

Act 32

Health Insurance Options Feasibility Study





STATE OF WISCONSIN



Department of Employee Trust Funds

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October 31, 2011

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Dear Governor Walker, Senator Darling and Representative Vos:

Wisconsin Act 32 requires the Secretary of the Department of Employee Trust Funds (ETF) and the Director of the Office of State Employment Relations (OSER) to study the feasibility of several specific potential health care insurance reforms for public employees, and report the findings and recommendations to the Governor and the Joint Committee on Finance no later than October 31, 2011.

The Executive Summary outlines the topics of analysis and highlights the key findings. The report highlights key policy decisions that need to be made by policymakers prior to implementing any of the reforms and recommends that, as details of the reforms are developed, they be subjected to a careful cost analysis, including an actuarial analysis, to better understand the associated costs and impacts.

We respectfully submit the attached report for your review.

Sincerely,

David A. Stella
Secretary
Department of Employee Trust Funds

Greg Gracz
Director
Office of State Employment Relations

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Submitted by
the Department of Employee Trust Funds and
the Office of State Employment Relations

October 31, 2011

Executive Summary

Background

The biennial budget bill signed into law on June 26, 2011 (Wisconsin Act 32), included a non-statutory provision that charged the Secretary of Department of Employee Trust Funds (ETF) and the Director of the Office of State Employment Relations (OSER) with the task of studying the feasibility of five potential strategies for increasing affordability of health care insurance coverage for public employees and possibly for participants in the state Medical Assistance program. The provision states that the Secretary and Director shall report their findings and recommendations to the Governor and the Joint Committee on Finance no later than October 31, 2011. The budget language identified the following topics for analysis:

1. Offering to employees eligible to receive health care coverage under subchapter IV of chapter 40 of the statutes, beginning on January 1, 2013, the options of receiving health care coverage through either a low-cost health care coverage plan or through a high-deductible health plan and the establishment of a health savings account, as described in 26 USC 223.

2. Implementing a 3-level health insurance premium cost structure that would establish separate premium levels for single individuals, married couples with no dependents, and families with dependents.
3. Implementing a program to provide an online marketplace for the purchase of prescription drugs as a supplement to the pharmacy benefit management program provided under the group insurance plans offered by the Group Insurance Board.
4. Requiring state employees to receive health care coverage through a health benefits exchange established pursuant to the federal Patient Protection and Affordable Care Act of 2010.
5. Creating a health care insurance purchasing pool for all state and local government employees and individuals receiving health care coverage under the Medical Assistance program.

ETF administers retirement and other benefit programs for state and local government employees and retirees. OSER oversees the state civil service system, negotiates state labor contracts, manages labor relations, and leads the state's affirmative action and equal opportunity employment programs.

Key Findings

Low-Cost and High-Deductible Plan Design and Health Savings Accounts

- There are numerous ways to structure a high deductible benefits package, depending upon the intent of the policy change. Policymakers should outline the major objectives to be achieved and consider the limitations involved with these

mechanisms to guide the development of such a proposal.

- To effectively implement a “consumer-driven” model, it is imperative that employees have access to reliable, meaningful information about cost, quality of care, effectiveness and efficiency of health-care services and providers.
- Analysis is mixed regarding whether participation in a high-deductible health

plan fosters appropriate, timely treatment or whether higher out-of-pocket costs discourage participants from seeking appropriate care.

Three-Level Premium Cost Structure

- Three-level premium structures are relatively common in the health insurance industry, and this policy change has been investigated at ETF previously. Policymakers should outline the goals to be achieved, and consider who would benefit from this change and which populations would absorb additional cost.
- Contrary to the notion that employee+spouse contracts subsidize other family contracts, studies suggest the opposite. Based on ETF enrollment, those eligible for employee+spouse coverage have an actuarially higher cost factor than those for all other family groupings combined, including employee+spouse+dependents. This is because they generally consist of an older population.

Online Marketplace for Prescription Drugs

- Online prescription drug tools may be useful for some consumers, but also present a myriad of concerns, including limited consumer participation, formulary adherence, network compliance, limited pharmacy participation, and safety issues.
- The online prescription drug market is a relatively new, untested business model. Limited analysis has been published regarding the effectiveness of decreasing

prescription drug costs through the utilization of online prescription drug pricing and auction tools.

State Employee Coverage Through a Health Benefits Exchange

- The Office of Free Market Health Care (OFMHC) is leading the development of a Wisconsin-based Exchange. OFMHC is primarily focused on covering small employers and individuals through the Exchange.
- The Exchange structure could range from a minimal online portal presenting insurance options to the state playing the role of an active purchaser. As the development of the Exchange proceeds, policymakers should carefully analyze the range of options and related impacts involved with covering state employees through the Exchange.

State and Local Government Pooled with Medicaid

- There are a number of questions that should be investigated if policymakers plan to pool state and local government employees with the Medicaid population. There are numerous differences in the administration, purchasing practices and benefits packages for these programs.
- The ETF and Medicaid programs essentially operate similar to an “Exchange” model. Both programs leverage large populations to negotiate premiums, the risk is aggregated, but the insurers are separate entities retaining their own risk.

