STATE OF WISCONSIN
DEPARTMENT OF EMPLOYEE TRUST FUNDS
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CORRESPONDENCE MEMORANDUM

DATE: November 13, 2002

TO: Group Insurance Board

FROM: Tom Korpady, Administrator, Division of Insurance Services
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SUBJECT: Recommendations of the Study Group

The Health Insurance Study Group has completed their deliberations on proposed changes to the State Employee Group Health Insurance Program. The Study Group by consensus approved the following package of recommendations to be presented to the Board at the November 19, 2002 meeting. This memo presents a detailed discussion of those recommendations. The Study Group feels that it represents a comprehensive revision to the program that will address several problems, while maintaining many of the features that have worked well to provide high quality health care coverage at reasonable cost to state and local government employees and employers.

The recommendations are presented as a package with several components. Each of the individual elements of this package address problem areas that were identified by the group, and could stand alone. However, the Study Group feels that the package as a whole represents the best approach to deal with the problems and increasing cost of this program. Further, some of the recommendations are complimentary and, if approved and implemented as a package should reinforce and strengthen the effectiveness of each of the components.

The elements of the proposed recommendations are:

- Changing the current premium contribution structure to a tiered approach.
- Carving out the prescription drug benefit and contracting with a Pharmacy Benefit Manager (PBM) for all drug benefits under the program.
- Conversion of the Standard Plan and Standard Plan II plans into one Preferred Provider Plan.
- Integration of quality and safety standards into program requirements
- Exclusion of dental benefits from the participating plans and creation of a stand alone dental plan available to all state employees when a reasonable employer contribution becomes available.

The Study Group considered many different strategies and approaches before arriving at a consensus on these five elements. Discussions were held on defined contribution/ consumer choice type plans, but the Study Group felt that these plans are largely untested, and could lead to significant risk segmentation, which could put at risk the older or sicker members of our program. The Minnesota State Employee plan model was analyzed, and an illustration of how that plan might operate was developed by our actuary. While the Study Group felt that this plan had some potential, it was noted

that it is very new and has not yet proven to have the cost savings results that were hoped for. The group also noted that this model is very costly to set up and administer, and that it did not provide the care management that is currently resident in the HMOs. The Study Group considered implementing new office visit co-pays, but felt that this approach primarily shifted costs to our members. Although there have been some studies that suggest that co-pays may reduce some utilization, it was felt that they do little to significantly impact the actual provider cost nor improve the management of health care. A more aggressive approach to a Preferred Provider Plan model was discussed, but the Study Group was concerned that an inadequate network of preferred providers could seriously jeopardize access to adequate care for some of our members.

The recommendations presented below are a strategic approach to the identified problems. The Study Group emphasized that, as strategic solutions, they are intended to be a broad declaration of a policy direction, and that much work needs to be done to fill in the details. Further, since many of the recommendations will need legislative and collective bargaining changes before implementation, the Study Group acknowledges that input from those arenas will likely shape the final product.

I. Changing the current premium contribution structure to a tiered approach

Problem: *The current employer premium contribution formula has been in effect since 1984. Although it has been effective at fostering a competitive environment that is essential to the program, the formula has created some problems that would be better addressed with a new approach. The current formula has created an opportunity for plans to "shadow price". Being the lowest cost plan does not gain a competitive advantage over any other plan that is within 5% of that low premium price. Further, the low premium may be more a function of a better risk pool than of a more efficient system of health care delivery. The formula also creates inequities between employees in different counties when the employer contribution amount is calculated on a county by county basis. Finally, the formula has likely led, at least in part, to the adverse selection in the Standard Plan that has made that plan unaffordable for most our members.*

Recommended solution

The Managed Care Tiered Contribution model

This proposed change is a significant reform of the current premium contribution system. Instead of basing the employer's contribution toward premium on the lowest cost plan, it would array all the plans in one of three tiers. The tiers are delineated by the difference in the employee's monthly out-of-pocket premium contribution, and the employee's share would not vary regardless of the county of residence, nor between plans in the same tier. This approach maintains a managed competition model with insurers as the primary mechanism for delivering health care services, similar to the system currently offered to state employees. However, instead of basing employee contributions on the low cost plan, they are based on the risk-adjusted per-member-per-month (PMPM) cost of each plan, and using that measure, plans are placed in one of three tiers, and the employee share of premium is determined by the tier of the selected plan.

The PMPM adjusted cost method helps measure the relative efficiency with which a plan is able to provide care. The theory underpinning this contribution model posits that care should be directed to the most efficient plans, and not just the least expensive. Employees are encouraged to choose an efficient plan, even if that plan has higher overall costs due to the make-up of its risk pool. In this way, plans are not penalized for having a high risk population as long as they manage care for that risk appropriately. Conversely, a plan is not unduly rewarded merely for having a better risk profile if they

fail to manage that risk appropriately. Because the Standard Plan has very few cost management features and is therefore relatively inefficient, it would likely be placed in the high cost tier. However, the employee contribution would be capped by the cost of the tier, and some better risks may be attracted, thereby stabilizing that plan.

