland in 2014 concluding that the cost of providing initial procedures, drug therapy and counseling would be approximately .01% of the state's total health insurance costs; *See also* page 2.

DRAFT

MINUTES

December 13, 2016

Group Insurance Board

State of Wisconsin

Location:

Clarion Suites at the Alliant Energy Center – Michigan Room
2110 Rimrock Rd, Madison, WI 53713

BOARD MEMBERS PRESENT:

Michael Farrell, Chair
Bonnie Cyganek, Vice Chair
Herschel Day, Secretary
Terri Carlson
Chuck Grapentine
Michael Heifetz
Nancy Thompson
Ted Neitzke
Stacey Rolston
JP Wieske
Bob Ziegelbauer

PARTICIPATING EMPLOYEE TRUST FUNDS (ETF) STAFF:

Bob Conlin, Secretary
John Voelker, Deputy Secretary
Office of Strategic Health Policy:
Lisa Ellinger, Director
Sara Brockman, Board Liaison
Eileen Mallow, Deputy Director
Arlene Larson, Tara Pray, Renee Walk

OTHERS PRESENT:

ETF Budget & Procurement:
Jason Barrett, Dana Perry, Joe Schneider
ETF Information Technology Services:
Ryan Perkins
ETF Legal Services:
Diana Felsmann, Daniel Hayes, David Nispel
ETF Office of Communications:
Mark Lamkins
Martin Schreiber & Associates
Annie Early, Jeremey Shepherd
MercyCare:
Sherrie Sargent, DuWayne Severson
Michael Best Strategies:
Andrew Hitt
Momentum Insurance:
Stephanie Steel
Navitus Health Solutions:
Tara Argall, Pam Olson

EXHIBIT NO. DAY 5 4/2/18 RPTR SRB
For the Record, Inc.
(608) 833-0392

Board	Mtg Date	Item #
GIB	2.8.17	1

Aff. to GIB00711

ETF Office of the Secretary:
Liz Doss-Anderson, Pam Henning, Tarna Hunter, James Kates, Mary Richardson, Cheryllynn Wilkins
ETF Office of Strategic Health Policy:
Sarah Bradley, Rachel Carabell, Sherry Etes, Jessica Rossner, Joan Steele, Wade Whitmus
American Federation of State, County and Municipal Employers (AFSCME):
Susan McMurray
Anthem Blue Cross and Blue Shield:
Brian Martin, Ted Osthelder
Association of Career Employees:
Sally Drew, Jack Lawton
Aurora Health Care:
Andrew Hanus
Baraboo Ambulance:
Troy Snow
Dean Health Plan:
Angie Dalton, Brant Sonzogni, Michael Weber
Department of Administration:
Jennifer Kraus
Department of Justice:
Kevin Potter, Colin Roth
Division of Personnel Management:
Paul Ostrowski
General Public:
Hickory Hurie, Sharon Hutchinson
Group Health Cooperative – South Central Wisconsin:
Emily Halter
Grand Rounds:
Eric Weiner
Grunke Group:
David Grunke
Health Choice:
Bob Pearson
Humana:
David Ehrenfried, Mary Haffenbredl, Elisabeth Wright
Legislative Audit Bureau:
Emily Pape
Office of the Commissioner of Insurance:
Jennifer Stegall
Office of Representative Chris Taylor:
Maggie Gay
Office of Representative John Nygren:
Caroline Krause
Office of Senator Alberta Darling:
Rachel Keith
Physicians Plus:
Tom Luddy, Ron Sebranek
Protect Our Wisconsin Retirement Security (POWRS):
Roger Springman
Rural Wisconsin Health Co-Op:
Jeremy Levin
Segal Consulting:
Kirsten Schatten, Ken Vieira
State Engineering Association:
Bob Schaefer
United Healthcare:
Kurt Rich
Unity Health Insurance:
Cari Alexander, Terry Bolz, Rob Plesha
UW Madison:
Diane Blaskowski
UW System Administration:
LaDonna Steinert
WEA Trust:
Greg Cieslewicz
Wisconsin Academy of Physician Assistants:
Reid Bowers
Wisconsin Association of Health Plans:
Phil Dougherty, Tim Lundquist, Nancy Wenzel
Wisconsin Health News:
Sean Kirkby
Wisconsin Hospital Association:
Joanne Alig
Wisconsin Medical Society:
Chris Rasch
Wisconsin Public Radio:
Shamane Mills

