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Correspondence Memorandum

Date: October 26, 2018

To: Group Insurance Board

From: Renee Walk, Strategic Health Policy Advisor
Office of Strategic Health Policy

Subject: Review of Segal Consulting Reports & Future Considerations

This memorandum is for informational purposes only. No Group Insurance Board (Board) action is required.

Background

In 2014, following an internal review of programs, ETF recommended the Board issue a request for proposals (RFP) for the services of a benefits consultant. A contract was awarded to Segal Consulting (Segal) at the end of 2014. The Board received the first of two reports from Segal in March of 2015[1]; the subsequent report was delivered in November of that same year[2]. These documents are collectively referred to in this memo as the Segal Reports. Each of the reports laid out specific recommendations and strategies to help the Board modernize the Group Health Insurance Program (GHIP) and reduce costs.

This memo reviews the state of the GHIP, both at the time of the Segal Reports and presently. It provides a discussion of implemented recommendations, recommendations that are still in progress, and those that were not implemented. Finally, this memo reviews efforts under way to build on the progress made through implementing Segal Report recommendations.

Program Design and Participation Statistics

The GHIP provided coverage for 224,682 State and University of Wisconsin System (UW) members in 2017, the most recent complete year of data. Enrollment numbers in the state and UW employee medical plan have held mostly steady over the past four

[1] Segal Consulting. Health Care Benefits Consultant First Report—Observations and 2016 Recommendations. http://etf.wi.gov/boards/agenda-items-2015/gib0325/item4c1.pdf.
[2] Segal Consulting. Health Care Benefits Consultant Second Report—Observations and Recommendations for 2017 and Beyond. http://etf.wi.gov/boards/agenda-items-2015/gib1117/item3ar.pdf.

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy
Eileen K Mallow Electronically Signed 10/31/18

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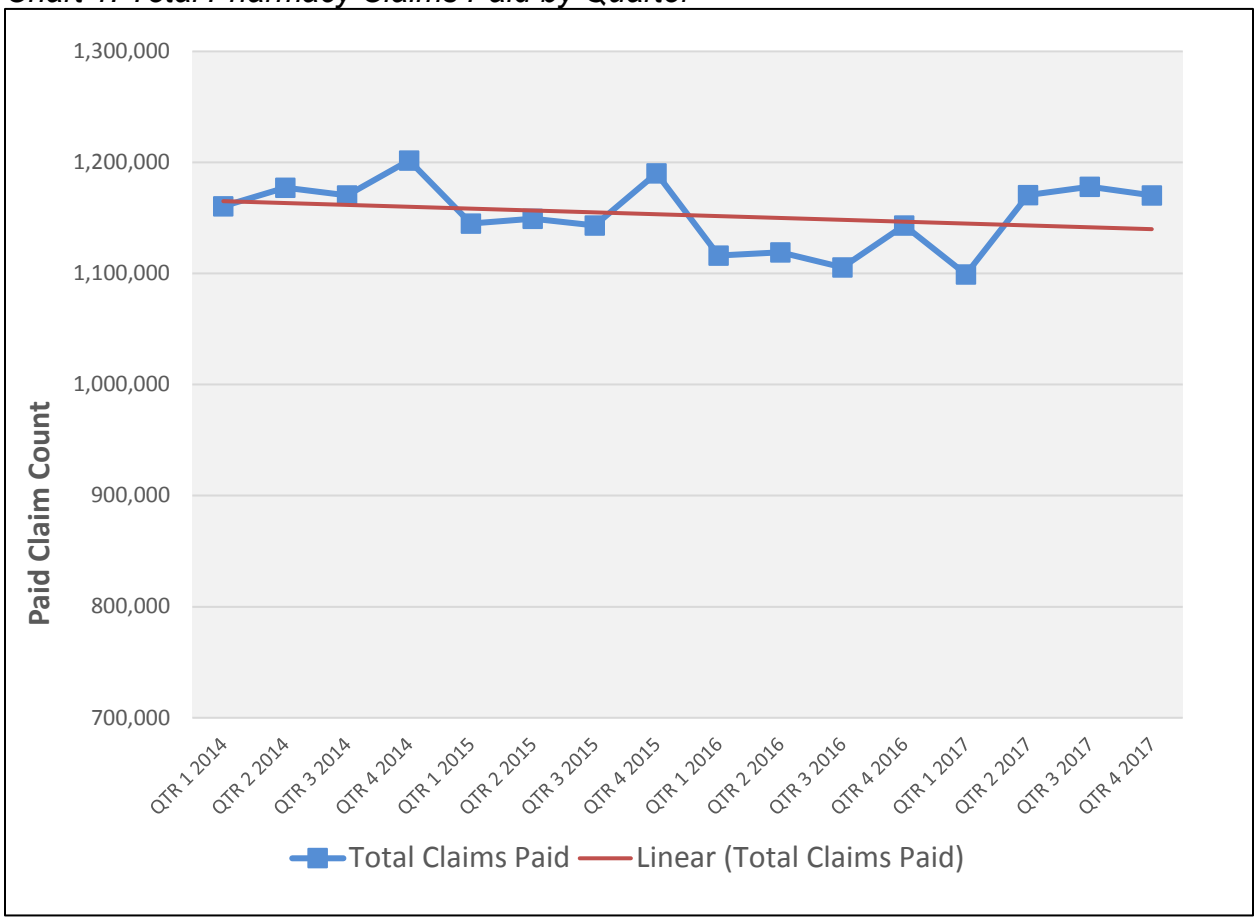
years -- down only slightly from 226,192 members -- when the Segal report was issued in 2014. A total of 2,819,587 medical claims were paid during 2017, or approximately 12.55 claims per member. This is consistent with 2014, which had a rate of 13.04 claims per member.

