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CORRESPONDENCE MEMORANDUM

DATE: May 20, 2011

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits & Insurance Plans
Division of Insurance Services

SUBJECT: Benefit Changes Relating to Act 10

This memo is for discussion purposes only. The information in this memo is subject to change, pending clarification of legal status of 2011 Wisconsin Act 10 or incorporation of this provision into the state budget. An additional Board meeting, conducted by phone, if necessary, will most likely be called if this provision becomes effective in law prior to the August Board meeting.

A study group met to establish recommendations for changes to the health insurance contract and Uniform Benefits package for the next contract year for the state program only. The study group also took the opportunity to discuss some of the potential benefit changes required under 2011 Wisconsin Act 10. These consist of options to attain the required 5% reduction in the cost of health insurance described under Section 9115 (4), and the change in employer contributions required under Section 77 for 40.05 (4) (ag) 2.

5% COST REDUCTION: Section 9115, Nonstatutory provisions; Employee Trust Funds (4) states:

"REDUCTIONS IN HEALTH CARE PREMIUM COSTS FOR HEALTH CARE COVERAGE DURING 2012 CALENDAR YEAR. The group insurance board shall design health care coverage plans for the 2012 calendar year that, after adjusting for any inflationary increase in health benefit costs, as determined by the group insurance board, reduces the average premium cost of plans offered in the tier with the lowest employee premium cost under section 40.51 (6) of the statutes by at least 5 percent from the cost of such plans offered during the 2011 calendar year. The group insurance board shall include copayments in the health care coverage plans for the 2012 calendar year and may require health risk assessments for state employees and participation in wellness or disease management programs."

Reviewed and approved by Lisa Ellinger, Administrator, Division of Insurance Services.

Lisa Ellinger — Signature
5/23/11 — Date

Board	Mtg Date	Item #
GIB	6.7.11	5C

The provision appears to give the Board flexibility in determining if the reduction applies solely to the benefit side (i.e., actuarial reduction) or whether other program changes, in addition to actuarial reductions, could constitute the 5% cost reduction. Further, although this provision specifically addresses health plans that are in the lowest-cost Tier 1, that is, plans that offer Uniform Benefits, staff also believes the Board should implement a comparable benefit reduction in the Tier 3 Standard Plan. This is consistent with 40.03 (6) (c), which that allows the Board to modify the Standard Plan to establish a more cost effective benefit design.

Deloitte Consulting, the Board's consulting actuary, has calculated that a 5% cost reduction would result in a cost reduction of $32.40 per member per month (PMPM). For the state program, including graduate assistants and the quasi-governmental agencies such as the University of Wisconsin (UW) Hospital, this amounts to approximately a $65 million cost reduction in 2012.

The study group offered the Board alternatives, ranging from a plan with a higher deductible that tends to spread the impact among the most participants, to a plan with all copayments, which tends to have a greater impact on those participants who are the biggest utilizers of health care.

The Department of Employee Trust Funds (ETF) has received correspondence from a provider and a member, sharing their concerns over the potential changes. The provider expressed concern over the use of office visit copayments, stating that copayments may create, for ill members, barriers to receiving regular care – a situation that ultimately, could result in higher utilization of emergency care providers. The letter from the member asks that providers be made to reduce their costs as part of the 5%; make their bills and the insurers explanation of benefits more transparent; that the benefit reductions be spread across all benefits (coinsurance) rather than any copayments and deductible; and that durable medical equipment be paid at the same level as all other services.

The charts on pages three and four show three medical benefit options that would provide an appropriate range of copayments, deductible, prescription drug and eligibility alternatives for cost adjustment packages in order to attain the cost reduction of 5% in Uniform Benefits. Please note these cost sharing provisions do not apply to the optional dental benefit. Additionally, as described in a separate memo, the study group discussed several potential benefit changes for 2012 that have a cost impact and now recommends for consideration: palliative care consult and dental implants following accidental injury. These benefit changes are shown in the chart, should the Board be interested in pursuing them. Under each of the three options you will find the benefit option and the PMPM cost savings.

