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# *CORRESPONDENCE MEMORANDUM*

**DATE:** April 4, 2014

**TO:** Group Insurance Board Strategic Planning Workgroup

**FROM:** Lisa Ellinger, Administrator, Division of Insurance Services

**SUBJECT:** Strategic Planning Update

**This memo is for informational purposes only. No action is required.**

Department of Employee Trust Funds (ETF) insurance program staff initiated a formal, structured strategic planning process in late 2013. The objective of this effort is to draft a long-term strategic plan for our insurance programs to bring to the Group Insurance Board (Board) and its Strategic Planning Workgroup (Workgroup) for consideration and feedback this spring. Please see the attached report on this topic.

**Staff will be at the meeting to provide an overview of the report and answer any questions.**

Attachment: Strategic Insurance Initiatives

Reviewed and approved by Robert J. Marchant, Deputy Secretary

Electronically Signed:
04/07/14

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| GIBSPW | 4.16.14 | 4A |

DRAFT

# Strategic Insurance Initiatives

## Group Insurance Board Strategic Planning Workgroup

## 04/04/2014

| Board | Mtg Date | Item # |
|---|---|---|
| GIBSPW | 4/16/14 | 4A Attachment |

## Executive Summary

Department of Employee Trust Funds (ETF) insurance policy program staff initiated a formal, structured strategic planning process in late 2013. The primary deliverable for this effort is a draft long-term strategic plan for our insurance programs to bring to the Group Insurance Board (Board) and its Strategic Planning Workgroup (Workgroup) for consideration and feedback in 2014. This strategic plan has been created in a manner that ensures alignment with ETF's overall strategic plan and the agency's Transformation, Integration, and Modernization initiative.

To guide this effort, staff referred to ETF's Mission Statement and statutorily-defined creation and purpose. Staff also outlined the objective of our strategic planning work, and collectively developed statements of our mission, vision and goals. These statements and definitions follow below for the reader's reference.

### ETF Mission Statement

To develop and deliver quality benefits and services to our customers while safeguarding the integrity of the Trust.

### Wis. Stat. 40.01(1) Creation and Purpose

A "public employee trust fund" is created to aid public employees in protecting themselves and their beneficiaries against the financial hardships of old age, disability, death, illness and accident, thereby promoting economy and efficiency in public service by facilitating the attraction and retention of competent employees, by enhancing employee morale, by providing for the orderly and humane departure from service of employees no longer able to perform their duties effectively, by establishing equitable benefit standards throughout public employment, by achieving administrative expense savings and by facilitating transfer of personnel between public employers.

### Strategic Planning Objective

To undertake a collaborative strategic planning process involving the state, as an employer; ETF, as an administrator; the Group Insurance Board; and others, as appropriate, to define the strategic mission, vision and goals that will guide the future design and administration of the employee benefit plans administered by ETF and to identify concrete, measurable objectives toward achieving the strategic mission, vision and goals.

### Health Benefits and Insurance Plans Bureau (Bureau) Mission

To develop, deliver and communicate insurance benefits that maximize quality and value.

### Bureau Vision

In the next five years, pursuant to the guidance of the Group Insurance Board, we will engage our members, employers, Board, and vendors in a partnership to collectively improve the quality and value of our insurance benefits. We will achieve our vision through the following goals:

Goals:

- **Maximize Quality and Value** by strategically using, improving, expanding, and communicating data and metrics to inform evidence-based, forward-thinking decision making at all levels.
- **Contain Costs** by proactively identifying program efficiencies and targeting sustainable program costs for our employers and members, while maintaining quality benefits.
- **Improve Health and Wellness** by designing life enhancing benefits that are responsive to our members' needs.
- **Engage and Educate our Members and Employers** with the information needed to maximize the efficient, appropriate utilization of insurance benefits and services.
- **Deliver Benefits that Enable Public Employers to Attract and Retain a Quality Workforce** by providing a competitive benefits package.
- **Model Administrative Innovation** by continuously supporting the development and expansion of insurance policy expertise to keep current with industry trends and proactively identify potential opportunities.

Staff identified the priority program areas that most strongly support these goals. Those priority areas, and the location of their discussion in this report, are as follows:



Report Organization

Staff are developing detailed work plans to outline a five-year strategic approach to analyze, research and implement initiatives related to the priority topics listed above. This report is an abbreviated version of the staff work plans. Each topic addressed in this report covers the following:

- The ETF staff who will lead the effort.
- Objectives: Description of the desired outcome.
- How the objectives support the mission, vision and goals.

- Current State: Description of current and past efforts related to this objective.
- Next Steps: Specific list of short-term steps planned to pursue the objective.
- Measures of Success: Specific deliverables or metrics to evaluate success and guide the evolution of the work plan.

The more extensive staff work plans also highlight internal collaboration, stakeholders, resource needs and a longer-term timeline.

The key deliverables for each of these initiatives during the remainder of 2014 are:

- Data & Measurement
  - Identify our uses for performance measurement and unit(s) of analysis.
  - Determine a set of measures and prioritize them on importance to measure for each purpose and unit of analysis.
  - Identify the data elements and sets needed to calculate each measure.
  - Finalize a plan to: a) procure data and pre-computed results, b) test the data, c) calculate the measures, and d) test the measure results.
- Data Warehousing
  - Fully identify the data resources presently used by Bureau staff and those that would be used if access was made readily available.
  - Obtain and/or create a “data dictionary,” or a repository of information about the data within each data resource.
  - Catalogue the uses and desired uses of each data warehouse.
- Steerage Models: Reference Value/Pricing, Centers of Excellence, Tiering
  - Determine elective episodes of care which may be good candidates for steering members to regional Centers of Excellence.
  - Build reporting requirements related to the identified episodes of care into the contracts to collect sufficient baseline data to assist in monitoring success of the intervention.
- Disease Management
  - Create details of an expanded Shared Decision Making (SDM) program and select metrics to monitor outcomes.
  - Create details of an Advance Care Planning (ACP) program, and select metrics to monitor outcomes.
- Wellness
  - Analyze the concept of providing a wellness program through a single third party administrator, rather than through individual health plans.
  - Analyze implementing premium differentials or credits based on wellness program participation.
  - Continue researching other wellness programs, both in the private and public sector, to identify program elements that would be the most cost effective and successful in Wisconsin.
- Member Education / Communication / Engagement
  - The communications plan related to the High Deductible Health Plan and Health Savings Account is the top priority for 2014.
- Pharmacy and Specialty Pharmacy
  - Discuss expanding Specialty Pharmacy network options.

    - Develop a baseline of cost and utilization for both medical and retail specialty.
    - Develop initiatives to identify and measure quality outcome metrics including clinical outcomes and patient satisfaction.
    - Hold a Specialty Drug Symposium in fall 2014 with participating health plans.
    - Pursue cost reduction strategies through care management and price negotiations with insurers and providers.
- Annual Health Insurance Negotiations / Consumer Driven Health Care Design
    - Identify gaps or suspected missing data in health plan data submissions.
    - Negotiate CPI-level tier 1 premium rate increases.
    - Continue discussions with other states and participating health plans regarding a two-year health plan contract.
    - Complete design of a high deductible health plan and HAS for 2015.
- Affordable Care Act Impacts
    - Develop recommendation for the Board on Maximum out-of-pocket calculations.
    - Work with other state agencies to examine policy considerations related to “pay or play” provisions.
    - Monitor federal guidance on how the value of a program will be calculated for the “Cadillac Tax” threshold.
    - Monitoring the development and participation in the Exchanges/Marketplace.
- Dental Coverage
    - Explore self-insured and fully-insured models, estimation of cost, benefit structures, and determine what administrative requirements should be applied to a stand-alone dental model.
- Spousal / Domestic Partner Coverage Options and Opt-Outs
    - Work with the Board’s consulting actuary to complete actuarial analysis of options and develop a report for the Governor and the Joint Finance Committee by June 30, 2014.
- Optional Guidelines Update
    - Work with the insurance industry and the Office of Commissioner of Insurance (OCI) to establish standards of quality for LTC insurance policies.
- Telehealth
    - Investigate the current research on telehealth cost savings and impacts on outcomes.
    - Collaborate with other state agencies to investigate the potential cost savings and access improvements in telehealth.
    - Survey health plans to better understand current provision and breadth of available telehealth services.