Study Method

Staff reviewed existing literature and comparable model programs in Wisconsin and other states. This Study reports findings and important considerations involved with the potential benefit design concepts outlined in Act 32. If the Governor and Legislature

consider further pursuing any of these program changes, it is strongly recommended that policy makers conduct an extensive actuarial analysis to better understand the associated costs and impacts. Additional detail and a more concrete framework for each of these concepts would be necessary to complete that level of analysis on these topics.

Findings and Considerations

Study Topic #1

Offering health care coverage through either a low-cost health care coverage plan or through a high-deductible health plan and the establishment of a health savings account.

Background

A high-deductible health plan (HDHP), paired with a health savings account (HSA), would be a significant change in the benefits package structure for state employees. Extensive communication, both up-front and on an on-going basis, would be necessary to educate employees on the restrictions and considerations involved with participation in an HDHP/HSA plan.

There are numerous ways to structure an HDHP/HSA benefit package, depending upon the intent of moving to this sort of plan. Policymakers should outline the major objectives to be achieved to guide the development of such a proposal. Objectives to consider include:

- providing a low-cost option that is more affordable to employees
- making employees more “aware” of their health care costs
- increasing the employee contribution toward health care costs
- reducing overall health care costs
- reducing health care costs to the employer, employee, or both
- full or partial funding of HSAs by the employer
- maintaining or changing the state’s

commitment to retiree health insurance coverage

Coverage through an HDHP limits participation in other health coverage that the employee may have available to them. For example, the employee cannot be covered by a spouse’s health plan if enrolled in a HDHP. However, employees can have other “stand-alone” coverage such as disability, dental care, vision care, and long-term care.

If prescription drugs are covered under an HDHP, participants are required to pay the full cost for prescriptions (rather than a co-payment) until their deductible is met. Any vision or dental benefits that are offered through an HDHP would also be subject to the deductible, unless the service is determined to be a preventive care benefit (such as vision screening for kids). If vision and/or dental coverage are offered through an HDHP, the employee can use HSA funds to pay for the expenses.

Individuals covered by an HDHP cannot participate in a regular flexible spending account (FSA) plan. However, a “limited FSA” plan can be offered that can be used to pay for other eligible expenses such as vision or dental expenses that are offered outside of the HDHP. A limited FSA could also cover out-of-pocket expenses incurred after the deductible is met. An employer may offer multiple FSA plans to employees—a limited FSA for employees who are enrolled in an HDHP, and a regular FSA for others.

Employees may still participate in a dependent day care FSA because it is separate from the medical FSA and the HDHP/HSA plan.

HSAs are subject to various limitations that should be considered. Money in an HSA account must be used for eligible health

expenses only. If money is withdrawn for other purposes, it is taxable. Although contributions and interest income from an HSA account are tax free, there may be costs associated with such accounts (administration, transaction fees, etc.), for which the participant may be responsible.

The fundamental philosophy underlying consumer driven health care is that if consumers have an increased financial interest in their health care costs, they will make intelligent decisions about their health care consumption. For this theory to work, it is imperative that employees have access to reliable, meaningful information about cost, quality of care, effectiveness and efficiency of health care services and providers, including physician-specific information.

An increasing amount of information is available pertaining to health care cost and quality, but the information is far from consistent, robust, and completely transparent. To successfully initiate a consumer-driven health model will require a significant investment in infrastructure and resources to help employees understand and access health

care cost and quality information.

The current purchasing model for state employee health insurance rewards participating health insurers that perform well on quality measures through the negotiation process. This system also relays quality information to members in the annual enrollment materials.

Another series of questions that warrant serious attention involve the impact of an HDHP/HSA plan on the long-term health of participants. There are mixed analyses regarding whether participation in an HDHP fosters appropriate, timely treatment or whether higher out-of-pocket costs discourage participants from seeking appropriate care. It is debatable whether HDHP plans reduce overutilization of services or if they reduce the consumption of necessary care.

The results of a survey in the July/August 2008 publication of "Health Affairs," (see box below) suggest that the impact of Consumer-Driven Health Plans (CDHPs) is mixed.¹ According to the article:

"There are some early indications that health care consumers may forgo medical care in the face of greater financial risk. Employers and other purchasers may need to reevaluate the appropriateness of high deductible plans for those with high health care needs, if the results found here are substantiated by analysis of claims data. Consumers appear more likely to be motivated to seek out and use both health in-

formation and cost information when they are given information tools. Universalizing information support to all health care consumers appears to be a positive next step. Differences in access and skill in using the Internet, however, may need to be addressed if income and race/ethnicity-based disparities are not to be increased."

Health Affairs — July/August 2008

Likewise, a report based on the Commonwealth Fund Biennial Health Insurance Survey (2003), found HDHPs to have little impact on cost or coverage and suggested that HDHPs can “undermine the basic purposes of health insurance: to reduce financial barriers to needed care and protect against financial hardship.”²

The Study authors acknowledge that some of the referenced materials are a bit dated. Staff will continue to track and compile more recent analysis on this topic.