If it is determined that a more complex risk adjustment is necessary, the Board's actuary could establish plan qualification based not only upon review of this PMPM cost versus norms, but also could adjust for efficiencies of care management, provider fee schedules and administrative costs.

The Managed Care Tiered method described here allows latitude in setting the tiers. The State gains flexibility in establishing the employee share of the premium at appropriate levels. The Board could establish general guidelines, and negotiations in the collective bargaining process could work around those levels.

This approach also maintains the strengths of the program in that it continues to rely on HMOs as intermediaries. The HMOs in Wisconsin have, in general, been of very high quality. State employees have rated the plans very highly as evidenced by their scores on the annual report cards and Consumer Assessment of Health Plans (CAHPs) surveys. Wisconsin HMOs have also consistently scored higher on Health Plan Employer Data and Information Set (HEDIS) measures than HMOs nationwide. In fact, according to National Council on Quality Assurance, of the top 15 accredited organizations for the Effectiveness of Care measures, 4 are Wisconsin HMOs. HEDIS is the most widely used set of performance measures in the managed care industry. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization. The purpose of HEDIS is to improve upon the quality of care provided by organized delivery systems by providing measures designed to increase accountability of managed care.

Perhaps most important is containing future costs, the Study Group believes that under this method the plans would continue to bid competitively and the negotiation process could become more meaningful. HMO's would have an incentive to be placed in the lower cost tiers, but they would not be penalized for serving a higher cost population. During annual negotiations with the plans, staff could provide absolute target ranges for HMO's to attain the lower cost tiers and the plans would have full knowledge of the impact of their final bid pricing decisions.

<u>Premium Contribution as a Compensation issue.</u>

One important concern with this model is whether the out-of-pocket monthly premium contributions provide sufficient incentive for employees to choose a more efficient plan, thereby providing incentive to plans to be as efficient as possible. This tiered approach allows the State and it's employees to bargain for different levels of employee cost sharing independent of the premium bids of the plans. These levels can easily be set to require more cost sharing by employees, to maintain the current split between the State and its employees, or to require less. However, the Study Group believes the most important consideration is to maintain some necessary distance <u>between</u> the tier levels.

Tier 1. Low or no cost
Tier 2. Moderate cost
Tier 3. Higher cost

The employee share of premium for each of the tiers could be established during collective bargaining, because as a compensation issue this is clearly beyond the scope of this review. However, the study group believes that at a minimum the difference between tiers should be sufficient to provide

meaningful incentives to plans to bid their best price. This will only be accomplished if there are sufficient cost differentials between the tiers to attract employees to enroll in plans in the lower cost tiers. The Study Group also noted that in pricing the employee share of premium for these tiers, thought should be given to how absolute dollar amounts will affect employees at different income levels.

II. Carving out the prescription drug benefit and contracting with a Pharmacy Benefit Manager (PBM) for all drug benefits under the program.

Problem: *Prescription drug coverage is the fastest growing cost component of our program. This coverage is embedded in the current benefit plan leading to unequal administration and inefficiency. Some HMOs seem to be doing a fairly good job in managing this benefit, while others are not doing as well. Further, the Board has been reluctant to design a different benefit structure because of the fears of unequal administration from plan to plan.*

Recommended Solution

The Study Group proposes that the Board eliminate coverage of prescription drugs from the Uniform Benefits package, remove the coverage from the Standard Plans and contract with a Pharmacy Benefits Manager (PBM) to provide drug coverage equally to all participants of all of our plans. A PBM is a third party administrator of a prescription drug program. PBMs are primarily responsible for processing and paying prescription drug claims. In addition, they typically negotiate discounts and rebates with drug manufacturers, contract with pharmacies, and develop and maintain the formulary. PBMs are flexible in the development of benefit packages and accommodate the plan sponsor's requirements for co-pays and deductibles. A change from the current system to one PBM vendor can be relatively transparent to our members. Many HMOs currently provide their drug benefit through PBMs, and three years ago we moved administration of the Standard Plans' drug coverage to a PBM. PBMs do not manage which prescriptions are written, but may offer the State access to better discounts or rebates on the drugs that are provided. Further, because all drug coverage will be funneled through the claims system of the PBM, they often can provide checks and balances to alert the member to dangerous drug interactions and contraindications.

The State plans currently expend in excess of $100 million per year in prescription drug costs. While this is a very large number, under the current system, it is split among all of our plans. By carving this coverage out and bidding it as a separate benefit, the Study Group believes that the Board will have much greater clout to negotiate better discounts, rebates, and ancillary services. The group also discussed the possibility of partnering with other health benefit plan providers in a "buyers cooperative" format to gain even better bargaining power. Staff noted that there have been preliminary discussions with Wisconsin Education Association Insurance Trust and other private sector providers about this approach.

Finally, a separate prescription drug benefit will allow the Board greater flexibility in considering cost effective benefit design changes without the concern over the impact on our members that could result from unequal administration from plan to plan.