Legislative Fiscal Bureau: Jere Bauer, Rachel Janke	Wisconsin State Journal: David Walhberg
M3 Insurance: Nathan Janke, Brad Niebuhr	WisPolitics.com: Polo Rocha
MacIver Institute: Chris Rochester	WPS Arise: Matt Harty

Michael Farrell, chair, called the meeting of the Group Insurance Board (Board) to order at 8:30 a.m.

CONSIDERATION OF NOVEMBER 30, 2016 OPEN AND CLOSED MEETING MINUTES

MOTION: Mr. Wieske moved to approve the open session meeting minutes of the November 30, 2016, meeting as submitted by the Board Liaison. Mr. Heifetz seconded the motion, which passed on a voice vote. Ms. Thompson abstained from voting.

MOTION: Mr. Wieske moved to approve the closed session meeting minutes of the November 30, 2016, meeting as submitted by the Board Liaison. Mr. Heifetz seconded the motion, which passed on a voice vote. Ms. Thompson abstained from voting.

ANNOUNCEMENTS

Ms. Ellinger made the following announcements:

- The Pharmacy Benefit Manager Request for Proposal (RFP) was released on November 18, 2016. The first round of vendor questions were due December 9, 2016.
- The contract negotiation process with Truven Health Analytics began on December 12, 2016.
- WisconsinEye was not present to record the meeting.

Ms. Ellinger provided a brief overview of the meeting structure, stating that it would largely be held in closed session for the assessment and deliberation of proposals for the State of Wisconsin Health Benefit Program (RFP#ETG0003). The purpose of the closed session was to protect confidential and proprietary information obtained as part of the RFP process.

OPERATIONAL UPDATES

Mr. Farrell referred the Board to the Operational Updates in the Board Packets (Ref. GIB | 12.13.16 | 3) and offered that staff were available if the Board had questions. Of

note, several letters were submitted for the Board's consideration from legislators and members, including a letter from the chairs of the Joint Committee on Finance.

ASSESMENT AND DELIBERATION OF PROPOSALS FOR THE STATE OF WISCONSIN GROUP HEALTH BENEFIT PROGRAM (ETG0003)

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

Ms. Ellinger referred the Board to the memo, Request for Proposals for the State of Wisconsin Health Benefit Program: Results and Analysis (Ref. GIB | 12.13.16 | 4A). The memo presented a variety of options for the State of Wisconsin Group Health Insurance Program (GHIP). These options aimed to maintain benefits, contain costs and improve quality.

A total of nine proposing vendors submitted responses to the RFP, including two statewide/regional vendors and nine regional vendors. Ms. Ellinger stated that not all currently participating plans responded to the RFP.

Ms. Ellinger provided an overview of the RFP scoring process and evaluation categories. She emphasized that the RFP was focused on a balance between cost and quality performance.

The November 30 Board meeting was the first opportunity for the Board to review the results of the RFP in detail. Feedback and guidance provided by the Board was used by ETF to develop potential scenarios. Primary objectives identified by the Board included reducing long-term costs, ensuring member access to providers, vendor proposal scores, improving quality and maintaining benefit levels.

Ms. Ellinger presented seven program scenarios developed by ETF based on Board priorities and RFP results. The seven scenarios produced equivalent future costs, allowing the Board to focus on the non-financial merits of each scenario. Ms. Ellinger stated the scenarios were ordered from the least change (Option 1) to the largest degree of change (Option 7).

