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Correspondence Memorandum

Date: October 7, 2019

To: Group Insurance Board

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

Subject: Current Group Health Insurance Projects and Priorities

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

Background

The table officers of the Group Insurance Board (Board) have requested the Department of Employee Trust Funds (ETF) inform the Board about projects, concepts and issues that have been either worked on by ETF; requested by the Board and not completed; or identified for future consideration.

Attachment A contains a summary of general concepts and strategies that have been pursued by ETF on behalf of the Board over the past ten years (January 2009 to present). The summary excludes historical changes that were intended to be purely policy clarifications or did not otherwise constitute substantial changes to program administration, benefits or member experience.

The remainder this memo discusses ETF's current list of priority areas, for the Board's consideration. Each item includes a description of the expected level of staff effort to research and implement solutions, by full time equivalent (FTE) employee, and a risk/reward description that will be discussed at the Board meeting. Note that the time estimates may extend if several implementations overlap.

Areas of Focus for Consideration

ETF has identified the following as areas of opportunity in the programs the Board oversees:

- Wisconsin Public Employers (WPE) health insurance program:
  The WPE health insurance program has declined in membership during recent years. Survey results from the 2019 local employer survey (Ref. GIB | 8.21.19 | 4) showed that many local employers find the program's cost prohibitive and premiums to be too volatile year over year. That said, employers reported very

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positive customer experiences overall, and many believe the benefits were of value in recruiting and retaining employees.

Participating health plans report challenges in providing sustainable rates for the WPE program, partly due to the number of subscribers enrolled per employer or per region. The Board is required to offer the WPE program to local employers under Wis. Stats. §40.51(7) but has not taken an active approach to managing the program in recent years. A better understanding of the Board's intent for this program (e.g., to grow versus maintain status quo) would help ETF provide proactive recommendations for the program's development.

- ETF staff effort: 2-3 FTE for 8 months, plus actuary support
- Risk/Reward: High-risk, medium reward

- High-Deductible Health Plan (HDHP) program: Under Wis. Stats. §40.515, the Board must offer a HDHP option coupled with a Health Savings Account (HSA) to state employees. The Board's HDHP has a $1,500 deductible for single plans and $3,000 for family plans. State employers contribute $750 to the HSA for single plans and $1,500 for family plans. Enrollment in this plan has been somewhat slow, and although the plan has been met with skepticism by some members, enrollment has risen year over year. However, the program was implemented without a clear enrollment goal from the Board, and active education regarding the offering has only recently begun via the ALEX Benefits Counselor tool. Clearer direction from the Board on the role this benefit should play in the products made available to state employees would help ETF prioritize resources, training and member education in this area.
  - ETF staff effort: 1-2 FTE for 5-6 months
  - Risk/Reward: Low-risk, medium reward

- Value-based insurance design (VBID): Value-based insurance design is a concept where member cost sharing for services (e.g., copays, coinsurance, etc.) is proportionate to the medical value of the service. The Board began its first VBID program in 2019 for diabetic members. Members who participate in disease management coaching for diabetes receive lower cost sharing on their prescription drugs to manage their diabetes. There may be additional clinical conditions or service sets the Board could incentivize in order to help members better adhere to treatment programs, improve health and potentially manage condition-related costs to the program long-term.
  - ETF staff effort: 2-3 FTE for 12 months
  - Risk/Reward: Medium-risk, medium to high reward

- Value-based payments/contracting (VBP): Value-based payments are generally arrangements with service providers or product manufacturers that pay the provider relative to the effectiveness of the service or product. This can take a variety of forms, from physician contract arrangements that reimburse based on patient outcomes to drug manufacturer contracts for certain medications based

on the demonstrated effectiveness of the drug. While the Board does not directly contract for medical or pharmaceutical products or services, it could consider options for either direct contracting or incentivizing current program vendors to pursue such contracts.
    - ETF staff effort: 2-3 FTE for 12 months
    - Risk/Reward: Medium to high-risk, medium reward

- Onsite clinics: In 2018, the Board asked ETF to examine the feasibility of onsite clinics for state employees. ETF completed an initial review. While some employers have successfully implemented such clinics, there are aspects of the Board's programs and of the state employee population itself that present challenges to implementing them in a way that wouldn't add costs to the program. ETF could complete a feasibility review for onsite clinics in the state employee population.
    - ETF staff effort: 2-3 FTE for 6 months
    - Risk/Reward: High-risk, medium to low reward