	UNIFORM BENEFITS – STATE ACTIVE PROGRAM ONLY						
	Current	Option 1		Option 2		Option 3	
Medical		Bene	PMPM	Bene	PMPM	Bene	PMPM
Deductible (Sgl/Fam) – *Applies to services that do not have a copay*	$0	$50/ $100	$5.44	$0	-$0.13	$185/ $370	$20.37
DME[1] Coinsurance	80%	80%	N/A	80%	N/A	80%	N/A
Office Visit Copay – *Applies to all office & urgent care visits*	$0	$10	$11.41	$15	$15.28	N/A	N/A
Inpatient Copay per Admit	$0	$125	$0.79	$100	$0.63	N/A	N/A
Outpatient Surgery Copay	$0	N/A	N/A	$50	$1.76	N/A	N/A
Radiology Copay – *Applies to outpatient radiology (excludes standard x-rays)*	$0	$50	$2.64	$50	$2.64	N/A	N/A
ER Copay - *Applies even after out of pocket (OOP) is met*	$60	$75	$0.57	$75	$0.57	$75	$0.57
DME/Medical/Durable Diabetic OOP – *Maximum member cost of covered items*	$500	N/A	N/A	N/A	N/A	N/A	N/A
OOP Max[2] (Sgl/Fam) – *Medical services only; copays do not apply*	$500[3]	$500/ $1000	N/A	$250/ $500	N/A	N/A	N/A
SAVINGS	**N/A**	**--**	**$20.84**	**--**	**$20.74**	**--**	**$20.93**

[1] Durable Medical Equipment (DME) benefits include medical supplies, durable diabetic equipment and supplies, cochlear implants (covered at 100% for children), and hearing aids (up to $1,000 per aid every three years for adults, covered at 100% for children). This does not apply to the Standard Plan.
[2] Benefits for Hearing Aids and nonsurgical treatment of Temporomandibular Disorders (TMD) have dollar limitations that apply, even after the OOP is met. Copayments also continue to apply after the OOP is met.
[3] OOP is per participant. The following benefits currently do not apply to the OOP: ER Copay, Hearing Aids, and Cochlear Implants. This does not apply to the Standard Plan.

	Current	Option 1	Option 2	Option 3
Pharmacy				
Copays (Level 1/2/3)	$5/$15/$35	$5/$20/$40	$5/$20/$40	$5/$20/$40
Annual Pharmacy OOP Max[4] (Sgl/Fam)	$410/$820	$1,000/$2,000	$1,000/$2,000	$1,000/$2,000
SAVINGS	**N/A**	**$2.96**	**$2.96**	**$2.96**
Eliminate PPIs & NSAs coverage	N/A	$1.20	$1.20	$1.20
Mandatory 90-day retail or mail order	N/A	$3.71	$3.71	$3.71
Tablet-splitting w/opt out	N/A	$1.00	$1.00	$1.00
Mandatory specialty program	N/A	$0.36	$0.36	$0.36
SAVINGS	**N/A**	**$6.27**	**$6.27**	**$6.27**
Contractual/Administrative				
Eliminate 2-mo run-out for termed/retiring employees	NO	YES	YES	YES
18 mo max for COBRA	NO	YES	YES	YES
SAVINGS	**N/A**	**$3.00**	**$3.00**	**$3.00**
Potential Benefit Additions				
Palliative Care Consult	N/A	($0.05 - $0.10)	($0.05 - $0.10)	($0.05 - $0.10)
Dental Implants – up to $1,000/ tooth	N/A	($0.24)	($0.24)	($0.24)
COST	**N/A**	**($0.32)**	**($0.32)**	**($0.32)**
TOTALS *(Medical, Pharmacy & Contractual/Admin Changes less Benefit Additions)*				
TOTAL SAVINGS[5]	N/A	$32.77	$32.66	$32.85
% SAVINGS	N/A	5.06%	5.04%	5.07%
TOTAL OOP *Medical & Pharmacy*[6]	$910/$1320	$1,500/$3,000	$1,250/$2,500	$1,185/$2,370

[4] Prescriptions in Level 3 do not apply to the OOP.
[5] This may be impacted by the Board's assessment of mental health parity.
[6] Medical copayments continue to apply after the medical OOP is met.

All of the options listed above include reductions in medical and pharmacy benefits, along with eligibility changes. If the Board wishes to consider changes to the medical plan only, it could be accomplished with:

- $300/$600 upfront deductible, or
- $100/$200 upfront deductible; copayments on the following services: $20 office visit ($20), inpatient admit ($200), and outpatient surgery ($100); increasing the emergency room copayment to $100; and increasing the DME OOP to $1,000/$2,000.