The crucial next step in this process is to gather Board and Workgroup input on this report. As stated above in the Bureau Vision statement, the goal is to pursue the identified objectives under the guidance of the Board. Board review and feedback will ensure that staff are focusing our time and effort on the areas that are the top priorities of the Board.

**Strategic Initiative 1**
**Data & Measurement**
**Lead ETF Staff: John Bott**

## Objectives

- More members access health care from ETF-designated, higher-value providers.
- Members experience less potentially preventable adverse health events, compared to the trend.
- The State of Wisconsin experiences health care cost reduction, compared to the trend.

## How the objectives support the mission, vision and goals

The objectives focus on measuring and obtaining value in health care services for our members, where "value" is based on quality and cost.

## Current State

Health plans: Measurement results and data ETF presently receives from participating health plans include HEDIS, CAHPS and grievances. These measures are used for the current health plan tiering process, but are not sufficient to provide our members meaningful information to make health care decisions based on value. More broadly, there are measures that can be applied to the health plan level that are superior. In regard to data to support these measures, the quality of the Wisconsin Health Information Organization (WHIO) data needs further examination. While most participating health plans submit data to WHIO, several do not.

Hospitals: The most advanced measures are at the hospital level. The quality of existing data can support a number of these measures. Hospital measurement is new ground for ETF. To date, ETF has yet to procure any such hospital data set and we have not comparatively measured hospital performance. Currently, the Statewide Value Committee (SVC) is working to establish common measures for accountability. Since this measurement development began in August 2012, the SVC has "endorsed" only six measures. While some are useful measures, the set is too small at this time to responsibly make statements about value.

Physicians: ETF has yet to comparatively measure physician performance at the individual, clinic or group level. In Wisconsin, measurement for accountability has occurred at the group and clinic level, via the Wisconsin Collaborative for Healthcare Quality (WCHQ). WHIO also plans to release a public report of clinic performance in 2014. While WHIO is a potential data source for physician-level measurement, it needs further examination to determine if the data quality is sufficient to compute meaningful measures. Again, the SVC has yet to endorse an adequate measure set to responsibly make statements about physician value.

## Next Steps

The following are the key steps for 2014:

- Identify our uses for performance measurement and unit(s) of analysis.

- Determine a set of measures and prioritize them on importance to measure for each purpose and unit of analysis. This step also involves addressing how they are to be computed (e.g., composites).
- Identify the data elements and sets needed to calculate each measure. This step appreciates the caveat that some measures may have pre-computed results.
- Finalize a plan to: a) procure data and pre-computed results, b) test the data, c) calculate the measures, and d) test the measure results.

## Measures of Success

Members choose value

- More than 50% of members' access health care from ETF-designated, higher-value providers by the end of the second year of implementation of the given project (i.e., tiering, reference value).
- More than 75% of members access health care from ETF-designated, higher-value providers by the end of the third year of implementation of the given project.

Members receive higher quality care

- Members experience 25% less potentially-preventable adverse health events* compared to the trend by the end of the second year of implementation of the given project.
- Members experience 33% less potentially-preventable adverse health events compared to the trend by the end of the third year of implementation of the given project.

The State realizes savings

- The State of Wisconsin experiences a 15% health care cost reduction** compared to the trend by the end of the second year of implementation of the given project.
- The State of Wisconsin experiences a 25% health care cost reduction compared to the trend by the end of the third year of implementation of the given project.

*The types of "adverse events" will consist of the outcome measures used in gauging value in the given project.
**Cost reduction related to the given project. For example, employing reference value for procedure X: State realizes a 15% cost reduction for procedure X.

**Strategic Initiative 2**
**Data Warehousing**
**Lead ETF Staff: John Bott**

## Objectives

- Improve ETF's understanding of the insurance services and benefits used by members and employers by enabling better analysis through an aggregated view into the currently disparate data warehouses.
- Reduce time expended by staff in creating "workarounds," given the present state that data warehouses operate in silos.
- Staff can better analyze and understand the insurance services and benefits used by members and employers over time.

## How the objectives support the mission, vision & goals

The mission states: *"develop [and] deliver…insurance benefits that maximize quality and value".* If we are to adhere to this we need to effectively use the data we have to evaluate various attributes of these benefits if we are to ensure and improve their value.

The above objectives specifically address maximizing quality and value. The objectives are closely related to the stated goal of containing costs. More peripherally, they are also related to the goal of engagement and education of our members and employers.

## Current State

Presently, we have data warehouses, databases, and data collection efforts that were created for, and serve, a given function. To perform projects and conduct analysis beyond what the data sources were conceived to do (e.g., draw on/combine two or more data sources) are either inefficient to perform or simply not possible. This is due to the fact that using data for a use it was not intended for requires manual compilation and analysis in Excel or Access.

This present state is well understood by ETF and change is afoot. In the years ahead, ETF will be analyzing data warehousing and analytics needs as part of the TIM and Benefits Administration System (BAS) implementation efforts.

## Next Steps

As noted above, the project will be developed in parallel with the larger TIM and BAS initiatives that will be implemented at ETF over the next several years. The following are estimated next steps in the first year, as well as years two through five:

- Develop a work plan and implement Year 1 tasks;
- Fully identify the data warehouses presently used by Bureau staff and those that would be used if access was made readily available.
- Obtain and/or create a "data dictionary," or a repository of information about the data within each data resource identified from task #1 immediately above.
- Catalogue the uses and desired uses of each data warehouse: standalone data warehouses and if two or more were linked.

**Measures of Success**

The section titled “Objectives” above states the primary objective as linking existing ETF data resources to gain efficiencies. Thus, the measures of success are based on the number or rate of ETF data warehouses Bureau staff identify as valuable to their work to connect.

**Strategic Initiative 3**
**Steerage Models: Reference Value/Pricing**
**Lead ETF Staff: Alternate Health Plan Program Manager**

## Objectives

- Determine if there is any elective episode of care for which, beginning in 2016, it would be advisable to use reference value/pricing as a way to steer members toward regional Centers of Excellence that offer the best value (i.e., quality and cost).

## How the objectives support the mission, vision and goals

- With sufficient price and quality information, reference value/pricing raises cost-awareness and empowers members to select low-price services provided at designated facilities, while maintaining high-quality outcomes.
- Reference value/pricing can lower cost by incentivizing providers to lower prices to maintain designated provider status.