- Avoidable emergency room (ER) utilization: The first trend analysis by IBM Watson Health, the Board's data warehouse vendor, indicated that unnecessary visits to the ER cost the Board's programs a substantial amount of money. Many people could be better served by improved access or assistance in finding primary care; others by gaining help in managing preventable or treatable conditions. ETF has begun an analysis of options for avoidable ER use and could prioritize a review of this issue, if directed by the Board.
    - ETF staff effort: 3 FTE for 3-6 months
    - Risk/Reward: Medium to low-risk, medium reward

- Specialty drugs provided under the medical benefit: While the Board and ETF typically think of the contracted pharmacy benefit manager (PBM) as the primary means by which members get prescription drugs, there are many drugs provided through the medical benefit in virtue of where those drugs are provided (e.g., in a hospital or outpatient clinic). The PBM does not manage these drugs and does not negotiate their cost. Some in the insurance and health policy communities have questioned to what extent those drugs add to insurance costs and whether finding a way to bring those drugs under management of the PBM would result in cost savings. This is the second area of potential identified by IBM Watson Health in their trend analysis, and ETF could also provide a review and options to the Board upon request.
    - ETF staff effort: 2 FTE for 6-8 months
    - Risk/Reward: Medium-risk, medium reward

- Mental health access and parity analysis: The National Alliance on Mental Illness (NAMI) estimates that one in five people experience a mental illness in their lifetime. Data from the Board's data warehouse indicates mental illness costs an estimated $2,048 per patient. There are indirect costs as well; for example, NAMI

also estimates that people with depression have a 40% higher risk of developing cardiovascular and metabolic diseases than the general population[1]. IBM Watson Health identified this as the third priority area in the trend analysis completed for ETF. ETF recommends an analysis of the impact of mental health on members; a review of how plans have implemented the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008; and the state of current provider access for members.
    - ETF staff effort: 2 FTE for 12 months
    - Risk/Reward: Low-risk, medium to high reward

- Social determinants of health: Social determinants of health have been well known in the public health community for many years and recently gained broad attention as payers and providers look for ways to manage costs. Social determinants of health, according to a report by the Kaiser Family Foundation, "include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care." Some recent studies have suggested that up to half of all costs associated with health conditions are related to or governed by social determinants. Most programming efforts in this area have focused on the Medicaid population, but recently Medicare has started to look at ways to support non-clinical health services. ETF recommends an analysis of the social determinant and equity factors particular to an employed population, and at the Board's request could provide options for addressing these factors for the Board's membership.
    - ETF staff effort: 2 FTE for 12 months
    - Risk/Reward: Medium-risk, medium to high reward

Summary and Next Steps
The list above is not a comprehensive work list, and the Board may have other project ideas it would like ETF to investigate or may not wish to pursue one or more item above. ETF seeks the Board's input in prioritizing future work.

Staff will be available at the Board meeting to address any questions.

Attachment A. Projects and Change Concepts, January 2009 to August 2019

[1] https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

Projects & Concepts, January 2009 to August 2019

Benefits Impacted	Project Description	Year(s) Brought to Board	Rationale	2019 Status
All Benefits	Segal Benefits Consultant Reports	2015	Contract with Segal for benefits consulting recommended by Strategic Planning Workgroup, resulted in two reports published in 2015. Majority of recommendations investigated and implemented in subsequent years.	Report recommendations completed
All Benefits	ALEX Benefits Counselor	2018	Online decision support tool for members to help in selecting a health plan design and supplemental benefits	Current product offering
Data Warehouse	Build and implement claims data warehouse	2016	Recommended by Segal Reports, plans required to submit complete and comprehensive claims data	Current policy
Dental Benefits	Uniform Dental Benefit	2015	Recommended by Board strategic planning process and Segal Reports, dental benefit carved out to a third-part administrator	Carved out benefit through Delta Dental WI
Dental Benefits	Stand alone dental product	2011 (not adopted) 2012 (not adopted) 2013 (uniform benefit adopted) 2014 (RFP approved) 2016 (carve out benefit authorized)	Create a stand-alone dental benefit, outside of the health plan Board authorized an RFP for stand-alone, self-insured preventive dental benefit in 2016, following earlier recommendations of strategic planning workgroup	Current policy
Eligibility/Enrollment	Limit rehired annuitants at the University of Wisconsin from enrolling in health insurance as graduate assistants	2009	Reflected in State Statute §40.52(3), plan pricing was established assuming a younger group and thereby less expensive risk	Current policy
Eligibility/Enrollment	Domestic partner coverage	2010 2018 (coverage removed)	Added by emergency rule in 2010 and implemented; coverage later removed in biennial budget	Not currently covered
ERA Benefits	ERA Benefits RFP	2018	RFP for new vendor for ERA/HSA/Cafeteria Plan benefits. RFP approved, new vendor selected and implementing in 2019	Current product offering