The GHIP also provides coverage to local employers who elect to join the Board's program. Local employers provided an additional 38,056 members in 2017 and 424,131 medical claims, or about 11.14 claims per member. This is compared to 2014's enrollment of 42,997 members with an average of 10.97 claims per member. Local employer enrollment decreased in 2017, following the departure of a few larger-sized groups from the program; however, it appears that utilization among the remaining members has been similar.

All participants in the GHIP are offered Uniform Benefits (UB). At the time the Segal Reports were published, state and UW members had three cost sharing options to choose from—the It's Your Choice (IYC) Health Plan, the IYC High Deductible Health Plan (HDHP), and the IYC Access Health Plan (Access Plan). Local employers had the same program options as state employees, plus a Local Deductible option that offered a $500 deductible per person. A detailed listing of plan designs at the time of the Segal Report and plans currently available is provided in Attachment A of this memo.

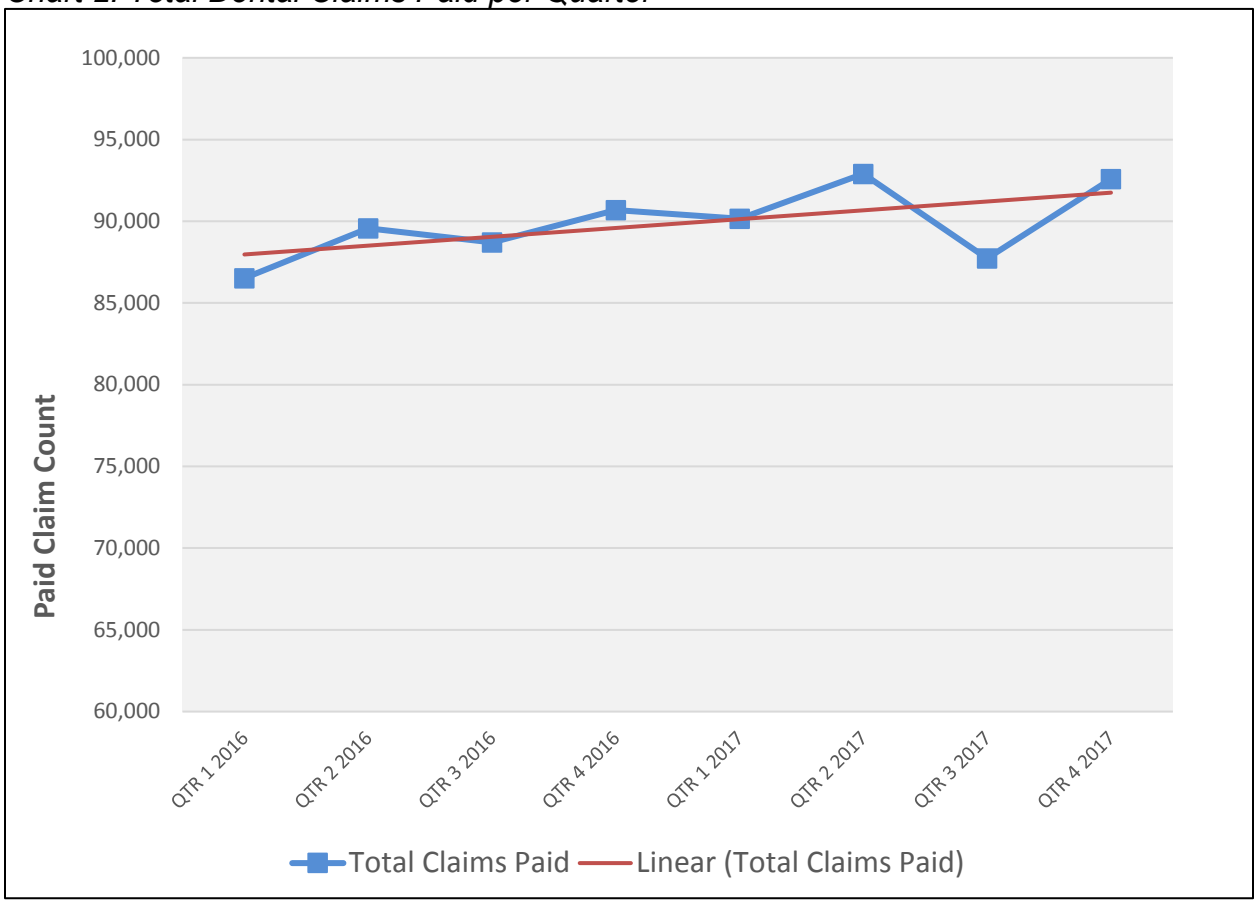
Pharmacy benefits are carved out of the medical benefits and administered by a single vendor, Navitus Health Solutions (Navitus). These benefits are self-funded and generally a required part of the health program; there are ways by which a member might drop pharmacy coverage, but it results in no reduction in out-of-pocket cost. The Board offers a single benefit design option to State and Local program employees. The total utilization decreased very slightly between 2014 and 2017. Chart 1 shows the total pharmacy claims paid each quarter of those years. A summary of pharmacy benefit designs in 2014 and present are included in Attachment B.

Chart 1. Total Pharmacy Claims Paid by Quarter