The cost-sharing structure must also be closely studied. If an HDHP/HSA option is offered alongside other health plan options such as Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs), there could be long-term impacts on those alternative plan offerings. For example, if “healthier” employees who expect to incur low health costs migrate to an HDHP, this would leave the higher-cost employees in the other plans, deteriorating the risk pool and increasing the premiums for those options. Model HDHP programs should be reviewed to determine whether participation in an HDHP results in an actual decrease in health care costs, or if it is simply shifting more of the cost to the consumer.

Historically, the State of Wisconsin Group Health Insurance Program has been structured to offer retiree benefit options, and policymakers should carefully consider the potential effect plan design changes would have on retirees. Many retirees use accumulated sick leave conversion credits (ASLCC) to pay for health insurance premiums, but those credits cannot be used to

pay for deductibles. Therefore, a conversion to a HDHP could have a substantial effect on retirees if there is no mechanism to help fund the high deductibles. Wisconsin policymakers may want to look to the state of Indiana model (described below), which has maintained coverage for their retirees through the use of a Health Reimbursement Account (HRA).

If the state of Wisconsin considers changing the structure of retiree health insurance benefits, policymakers should also consider the impact on the State’s Governmental Accounting Standards Board (GASB) liabilities. The current ASLCC program is a pre-funded, fixed dollar amount, which greatly minimizes the State’s GASB liability in this area.

HDHPs combined with savings arrangements are becoming more common as offerings through employer group health plans. According to the most recent 2010 Kaiser/HRET Employer Health Benefits annual survey, 34% of larger employers offer such arrangements. However, the number of employers specifically offering the HDHP/HSA model is a lower percentage. Of large firms with more than 200 workers, only 12 percent offer the HDHP/HSA combination and only six percent of employees are enrolled. While these percentages are up from approximately two percent five years earlier, they still indicate that their adoption in employer sponsored group health insurance remains relatively limited.³

Findings affirming the efficacy of these plans remain largely anecdotal. Below, we present two case studies from the County of Manitowoc, Wisconsin, and from the state of Indiana.

Case Study: Manitowoc County, Wisconsin

One example of a local government entity in Wisconsin that changed to an HDHP/HSA plan is Manitowoc County. Manitowoc County implemented a fully insured HDHP with an HSA for approximately 1,000 subscribers on January 1, 2007. The County then converted to a self-insured HSA effective January 1, 2009.

Despite the change to an HDHP, the County experienced hefty premium increases in the early years of the program. The original premium rates were “underbid” and the County experienced a capped increase of 9% for 2008 (experience would have warranted a 16.5% premium increase). The County then increased rates 27% for 2009 to make up for losses from the previous year.

In 2009, the self-insured group experienced a notable number of high-cost cases which led to a 16% premium increase effective January 1, 2010. In the following year, their experience leveled off and the plan increased premiums 5% for 2011. For 2012, the County reduced rates by an average of 6.5% due to a reduction in both the prescription drug benefit and administrative expenses. It should be noted that the County pays the entire premium amount.

From the inception of the HDHP, the in-network benefit structure has been a \$1,500 deductible for single contracts, and \$3,000 for family coverage, followed by 100% coverage after the deductible is met. Preventive care services are exempt from the deductible, and drug coverage is currently included. However, beginning in 2012, most members will have a \$10/\$25/\$50 (generic/formulary/non-formulary) drug co-payment that will continue after the deductible is met. Further, it is expected that “protective occupation” employees will see their deductible increase to \$3,500 for single coverage, and \$7,000 for families for next year.

For many years, the County had fully funded the employee deductible through the HSA. However, starting with the 2011 plan year, the employer only funded half of the deductible amounts, and the County plans to contribute no funding toward the HSAs in 2012.

The County does not track the out-of-pocket costs paid by their employees, so it is unclear whether the HSA has been adequate in covering employee out-of-pocket costs.

In 2006, the County insured 140 retirees. Most retirees have since left the program in Manitowoc, as the employer does not fund any part of the premium or deductible for that population and the plan does not offer reduced rates for those on Medicare. The County directs retirees to the county Medicare/Medicaid advisor for assistance finding individual policies.

The Manitowoc County experience is instructive in that it reveals that an HDHP is not immune to significant increases in premiums, even when the group size decreases and sheds risk due to the exit of most retirees from the plan.

Case Study: State of Indiana

A Consumer-Driven Health Plan (CDHP), including an HSA, was first offered to Indiana's 30,000 state employees in 2006. In the five years (2006-2010) following implementation, CDHPs went from attracting minimal participation to becoming the dominant choice among state of Indiana employees. Five percent of employees opted for the CDHP in 2006, whereas over 70% enrolled in a CDHP for the 2010 plan year.

By 2010, the state of Indiana offered two CDHP options, as well as a PPO and an HMO (but the HMO will no longer be offered in 2012). Each of the available options includes a "non-tobacco use" reduced premium incentive. A full summary of the Indiana benefits structure and a comparison to Wisconsin follows in Table 1.

For 2010, the CDHPs premiums increased 7.6% and the PPO premium went up 11.2%. The increases for 2011 were 6.9% and 13%, respectively. The state partially funds the high deductibles through an HSA contribution. For 2011, this amount will decrease to 50% of the CDHP deductible, rather than the 55% threshold it previously funded.