## Current State

- Currently, there is no direct financial incentive for members to select low-price providers if providers are within the HMO or PPO network of providers.
- ETF is working with the Wisconsin Health Information Organization (WHIO) to access claims data to determine the top cost-drivers in the health insurance program. Once sufficient claims data can be accessed to determine cost-drivers and identify services with significant price variation, appropriate reference prices could be established.
- Research suggests that some enrollees may perceive a correlation between high price and high quality and be inclined to select high-price services.
- Health plans have the incentive to maintain good contracting relationships with providers, especially those hospitals whose absence would make a plan less attractive.
- Out-of-pocket maximums (MOOP) may apply only to in-network coverage. Consequently, plans could have an unlimited out-of-pocket maximum for out-of-network coverage. (Note: California Public Employees Retirement System awaits a decision from the federal government on this issue. Speculation is that out-of-pocket costs above a reference price would likely not be subject to the MOOP because members have the option to avoid these costs by selecting a designated facility.)

## Next Steps

- Gather the information necessary to determine how to proceed for 2016 and establish baseline information to permit analysis of the success of episode of care candidates at achieving policy objectives.
- Determine elective episodes of care which may be good candidates for steering members to regional Centers of Excellence.

- Build reporting requirements related to the identified episodes of care into the contracts so that ETF has sufficient information to determine how to proceed, and to collect sufficient baseline data to assist in monitoring success of the intervention.
- Identify other data sources and obtain relevant data so that ETF has sufficient information to determine how to proceed for 2016.

**Measures of Success**

- Quantitative Analysis
  - Cost savings to group health Insurance program
  - Savings to members in cost-sharing
  - Performance measures
    - Hospitals
    - Physicians
- Qualitative Analysis
  - Member satisfaction surveys
  - Grievance/complaint reporting

**Strategic Initiative 4**
**Disease Management**
**Lead at ETF: Dr. Tom Hirsch**

## Objectives

ETF will collaborate with the health plans to improve the likelihood that members and families experience health care that is:

- Evidence based
- Cost effective
- Consistent with a well-informed individual's preferences

## How the objectives support the mission, vision and goals

Expanding a shared decision making (SDM) program and requiring health plans to provide advanced care planning (ACP) programs will enhance the value of health insurance benefits by:

- Increasing quality: Well-informed members will select diagnostic testing and/or medical interventions that are consistent with their preferences, thereby increasing their satisfaction with their health care experience.
- Decreasing costs: Well-informed members will choose less aggressive (i.e., less costly) interventions approximately 20-25% of the time, whether for total joint replacement for advanced osteoarthritis, aggressive use of chemotherapy and/or hospitalization at the end of life.

## Current State

Based on the published literature, some patients accept diagnostic studies and/or treatments they would not have selected had they been better informed.

## Next Steps

- Monitor Guidelines Study Group buy-in.
- Develop standardized methodology with ETF staff so that health plans can accurately determine that an ETF member or beneficiary deceased during a specified time period.
- Create details of an expanded SDM program.
- Create details of an ACP program.
- Select metrics to monitor outcomes for the SDM and ACP programs.
- Submit benefit design and metrics to the health plans for feedback.
- Request GIB support to expand the SDM program and to require an ACP program for January 1, 2015.
- Create draft guidance for SDM expansion and creation of an ACP program and submit to the health plans for their final feedback.
- Create final guidance for SDM expansion and ACP program creation and submit to health plans

- Health plans inform ETF of their protocols to comply with ETF requirements for expanded SDM and ACP programs to go live January 1, 2015.

**Measures of success**
Metrics will be developed and vetted through the process described above.

**Strategic Initiative 5**
**Wellness**
**Lead ETF Staff: Sarah Bradley**

## Objectives

- The short-term 2014 objective for the wellness work plan is to increase overall participation in the $150 wellness incentive, targeting a 30% increase over the 2013 participation level.
- The long-term objective is to launch a robust, multi-phased workplace wellness program in 2016 that would increase the number of employee opportunities to engage in a healthy lifestyle, both at work and outside of work, and decrease health care and disability costs.

## How the objectives support the mission, vision and goals

A robust wellness program supports all aspects of the mission, vision and goals through its potential to impact cost, encourage member engagement, enhance the existing insurance benefits and provide an opportunity for modeling administrative innovation.

## Current State

The 2014 contract established a uniform basic wellness incentive for all health plans. Adults can receive a $150 incentive for completing a biometric screening and Health Risk Assessment (HRA). There will be greater access to workplace biometric screenings in 2014, due to the Department of Administration (DOA) contract with Optum for statewide workplace biometric screening. Several health plans also offer additional services and discounts related to wellness. However, engagement and follow up with individuals by the health plans based on the screening results is inconsistent. DOA is also in the process of determining how taxability of the $150 incentive will be handled by the employer.

## Next Steps

The ETF Guidelines Study Group (Study Group) is set to consider two issues related to wellness in March and April, 2014:

- First, the group will discuss the concept of providing a wellness program through a single third party administrator (TPA), rather than through individual health plans.
- Second, the Study Group will discuss whether a recommendation should be made to the Office of State Employment Relations (OSER) to implement premium differentials or credits based on wellness program participation.

ETF will continue researching other wellness programs, both in the private and public sector, to identify program elements that would be the most cost effective and successful in Wisconsin.

Both cost and program delivery analysis will be conducted to determine the pros and cons of moving administration of a wellness program from the individual health plans to a single vendor/TPA. This research will be provided to DOA and its wellness coordinator and the Study Group to help develop informed recommendations for the Board and the Workgroup, as appropriate.

Other activities planned for 2014 include:

- Continue to support DOA in promoting and fully utilizing the Optum biometric screening contract statewide.
- Continue to improve and expand employer and employee/member wellness communications from ETF, DOA, and health plans.
- Identify opportunities to offer additional wellness services and interventions at biometric screenings and after members complete the HRA. Evaluate whether the Optum contract could be expanded to offer these services.
- Gather data on: highest-impact programs, successful programs in other states, 2013 and 2014 baseline participation, and HRA data from health plans.
- Coordinate with other ETF Division of Insurance Services surveys to collect input from employees and employers regarding wellness program offerings.
- Finalize communication plans about the taxability of incentives for 2014 and beyond. Include communication plan for payroll council, employers, and employees.
- Determine how a benefit consultant could assist with developing wellness programs.
- Evaluate advantages and disadvantages of TPA for wellness program administration.

**Measures of Success**

- Increased participation in $150 incentive by 30%, primarily due to increased accessibility to biometric screenings being conducted by one vendor rather than individual health plans.
- A 25% increase in employer and employee communication regarding the current wellness program.
- Minimal communication delays for taxability issue and potential impact on 2015 premiums.

**Strategic Initiative 6**
**Member Education/Communication / Engagement**
**Lead ETF Staff: Tara Pray**

## Objectives

To effectively communicate and provide education to our members on important aspects of their health benefits and insurance plans, so that they:

- Understand changes and new offerings related to their health benefits;
- Can make the best decisions for themselves and their families when choosing their health benefits; and
- Can utilize their health benefits effectively.

## How the objectives support the mission, vision and goals

This objective primarily supports the goal of engaging and educating our members. This effort also supports the goal of maximizing quality and value. By effectively educating and engaging our members, members will make better informed decisions about their health care and choose health care options that are high in quality and value.

## Current State

Currently the communication plan related to health benefits and insurance plans is primarily limited to the written materials produced surrounding the fall enrollment period. ETF's efforts to communicate with members about health benefits are not current with the most modern methods and formats that many people are accustomed to receiving -- such as frequent e-mails with bits of important information, short web videos, interactive web materials and messages delivered via social media.