Dental benefits were coordinated by health plans when the Segal Reports were issued. Each health plan would either directly offer or subcontract their dental benefits, and health plans were allowed some latitude in the dental services covered under the plans. This led to variation in the true benefit received under each plan. Dental benefits were carved out of the health plans in 2016, self-insured, established as Uniform Dental Benefits, and made optional for local plans. Several local employers opted to drop the Uniform Dental Benefits. While the majority of state employees as of 2017 still opted to enroll in Uniform Dental with their medical benefits, only 2,054 local employees enrolled in the benefit. State and local utilization has increased slightly over the past two quarters of benefit carve-out (see Chart 2).

Chart 2. Total Dental Claims Paid per Quarter



Implemented Recommendations

Over the past three years, ETF and the Board have moved forward with several of the recommendations contained in the Segal Reports. Specifically, the Board approved the following health benefit design changes:

- Adding an annual deductible to the medical plans;
- Transitioning to an office visit copay from coinsurance;
- Increasing the employer health savings account (HSA) contribution to encourage participation in the HDHP for state employees; and
- Promoting telehealth use.

ETF is still analyzing the cost and utilization impacts of these changes to the programs.

Part of this analysis is facilitated by the implementation of a significant initiative identified in the Segal Reports and approved by the Board: the development of the Data Analytics and Insights (DAISI) data warehouse, contracted through IBM Watson. Currently the DAISI implementation is well under way, and ETF staff is becoming more familiar with the capabilities of the tools provided. See GIB Item 9 for additional information on the status of the IBM Watson implementation.