Per Indiana Code passed in 2007, the state also contributes in two ways to a Retirement Medical Benefits Account (Health Reimbursement Account or HRA) for each employee for use after retirement or disability. An HRA is a better mechanism for these populations, as it is less restrictive than an HSA. These funds may be used to pay health plan premiums, deductibles, and out-of-pocket medical and prescription drug expenses.

The state contributes the following amounts to each employee's HRA on an annual basis:

Age less than 30:	\$500.00/year
Age 30-39:	\$800.00/year
Age 40-49:	\$1,100.00/year
At least 50:	\$1,400.00/year

And, when the employee retires or begins participation in a disability program, the state contributes \$1,000.00 multiplied by the participant's years of service with the state (rounded down to the nearest whole year). Employees must retire from the state and have 15 years of service to receive the funds.

According to a 2009 Mercer Case Study of the state of Indiana program:⁴

- The average cost for the PPO option was \$12,317 compared to \$5,462 for CDHP1 and \$9,444 for CDHP2.
- The CDHPs had combined savings of 10.7% per year and were projected to save \$17

State of Indiana Case Study Continued

to \$23 million for the state in 2010.

- State employees and their families enrolled in CDHPs were projected to save \$7 to \$8 million in 2010.
- Both CDHPs had lower-than-average age populations, but a higher average family size compared to the PPO.
- The actuarial values of the CDHPs were somewhat lower than the PPO plan, meaning that employees paid more out-of-pocket than if they had enrolled in the PPO. However, the CDHPs were not significantly lower in value.
- Individuals who moved to either CDHP option had reduced utilization and intensity of services.
- There was no evidence that CDHP participants were avoiding care. Sources of savings appeared to come from better use of health care resources and more cost-conscious decision making.

Table 1: Comparison of Benefit Options, Indiana and Wisconsin, 2012

	Indiana			Wisconsin (active/COBRA only)			
	CDHP1	CDHP2	Traditional PPO	Uniform Benefits		Standard Plan PPO	
Deductible annual (single/family)	\$2,500 \$5,000	\$1,500 \$3,000	\$750 (\$1,500 non-network) \$1,500 (\$3,000 non-network)	None		\$200 (\$500 non-network) \$400 (\$1,000 non-network)	
Out-of-pocket max OOPM (single/family)	\$4,000 \$8,000	\$3,000 \$6,000	\$2,500 (\$5,000 non-network) \$5,000 (\$10,000 non-network)	\$500 \$1,000		\$800 (\$2,000 non-network) \$1,600 (\$4,000 non-network)	
Notes	The family OOPM limit must be satisfied by either one enrollee or all enrollees collectively. The single OOPM is not used for the family plan.			All family OOPMs are in aggregate, but no individual will exceed the single OOPM.			
State HSA contribution-annual max	\$1,123 \$2,250	\$674 \$1,348	None	None		None	
Copays	Rx only			Rx and \$75 Emergency Room, per visit		Rx and \$75 Emergency Room, per visit	
Member premium annual (single/family)¹	\$797 \$1,061	\$1,443 \$2,883	\$3,933 \$9,786	Tier ²	1	2	3 ³
				Single	\$972	\$1,416	\$2,628
				Family	\$2,412	\$3,564	\$6,576
Employer premium annual	\$3,987 \$12,556	\$4,436 \$13,458	\$5,110 \$14,805	Average \$ 6,708 \$17,016		\$11,143 \$27,811	
Miscellaneous	Non-tobacco incentive reduces member premiums by \$650/year for any category			No monetary wellness incentives			
Prescription Tiers per 30-day supply⁴	Generic		\$10 copay	Level 1		\$5 copay	
	Formulary		\$30 min copay, 20%, \$50 max	Level 2		\$15	
	Brand-name formulary		\$50 min copay, 40%, \$70 max	Level 3		\$35	
	Specialty		\$75 min copay, 40%, \$150 max	Out-of-Pocket Max for Rx: \$410 indiv/\$820 family Note: Level 3 copays do not apply to OOPM			
Coinsurance	20% network 40% non-network	20% network 40% non-network	30% network 50% non-network	10% most services 20% durable medical equipment		10% network 30% non-network	
Benefits	<ul style="list-style-type: none"> Preventive care covered in full in-network, 40% copay non-network, not subject to deductible⁵ 80% coverage after deductible for all other covered services. 		<ul style="list-style-type: none"> Preventive care covered in full in-network, 50% copay non-network 70% coverage after deductible for all other covered services. 	<ul style="list-style-type: none"> Preventive care covered in full 90% coverage for all other covered services. Includes basic dental benefits. 		<ul style="list-style-type: none"> Preventive care covered in full in network. Non-network: deductibles and coinsurance apply 90% coverage for all other in-network covered services. 70% coverage non-network 	

¹ Premiums and HSA amounts are rounded to nearest dollar² State Patrol and UW Graduate Assistants pay lower premiums in Wisconsin. Quasi-governmental agencies may have different premium structures.³ Wisconsin's Standard Plan is in Tier 3. For 2012 all alternate plans are in Tier 1. There are no Tier 2 plans.⁴ Indiana and Wisconsin Rx plans both have a mail order option that gives a 3-month supply for 2 copays.⁵ Indiana's listing of "Preventive" care is broader than the strict interpretation of Federal guidelines, and includes routine vision and hearing exams, office visits for preventive care.