Life Insurance	Life Insurance Vendor RFP	2019	RFP for vendor for life insurance product. RFP approved by the Board	RFP pending
Medical/Uniform Benefits	Non-payment of services for medical errors	2009	Adopted by CMS in 2008	Plans required to add language to support policy in their contracts with providers and hospitals
Medical/Uniform Benefits	Change Medicare Family 2 premium rate to only apply after all family members are covered by Medicare.	2009	Described as a fairness issue; insured persons with one person on Medicare and one not paid more in premiums than in cases where two people on the contract had Medicare and one or more family members did not.	
Medical/Uniform Benefits	Updating coverage of behavioral health services to comply with Mental Health Parity Act	2009	Federal requirement	Current plan meets mental health parity requirements
Medical/Uniform Benefits	Adding a coverage exception for Case Management/Alternate Treatment	2009	Allows the opportunity for an attending physician to make recommendations in agreement with the health plan if tha recommendation is expected to be more cost effective than an alternative, covered treatment	Language remains in the Uniform Benefits portion of the contract
Medical/Uniform Benefits	Emergency room copayment waiver	2010	Waiver recommended by ETF staff; cost estimated to be negligible	Current policy
Medical/Uniform Benefits	Adding coverage for acupuncture	2009 (not added)	Not added in 2009 because alternate care provision could be used to cover case-by-case	Not currently an explicitly covered benefit (Pilot program beginning 2020)
Medical/Uniform Benefits	Orthognathic surgery	2009 (not added)	Change not recommended to the Board because of cost and benefit availability under the Standard Plan in 2009	Currently a covered benefit
Medical/Uniform Benefits	Adding coverage of dental implants	2009 (not added) 2010 (not added)	Identified as a most-effective treatment in some cases, but not recommended for coverage in 2009 or 2010 due to cost	Currently a covered benefit

Medical/Uniform Benefits	Bariatric Surgery	2009 (not added) 2010 (not added) 2012 (not added)	Change requested by numerous participants, but esimated premium cost to add was substantial and so not recommended by ETF for several years; had been covered by the Standard (Access) Plan until 2018	Coverage added for 2020
Medical/Uniform Benefits	Adding a two-person premium rate or three-tier premium structure	2009 (not added) 2011 (not added)	Option requested by a local employer in 2009; cost difference estimated by the actuary did not indicate substantial differences in rates, and would require a statutory change Investigated again as part of the WI Act 32 Feasibility Study conducted in 2011	Not adopted
Medical/Uniform Benefits	Acute Inpatient Rehabilitation Limits	2009 (not adopted)	The acute rehab benefit in 2009 was unlimited. The Board investigated limiting to 90 days, but did not move forward at that time.	Not adopted
Medical/Uniform Benefits	Emergency room copayment amount	2009 (not changed)	In 2009 the Board looked into several changes to the ER copay, including changing the copay waiver for admissions to the hospital and increasing the copay from $60 to $70	Current ER copay rate is $75
Medical/Uniform Benefits	State employee coverage through Exchange	2011 (not adopted)	Investigated as a part of the 2011 ETF/OSER Act 32 Feasibility Study; predicated on a Wisconsin state-based exchange which was not developed	Not current policy
Medical/Uniform Benefits	High deductible health plan (HDHP)	2011 (not adopted) 2014	Initially investigated as part of the 2011 ETF/OSER Act 32 Feasibility Study and referred to governor's office; no action taken at that time Late required under 2013 WI Act 20 and implemented starting in 2015 with required HSA	Currently available plan design
Medical/Uniform Benefits	HEDIS and CAHPS data collection and reporting	2011 2015 (revised report card) 2017 (revised report card)	Implemented by former ETF medical officer resource	Current policy, though considering options for moving from HEDIS and CAHPS to data warehouse