The most comprehensive information is provided each fall during the It's Your Choice (open enrollment) period. While the information is robust and comprehensive in the booklets, we have received feedback that they are cumbersome, not user friendly and benefit changes are not readily apparent. Revamping the IYC materials is a part of this strategic planning effort.

The major effort related to member communication and education for 2014 will be the roll out and promotion of the new High Deductible Health Plan (HDHP) and Health Savings Account (HSA) offerings. The communications related to these new benefits will be the priority efforts in 2014 and 2015. We plan to treat this effort as a pilot and apply our "lessons learned" to other communication and education efforts.

## Next Steps

The communications plan related to the HDHP and HSA (and potentially a limited medical flexible spending account) is the first major initiative in 2014. That plan is being developed this spring. Additional planned activities include:

- Establish a communications Workgroup;
- Create detailed 5 year communication and education plan; and
- Work with ETF Communications Office staff on Division of Insurance Services-related communication offerings.

**Measures of Success**

Determining measures of success will be a charge of the communications Workgroup. Metrics for discussion will include the following:

- 5% of subscribers choose HDHP / HSA offering.
- 10% of subscribers viewed an online video.
- 50% of employers participate in each webinar.
- 5% reduction in calls to Call Center from members needing clarification on health benefits.
- 80% of surveyed University of Wisconsin (UW) subscribers feel they have all the information they need to make an informed decision about choosing their health benefits. UW is currently the only employer that conducts an Annual Benefit Enrollment Survey.

**Strategic Initiative 7**
**Pharmacy**
**Lead ETF Staff: Jeff Bogardus**

## Objectives

- Working in conjunction with the Specialty Pharmacy work plan, explore expanding our preferred specialty pharmacy network to include multiple specialty pharmacies or integrated specialty care groups/organizations.
- Explore appropriate opportunities to reduce drug costs under the medical benefit; ensure steerage of care to most cost-effective site of care.
- Through a combination of (a) pharmacy network and formulary management; (b) a reduction in the member contribution for generic medications; and (c) medication therapy management (MTM) and clinical programs provided by the Pharmacy Benefit Manager (PBM), increase the medication adherence under appropriate medical guidelines for chronic conditions that include Diabetes, Hyperlipidemia, Asthma and Hypertension.

## How the objectives support the mission, vision and goals

All objectives support the mission and vision to -- in partnership with members, employers, Board, and vendors -- develop, deliver and communicate insurance benefits that maximize quality and value. Each of the objectives will analyze the current delivery of benefits and whether there are ways to improve service delivery and quality. The third objective aims to improve the health and wellness of our members by increasing the likelihood of adherence to prescribed treatments with easy access to pharmacy treatments with proven efficacy.

## Current State

### Specialty Pharmacy Network

The Board's PBM, currently Navitus Health Solutions, LLC (Navitus) provides the SpecialtyRx program to the State and WPE programs' members. The SpecialtyRx program utilizes a preferred specialty pharmacy, Diplomat Specialty Pharmacy (Diplomat). Diplomat provides an extensive array of services for members who use specialty medications, which includes clinical management services for the member, in coordination with their provider. By ensuring effective interaction between the member's provider and the specialty pharmacy, the program makes certain that members have the medications they need on a timely basis, and that they are taking them appropriately and avoiding adverse reactions that may be caused by conflicting medications.

Members are incentivized to participate in the SpecialtyRx program and utilize Diplomat by being provided with a lower copayment. While participation in the Specialty Rx program is encouraged, members can still obtain specialty medications at any in-network pharmacy that has access to the drug. The copayment for specialty medications when the member utilizes a pharmacy other than Diplomat is $50, as of January 1, 2013.

Medical Benefit Drug Claims

Costs for prescription drugs dispensed and administered in hospital facilities can be as much as ten times higher than the costs for the same drugs dispensed through a network pharmacy.

Instances where non-covered drugs are dispensed by the doctor in a medical facility and the claim is processed through the medical benefits circumvents the State and WPE programs' and the PBM's efforts aimed at controlling the costs of prescription drugs by providing value and efficacy to the drugs made available on the formulary.

Increase Medication Adherence for Certain Chronic Conditions

Following are the programs currently implemented by Navitus for the State and WPE programs:

- Cost Savings programs
    - Lower Cost Rx + Generic Alternative
    - RxCents Tablet Splitting
    - Dose Consolidation
    - Controlled Substance Monitoring Repeat Alerts
    - Atypical Antipsychotic Duplicate Therapy
    - Retrospective Opioid Overutilization Program
    - Quality Improvement Programs (Metformin Pharmacoadherence, Asthma Management)

- Available Clinical Programs
    - Value-Based Benefit Design – Diabetes
    - Asthma Management Program
    - Pharmacoadherence Program (member non-adherence)
    - Pharmacy Care Incentives (member education)
    - Prescriber Insights (prescriber behaviors)

- Medication Therapy Management
- Health-related programs
    - Controlled Substance Monitoring
    - Expanded Fraud, Waste & Abuse
    - Multi-Prescriber/Multi-Prescription
    - Duplicate Therapy

**Next Steps**

- Discuss expanding Specialty Pharmacy network.
- Facilitate meeting integrated specialty care organizations and groups.
- Medical Benefit Drug Claims -- Research Uniform Benefits and Guidelines for potential exclusions.
- Conduct a Gap analysis for all objectives.

**Measures of Success**

- Reduced drug spend;
- Improved member adherence; and
- Improved member health status.

**Strategic Initiative 8**
**Specialty Pharmacy**
**Lead ETF Staff: Bill Kox**

## Objectives

Improve quality and outcomes measurement and reduce specialty drug cost increase trend to the overall average cost trend.

## How the objectives support the mission, vision and goals

- Maximizes quality and value by ensuring that high-cost specialty drugs are used appropriately to achieve optimal clinical results and improved member satisfaction.
- Contains cost by developing purchasing strategies such as capitation agreements and other global payment strategies that encourage efficient use of specialty drugs.
- Improves health and wellness by ensuring that specialty drugs will be used where they are most effective.

## Current State

Specialty drugs are currently the fastest growing category of spend in our program. The pharmacy benefit program alone increased 100% from 2009 to 2012 ($27 million to $53 million). Nationwide estimates suggest that by 2017 specialty pharmacy will increase from the current 20% to 50% of total retail drug spend. Navitus estimates that our program is on track to reach 45% of drug spend by 2016. These figures do not include specialty medical drug costs.

The current environment provides the impetus for these trends. Pharmaceutical manufacturers have shifted their business models to increasingly concentrate on the development of specialty drugs due to their profitability and general lack of competition from generic or other patented formulations.

While some of these treatments will partially supplant current medical therapies in areas such as oncology, overall treatment costs are likely to increase. Food and Drug Administration (FDA) clinical trial research suggests that efficacy varies greatly; for example, certain Hepatitis C drugs offer substantially improved treatment outcomes for targeted patients, while certain oncology drugs may offer only limited therapeutic value.

Thus far, Navitus appears to have achieved some success in controlling specialty drug cost increases. For example, in 2012 the Board provided Navitus with requested contractual incentives for participants to select its contracted specialty pharmacy. However, several large medical and pharmacy groups indicate they can match these cost savings, while providing better case management, lower risk of complications, fewer treatment delays, higher quality of care, and better patient outcomes. Staff is awaiting supporting information and documentation from the Pharmacy Society of Wisconsin

## Next Steps

- Obtain Board approval for listing the FDA indications approved by the Navitus Pharmacy and Therapeutics committee in the Uniform Benefits Certificate.
- Develop a baseline of cost and utilization for both medical and retail specialty.
- Develop initiatives to identify and measure quality outcome metrics including clinical outcomes and patient satisfaction.
- Hold a Specialty Drug Symposium in fall 2014 with participating health plans to identify the current best practices for managing specialty drug use and measuring clinical and quality of life improvement.
- Pursue cost reduction strategies through care management and price negotiations with insurers and providers.