A Manhattan Institute study also examined Indiana's reforms. It found that net payouts under the two consumer-directed plans were far lower than under the PPO, largely because of adverse selection. In other words, younger and healthier employees were more likely to choose the consumer-directed plans, particularly the most basic plan options.⁵ The fact that employees and/or families with high medical utilization were less likely to enroll in a CDHP could, in part, account for why the CDHPs had reduced utilization and lower cost.

Study Topic #2:

Implementing a 3-level health insurance premium cost structure that would establish separate premium levels for single individuals, married couples with no dependents, and families with dependents.

Background

Three-level premium structures are relatively common in the health insurance industry, and requests for such a premium structure are received by the Department periodically. Those who request this believe that such a structure will reduce the overall cost of coverage for the employer group, and offering this structure will result in savings that can then be passed on to those couples being provided a two-person rate.

The majority of such requests come from older couples whose children have typically left the home and who are seeking ways to reduce the cost of their post-retirement health insurance. Among the rationales offered is that families with one or more children must cost more than a couple and therefore a rate under which couples pay less would be fairer. Less common are requests from widowed

or divorced individuals with one dependent. However, under this proposal only those families consisting of two married individuals would benefit. Single parents who are more likely to cost the health plan less will not benefit, while older married couples that will benefit typically do not produce any savings justifying such a rate structure as described below.

The notion that the state employer group overall premium cost will be reduced with such a structure could have some validity if the state were a small group. However, in the large group market, group health plan claims experience, such as those offered in the state's program tend to be sufficiently credible that they are not typically pooled with other employer groups. As a result, the claims experience for the entire group will typically result in premium rates necessary to support it, regardless of the manner in which it apportioned within the group. Therefore, the pertinent question within the state program is: who benefits from such a structure and who pays for it?

The nature of insurance requires that, inevitably, those individuals with greater health insurance claims are subsidized by those with fewer or no claims. The question of how, and whether, to set premium categories is usually dictated by the extent to which specific sub-groups of individuals are to be recognized, the effect that such recognition will have on their participation, as well as by the need for balancing administrative efficiency and fairness that comes with greater number of premium categories.

Historically, the state has opted for the most basic premium categories, single and family, as required by § 40.52(1) stats. This is in part due to a recognition that the less one attempts to carve out certain sub-groups, the easier it is to

establish and administer rates and the less other sub-groups within the group will be inclined to petition for favorable treatment. Nevertheless, two deviations from this structure have been made in the past because the sub-groups within the state program have been determined to be large, relatively stable and substantially lower in cost than the group as a whole.

The two allowances for such deviations currently in statute include those retired individuals for whom Medicare is the primary payer (§ 40.52 (2)) and those graduate assistants and short-term academic staff employed by the University of Wisconsin (§ 40.52 (3)). In both cases, individuals in these separate rating groups have been determined by the Group Insurance Board's consulting actuary (actuary) to cost approximately 25% less than the average within the group as a whole. For older individuals with Medicare it is due to the fact that Medicare pays over two-thirds of the cost of claims. For the graduate assistant group, it is because this group is composed primarily of younger and healthier individuals in the twenty to early-thirty age band.

The rationale for the Medicare and graduate assistant exceptions to the rating structure does not hold for the married couple group. To evaluate the likely impact of requiring a employee+spouse rate, ETF provided the actuary with a detailed breakdown of the number of individuals and number of health insurance contracts by age band for single individuals, employee+spouse and all other family categories. Using average cost factors associated with these age bands, based on ETF enrollment, the actuary found that the cost factor for employee+spouse contracts to be 3.8% higher than those for all other family groupings combined, including employee+spouse+dependents.

Currently the ratio of family to single premium under the state employee program is 2.5 to 1. This ratio has been used for many years and is appropriate given the current make-up of the insured population. For the purpose of illustration, the effect of a three-level premium structure was calculated using an industry standard ratio of 1.0 for single, 2.0 for married couples, 3.0 for all other families. According to the actuary, the estimated cost-shift of such a structure would be \$9.3 million annually with \$8.2 million cost to the state, and \$1.1 million cost to the active employee population carrying family coverage. The net benefit would accrue to the retired married couple population.

Recently published analysis supports the conclusion that the make-up of the two person family rate is key. The study looked at actual claims behind employee, employee+spouse and employee plus family rate structures for one very large Midwestern commercial group population in excess of 500,000 lives. It found that the potential costs of the employee+spouse category was greater than that of the employee+family category. In this instance, adults in employee-only and employee+spouse contracts were "much more expensive than the adults on contracts with children."⁶ In this study, the cost factor differential was 4.5% higher.

Recognizing that these analyses cannot be said to be conclusive without more research, they nevertheless strongly suggest that the current rating structure used by the state is appropriate. Contrary to the notion that employee+spouse contracts subsidize other family contracts, they suggest the opposite. Based on our review, there is little actuarial justification for providing a lower rate to married couples when the costs for such a rate will likely be borne by other families with similar or lower costs on average, such as single adults with children.