Ms. Ellinger stated the status quo for the GHIP was not presented as an option; and that the program is in transition. The Board previously approved several initiatives that will ultimately change the program, regardless of any decisions the Board may make about self-insurance. These initiatives included the implementation of the StayWell contract for the Third Party Administration of Wellness and Disease Management programs (RFP#ETG0005), and the decision to issue an intent to award the contract for a Data Warehouse / Visual Business Intelligence Solution (RFP#ETG0004/ETG006) to Truven Health Analytics on November 30, 2016.

All options presented were summarized in Table 12 of the memo (Ref. GIB | 12.13.16 | 4A), which is included below for reference.

Table 12. All Scenarios

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

Health Insurance: 2018 Program and Operational Considerations

Ms. Larson, Ms. Pray and Ms. Walk presented the memo, Group Health Insurance Program and Wisconsin Public Employers Program: 2018 Program and Operational Considerations (Ref. GIB | 12.13.16 | 4B). Program structure changes currently under consideration by the Board require and/or create the opportunity to revamp the following aspects of the health insurance program:

- Reduce the number of options available in the Wisconsin Public Employers (WPE) Program,
- Combine the WPE with the Local Annuitant Health Program (LAHP),
- Consolidate the It's Your Choice (IYC) Access Plan (Standard Plan) into statewide/nationwide contracts, and
- Make new Medicare Advantage options available to for 2019.

Ms. Walk provided an overview of the WPE Program recommendations. In 2015 Segal Consulting recommended offering only Program Options (PO) that mirror state benefits. These two plans are PO 16 – IYC Local Health Plan and PO 17 – IYC Local High Deductible Health Plan (HDHP). Staff stated that most local government employers offer employees plan options that do not mirror the state employee plans, PO 12 – IYC Local Traditional Plan and PO 14 – IYC Local Deductible Plan.

ETF surveyed WPE employers in late 2016 to ask whether they would consider terminating participation in the program if ETF limited options to PO 16 and PO 17. Most responded that they would prefer to offer benefits to their employees that are more generous than the state plans, and they would prefer not to be forced to change their benefits. These employers were also undecided about remaining in the program if the Board changes program options.

ETF recommended reducing the available options to three POs for 2018 – PO 12, PO 16 and PO 17. New deductibles for the state plans (POs 16 and 17) provide options comparable to PO 14 that were not previously available. Maintaining the inclusion of PO 12 provides the richer benefit option local governments can use as a competitive recruitment tool, while bringing local government offerings into closer alignment with state plans.

Ms. Larson provided an overview of the LAHP recommendations. She stated the LAHP is required by Wis. Stat. § 40.51 (10), is fully insured, offers different benefit levels than other ETF-administered programs, and is administered by WPS. The program serves a small population of annuitants from municipalities who are not otherwise eligible for program participation and who may not have an insurance offering through their former employer. LAHP offers a Medicare Supplement to retirees over age 65 and a Preferred Provider Organization (PPO) for retirees under age 65.

Combining the LAHP with the WPE would simplify administration and could also stabilize volatile rates in the LAHP. Previous analysis indicated no adverse program impact on the WPE.

ETF recommended administering the LAHP within the WPE program structure, with additional changes to implement limited enrollment periods and eliminate individual medical underwriting of late applications.

Ms. Larson provided an overview of the IYC Access Plan recommendations. The IYC Access Plan is statutorily required. The program is currently a self-insured, Tier 3 PPO that is administered by WPS and available nationwide.

The program is attractive to out-of-state members and those who desire freedom of choice for providers. However, the program has low and decreasing membership.

The IYC Access Plan also has slight benefit variations from Uniform Benefits.

ETF recommended pursuing a strategy that would establish a Tier 1 statewide/nationwide plan to replace the IYC Access Plan to ensure that it is a competitive offering. In order to achieve this objective, ETF also recommended adjusting benefit offerings to align with Uniform Benefits, implementing a meaningful differential between in-network and out-of-network costs in order to steer care in-network, and investigating any statutory changes necessary to implement this program change.

Ms. Pray provided an overview of the Medicare options recommendations. Currently, Medicare-eligible annuitants have several options available for coverage under the GHIPL the IYC Health Plan; the IYC Medicare Advantage (MA) plan; and the IYC Medicare Plus supplement.