Medical/Uniform Benefits	Department Initiatives in health plan contracts focused on safety and quality of care	2011 2018 expanded	Initiatives added related to low back pain, high tech radiology, coordination of care after hospital discharge, shared decision-making, and end of life care; low-value care monitoring added for 2019 contract	Current policy
Medical/Uniform Benefits	Advanced imaging prior authorization	2012	Recommended by ETF medical consultant, implemented in 2013	Current policy
Medical/Uniform Benefits	Require plans to help members designate a primary care provider	2012 (not adopted) 2018	Recommended based on anticipated savings	Current policy, allows for PCP or primary care clinic to be elected
Medical/Uniform Benefits	Nurse-midwife coverage	2012 (not recommended)	2011 Wisconsin Act 32 required the Board to study including benefits	
Medical/Uniform Benefits	Self-insuring the medical benefit	2013 (not adopted) 2015/2016 (not adopted)	Initially studied by Deloitte in 2013, projected cost increase; reviewed again by Segal in 2014 and recommended, but contracts refused by Joint Committee on Finance	Not current policy
Medical/Uniform Benefits	Advance care planning	2014	Require that plans contract with or provide a credible program based on defined criteria	Current policy
Medical/Uniform Benefits	Require plans to submit data to Wisconsin Health Information Organization (WHIO)	2014	Contract requirement that any participating plan submit data to WHIO for members in Wisconsin. Goal of supporting the development of WHIO as an all-payer claims database	Current policy
Medical/Uniform Benefits	Adding telehealth benefit	2014	First discussed in 2014, language added to "not prohibit" telehealth Additional contract language added to require product be offered in 2018 Benefit standardized in UB for 2019	Current policy
Medical/Uniform Benefits	Adding an alternate HMO option to the State Plan	2014 (not added)	Option not carried forward due to concerns about member confusion	Not current policy (only one option for state members)
Medical/Uniform Benefits	Reducing the number of available local program benefits	2016 (not adopted)	Recommended by Segal Reports, local employers were not in favor and indicated need for full array of program options	Not current policy

Medical/Uniform Benefits	Medicare Advantage product	2017	Recommended as a lower cost option for Medicare retirees; implemented in 2019	Current policy
Medical/Uniform Benefits	Expanding coverage under the IYC Health Plan for students living out of state	2018 (not adopted)	Requested by members, current plans only cover students within service area. Not implemented due to concerns about cost as well as impact to Access Plan	Not current policy
Pharmacy Benefits	Annual out of pocket maximum increase	2009	Plan to increase out of pocket maximum for pharmacy benefits over the proceeding 1.5 years to $410 for an individual and $820 for family	Adopted in 2009, further adjusted by future Boards
Pharmacy Benefits	Quantity limits for high cost drugs	2010	Response to oral chemo drugs and other medications that have significant side effects; limits the initial fill in case medication is not continued	Current policy
Pharmacy Benefits	Adding a Medicare Prescription Drug Plan	2009 (not added)	Option would provide program savings opportunity	provided through pharmacy benefit manager
Pharmacy Benefits	Online prescription drug purchasing marketplace supplement to pharmacy benefit	2011 (not adopted)	Investigated as a part of the 2011 ETF/OSER Act 32 Feasibility Study; concern about impact to PBM's negotiated rates and rebates	Not current policy
Pharmacy Benefits	Limiting coverage for "lifestyle" drugs (e.g. erectile dysfunction, acne medications, etc.)	2012	Cost sharing increased due to these drugs not being considered medically necessary	Not currently covered
Pharmacy Benefits	Level 4 for specialty medications	2012	Level added to manage costs in the program	Current policy
Pharmacy Benefits	Narrow retail pharmacy network			
Rates	Local rate capped at 1.5 times the state rate unless justified by experience and group size	2010	Recommended by actuary, in response to Board concerns about local program rate increases	Policy continued in 2020 rating

Supplemental Plans	Uniform supplemental plan offerings to all State agencies	2016	Prior benefit variety caused confusion for employees transferring between agencies; uniform requirements also allow Board to institute performance and loss ratio requirements	Current policy
Supplemental Plans	Alignment strategy to reduce number of vendors offering same or similar benefits	2017	Means of reducing duplication of benefits and increasing administrative simplicity	Current policy
Wellness	Standard wellness benefit	2010 (not added) 2012 (first change implemented)	Value identified in offering a standard benefit in 2010, but ETF did not have resources to implement and recommended waiting 2012 change to require plans provide an annual health assessment and biometric screening, later to standardize the $150 incentive	Carved out benefit through StayWell
Wellness	Premium differentials for obesity and tobacco use	2012 (not recommended)	Not added due to administrative complexity, potential statutory limits, and potential discrimination complaints	Not current policy
Wellness	Sole-source wellness vendor	2016	Benefit provided through plans was not uniform, and had low participation	Current policy
Wellness	Premium differential for participation in lieu of cash incentive	2017 (in progress)	Recommended to transition to premium differential to reduce member tax liability; however ETF system limitations have delayed implementations	In progress