Study Topic #3

Implementing a program to provide an online marketplace for the purchase of prescription drugs as a supplement to the pharmacy benefit management program.

- Bid for Medicine
- RxEOB
- Pill Bid
- GoodRx
- RxBids
- BidRx

Background

There are several definitions of an online prescription drug marketplace in the industry today. These definitions can be categorized in three ways:

- a. A Web portal that provides members with drug cost information based on specific pharmacies;
- b. An Internet-based search feature that lists preferred formulary alternatives and the cost differential associated with each; and
- c. An Internet-based electronic marketplace linking buyers (members) and sellers (pharmacies) together.

It is unclear in the statutory language, what is specifically meant by an “online marketplace.” However, this study interprets the requirement to encompass the third category (c) above.

There are several companies that provide the services defined in the three categories, and each provides varying levels of integration with a group insurance plan’s benefit design. The level of transparency to the plan and the members can also vary greatly.

The following companies are just some among many that offer tools that provide online consumer-based prescription drug pricing and information:

- DestinationRx
- LowestMed

These tools provide varying degrees of pricing transparency, consumer engagement, accessibility to therapeutic alternatives and facilitation with prescribing physicians. Some tools permit the legal purchase of prescription drugs online.

The online tools offered by DestinationRx, RxEOB, GoodRx and LowestMed can be categorized as online prescription pricing comparison tools, and fit into categories (a) and (b) above. They are more broadly defined as online tools that enable members to compare prescription benefit out-of-pocket costs. Online prescription drug pricing tools target both insured and uninsured consumers. It should be noted that Navitus Health Solutions (Navitus), the Group Insurance Board’s contracted Pharmacy Benefit Manager (PBM), currently provides similar tools to state group health insurance members.

Examples of companies that offer online bidding or an “auction” for prescription drugs include: RxBids, BidRx, Bid for Medicine and Pill Bid. These companies generally define an online marketplace as an Internet-based electronic marketplace linking buyers and sellers and fall into category (c) above. Registration is generally provided at no cost to the consumer and targets both insured and uninsured consumers.

These online bidding tools appear to provide minimal incentives for insured individuals covered by flat co-payment structured

pharmacy benefits. These programs may be most attractive for consumers enrolled in high-deductible and/or coinsurance prescription drug benefit plans or the uninsured.

While these tools may be useful for some consumers, online marketplace options present a myriad of concerns, including limited consumer participation, formulary adherence, network compliance, limited pharmacy participation, and safety issues through poly-pharmacy usage if not coordinated with the current pharmacy benefit manager. Poly-pharmacy is a term used to describe the situation when a patient is prescribed multiple, uncoordinated medications. Poly-pharmacy often occurs because an individual patient may be under the care of multiple physicians and may have prescriptions filled at multiple sources. These prescriptions may interact with each other, causing side effects (sometimes dangerous) or they may work against each other, eliminating the benefit of the medication.

Few studies have been published regarding the effectiveness of decreasing prescription drug costs through the utilization of online prescription drug pricing and auction tools. According to the article, “Evaluation of Health Plan Member Use of an Online Prescription Drug Price Comparison Tool,” published by the Journal of Managed Care Pharmacy: “Although a number of health plans and PBMs have implemented online cost comparison tools, there is little published quantitative research evaluating the use of these price tools.”⁷

According to a study by the Pew Internet & American Life Project, “only 4% of Americans have ever purchased prescription drugs on the Internet.”⁸ This study also notes that purchasing drugs on the Internet also presents

publicly perceived safety concerns: “Sixty-two percent of Americans think purchasing prescription drugs online is less safe than purchasing them at a local pharmacy.” Not only have few Americans purchased drugs online, insured consumers are less likely to do so. According to a study of prescription drug, hospital, and physician cost comparison tools by the California Health Care Foundation in 2006, consumers with prescription drug insurance were less likely to search for prescription prices online.⁹

The volume of prescriptions purchased in the United States between 1999 to 2009 increased by 39%, which is a significant increase in utilization, considering the population in the United States increased by only 9%.¹⁰ Recent studies reported by Express Scripts illustrate that the demand for prescription drugs is relatively price inelastic, ranging from -0.18 to -0.60, which means that the demand response is somewhat small relative to the increase in price.¹¹ For example, given price elasticity of -0.18, a 40% increase in prescription drugs costs leads only to a 7.2% decrease in utilization. One of the main objectives of an online marketplace is to increase competition and decrease costs to the consumer. Given the general price inelasticity of prescription drugs, an online marketplace may be best suited to the target audiences noted above – those in HDHPs, and the uninsured.

If policymakers would like to further explore an online bidding tool or an “auction” for prescription drugs, there are a number of considerations that should be investigated:

- The online prescription drug marketplace is relatively new concept and there is no time-tested business model for this type of service. There needs to be a clear understanding of the online marketplace

vendor's business model to ensure that it aligns with the intentions of policymakers, as well as the group health insurance program.