## Measures of Success

It will likely take several years or more to integrate quality reporting, case management, and cost reduction strategies. Metrics will need to be developed for Cost and Quality.

Cost Metrics include:

- Total specialty drug spend,
- Identification of specialty drug trend and trend drivers, and proportion to medical and balance of prescription drug spending,
- Number of members affected overall, and by disease state, health plan, national and state public sector benchmarks.

Quality metrics will include:

- Patient satisfaction measures,
- Clinical outcomes measures reported by health plan and provider group.

**Strategic Initiative 9**
**Annual Health Insurance Negotiation Process /**
**Consumer Driven Health Care Design**
**Lead ETF Staff: Mary Statz**

## Objectives

- Develop and finalize pricing for the High Deductible Health Plan (HDHP).
- Audit the "Addendum 1" data submitted by the health plans.
- Maintain health insurance premium increases aligned with the Consumer Price Index (CPI) or lower.
- Review and evaluate the quality credit awarded to health plans through negotiations.
- Review and consider the impact of the number of health plans participating in each region or market.
- Track and maintain premium increases to stay below the "Cadillac Tax" (2018) threshold.
- Research and/or pilot a two year contract term.
- Audit contract compliance.
- Identify process steps that can start earlier in the calendar year.

## How the objectives support the mission, vision and goals

- The objectives support the mission to develop and deliver insurance benefits that maximize quality and value.
- The objectives support the vision to engage our various partners to collectively improve the quality and value of our insurance benefits.
- The objectives support the goals of maximizing quality and value, containing cost, and modeling administrative innovation.

Introducing an HDHP coupled with a Health Savings Account (HSA) follows what other employers have done in recent years and provides a lower out-of-pocket option for participant costs for health insurance premiums. Reviewing premium increases, quality credit elements, and the number of health plans in each region or market will assist us in evaluating costs. Auditing health plan submitted data and contract compliance ensures we are making decisions using valid data and that our participants are getting health care services as provided for under Uniform Benefits. Researching a two year contract term is one step in changing the way we purchase health care and has the potential for savings.

## Current state

State statute requires an HDHP and HSA to be offered, effective January 1, 2015.

Currently, health plan negotiations are an annual process with these key events and dates:

- February Board meeting memo that summarizes possible changes to the Guidelines collected from ETF staff and participating health plans.
- Study Group meetings begin in February and continue into April (generally three meetings are held each year).

- Memo noting key dates for health plan submissions sent to the health plans in late April or early May.
- Estimated bids from health plans are due in late April or early May.
- May Board meeting with Guidelines changes for upcoming plan year.
- Addendum 1 and 2 information due from health plans in late May or early June.
- Preliminary bids due from health plans in early July.
- Health plan negotiations the last week of July.
- Best and final bids due to consulting actuary by August 1.
- Health plans notify ETF of contract termination in early August.
- August Board meeting technical changes to the Guidelines and rate approval.
- Contracts are sent to the health plans for signatures in September.
- November Board meeting technical changes to the Guidelines.

Much of the work associated with negotiations begins in May and continues through August. This is also the time *It's Your Choice* materials are being written and finalized, resulting in stretched staff resources.

Staff has concerns regarding the accuracy of addendum 1 health plan submissions and contract compliance.

ETF staff have initiated conversations with other states (North Dakota, Iowa, Missouri, and Montana) that have multi-year contacts with health plans and with several participating health plans to learn if they would be interested in a two year contract period.

Staff have been meeting one-on-one with health plans to indicate our long term goals for future premium increases and avoiding the Cadillac Tax in 2018.

**Next Steps**

- Identify gaps or suspected missing data in health plan addendum 1 submissions and have the Board's consulting actuary question the health plans regarding the data submitted/not submitted. Seek another data source to verify the health plan submission.
- Negotiate CPI-level tier 1 premium rate increases.
- Continue discussions with other states and participating health plans regarding a two-year health plan contract. Learn how the ETF Benefit Consultant views a two year contract term and evaluate suggestions and comments.
- Have the Alternate Health Plans Program Manager keep a contract compliance issue log. If a trend appears, evaluate the value of auditing health plans on compliance for that contract term.
- After negotiations are complete, conduct a staff meeting to review the 2014 process and identify process steps that could have been done earlier in the timeline and look for opportunities to improve the process, data flow, and communications.
- Meet with newly-contracted consulting actuary to review annual process and data requests.

**Measures of Success**

- Negotiation decisions (tier break points, quality credit, premium rate increases) are made using complete and accurate data.
- Two annual tasks are identified as candidates for an earlier timeline. A pilot for two-year contract terms is approved for development in 2015.

**Strategic Initiative 10**
**Federal Health Care Reform Impacts**
**Lead ETF Staff: Arlene Larson**

## Objectives

- Prepare for compliance with federally-required Maximum Out-of-Pocket (MOOP) changes for 2015. This requires input from health plans, Navitus Health Solutions (Navitus) and the Guidelines Study Group, followed by a decision from the Group Insurance Board (Board).
- Prepare the Wisconsin Public Employer (WPE) contract and all employers for the Employer Shared Responsibility "Pay or Play" and the 90-day waiting period mandates. This includes implementing a contractual expansion of WPE enrollment opportunities and staff participation in State Workgroup meetings to minimize penalties in 2015.
- Avoid the "Cadillac Tax" that is scheduled to be effective January 1, 2018.
- Monitor the development and participation in the Marketplaces (or Exchanges).

## How the objectives support our mission, vision and goals

- Codifies benefits that maximize value by complying with federal law.
- By participating in employer teams to develop and communicate consistent insurance information, staff will facilitate efficient compliance with federal law.
- Proactive compliance should result in lower penalties starting in 2015, thus containing costs in the program.

## Current State

MOOP

We are using the 2014 federal safe harbor, with separate "silos" for medical and prescription drug MOOPs. The services that apply to the federal MOOP are in-network Essential Health Benefits (EHB), including out-of-network Emergency Room visits; certain prescription drugs; and pediatric dental care that is included in the medical certificate of coverage. The 2014 MOOPs are $6,350 single/$12,700 family.

Uniform Benefits (UB) has a number of MOOPs that are distinct and some do not accumulate to the federal MOOP. Our contracts are not completely clear in the administration of all MOOPs. Under our adoption of Pennsylvania's EHB, our program can retain the following plan payment dollar maximums:

- Hearing aids ($1,000/aid /member over age 18)
- Temporomandibular joint (TMJ) --diagnostic and non-surgical treatment ($1,250/member/year)
- Dental implants ($1,000/tooth)

As a "large group" as determined under federal law, our program is not required to offer all EHBs (e.g., habilitative).

It is unlikely that anyone would reach the federal MOOP in UB or the Standard Plans that are offered to members of the State and WPE group health insurance programs. The HDHP is a more likely candidate to achieve this outcome, depending on the

benefits of that plan. Federal law requires that the medical and prescription drug portions of the program be combined under one overall deductible.