Segal also had several recommendations related to a concept called Total Health Management. Total Health Management is essentially a population health management strategy with behavioral economics components that incentivize behavior changes. In 2016 the Board approved contracting for a sole-source wellness vendor, StayWell, to assist in laying the foundational work for improving population health. Over the course of its contract with the Board, StayWell has been successful in increasing member engagement with wellness programming. StayWell has also started offering a standard set of disease management coaching programs. See GIB Item 7B for additional information on the current status of the Well Wisconsin Program and StayWell. While the Segal Reports advocated for a complete carve-out of disease management programming from health plan contracts, health plans were reticent to give up disease management responsibility in a fully-insured program environment. Instead, ETF is leveraging the competitive model of the Board's programs to encourage innovative pilot program proposals from health plans, while guaranteeing at least a minimum threshold of quality programming through StayWell.

The Segal Reports recommended several changes to the pharmacy benefit program and vendor relationship. First, the reports recommended implementing pricing guarantees into the pharmacy benefit manager (PBM) contract. These guarantees were added as a part of the PBM RFP that was completed in 2017, and to date Navitus has met or exceeded these guarantees. The Segal Reports also made recommendations to implement value-based benefit plan designs to encourage members to seek appropriate care and follow maintenance regimens for chronic conditions. Navitus implemented pharmaco-adherence programs at the beginning of 2018, focusing on encouraging members to manage respiratory conditions. Finally, the Reports recommended changes to the pharmacy benefit design for all members. Following those recommendations, the Board approved increasing the separate out of pocket limits for pharmacy benefits and coinsurance for Tier 2, 3, and 4 drugs in 2016, as well as moving to a narrow pharmacy network and exclusive specialty pharmacy vendor in 2018. Analysis of the impacts of more recent program changes will be brought to the Board once a full year of outcomes is available.

Recommendations in Progress

Staff continues to work on the implementation of reporting and analytics recommendations from the Segal Reports, following the implementation of the data warehouse with IBM Watson. Starting in 2015, staff implemented the current health plan report card to create a common means of reporting health plan quality to members. Report card scores were also used during health plan negotiations to provide up to a 1% quality credit to a health plan's rate bid, to encourage quality improvement. The report card continued in this iteration until an effort to further modernize scoring that began in 2016. ETF also worked with health plans to review and update the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures used to calculate the ETF report card. These changes were presented to the Board in late 2017, were used to apply the quality credit for 2019 contracts and have been implemented for the 2019 It's Your

Choice Open Enrollment period. In the coming years, staff will work with the information provided in the data warehouse as well as the continued submission of HEDIS and CAHPS data from health plans to determine how best to measure quality.

The Segal Reports also recommended the implementation of performance standards and monitoring as it pertains to health plan program administration. ETF added a significant number of performance standards and reporting requirements to the 2018 health plan contracts. The implementation of these reports has been mixed; some reports remained in the contract following the self-insurance request for proposals (RFP) that were only relevant for self-insured programs. Health plans also later found that some reports were challenging to provide, or that the requested methodology showed misleading outcomes. We have considered plan feedback and are working to refine performance standard requirements and reporting, including considering whether service level agreements instead of performance standards might be a more appropriate means of ensuring good customer service. Additional information on performance standards and service level agreements will be provided to the Board at the February 2019 meeting.

Implementation of programmatic changes recommended by the Segal Reports continues as well. Since the program continues to be fully-insured, ETF has opted to leverage the competitive HMO model to promote pilot opportunities for plans. Plans have specifically been encouraged to provide value-based insurance design options, as proposed by the Segal Reports. Pilots must be proposed as a complete program, with quality monitoring methodology and reporting designed as a part of the proposal. In addition to the StayWell/Navitus valued-based program described above, we are working with Dean Health Plan to launch a value-based insurance design pilot for 2019 that focuses on promoting chronic disease management for members with diabetes.

Following Segal's recommendation to implement a sole-source wellness vendor, StayWell has become a critical strategic partner for health promotion. Segal also recommended in its initial reports that the Board implement a premium differential instead of the $150 gift card to further promote participation in wellness. The Board initially approved this change in 2017; however, on further development of the project ETF found that there were systems limitations that would not support the change at that time. We now expect existing systems to be able to support the differential in program year 2020.

Recommendations Considered but Not Implemented

In addition to those programs that the Board and ETF have implemented or are in the process of implementing, there are a handful of recommendations that have been investigated over the past four years but were not implemented.