- The potential for savings derived from discounted pricing will be dictated by the design of the services from online market place vendors, the availability of drugs and the pharmacies/manufacturers that are contracting with the vendor. If the vendor has a limited network of pharmacies, there may be limited utilization by state employees.
- Regulatory structure, safety issues, and liability issues would all have to be considered carefully. This would also include what protections and recourse members would have in this system.
- How this type of drug purchasing opportunity would benefit our members would have to be clearly identified along with the incentives for our members to utilize this service. Lower drug prices are, of course, an obvious incentive if the member is paying out of their own pocket. Likewise, being able to shop for the lowest price on a drug that is currently excluded from our existing PBM formulary would benefit the member.
- The level of involvement of the major players in the pharmacy benefits industry (e.g., Walmart, Walgreens, etc.) should be evaluated. If the major players will not participate, then investigating the reasons why may offer insight into the validity of the concept.
- Identifying who profits or benefits from

the asserted "savings" is imperative to ensure there is transparency. In addition, an evaluation of the impact on in-state businesses (i.e., local, retail pharmacies) should be performed, as well as the impact on our current pharmacy benefit program (e.g. rebates, negotiated discounts, pharmacy network contracting, clinical program management, etc.).

- While some vendors do have customization provisions for plan sponsors to include benefit plan designs, member eligibility and copayment structuring, there is no clear indication of what this might cost if the state were to sponsor such a benefit. Likewise, the contractual provisions would have to be scrutinized if the Group Insurance Board or the state were to enter into any specific agreements with these vendor types. (Note: it is unclear whether the intent of the statutory language is to have the Group Insurance Board administer, and contract for, these services.)
- While the vendors contract with retail pharmacies in a member's area, as well as mail order pharmacies, there is no clear indication that the vendors are partnered with a PBM or some other entity that would have a claim adjudication link.

Based on the information gathered, it appears that auction-driven online marketplace tools could potentially impact current plan rebates and negotiated discounts, create a loss of interaction between members and the pharmacist, and lack in transparency. Tools of this nature may be less effective than what a PBM would provide in a pure pass-through arrangement.

Study Topic #4

Requiring state employees to receive health care coverage through a health benefits exchange

Background

The Patient Protection and Affordable Care Act (PPACA) that was signed into law on March 23, 2010, calls for the creation of state-based health insurance Exchanges by January 1, 2014. Health insurance Exchanges represent a virtual marketplace where qualifying private citizens can purchase health insurance from private health insurance companies.

On January 27, 2011, Governor Walker created the Office of Free Market Health Care (OFMHC) by Executive Order # 10. The OFMHC is directed to develop and recommend a plan that encourages competition through the leveraging of a free-market approach based on the following:

- Assess the impact of PPACA on Wisconsin insurance markets and programs.
- Conditionally develop a plan for the design and implementation of a Wisconsin health benefit Exchange that utilizes a free-market, consumer driven approach.
- Explore all opportunities and alternative approaches, including waivers if necessary, that would protect Wisconsin from the establishment of a federal health benefit Exchange.
- Encourage transparency in state efforts so that Wisconsin residents and employers may make appropriate health care decisions.
- Seek counsel from a wide range of health care stakeholders including—but not

limited to—consumers, small businesses, providers, insurers, labor unions and other vested organizations.

To date, the OFMHC has not considered including the members covered by the health insurance programs administered by ETF or other large employers (over 100 employees) as participants in the Exchange because federal law does not allow large employer participation until 2017. OFMHC is currently drafting a Request for Proposals (RFP) that will provide more detailed information about the functionality and operation of the Exchange.

In the near term, the OFMHC is primarily focused on covering small employers and individuals through the Exchange. The OFMHC is currently collecting feedback from various stakeholder organizations as they develop the structure for the Exchange. Community Advocates Public Policy Institute (CAPPI) provided the OFMHC with recommendations pertaining to the development of a successful Exchange-based Small Business Health Options Program (SHOP).¹² There were three fundamental principles in the CAPPI summary:

1. The pool must be average in risk.
2. The pool must be very large in size.
3. The participants must have economic incentives to choose low-cost health care plans.

To promote average risk, CAPPI suggested measures designed to stabilize the SHOP Exchange pool's risk profile, ensuring that employers that place employees in the pool do not face "adverse selection" from other employers who dump a few unhealthy employees into the pool while covering the

healthy majority of their workers elsewhere. The risk stabilization measures will also support the second recommendation by increasing the size of the SHOP Exchange pool.

To promote an Exchange pool that's very large in size, CAPPI recommends opening the Exchange to all small employers (including those with 51-100 full-time employees) as soon as they are eligible, in 2014. CAPPI also recommends covering all entities of government in the state through the Exchange when large employers are eligible to join in 2017.

To promote economic incentives for participants to select low-cost health care plans, CAPPI suggests that insured individuals absorb the additional expense if they select more expensive plans that are available.

As the development of the Exchange proceeds, there are a number of considerations that should be investigated if policymakers plan to cover state employees through the Exchange:

- Several states are moving forward with varying models of an Exchange, but all are in the early stages of development. Wisconsin should continue to track our peers' efforts.
- The Exchange structure could range from a minimal online portal presenting insurance options, to the state playing the role of an active purchaser.
- Coverage for state employees through the Exchange could be mandatory or voluntary.
- The legal status and the future for federal health care reform are uncertain, and there is potential for reversal of federal reform law.

