STATE OF WISCONSIN
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: April 18, 2019

To: Group Insurance Board

From: Sara Brockman, Health Program Manager
Office of Strategic Health Policy

Subject: 2018 Health Plan Performance Report

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

Attached is the *2018 Health Plan Performance Report*. The report provides performance outcomes for the 10 fully-insured health plans contracted by the Group Insurance Board (Board) to provide Group Health Insurance Program (GHIP) coverage for plan year 2018.

This is the first annual performance report to the Board. Health plans are deidentified and are listed in random order.

2018 was the first plan year of performance measurement for the GHIP, therefore comparisons to prior plan years cannot be made. Future annual reports to the Board will include data comparison and trend detail.

Overall, health plans met or exceeded most measurement targets on a regular basis. Health plans also consistently submitted quarterly performance reports in a timely fashion and provided sufficient details in the event of a performance exception.

Average health plan performance exceeded the annual performance target for four of the six performance measures:

- Processing Accuracy
- Claims Processing Time
- Call Answer Timeliness
- Open Call Resolution Turn-Around Time

Average health plan performance narrowly failed to meet the annual performance target for the remaining two measures, Call Abandonment Rate and Electronic Written Inquiry Response, largely due to ongoing performance difficulties with one plan. A performance

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy
Eileen K Mallow Electronically Signed 4/29/19

Board	Mtg Date	Item #
GIB	5.15.19	8A

monitoring plan was established with the plan in question and performance penalties assessed as deemed appropriate by the Department of Employee Trust Funds.

Additional performance and penalty assessment detail is outlined in the report.

Staff will be at the Board meeting to answer any questions.

Attachment: 2018 Health Plan Performance Report

Group Health Insurance Program

2018 Health Plan Performance Report

April 18, 2019

Prepared for the Group Insurance Board, May 15, 2019

I. Overview

The Department of Employee Trust Funds (ETF), with direction from the Group Insurance Board (Board), administers the State of Wisconsin Group Health Insurance Program (GHIP) created under Chapter 40 of the Wisconsin Statutes. The Board contracted with 10 fully-insured health plan providers for plan year 2018 to offer GHIP coverage to employees and retirees of state agencies, University of Wisconsin System, University of Wisconsin Hospitals & Clinics Authority, and participating local government employees. ETF manages the contracted health plans on behalf of the Board.

This is the first annual *Health Plan Performance Report* to the Board. Health plans are deidentified and randomized for the purposes of this report. As 2018 was the first plan year of performance measurement, comparisons to prior plan years cannot be made. Future reports to the Board will include data comparison and trend detail.

The measures in this report were developed by ETF staff to reflect national best practices and are reviewed annually for continuation, modification, or retirement. Health plans submit performance metrics on a quarterly basis, using an ETF-provided reporting template. The performance report is accompanied by a quarterly vendor performance certification that attests all required performance standards were administered and completed in adherence with contractually stipulated terms and conditions.

Quarterly health plan performance reports are reviewed for performance standard compliance on a quarterly basis. Each performance standard has a related penalty, which is typically $5,000 dollars for each percentage point for which a standard is not in each month. Applicable penalties are also assessed on a quarterly basis. Penalties may be waived in certain circumstances when ETF staff determine it is warranted.

II. Annual Average Health Plan Performance Summary by Measure

Table 1 provides an overview of the annual average health plan performance by measure for quality and timely service to our members. Individual health plan performance for each performance measure can be found on subsequent pages as noted in Table 1. Please note that health plans are deidentified for the purposes of this report.

Overall, health plans met or exceeded most measurement targets on a regular basis. The difference between the performance target and the actual 2018 average performance is noted for each measurement in the column titled 2018 Average Variance. Measures that exceeded the performance target are noted with a green arrow, while measures that failed to meet the performance target are noted with a red arrow.