A number of health plans have requested that we silo the MOOPs where allowed by federal law. Several are concerned about the system programming needed to incorporate daily feeds from Navitus to facilitate the claim adjudication of an overall MOOP. A lesser but relevant concern involves the inclusion of pediatric dental services. Note: There are issues related to adjusted claims that can result in members achieving the MOOP and then following adjustments, being informed that they are again subject to cost sharing for a period of time. However, since a data exchange is necessary to track the HDHP's deductibles, it may be that plans can use the same system to track an overall MOOP. Staff has and will continue to meet with Navitus and the health plans to discuss this process and implementation.

Pay or Play

Certain state statutes, policies and contract language exposes employers to federal penalties. The scope of the issue -- that is, how many employees and classifications could result in penalties to employers -- is unclear and is being studied. Analysis of the potential for penalties will assist in developing potential changes to policy and statute. Employer understanding of the ramifications of the law varies widely. ETF staff is working with the Office of State Employment Relations (OSER) and state agencies to establish a course of action. Applicable findings will be shared with WPEs as items to consider.

Staff is presenting a WPE contract change to the Study Group and subsequently to the Board to help certain WPEs minimize penalties. The new language will provide the flexibility to offer an enrollment opportunity to an employee who was working two-thirds time and who gets a full time job (30 or more hours per week) that entails a change in employer contribution. Currently, these employees are prohibited from enrolling at the time of the position and contribution change.

Cadillac Tax

The Cadillac Tax is a 40% excise tax that will be applied to any excess in the cost of employer sponsored health care coverage provided to an employee over $10,200 single and $27,500 family, effective 2018. Higher amounts (an additional $1,650 single/$3,450 family) will apply to qualified retirees (age 55 or older and not eligible for Medicare) and certain high risk professionals. The law describes these professionals, in part, as those in law enforcement, fire protection, construction, forestry and fishing industries and employed to repair or install electrical and telecommunication lines.

Federal regulations specifying how to compute the cost of coverage have not been issued to date but some guidance has been provided, as follows. The aggregate amounts include medical and prescription drug coverage. They may exclude separate dental and vision coverage. The cost of all available plans must be aggregated. Employer contributions toward Health Savings Accounts (HSA) must be included. Consolidated Omnibus Budget Reconciliation Act (COBRA) rates are currently described as the proxy.

The aggregate 2018 thresholds will increase if the cost of coverage in the "Blue Cross/Blue Shield (BCBS) standard benefit option" of the Federal Employee Health Benefits Program goes up by more than 55% between 2010 and 2018. The regulation also allows for an age/gender adjustment tied to the above BCBS plan. Beginning in 2019, thresholds will be indexed for inflation, aligning with the consumer pricing index (CPI) plus 1%. In 2020, thresholds will be adjusted by CPI alone. These thresholds will be rounded to the nearest multiple of $50.

It is plausible that our program could surpass the $10,200 single and $27,500 family thresholds in 2018 or soon thereafter. In 2014 the State annualized weighted average is $8,522.04 single and $21,277.92 family. For WPE Program Option 2, it is $8,226.48 single and $20,335.56 family. Note: Our program currently has no structure to differentiate between regular and higher risk professionals/qualified retirees that permit an additional $1,650 single and $3,450 family toward the threshold.

Marketplace/Exchanges

Under current federal law and beginning in 2017, large employers with 100 or more employees will be able to enroll their employees and their dependents in the Marketplaces. Individual Marketplaces were first offered effective January 1, 2014. A limited amount of health plans in Wisconsin offer them. The initial enrollment period ended March 31, 2014. Marketplaces are not available to Medicare eligible members. Chapter 40 would require modification to allow State and WPE employees and annuitant's accessibility as a group into the Marketplace.

## Next Steps

MOOP

Staff is discussing options, including health plan responses, with the Guidelines Study Group. Staff will develop recommendations for the Board to be presented at the May meeting. Staff will implement necessary changes within the context of the annual Guidelines process. If the Board selects an overall MOOP, staff will coordinate meetings with health plans and Navitus to get systems ready and operational.

The goal is to design and implement in 2014, effective January 1, 2015. If necessary, we could reconsider our decisions in later years and adjust them.

Pay or Play

Staff will work with agencies on data queries to determine the scope of expected penalties. Staff will use the results to appropriately address concerns with current policy and statutory language. Any lessons learned may be used with the WPE program.

Employers are pulling and refining queries at this time. In 2014 these results will be taken to upper management to determine what steps should be taken to reduce the likelihood of penalties. If statutory changes are determined to be advisable, OSER may bring them up during the next budget cycle. As federal regulations change over time, staff will review them and adjust processes accordingly.

Cadillac Tax

- Investigate various options to control the cost of our program, including reducing annual increases and benefits to remain below the thresholds;
- Discuss feasibility with stakeholders;
- Monitor federal guidance on how the value of a program will be calculated;
- If any administrative changes can be made that lower the cost toward the threshold, investigate taking advantage of them; and
- Investigate methods to track higher risk professionals and early retirees as defined in the regulation.

Marketplace/Exchanges

Develop an annual policy to investigate the claim risk of the Marketplaces, especially the group Marketplaces after 2017. Compare the outcomes to our group health insurance program.

## Measures of success

MOOP

- The incorporation of clear contract language that is operationalized by the health plans and Navitus, effective January 1, 2015.

Pay or Play

- Obtaining a good estimate of penalty scope from the University of Wisconsin (UW), University of Wisconsin Hospital and Clinics (UWHC) and Central Payroll enrollment records in the first half of 2014.
- Asking other payroll processing centers and WPEs in the 2nd quarter for input on how to pull queries.
- Developing and implementing WPE contract language within the Study Group and Guidelines process for 2015.
- Collaborating with OSER, if necessary, on potential statutory changes for the next biennial budget.

Cadillac Tax

- Facilitating a robust annual review process; and
- Maintain a program that consistently falls below the Cadillac Tax thresholds.

Marketplace/Exchanges

Staff believes that measures of success would be a thorough understanding of the risk profile of Wisconsin's Marketplace and any group Medicare supplements.

**Strategic Initiative 11**
**Dental Coverage**
**Lead ETF Staff: Shayna Gobel**

## Objectives

The primary objective is to potentially implement a stand-alone dental plan offering beginning in 2016 that will enhance the quality and value of the dental benefit while maintaining cost-neutrality.

In addition, we will review modifying the employee-pay-all dental plans to provide complementary benefits that integrate with the stand-alone dental plan for 2016 and in order to make comprehensive dental coverage available for state employees and retirees.

## How the objective supports the mission, vision and goals

The objectives will enhance ETF insurance benefits by:

- Increasing quality and value: Administration and quality assurance of claims and processing can be easily reviewed in this benefit model by ETF staff or external auditors. Reducing administration costs may result in a cost-savings, which can be used to further enhance benefits or maintain the cost of premiums.
- Engaging and educating members: Members will have the opportunity to review the various options available to them, and choose the level of coverage they desire. There will be substantially less confusion than the current model, given that each plan markets differently and has different provider networks and network structures (PPO, HMO).
- Delivering benefits that attract and retain a quality workforce: The dental benefits offered through a standalone dental plan and truly supplement dental benefits allow for a comprehensive overall dental benefit.
- Improving the health and wellness of members: Routine dental care has been shown to increase overall wellness and help to identify risks and certain diseases in patients.

## Current State

To the extent that health plans offer dental benefits to state and local members through the Group Health Insurance Programs, the dental benefits must follow the uniform dental benefits plan design implemented in 2014. Transitioning to a stand-alone dental plan would help address issues related to member access to coverage, administration of dental benefits, provider networks, and the Affordable Care Act. In addition, modifying the supplemental dental plans is necessary to integrate with a stand-alone dental plan in order to provide the option of comprehensive dental coverage.