Other programs have claimed savings of 3%-5% in the cost of their prescription drug coverage by taking this approach. Because some of the plans participating in the State program have already been efficiently administering their drug coverage, it is not clear what level of savings the Board could expect.

III. Conversion of the Standard Plan and Standard Plan II plans into one Preferred Provider Plan.

Problem: *The Standard Plan has become so expensive that it does not appear to be sustainable. The plan has remained substantially unchanged for the past 30 years, and it is not a cost-effective design. Standard Plan 2 was created to offer employees a lower cost free access plan, but it has further segregated this risk pool.*

Recommended Solution

The Study Group recommends elimination of both the Standard Plan and Standard Plan 2, and creation of one plan using a Preferred Provider Plan (PPP) model. Under a PPP model, participants may see any provider, but if they see a provider within an established network, they receive a higher benefit level. The Study Group recommends that the Board utilize the current benefit levels of both the Standard Plan and the Standard Plan 2 to delineate the difference between in-network and out-of-network coverage. In other words, if a participant went to an in-network provider, they would receive the Standard Plan level of benefits, and if the participant went to an out-of-network provider, they would receive the Standard Plan 2 level of benefits. While other more aggressive options were reviewed, this recommendation is based upon discussions of the Study Group, which expressed concern over adequate access to providers at a cost that would not be prohibitive to getting care. They also noted that, based on the results of the recent survey of Standard Plan participants, there was considerable interest in retaining the Standard Plan level of benefits.

The Study Group believes that this benefit design change is a significant improvement over the current design, and may provide an affordable option to people who need the freedom to choose providers who may not participate in an HMO. Further, if this change is implemented in conjunction with the tiered contribution approach, the plan may attract a better risk population to help lower the premium rate. It was noted that our current administrator gives us access to a nation-wide PPP network, so this proposal may help provide a better option to our out-of-state participants as well.

IV. Integration of quality and safety standards into program requirements

Problem: *Patient safety and quality measures are receiving much more attention for the impact they have on desired outcomes and the cost of health care. A 1999 Institute of Medicine report estimated that preventable medical errors cost Americans 1 million injuries, 120,000 deaths, and $69 billion dollars per year. Although the Board has long been active in collecting quality data, much more can be done.*

Recommended Solution

The Study Group discussed the Department and Board membership in the Leapfrog initiative. Leapfrog membership confers a responsibility to hold health plans accountable for Leapfrog implementation. Therefore, the Study Group recommends incorporating these standards into the evaluation of health plans along with the incorporation of incentives for members to utilize higher quality providers, and providers who have embraced the safety standards. For example, the Study Group discussed the possibility in using the standards as an element in the process of placing the plans in the tiers. If a plan did not comply with the standards or had poor outcomes, the Board might decide to place them in a higher premium tier.

The Study Group also recommends requiring health plans to collect and report the quality and outcomes data of their contracted hospitals in a format that was recently approved by the National Quality Forum (NQF). The NQF is a private, nonprofit entity that is developing comprehensive hospital quality measurements and a public reporting strategy that addresses priorities consistent with national aims for quality improvement in health care. Although this is a significant increase in the reporting standards for the providers, it was noted that the Centers for Medicare and Medicaid Services will be requiring this information, so providers will need to begin providing it.

Finally, the Study Group recommends that current efforts to educate our members about health care quality and safety be continued and expanded. The reporting of the HEDIS quality measures by plan in this year's Dual-Choice Booklet, and several recent articles in the "It's Your Benefit" newsletter are examples of these types of efforts.

V. Exclusion of dental benefits from the participating plans, and creation of a stand alone dental plan available to all state employees when a reasonable employer contribution becomes available.

Problem: *The state currently has no uniform dental coverage available to its employees. Many plans have included limited dental coverage in their base plans, but that coverage is very limited both in scope and in availability. A recent survey by Mercer/Foster Higgins noted that dental coverage remains the rule among large employers. 95% provide dental benefits, and in most cases it is comprehensive coverage with only about 8% providing preventative coverage only. Only about one-fifth provide this coverage through their medical plans. If the state is to provide a competitive benefits package, it is clear that this type of coverage should be more widely available. Further, in 2001, we estimated that the current system already costs the state $16.2 million per year because it is embedded in the cost of the low cost plans that set the employer contribution levels.*

Recommended Solution

The Study Group discussed the unequal availability and administration of the minimal dental benefits that are offered in a few of the participating health plans. There are many areas of the State where the plans offer no dental coverage, some plans offer minimal benefits and or very limited dental provider panels, and yet the State is paying over $16 million per year because of the current plan design. The Study Group recommends that - if and when the State agrees to a reasonable contribution amount, - plans would be prohibited from including dental coverage in their benefit structure. At that time, the Board should develop and implement a stand-alone dental benefit program that would be universally available to all state employees. Consistent with past Board discussions, employees would be expected to participate in the premium contribution, and the benefit level would be reasonably comprehensive, but tailored to account for the level of premium that is available.