The 2018 average performance exceeded the performance target for four of the six performance measures. The remaining two measures, Call Abandonment Rate and Electronic Written Inquiry Response, narrowly failed to meet the 2018 average performance target largely due to ongoing performance difficulties with one plan, "Plan 08." Due to consistently poor performance across multiple measures in consecutive quarters, a performance monitoring plan was established with "Plan 08" beginning in the second quarter of 2018. No other health plans warranted a performance monitoring plan in 2018.

Table 1 – Annual Average Health Plan Performance Summary by Measure

Performance Measure	Performance Target	2018 Average Performance	2018 Average Variance	Report Detail Page
A. Claims Processing				
1) Processing Accuracy[1]	97%	99.3%	2.3% ↑	Page 4
2) Claims Processing Time[1]	95% processed within 30 days	97.6%	2.6% ↑	Page 5
B. Customer Service				
1) Call Answer Timeliness[1]	80% ≤ 30 seconds	82.3%	2.3% ↑	Page 6
2) Call Abandonment Rate[1]	< 3% of calls abandoned	3.1%	0.1% ↑	Page 7
3) Open Call Resolution Turn-Around Time[1]	90% resolved within 2 days	95.2%	5.2% ↑	Page 8
4) Electronic Written Inquiry Response[1]	98% response within 2 days	97.5%	-0.5% ↓	Page 9

1: First year of measurement, comparisons to prior plan years cannot be made at this time

III. Claims Processing

1) Processing Accuracy

Accurate claims processing prevents numerous potential negative impacts for program participants, such as account posting errors and incorrect patient statements, and helps health plans to prevent financial losses and payment delays.

- **Measurement Description**
  - At least 97% level of processing accuracy
  - Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed

- **Key Findings:**
  - All participating health plans demonstrated an ability to meet or exceed claims processing accuracy targets
  - "Plan 09" failed to meet the 97% measurement goal in Q3 – the variance was allowable, and "Plan 09" reported improved performance the following quarter

Table 2A – Processing Accuracy: Annual Average Health Plan Performance

Performance Measure	Performance Target	2018 Average Performance	2018 Average Variance
Processing Accuracy	97%	99.3%	2.3% ⬆

Table 2B – Processing Accuracy: Quarterly Performance by Health Plan

Health Plan	Q1	Q2	Q3	Q4	2018 Average Performance	2018 Average Target Variance
Plan 01	100%	98%	99%	100%	99%	2% ⬆
Plan 02	100%	100%	100%	100%	100%	3% ⬆
Plan 03	99%	100%	100%	100%	100%	3% ⬆
Plan 04	99%	99%	99%	99%	99%	2% ⬆
Plan 05	99%	99%	99%	99%	99%	2% ⬆
Plan 06	100%	99%	100%	100%	100%	3% ⬆
Plan 07	100%	100%	100%	100%	100%	3% ⬆
Plan 08	99%	98%[1]	99%[1]	100%[1]	99%	2% ⬆
Plan 09	97%	97%	95%[2]	98%	97%	0%
Plan 10	100%	100%	100%	100%	100%	3% ⬆

1: Performance monitoring in place
2: Variance cause identified and resolved promptly

2) Claims Processing Time

Claims processing time is an important factor in containing program costs and improving participant satisfaction. Prompt claims processing provides members with timely billing statements, which is especially important for participants with a higher amount of shared costs.

- **Measurement Description:**
  - At least 95% of claims received must be processed within 30 business days of receipt of all necessary information, except for those claims which the health benefit program is the secondary payer

- **Key Findings:**
  - 9 out of 10 participating health plans exceeded the 95% performance target each quarter
  - "Plan 08" was the only health plan that failed to meet the 95% performance target
    - A performance monitoring plan was established with "Plan 08" in Q2
    - Penalties were assessed for this measure in Q4 due to ongoing performance concerns

Table 3A – Claims Processing Time: Annual Average Health Plan Performance

Performance Measure	Performance Target	2018 Average Performance	2018 Average Variance
Claims Processing Time	95% processed within 30 days	97.6%	2.6% ⬆