CONSIDERATIONS:

- Changes Apply to All Plans: It is our interpretation that the intent of the law is to make changes to all of the plans in all of the tiers. If we were to take a more narrow interpretation of the language -- that it requires changes to Tier 1 plans only -- it would subject plans in Tiers 1 and 2 to significant adverse selection and ultimately would diminish the effects of the benefit changes. Comparable changes will apply to the Standard Plan in-network benefits.

- Copayments: The law requires copayments to be part of the program's health care coverage for 2012 -- although copayments on prescription drugs and emergency room care are already in place. Therefore, health care coverage with no additional copayments could still be considered in compliance.

    - If office copayments are implemented, it could potentially drive some care to an outpatient setting, if there is no similar member liability.

- Impact on Health Care Utilization: The options shown above affect participants differently. A deductible affects all participants, including those who are infrequent users of health care. A copayment has a greater impact on those who more frequently utilize health care, such as individuals with chronic conditions. Some studies suggest that a modest copayment, such as $15, leads to improvement in care because the participant is more vested, while excessive copayments can be a disincentive to get needed care. Depending on the service provided, $15-$30 copayments are common throughout the industry.

- OOP Impact: Due to health plan system limitations and commercial plan design conventions, copayments do not apply to the OOP and continue to be assessed after the OOP is met. Options 1 and 2 have greater OOP and therefore, a greater impact on participants, especially those who are high utilizers.

- Preventive Services: With the relinquishment of grandfather status for State employees due to the decrease in employer contribution share, preventive services as required under the federal Patient Protection and Affordable Care Act are payable at first dollar and will not have a deductible, coinsurance or copayment applied. Local employees relinquished grandfathering effective January 1, 2011.

- Health Plan Administration: Health plans have various administrative capabilities and the options shown are believed to be administratively possible, based on input from the health plans.

- Comparability: Board members may wish to know how the proposed benefits compare to other public employers and health plans' commercial book of business. Below is a brief comparison of benefits, based on input from health plans and information collected from benefit booklets that are available online. Please note that these options may not fully describe all offerings available to employees but are viewed as representative of the breadth of their offering.

Employer	Medical				Pharmacy	
	Deductible	Co-insurance	Copays	OOP	Copays	OOP
Dane County – HMO Plan	$0	80% - DME	$25 – ER	None	$6 / $10	None
Milwaukee County – HMO Plan	$500 / $1500	100%	$20 – OV $150 - ER	None	$5 $30 $50	None
Brown County – PPO Plan	$50 / $150	100% 80% -DME & UC after ded	$15 – OV $50 – ER	$600/ $1,800	20% 25% 25% + $15	$1,000 / member
Marathon County – PPO Plan	$300 / $900	90%	90% after deductible	$650/ $1900	0% 15% 15% + $15	$400 / $800
Commercial Book of Business - *Common Benefits*	Sgl: $500 - $2,000 Fam: $1,000 - $4,000	80%	$25/$35 - OV $100 - ER	Sgl: $1,500 - $3,000 Fam: $3,000 - $6,000	N/A	N/A

- Administrative Efficiencies: Three of the possible changes to prescription drugs do not reduce benefits. Instead, they change the point-of-service. The mandatory specialty program requires the use of Navitus mail order specialty drug vendor (as opposed to a local retail outlet). There are additional tablet-splitting opportunities. Tablet-splitting is a program that provides participants the opportunity to split a double dosage in half, thus, requiring only half the number of pills to be purchased for a 30-day supply.

- Health Risk Assessments (HRA): As explained in the Guidelines and Uniform Benefits memo, a recommended contract change for 2012 is to require health plans to have HRAs available for participants. This did not include offering any incentives, such as

copayments or other cost-sharing reductions. Health plans indicate that HRA response rates are extremely low if there are no incentives for taking the HRA. In addition, employers typically offer the incentives because they realize the benefits of HRA participation, such as reduced absenteeism and increased productivity.

- Employee Reimbursement Account (ERA): Traditionally, the benefit plan has made it relatively easy for state employees to determine the amount to set aside to cover their expected cost-sharing for eligible expenses. A benefit plan that does not have a fixed OOP maximum may make it more challenging for employees to estimate their cost-sharing amounts.