### Comprehensive Dental Coverage

The uniform dental benefit offers comprehensive diagnostic and preventive dental coverage, but offers minimal basic, major, and restorative coverage. State employees have the option to enroll in an employee-pay-all dental plan to supplement benefits that

are not covered under the uniform dental benefit. However, these supplemental plans currently have significant gaps and overlaps in coverage when combined with the uniform dental benefit.

There are six options for supplemental dental coverage and each offers varying coverage for services and levels of payment. The choices are complex, between EPIC's Benefits+, two variations on EPIC Dental Wisconsin, and three versions of Anthem DentalBlue. In addition, the benefits of each plan are based on a model used since the 1960s, with elaborate lists of exclusions and limitations. Enrollment opportunities for each plan also vary, making it difficult for employees to know when they can or cannot enroll in supplemental coverage. Some members have voiced concern over the level of coverage and benefits offered between the uniform dental benefit and the supplemental dental plans. The required provider networks for in-network coverage vary between the plans, making it difficult for members to coordinate care at an in-network rate. In addition, the administration of the supplemental plans is completely separate from the uniform dental benefit, which complicates data sharing between the supplemental plans, uniform dental plans, ETF, and members.

In order to create a more comprehensive plan and reduce the confusion among members, the supplemental plans must be modified to streamline the decision-making process and offer dental coverage that complements the benefits available under uniform dental and/or the stand-alone dental plan. Restructuring the administration process for the supplemental plans would simplify the process for members to receive accurate information from the plan, ETF, and/or their employer, and would enable ETF to easily review the data for measurement of cost-effectiveness and health outcomes.

Access to Coverage

A common concern among members enrolled in the Standard Plan and the State Maintenance Plan is that there is no dental benefit. Expanding the dental benefits to these members would be well-received, and may help balance enrollment between the self-insured and alternate plans. Under a stand-alone dental plan, coverage could easily be expanded to members of the Standard Plan, State Maintenance Plan, Medicare Plus, and all local government employees and retirees at our discretion. A stand-alone dental plan would allow employees to have the choice to opt-in or opt-out of dental coverage.

In addition, employees have the option to elect supplemental dental coverage that would create a comprehensive dental plan when combined with the stand-alone dental plan. Given that oral health is correlated with employees' overall health and productivity, access to comprehensive dental care at affordable prices is an important consideration for wellness, efficiency, and retention.

Dental Administration

Each health plan either administers their own dental benefit, or contracts with a third party administrator (TPA) to manage the dental benefit. Currently, nine of the health plans administer their own dental benefits, and the remaining plans use a total of five different TPAs.

The American Dental Association (ADA) favors the dental carve-out model because health plans that administer their own dental benefits are not necessarily experts in this field -- there are significant differences between medicine and dentistry. According to the ADA, health plans may have a focus on the medical benefit and focus fewer resources in administering the dental benefit. The state would have more input on the administration of dental benefits under a stand-alone dental plan, and program management becomes more streamlined by having a limited number of dental administrators. A stand-alone dental plan would create ease in auditing the dental administrator(s), and would ensure that the administrator has apt knowledge and experience in managing a successful dental plan. We can eliminate overlapping dental administration costs by limiting the administration to one or two TPAs, which should be reflected in the health plan premium bids. However, there is a potential for adverse selection of the dental plan. Communication of dental changes during open enrollment and maximizing the value of the stand-alone dental plan will be key in reducing adverse selection.

Provider Networks

The provider networks for dental coverage are currently regulated by the health plan or its dental administrator. Some health plans offer a very restricted network of providers. Others offer a Preferred Provider Organization (PPO)-structured dental plan, where members can see any dentist they wish and have varying cost-sharing associated with “preferred” and “non-preferred” providers. The State would easily have input on provider networks under a stand-alone dental plan, and have the potential to offer nationwide provider options. There are current dental administrators that offer a nationwide provider network, and it is a negotiable option if we choose an administrator without nationwide providers. In addition, the State would be able to negotiate lower reimbursement rates with providers to lower overall cost to the dental plan. For example, the State of Minnesota sets provider reimbursement rates up to 10% below commercial levels and has had little to no loss of provider network. Providers are willing to accept lower reimbursement in order to gain access to the large state employee population.

Affordable Care Act Considerations

A stand-alone dental plan eliminates the cost associated with the Affordable Care Act (ACA)’s Essential Health Benefit (EHB) rules. Currently, there cannot be any monetary limits on benefits that are considered EHBs, including pediatric dental benefits. Stand-alone dental plans meet the “Excepted Benefit” provision of the ACA, which means that benefits offered through a stand-alone dental plan are not subject to the EHB requirements. For example, stand-alone dental plans are allowed to place monetary limits on benefits that are considered EHB, and the plan is not subject to the annual maximum out-of-pocket restriction that is applied to EHBs.

In order to meet the definition of the “excepted benefit” of the ACA, a stand-alone dental plan must be optional *and* have some employee contribution to premium. Employees cannot currently opt-out or opt-in to the uniform dental benefit because it is correlated with the health plan that the employee elects. In addition, the uniform dental benefits do not require an additional employee contribution to the premium to be paid outside of the standard health insurance contribution. Excepted benefits are currently a topic of

discussion by the Department of Health and Human Services, so the definition may be clarified further.

The “Cadillac Tax,” or excise tax on high-cost coverage, does not include benefits offered through a stand-alone dental plan. The Cadillac Tax is a 40% excise tax imposed on benefits exceeding a certain threshold beginning in 2018. A stand-alone dental plan is a positive first step toward avoiding the Cadillac Tax.

**Next Steps**

The immediate next step is to obtain input from such interested parties as the Guidelines Study Group, the Board, and the Board’s Strategic Planning Workgroup. We will explore self-insured and fully-insured models, estimation of cost, benefit structures, and determine what administrative requirements should be applied to the stand-alone dental model. In addition, we will begin discussions with the supplemental dental plan administrators, and collect feedback from the Fringe Benefits Committee.

**Measures of Success**

- Complete steps on time, with potential implementation in January 2016.
- Enrollment in stand-alone dental plan at or greater than required for cost-neutrality (to be determined by the Board’s consulting actuary - over 50%).
- Increase utilization of preventive dental procedures (current utilization is unknown- we should strive for 75% utilization to exceed the national average).
- Improve health of covered Wisconsin Retirement System (WRS) members due to improved oral health, as measured by correlation between preventive dental care and specified health markers.
- Increase value of the dental plan by maximizing benefits and decreasing costs unrelated to provider payments (administration costs, administrative errors).
- Plan designs will allow for a comprehensive dental option (little to no overlap or gaps) when combining the stand-alone dental with optional supplemental coverage.
- Benefits Administration System (BAS) will include enrollment information, and dental plans will provide claims data for measurement of quality and health outcomes.
- Minimal concern or positive reaction to the change from members.
- Less than ten letters or “controlled correspondence” concerns related to dental changes in 2016.
- Expand access to dental coverage to state employees in State Maintenance Plan (SMP) and Standard Plans.
- Great success: Expand coverage to local employees and Medicare Plus by 2018.
- Expand choices for dental providers, especially in rural areas.
- Great success: coverage at all Wisconsin (and nearby regions of Michigan, Minnesota) providers.
- Decrease administration costs by 10%.
- Control premium rates for supplemental dental plans to rise no more than the CPI each year.
- Increase quality of administration by completing biennial audits of the dental TPA(s) beginning in 2018 for plan years 2016-2017.