Table 3B – Claims Processing Time: Quarterly Performance by Health Plan

Health Plan	Q1	Q2	Q3	Q4	2018 Average Performance	Performance Target Variance
Plan 01	100%	100%	99%	99%	100%	5% ⬆
Plan 02	100%	100%	100%	100%	100%	5% ⬆
Plan 03	99%	100%	100%	100%	100%	5% ⬆
Plan 04	99%	98%	98%	98%	98%	3% ⬆
Plan 05	100%	100%	100%	100%	100%	5% ⬆
Plan 06	100%	99%	100%	100%	100%	5% ⬆
Plan 07	100%	100%	100%	100%	100%	5% ⬆
Plan 08	59%	76%[1]	92%[1]	92%[1,2]	80%	-15% ⬇
Plan 09	99%	97%	99%	99%	99%	4% ⬆
Plan 10	100%	100%	100%	100%	100%	5% ⬆

1: Performance monitoring in place
2: Penalty assessed

IV. Customer Service

1) Call Answer Timeliness

The ability for a participant to connect with a live customer service representative in a short period of time is important for customer satisfaction and improves the likelihood of timely and accurate issue resolution.

- **Measurement Description:**
  - At least 80% of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within 30 seconds

- **Key Findings:**
  - 5 out of 10 health plans failed to meet the 80% performance target in Q1 due to an influx of calls related to new enrollments
    - This variance was allowed as eight health plans exited the GHIP at the end of 2017, resulting in approximately 60,000 participants selecting a new plan
  - "Plan 07" and "Plan 09" each failed to meet the 80% performance target in one additional quarter – the variances were allowable as they pertained to open enrollment and a change in plan offerings
    - The 2018 average annual performance for both "Plan 07" and "Plan 09" was 78%, which is 2% lower than the 80% performance target, due to missing the target in 2 out of 4 quarters
  - "Plan 08" consistently failed to meet the 80% performance target
    - A performance monitoring plan was established with "Plan 08" in Q2
    - Penalties were assessed for this measure in Q4 due to ongoing performance concerns

Table 4A – Call Answer Timeliness: Annual Average Health Plan Performance

Performance Measure	Performance Target	2018 Average Performance	2018 Average Variance
Call Answer Timeliness	80% ≤ 30 seconds	82.3%	2.3% ⬆

Table 4B – Call Answer Timeliness: Quarterly Performance by Health Plan

Health Plan	Q1	Q2	Q3	Q4	2018 Average Performance	Performance Target Variance
Plan 01	76%[1]	85%	87%	82%	83%	3% ⬆
Plan 02	98%	100%	80%	80%	90%	10% ⬆
Plan 03	81%	85%	86%	90%	86%	6% ⬆
Plan 04	91%	92%	91%	92%	92%	12% ⬆
Plan 05	67%[1]	96%	93%	90%	87%	7% ⬆
Plan 06	93%	97%	94%	92%	94%	14% ⬆
Plan 07	57%[1]	85%	96%	75%[4]	78%	-2% ⬇
Plan 08	36%	36%[3]	55%[3]	55%[3,4]	46%	-34% ⬇
Plan 09	72%[1]	87%	73%[2]	81%	78%	-2% ⬇
Plan 10	91%	91%	91%	92%	91%	11% ⬆

1: Variance due to enrollment shifts caused by exiting health plans
2: Variance due to increased call center activity related to open enrollment
3: Performance monitoring in place
4: Penalty assessed

2) Call Abandonment Rate

Call abandonment rates have a direct relation to the amount of time a participant must wait to speak with a customer service representative. Lower call abandonment rates typically indicate short waiting times and increased customer satisfaction.

- **Measurement Description:**
  - Less than 3% of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received.