- Optional Dental Benefits: Please note that none of these options include eliminating the optional dental benefits that health plans currently provide because the dental benefits are not viewed to be part of the medical benefit.

- Medicare Retirees: The Board will have to determine the benefits that will be made available to retirees on Medicare. The current benefits are comparable to individual Medicare supplement policies that typically have no cost sharing. The Board should note that the changes proposed herein for active employees will have a different financial impact when applied to the Medicare population. For example, the proposed changes would account for more than a 5% benefit value change overall.

- Early Retiree Reimbursement Program (ERRP): The State has received ERRP dollars. The federal requirements pertaining to this program stipulate that these dollars cannot be inappropriately used to reduce employer health insurance costs. As a result, depending upon the ultimate effect of premiums negotiated and benefit changes, the dollars received from ERRP may need to be applied to reserves.

- Standard Plan: ETF and Wisconsin Physicians Service (WPS) have been investigating contract language to clarify areas in the contract that the third party audit of the program identified as ambiguous. Staff intends to bring these language changes to the Board at a later meeting when Act 10 changes are adopted.

- Participant Input: The study group has not solicited input from participants on benefit plan changes, recognizing the sensitive nature of the topic at this time.

EMPLOYER CONTRIBUTIONS and TIERING:

Act 10 changes the existing law regarding employer and employee contributions for the State group health insurance program offered by the Board. Currently, employees pay about 6% of the weighted average of the health insurance premium for a tier 1 plan, that is, a plan that has been determined to be efficient and low cost. The dollar amount of employee contribution is determined by the Office of State Employment Relations (OSER). Act 10 contains several areas that address how contributions will change. First, Act 10 specifies the amount employees will pay for tier 1 plans in 2011 under section 9115, Nonstatutory provisions; Employee Trust Funds, which reads:

"(1) STATE EMPLOYEE HEALTH CARE COVERAGE.

(a) Notwithstanding section 40.05 (4) (ag) and (c) of the statutes, as affected by this act, beginning with health insurance premiums paid in April 2011, and ending with coverage for December 2011, all of the following shall apply:

1. Employees covered under section 40.05 (4) (ag) 2. of the statutes, as affected by this act, shall pay $84 a month for individual coverage and $208 a month for family coverage for health care coverage under any plan offered in the tier with the lowest employee premium cost under section 40.51 (6) of the statutes; $122 a month for individual coverage and $307 a month for family coverage for health care coverage under any plan offered in the tier with the next lowest employee premium cost under section 40.51 (6) of the statutes; and $226 a month for individual coverage and $567 a month for family coverage for health care coverage under any plan offered in the tier with the highest employee premium cost under section 40.51 (6) of the statutes."

The monthly dollar amounts specified in the Act of $82 for single coverage and $208 for family coverage equate to an employer contribution that is 88% of the weighted average cost for the tier 1 health plans. Then, under Section 77, the statute 40.05 (4) (ag) 2. is changed so that in future years, the State will not pay an amount more than 88% of the average premium cost for tier 1 plans. Act 10 reads:

"SECTION 77. 40.05 (4) (ag) of the statutes is repealed and recreated to read:
40.05 (4) (ag) Except as otherwise provided in a collective bargaining agreement under subch. V of ch. 111, the employer shall pay for its currently employed insured employees:

1. *For insured part-time employees other than employees specified in s. 40.02 (25) (b) 2., including those in project positions as defined in s. 230.27 (1), who are appointed to work less than 1,566 hours per year, an amount determined annually by the director of the office of state employment relations.*
2. *For eligible employees not specified in subd. 1. and s. 40.02 (25) (b) 2., an amount not more than 88 percent of the average premium cost of plans offered in the tier with the lowest employee premium cost (emphasis added) under s. 40.51 (6). Annually, the director of the office of state employment relations shall establish the amount that the employer is required to pay under this subdivision."*

This statutory change can be implemented using existing procedures whereby ETF first establishes the weighted average of the health plans and then OSER applies the appropriate percentage threshold. This will maintain the levels set forth in the Act.

Staff will be available at the Board meeting to respond to any questions or concerns. We again thank the study group members for their participation in this process.