With structural changes to the GHIP, there is an opportunity to improve offerings for Medicare retirees. In addition, Segal has recommended that the Board consider offering more Medicare Advantage plan choices to state and WPE annuitants, noting that Medicare-eligible annuitants could see reductions in premiums if more Medicare Advantage plans were available.

ETF recommended minimal Medicare changes for 2018, with the intent to expand Medicare Advantage options for 2019. This will allow time to determine the most cost effective and highest quality program structure, as well as the necessary amount of time for a communications campaign, and better alignment with the timing of other Board initiatives.

ETF agreed to provide more information on the recommended program changes at the next Board meeting.

The chair announced the Board would convene in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (e) for the purpose of deliberating the potential investment of public funds and to review proposals for services for which

competitive and bargaining reasons required a closed session. Staff from the Department of Employee Trust Funds (ETF), Office of the Commissioner of Insurance (OCI), the Department of Administration (DOA), and actuarial advisors from Segal Consulting were invited to remain during the closed session.

> ***MOTION: Mr. Wieske moved to convene in closed session, pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (e) to deliberate or negotiate the investing of public funds or conduct other specified public business. Mr. Ziegelbauer seconded the motion, which passed on the following roll call vote:***
>
> ***Members Voting Aye: Carlson, Cyganek, Day, Farrell, Grapentine, Heifetz, Neitzke, Rolston, Thompson, Wieske, Ziegelbauer***

The Board took a break from 9:39 a.m. to 9:47 a.m.

The Board convened in closed session at 9:47 a.m. and reconvened in open session at 2:34 p.m.

The Board took a break from 2:34 p.m. to 2:40 p.m.

ANNOUNCEMENT OF ACTION TAKEN ON BUSINESS DELIBERATED DURING CLOSED SESSION

Mr. Farrell announced the Board met in closed session to assess and deliberate the many options for the State of Wisconsin Health Benefit Program presented by ETF staff and Segal Consulting. The Board asked ETF and Segal to gather more data in order to continue deliberations. Mr. Farrell stated that there is much complexity and large volumes of information related to these considerations, and the Board does not take these decisions lightly.

No action was taken during closed session. The Board will reconvene in January.

DISCUSSION AND CONSIDERATION OF 2017 UNIFORM BENEFITS – HHS NONDISCRIMINATION RULE

Ms. Ellinger referred the Board to the memo, Discussion and Consideration of 2017 Uniform Benefits – HHS Nondiscrimination Rule (Ref. GIB | 12.13.16 | 6), which included memoranda previously submitted for Board consideration. The item was added to the December 13 meeting agenda at the request of a Board member, as the Wisconsin Department of Justice (DOJ) indicated the intent to send representation to the Board meeting to discuss the issue.

The DOJ previously submitted a memorandum in regard to the July 12, 2016, Board action to approve changes to the Guidelines Contract and Uniform Benefits for 2017

(Ref. GIB | 7.12.16 | 3A). Mr. Potter stated that the August 10, 2016, memorandum was authored by the DOJ at the request of the governor's office for the benefit of the Board.

Mr. Potter noted the State of Wisconsin has joined a federal lawsuit in Texas challenging the federal Department of Health and Human Services (HHS) final regulations pertaining to Section 1557 of the Affordable Care Act (ACA) issued on May 18, 2016. The lawsuit requests a preliminary injunction be issued to preclude the enforcement of the HHS regulations. A hearing is scheduled for December 20, 2016.

Mr. Potter stated that the DOJ recommends the Board follow the law as it currently stands. The changes approved by the Board on July 12 are in compliance with the HHS regulations.

ETF was directed to proceed with the implementation of the language previously adopted. Should the court order a preliminary injunction, the Board will reassess the language at a future Board meeting.

ADJOURNMENT

MOTION: Mr. Grapentine moved to adjourn the meeting. Mr. Neitzke seconded the motion, which passed unanimously on a voice vote.

The meeting adjourned at 2:53 p.m.

Date Approved: _____

Signed: _____
Herschel Day, Secretary
Group Insurance Board