- **Key Findings:**
  - 9 out of 10 participating health plans met or exceeded the average annual performance target
    - The consistently poor performance of "Plan 08" is the primary reason that the 2018 average variance is 0.1% greater than the annual performance target of < 3% of calls abandoned
  - 3 out of 10 health plans had a call abandonment rate above the performance target in Q1
    - This variance was allowed as eight health plans exited the GHIP at the end of 2017, resulting in approximately 60,000 participants selecting a new plan
  - "Plan 08" was the only health plan that failed to meet the performance target in each quarter
    - A performance monitoring plan was established with "Plan 08" in Q2
    - Penalties were assessed for this measure in Q4 due to ongoing performance concerns

Table 5A – Call Abandonment Rate: Annual Average Health Plan Performance

Performance Measure	Performance Target	2018 Average Performance	2018 Average Variance
Call Abandonment Rate	< 3% of calls abandoned	3.1%	0.1% ⬆

Table 5B – Call Abandonment Rate: Quarterly Performance by Health Plan

Health Plan	Q1	Q2	Q3	Q4	2018 Average Performance	Performance Target Variance
Plan 01	1%	1%	0%	1%	1%	-2% ⬇
Plan 02	1%	1%	2%	1%	1%	-2% ⬇
Plan 03	1%	1%	1%	0%	1%	-2% ⬇
Plan 04	2%	2%	2%	2%	2%	-1% ⬇
Plan 05	4%[1]	2%	0%	1%	2%	-1% ⬇
Plan 06	0%	0%	0%	0%	0%	-3% ⬇
Plan 07	3%[1]	1%	0%	2%	2%	-1% ⬇
Plan 08	10%	41%[2]	6%[2]	21%[2,3]	20%	17% ⬆
Plan 09	2%	1%	2%	2%	2%	-1% ⬇
Plan 10	1%	1%	2%	1%	1%	-2% ⬇

1: Variance due to enrollment shifts caused by exiting health plans
2: Performance monitoring in place
3: Penalty assessed

3) Open Call Resolution Turn-Around Time

Prompt open call resolution typically results in fewer repeated calls and improved customer satisfaction and may also reflect the overall efficiency of a customer service team.

- **Measurement Description:**
  - At least 90% of customer service calls that require follow-up or research will be resolved within two business days of initial call
  - Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two business days, divided by the total number of issues initiated by the call

- **Key Findings:**
  - 8 out of the 9 measured health plans met or exceeded the 90% measurement target each quarter
  - "Plan 10" was granted a data reporting exemption due to system limitations
    - A written summary of activity was submitted – no issues were identified for 2018
  - "Plan 08" failed to meet the 90% measurement goal in Q1, which had a significant impact on their yearly average
    - A performance monitoring plan was established with "Plan 08" in Q2
    - Performance for this metric met or exceeded the 90% measurement goal for Q2 – Q4 of 2018

Table 6A – Open Call Resolution Turn-Around Time: Annual Average Health Plan Performance

Performance Measure	Performance Target	2018 Average Performance	2018 Average Variance
Open Call Resolution Turn-Around Time	90% resolved within 2 days	95.2%	5.2% ⬆

Table 6B – Open Call Resolution Turn-Around Time: Quarterly Performance by Health Plan

Health Plan	Q1	Q2	Q3	Q4	2018 Average Performance	Performance Target Variance
Plan 01	99%	99%	99%	99%	99%	9% ⬆
Plan 02	97%	97%	97%	98%	97%	7% ⬆
Plan 03	95%	93%	93%	93%	94%	4% ⬆
Plan 04	96%	97%	98%	98%	97%	7% ⬆
Plan 05	98%	97%	97%	96%	97%	7% ⬆
Plan 06	94%	94%	94%	95%	94%	4% ⬆
Plan 07	92%	94%	99%	99%	96%	6% ⬆
Plan 08	75%	90%[1]	90%[1]	94%[1]	87%	3% ⬇
Plan 09	97%	98%	97%	97%	97%	7% ⬆
Plan 10	n/a	n/a	n/a	n/a	n/a	n/a

1: Performance monitoring in place
2: Data reporting exemption granted due to system limitation, written summary of activity submitted as substitute

4) Electronic Written Inquiry Response

Prompt electronic written inquiry response times typically lowers the number of contacts a participant has with a health plan to resolve a question and is likely to improve customer satisfaction.