In the report, Segal discusses the potential effect of expanding the opt-out incentive, or adding a surcharge for certain enrollees, such as spouses. The Reports state that this may or may not be effective, given the uptake in and valuation of the Board's programs,

coupled with the amount that the incentive would need to be in order to encourage the opt-out. The current opt-out incentive is $2,000 for an employee who chooses not to take the state's insurance and must be re-applied-for every year. Under statute, employees cannot receive the opt-out incentive if they were eligible for state coverage in 2015 but did not elect it. ETF has considered methods to gather this information from employers, as the opt out is administered at the payroll center level. This data is not captured on the standard eligibility file that ETF manages and would be a costly feature to build into ETF's current systems; ETF can tell which members do not elect coverage, but not who elects to file for the incentive annually. Given that enrollment numbers are generally steady over the past few years, however, staff have not observed the opt out having a significant effect on plan uptake. Segal's report also mentions the possibility of adding a spousal surcharge. This change was determined to be administratively burdensome, and contrary to other stated program goals -- such as wellness engagement -- that seek participation from spouses as well.

Segal also proposed aligning the benefits for the State and Local programs as a way to streamline the GHIP programs and reduce administrative costs. This essentially would mean eliminating Program Option (PO) 2/12 and 4/14, preserving the other two programs that mirror options currently available to State employees. ETF initially proposed eliminating PO 4/14, the Local Deductible Plan, at the February 2017 Board meeting[3]. This plan varies significantly from other plan options offered by the Board, and the recommendation was based substantially on feedback from local employers; local employers in PO 2/12 stated that they felt the very rich program benefit was necessary to recruit employees, especially in very rural or small municipalities. The same feedback was not as prevalent from PO 4/14 employers. However, after the initial proposal, the largest PO 4/14 local (City of Madison) as well as other mid-sized local employers communicated to ETF that they were unable to accept PO 4/14 being eliminated. Some were bound by existing bargained contracts; others were unable to assume additional costs to their budgets but also did not feel they could reduce employee benefits. Following that input, ETF recommended the Board not eliminate PO 4/14.

Two key recommendations that the Board has not been able to implement were to self-insure and to regionalize the health insurance program. The Board did proceed with an RFP in 2016 to self-insure the program in 2018. Bids were collected and analyzed, and the Board elected to break the state into four regions with one to two plans per region, as well as offering a statewide PPO. ETF negotiated contracts for services; however, under state statute, all self-insured contracts for health benefits must be approved by the Joint Committee on Finance (JCF). JCF rejected those contracts in June of 2017, and ETF was then required to solicit new bids for 2018 and renegotiate contracts. While self-insuring and regionalizing the program ultimately did not take place as designed in the RFP, several health plans did leave the program following this series of events, and the net effect was to create a type of overlapping regional program.

[3] Group Insurance Board Memo, January 23, 2017. http://etf.wi.gov/boards/agenda-items-2017/gib0208/item8c.pdf

Another recommendation from Segal was to consider offering alternative Medicare Part D plan designs that might be lower cost. This was initially investigated as a part of the Medicare Advantage RFP in 2017. The responses returned did not clearly show a savings to the program if members elected this new option. In addition, given the number of changes that followed the self-insurance RFP, ETF felt that an additional option would cause confusion for members and that, ultimately, the risks of a new option outweighed the benefits.

Future Considerations

As the Board looks toward the future of the health programs that it oversees, there are still recommendations from the Segal report that have not been fully investigated. Segal recommended looking into the current tiering and premium structure for employees. Options include creating a four-tier premium structure instead of two and considering whether it is possible to base premiums on salary, rather than having a flat premium rate. Segal has also recommended the Board continue to monitor and consider strategies to mitigate the ACA Excise Tax. The Tax has been delayed until 2022 but has not yet been repealed.

Other recommendations coincide with research requests from the board; specifically, Segal recommended looking at the feasibility of onsite clinics, as well as methods for gain-sharing, shared-savings, centers of excellence, and other value-based purchasing options to incentivize members to look for high quality providers. ETF has provided an initial analysis of onsite clinics as a part of the November Board meeting and will provide analyses of the pricing and shared savings initiatives.

ETF staff is also working on initiatives for the Board. These are based on evaluation of the programs implemented from the Segal Reports and the data now available through the data warehouse analytics tools. The recommendations' focus will be to build on the initiatives already approved by the Board, with the goal of creating a holistic member benefits experience and promoting member health and engagement.