**Strategic Initiative 12**
**Spousal / Domestic Partner Health Insurance Coverage and Opt-Out Incentives**
**Lead ETF Staff: Shayna Gobel**

## Objectives

The current objective is to determine if we should implement a working spouse/domestic partner health care coverage exclusion, a surcharge for adding working spouse/domestic partner to health care coverage, or an incentive for an employee to opt-out of the State Group Health Insurance plans.

## How the objective supports the mission, vision and goals

The objective supports the following goals:

- Contain costs: Reviewing the impact of the implementation of spousal/domestic partner coverage changes will allow the Legislature to make an informed decision on the most appropriate method to reduce costs.
- Engage and educate members: Assuming the Legislature decides to implement a change in spousal/domestic partner coverage, members will need to be timely and properly informed of the change in order to make appropriate decisions related to health care coverage.

## Current State

Wisconsin Act 20 requires the Department of Employee Trust Funds (ETF) and the Office of State Employment Relations (OSER) to complete a study on the feasibility of excluding working spouses and domestic partners from electing health care coverage, and the feasibility of offering a $2,000 annual incentive payment to state employees who elect to opt-out of health care coverage.

The State Group Health Insurance Program currently does not have any restrictions or surcharges on covering spouses or legal domestic partners and does not allow the ability for an employee to opt-out of health insurance coverage with an incentive payment. This is a relatively new practice, gaining popularity over the last five years. There has been no formal actuarial research completed on this topic by the Board's actuary on our population. Staff have conducted independent research, initiated conversations with other states, and have completed research on the approaches to spousal and domestic partner coverage restrictions. Our findings have shown that there are many variations to exclusions and surcharges for working spouses and domestic partners, and to employee health insurance opt-out incentives.

In 2013, 6% of large employers used a working spouse exclusion and 20% of large employers required a surcharge to cover spouses who had access to other coverage.

## Next Steps

The immediate next step is to work with the Board's consulting actuary to complete actuarial analysis of the proposed changes. The analysis will take 7-10 weeks, at which time staff will review the actuary's report and begin compiling a report for the Governor and the Joint Finance Committee.

**Measures of Success**

- Completing steps on time, with report delivered by June 30, 2014
- Deliver a quality report to the Governor and Joint Finance Committee with data from the Board's consulting actuary
- Respond in a timely way to any Legislative action taken based on the results of the report

**Strategic Initiative 13**
**Optional Programs Guidelines Update**
**Lead ETF Staff: Roni Harper**

## Objectives

Develop updated Guidelines for the approval and effective oversight of optional insurance plans. This will include a separate Guideline for Long-Term Care (LTC) insurance to be implemented simultaneous to the repeal of an outdated Administrative Rule. A separate Guideline will cover other Optional/Supplemental employee-pay-all group insurance plans -- such as dental, vision, and wrap-around insurance — that are defined as "excepted" under the Affordable Care Act.

## How the objectives support the mission, vision and goals

- Improves health and wellness of state employees by facilitating the availability of voluntary insurance benefits that are of measurable value, to supplement primary health insurance.
- Enables engagement of members in choosing voluntary insurance that fits their household needs
- Enables engagement of employers in the process of selecting and retaining "excepted insurance" plans by standardizing the application process.
- Delivers benefits that enable employers to attract and retain a quality workforce by complementing the basic health insurance and retirement planning tools, with optional plans important to individuals.
- Models administrative innovation by building stronger inter-agency linkages to reduce duplication of processing and cultivating resources for ETF staff to further develop expertise in industry trends.

## Current State

The *Guideline for Optional Group Insurance Plans Seeking Group Insurance Board Approval for Payroll Deduction Authorization* (Guideline), created around 1992 and most recently revised in 1999, was a foundation on which the Division of Insurance Services (DIS) has built a fairly robust and functional system of optional insurance plans. However, aspects of the Guidelines have become obsolete due to changes in industry standards, health insurance, modes of communication and data management systems.

Specifically, the long-term care guidelines are out of date in terms of benefit requirements, in that insurers assert they cannot make products available to fit these standards.

## Next Steps

- Repeal administrative rule ETF 41 relating to long-term care. Note: This step is parallel to the remaining steps.
- Work with the insurance industry, the Office of Commissioner of Insurance (OCI), and ETF's benefits consultant to establish standards of quality for LTC insurance policies to replace those in ETF 41.
- Create a procedure for Board consideration of new plans -- and periodic review of existing plans -- that allows comparison of similar plans of a given type. This

will ensure that ETF, state agencies, and members are working with the optimal plans, not the “first plan in the door.”
- Create separate Guidelines for “employee-pay-all insurance plans” and LTC insurance.

**Measures of Success**

- A functional set of Guidelines for approval and oversight of optional insurance plans will be in place, so that employer and employee satisfaction with process and plans improves.
- At least two LTC insurance plans will be approved under the Guidelines for availability to State employees and their families, with the opportunity for payroll deduction and annuity deduction by 2017.
- A system of requirements checklists and materials submitted will be organized in such a way as to be accessible and comprehensible to any staff within DIS as needed.

**Strategic Initiative 14**
**Telehealth**
**Lead ETF Staff: Lisa Ellinger**

## Objectives

Analyze and research opportunities to decrease costs and expand access to health care through the use of telehealth services.

## How the objectives support the mission, vision and goals

This initiative has the potential to:

- Maximize Quality and Value by expanding access to the highest-quality and most cost-effective providers.
- Contain Costs by more efficiently providing care and reducing transportation costs for members.
- Improve Health and Wellness by expanding access to health care, particularly to members in rural areas and those in needs of specialty care.
- Model Administrative Innovation by appropriately modifying our covered benefits to keep pace with advances in technology.

## Current State

Telehealth services, which allow for the remote delivery of health care services, is becoming a standard of care in the health care industry. Fourteen states (not the state of Wisconsin) have adopted mandates for the coverage of telehealth services. The literature on the quality and cost effectiveness of telehealth is somewhat limited, and can vary, based on the procedure and/or delivery mechanism.

## Next Steps

- Investigate the current research on telehealth cost savings and impacts on outcomes.
- Collaborate with other state agencies – DHS and OCI, in particular -- to investigate the potential cost savings and access improvements in telehealth.
- Survey health plans to better understand current provision and breadth of available telehealth services.
- Work with actuaries to cost out expanded coverage of telehealth services.

## Measures of Success

Present the Board with analysis and evidence supporting potential opportunities in telehealth coverage.

## Additional Topics for Consideration

Through the strategic planning process, staff selected the priority program areas documented above to focus on for future research and analysis. Staff also considered the list of topics below in that prioritization process. Staff welcomes Workgroup feedback on whether any of these topics warrant immediate staff attention. We also welcome the addition of new topics from Workgroup members.

- Local Annuitant Health Plan
- Onsite Clinics
- Direct Provider Contracting
- Local Standard Plan
- Promotion of Comparative Effectiveness Research
- Impact of health maintenance on disability
- Overuse and misuse: monitoring, identifying outliers/fraud
- Adverse events: monitoring, identifying outliers/fraud
- Standardization of utilization reports from health plans
- Consumer Satisfaction Surveys
- Ethical Guidelines/expectations
- Retail clinics
- Medical tourism
- Medical homes/Accountable Care Organizations
- Medicare eligible retirees