- **Measurement Description:**
  - At least 98% of customer service issues submitted by email and website are responded to within two business days

- **Key Findings:**
  - 8 out of 10 health plans met or exceeded the 98% measurement target each quarter
    - The consistently poor performance of "Plan 08" is the primary reason that the 2018 average variance is 0.5% below the annual performance target of 98% response within two business days
  - "Plan 05" failed to meet the 98% performance target in Q1 due to an influx of written inquiries related to new enrollments
    - This variance was allowed as eight health plans exited the GHIP at the end of 2017, resulting in approximately 60,000 participants selecting a new plan
  - "Plan 08" consistently failed to meet the 98% performance target for the first 3 quarters of the year
    - The 47% response time reported in Q1 was 51% lower than the performance target, and had a significant impact on their yearly average
    - A performance monitoring plan was established with "Plan 08" in Q2
    - "Plan 08" reported 100% response time for Q4

Table 7A – Electronic Written Inquiry Response: Annual Average Health Plan Performance

Performance Measure	Performance Target	2018 Average Performance	2018 Average Variance
Electronic Written Inquiry Response	98% response within 2 days	97.5%	-0.5% ⬇

Table 7B – Electronic Written Inquiry Response: Quarterly Performance by Health

Health Plan	Q1	Q2	Q3	Q4	2018 Average Performance	Performance Target Variance
Plan 01	99%	99%	100%	100%	100%	2% ⬆
Plan 02	99%	99%	99%	99%	99%	1% ⬆
Plan 03	100%	100%	100%	100%	100%	2% ⬆
Plan 04	100%	100%	100%	100%	100%	2% ⬆
Plan 05	91%[1]	100%	100%	99%	98%	0%
Plan 06	99%	100%	100%	100%	100%	2% ⬆
Plan 07	100%	100%	100%	100%	100%	2% ⬆
Plan 08	47%	89%[2]	83%[2]	100%[2]	80%	-18% ⬇
Plan 09	100%	100%	100%	100%	100%	2% ⬆
Plan 10	99%	99%	99%	99%	99%	1% ⬆

1: Variance due to enrollment shifts caused by exiting health plans
2: Performance monitoring in place

V. Additional Key Performance Measures

Table 8 provides an overview of additional key measures pertaining to enrollment and major system changes. These additional key measures are reported for each month on a quarterly basis. Overall, health plans met or exceeded the additional key performance measurement requirements.

Table 8 – Additional Key Performance Measures

Performance Measure	Measurement Description	Performance Target	2018 Average Performance
A. Enrollment			
1) Enrollment File[1]	The health plan must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within 2 business days of the file receipt.	Daily 834 file acceptance and processing	100%
2) Enrollment Discrepancies and Exceptions[1]	The health plan must resolve all enrollment discrepancies (any difference of values between ETF's database and the health plan's database) as identified within 1 business day of notification by ETF or identification by the health plan.	Database = 1 day of notification	100%
	The health plan must correct the differences on the exception report within 5 business days of notification by the department.	Exception report = within 5 days of notification	91.6%[2,3]
3) Identification (ID) Cards[1]	The health plan shall issue ID cards within 5 business days of the generation date of the enrollment file containing the addition or enrollment change, except during the It's Your Choice Open Enrollment Period.	Issue ID cards within 5 days	100%
B. Other			
1) Major System Changes and Conversions[1]	The health plan shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the GHIP without specific prior written notice of a least 180 days.	Major system changes or conversions planned	None reported
		180 day written notice submitted	n/a

1: First year of measurement, comparisons to prior plan years cannot be made at this time
2: "Plan 01" failed to meet the exception report processing requirement in June 2018, cause identified and resolved promptly
3: "Plan 08" failed to meet the exception report processing requirement from January – September 2018, requirement met in Q4 2018