Staff will be at the meeting to answer any questions.

Attachment A: Plan Designs 2014-2018
Attachment B: Pharmacy Benefit Designs 2014-2019

Attachment A. Medical Plan Benefits, 2014 to 2018, Fully Insured, Non-Medicare Plans

State Non-HDHP (Program Option 1) and Local Program Option 6/16							
Plan Year	**Deductible Individual / Family**	**Medical Coinsurance**	**Device Coinsurance**	**Office Visit Copays**	**ER/Urgent Copays**	**OOPL Individual / Family**	**MOOP Individual / Family**
2014	N/A	90%/10%	80%/20%	N/A	$75	$500 / $1,000	N/A
2015	N/A	90%/10%	80%/20%	N/A	$75	$500 / $1,000	$6,600 / $13,200
2016	$250 / $500	90%/10%	80%/20%	$15 Primary Care / $25 Specialist	$75	$1,250 / $2,500	$6,850 / $13,700
2017	$250 / $500	90%/10%	80%/20%	$15 Primary Care / $25 Specialist	$75	$1,250 / $2,500	$6,850 / $13,700
2018	$250 / $500	90%/10%	80%/20%	$15 Primary Care / $25 Specialist	$75	$1,250 / $2,500	$6,850 / $13,700

State HDHP (Program Option 1) and Local Program Option 7/17							
Plan Year	**Deductible Individual / Family**	**Medical Coinsurance**	**Device Coinsurance**	**Office Visit Copays**	**ER/Urgent Copays**	**OOPL Individual / Family**	**MOOP Individual / Family**
2014	N/A						
2015	$1,500 / $3,000	90%/10%	80%/20%	N/A	$75	$2,500 / $5,000	$2,500 / $5,000
2016	$1,500 / $3,000	90%/10%	80%/20%	$15 Primary Care / $25 Specialist	$15 Primary Care / $25 Specialist	$2,500 / $5,000	$2,500 / $5,000

2017	$1,500 / $3,000	90%/10%	80%/20%	$15 Primary Care / $25 Specialist	$15 Primary Care / $25 Specialist	$2,500 / $5,000	$2,500 / $5,000
2018	$1,500 / $3,000	90%/10%	80%/20%	$15 Primary Care / $25 Specialist	$15 Primary Care / $25 Specialist	$2,500 / $5,000	$2,500 / $5,000

Local Program Options, 2014 – 2018 (No Change Each Year)							
Plan Year	**Deductible Individual / Family**	**Medical Coinsurance**	**Device Coinsurance**	**Office Visit Copays**	**ER/Urgent Copays**	**OOPL Individual / Family**	**MOOP Individual / Family**
PO 2/12 Local Traditional	N/A	100%	80%/20%	N/A	N/A	$500 per person for devices	N/A
PO 4/14 Local Deductible	$500 / $1,000	100%	80%/20%	N/A	$60	$500 per person for devices	N/A

Attachment B: Pharmacy Benefit Design, 2014 to 2018

Non-HDHP - Member Cost Share										
	Level 1	**Level 2**	**Level 1+2 OOPL** Individual/Family		**Level 3 †**	**Level 4** Preferred Specialty Drugs		**Level 4 OOPL**	**Level 4 †** Non-Preferred	**Federal MOOP**
Plan Year	Preferred Drugs	Preferred Drugs	Fully Insured Health Plans (UB)	Self-Insured Health Plans (SP)	Non-Preferred/ Non-covered Drugs	Fill @ Preferred Specialty Pharmacy	Fill @ Non-Preferred Specialty Pharmacy	Individual/ Family	Specialty Drugs Fill @ Any Pharmacy	Individual/ Family
2014	$5	$15	$410/$820	$1,000/$2,000	$35	$15	$50	$1,000/$2,000	$50	NA
2015	$5	$15	$410/$820	$1,000/$2,000	$35	$15	$50	$1,000/$2,000	$50	$6,600/$13,200
2016	$5	20% ($50 Max)	$600/$1,200	$1,000/$2,000	40% ($150 Max)	$50	40% ($200 Max)	$1,200/$2,400	40% ($200 Max)	$6,850/$13,700
2017	$5	20% ($50 Max)	$600/$1,200	$1,000/$2,000	40% ($150 Max)	$50	40% ($200 Max)	$1,200/$2,400	40% ($200 Max)	$6,850/$13,700
2018	$5	20% ($50 Max)	$600/$1,200	NA$^{\Delta}$	40% ($150 Max)	$50	NA* Commercial (Non-Medicare): MUST fill at a Preferred Specialty Pharmacy EGWP (Medicare): 40% ($200 Max)	$1,200/$2,400	NA**	$6,850/$13,700
2019	$5	20% ($50 Max)	$600/$1,200	NA$^{\Delta}$	40% ($150 Max)	$50	NA* Commercial (Non-Medicare): MUST fill at a Preferred Specialty Pharmacy EGWP (Medicare): 40% ($200 Max)	$1,200/$2,400	NA**	$6,850/$13,700