- Regulatory guidance regarding PPACA is just starting to be issued; the state needs to track the impacts on Exchange design.
- The state needs additional clarification on the future role of ETF and Group Insurance Board pertaining to the oversight, operations, administration, coordination of payroll deductions, information technology/information transfer, etc. in an Exchange model.
- There could be adverse selection issues with employees dropping coverage, though this could be influenced if all are required to have health insurance coverage per the individual mandate provision in federal law.
- The state employee group health insurance program includes coverage for out-of-state retirees and Medicare retirees; the impact on these populations should be considered.
- There are various risk segmentation issues involved with different pool structures pertaining to individuals and groups.
- State employees are currently covered with a uniform benefits package. It is unclear how the benefit design would change in an Exchange model.

Study Topic #5

Creating a health care insurance purchasing pool for all state and local government employees and individuals receiving health care coverage under the Medical Assistance program.

Background

There are numerous differences in the administration, purchasing practices and benefits packages for the populations involved in this proposal.

The state and local health insurance programs currently administered by ETF purchase health insurance on a fully insured basis from eighteen different health plans, in addition to a self-insured option through WPS Health Insurance. The contracts with these insurers are negotiated on an annual basis. ETF is able to charge premiums to the members through employers or annuity deductions from the Wisconsin Retirement System. If members are not eligible for either of these payment options the premiums are billed directly to subscribers from the corresponding health plan.

The Medical Assistance (MA) program is made up of four separate insurance programs (traditional Medicaid, BadgerCare Plus, SeniorCare, and Family Care). MA payment rates are established by the Department of Health Services (DHS). The MA program contracts with 17 HMO/SSI Providers, 9 FamilyCare Providers, and 5 PACE/Partnership Providers, and also pays providers on a fee-for-service (FFS) basis. The MA benefit package is more comprehensive than the state employee plan or typical commercial plans.

A crucial question for consideration is how commercial carriers would react to a proposal to combine these programs. Many of the plans that participate in the MA program are quite different from their commercial counterparts, and many insurers do not operate in the MA program today. It is unlikely that the industry would want reduced MA rates to become the standard payment structure. In addition, the MA program has far more contractual requirements than the contracts administered by ETF.

Another concept that needs to be more fully fleshed out is the intent of “pooling” these populations. Both the ETF and MA programs essentially operate similar to an “Exchange”

model. Both programs do leverage large populations to negotiate premiums, and that risk is aggregated for employers and participants, but the individual carriers in the programs are separate entities retaining their own risk. Even within the MA program, low income families and disabled participants are not “pooled,” per se—MA contracts separately for these distinct lines of business and pay differentially because the risk is very different.

In lieu of pooling, there are opportunities to align program objectives without integrating the populations. ETF and DHS have initiated discussions involving common areas of interest such as data collection, electronic information exchange, population health status, program cost drivers and disease management.

There are a number of questions that should be investigated if policymakers plan to pool state and local government employees with the MA population:

- Will all participating health insurers be required to cover all participants (MA and non-MA)?
- Will all current health insurance plans want to participate (e.g. HMOs in ETF’s program that do not participate in MA)? Would the program be able to attract insurers?
- Would all government entities be mandated to participate, or is participation optional?
- Will plans be allowed to limit their MA enrollment as many do now?
- Will there be one, uniform benefits package for all participants?
- How could this proposal impact the risk pool for ETF’s programs and what are the implications for the trust fund?
- What is allowable under federal law in terms of integrating MA participants with

other populations?

- What advantages would such a system provide to either program when compared to current administration?
- What level of integration is the goal? Full integration vs. essentially maintaining separate, distinct systems?

The Issue Brief, “What Health Insurance Pools Can and Can’t Do,” published by the California Health Care Foundation in November 2005, provides useful background on the promise and limitations of pools and cooperatives.¹³ The brief examines how insurance pools work, the risks they face, and the conditions necessary for a pool to succeed. It explains why pools are not the same as large employer groups, discusses the crucial role health plans play in establishing a successful pool, and describes the ways pools can attain the necessary market clout to succeed. The authors caution that attention must be paid to basic considerations such as the cohesiveness of a pool’s members and the market environment in which it operates.

Examples from other states

The National Conference of State Legislatures June 2010 (Volume No. 10) Briefs for State Legislators cites that several states have

created a combined health care purchasing agency that includes Medicaid, state employees and other agencies.¹⁴ Examples include the Kansas Health Policy Authority in 2005, the Oklahoma Health Care Authority in 1993 and the Georgia Department of Community Health. Although state and local employees are not “pooled” with Medicaid, the joint administration under one management structure results in “combining the state’s purchasing power.”

Researchers at Saint Louis University prepared a brief for the Missouri Foundation for Health. This brief illustrates that the key step toward increasing access to health insurance in Missouri would be the creation of an insurance purchasing pool.¹⁵ The success of a state sponsored insurance pool depends on the quality of the program design and the ability of the state to negotiate affordable insurance policies with private insurance providers. On its own, the insurance pool would not guarantee the availability of affordable insurance products in Missouri; rather, it would need to coincide with the implementation of a comprehensive Massachusetts-inspired universal health care plan including a premium assistance program, individual and employer mandates, and an expanded Medicaid program.

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