OOPL = Out of Pocket Limit
MOOP = Maximum Out of Pocket

UB = Uniform Benefits (eff 2016: IYC Health Plan); Fully Insured Health Plans
SP = Standard Plan (eff 2016: IYC Access Plan); Self-Insured Health Plans

† Level 3 & Level 4 Non-Preferred member cost shares DO apply to Plan Deductibles and Plan OOPLs, as well as the Federal MOOP
‡ Plan Deductibles and Plan OOPLs are combined medical and prescription drug costs
Δ By direction of the Joint Committee on Finance, self-insured health plans were no longer allowed to be part of the group health insurance programs offered by the GIB starting in 2018
* Mandatory Specialty Drug Program implemented in 2018 for commercial (non-Medicare) coverage only; all specialty drugs must be filled at a preferred specialty pharmacy
** Non-Preferred Specialty Drugs must be approved for coverage via Prior Authorization and will have the same cost share and OOPL as Preferred Specialty Drugs

HDHP - Member Cost Share													
	Level 1	**Level 2**	**Level 3 †**	**Level 4** Preferred Specialty Drugs		**Level 4 †** Non-Preferred	**Plan Deductible ‡** Individual/Family			**Plan OOPL ‡** Individual/Family			**Federal MOOP**
Plan Year	Preferred Drugs	Preferred Drugs	Non-Preferred/ Non-covered Drugs	Fill @ Preferred Specialty Pharmacy	Fill @ Non-Preferred Specialty Pharmacy	Specialty Drugs Fill @ Any Pharmacy	Fully Insured (UB)	Self-Insured (SP) In-Network	Self-Insured (SP) Out-of-Network	Fully Insured (UB)	Self-Insured (SP) In-Network	Self-Insured (SP) Out-of-Network	Individual/ Family
2015	$5	$15	$35	$15	$50	$50	$1,500/$3,000	$1,700/$3,400	$2,000/$4,000	$2,500/$5,000	$3,500/$7,000	$3,800/$7,600	$6,600/$13,200
2016	$5	20% ($50 Max)	40% ($150 Max)	$50	40% ($200 Max)	40% ($200 Max)	$1,500/$3,000	$1,700/$3,400	$2,000/$4,000	$2,500/$5,000	$3,500/$7,000	$3,800/$7,600	$6,850/$13,700
2017	$5	20% ($50 Max)	40% ($150 Max)	$50	40% ($200 Max)	40% ($200 Max)	$1,500/$3,000	$1,700/$3,400	$2,000/$4,000	$2,500/$5,000	$3,500/$6,550	$3,800/$7,600	$6,850/$13,700
2018	$5	20% ($50 Max)	40% ($150 Max)	$50	NA* Commercial (Non-Medicare): **MUST** fill at a Preferred Specialty Pharmacy EGWP (Medicare): 40% ($200 Max)	NA**	$1,500/$3,000	$1,700/$3,400	$2,000/$4,000	$2,500/$5,000	NA$^{\Delta}$	NA$^{\Delta}$	$6,850/$13,700
2019	$5	20% ($50 Max)	40% ($150 Max)	$50	NA* Commercial (Non-Medicare): **MUST** fill at a Preferred Specialty Pharmacy EGWP (Medicare): 40% ($200 Max)	NA**	$1,500/$3,000	$1,700/$3,400	$2,000/$4,000	$2,500/$5,000	NA$^{\Delta}$	NA$^{\Delta}$	$6,850/$13,700

OOPL = Out of Pocket Limit
MOOP = Maximum Out of Pocket
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