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Correspondence Memorandum

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To: Group Insurance Board

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Subject: High Deductible Health Plan Product Strategy

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

Background

At its November 2019 meeting the Group Insurance Board (Board), identified the high deductible health plan (HDHP) as an area for additional development and improvement. Specifically, the Board recognized that while annual growth in the HDHP has remained steady, there still appeared to be limited member understanding and even skepticism about this plan design.

This memo reviews:

- The legal basis for the plan as it stands,
- Guidance around HDHP plans generally and the Board's specific plan,
- A review of current industry trends for employers offering HDHPs,
- The current state of enrollment and use in the Board's HDHP plan, and
- Goals for stakeholder engagement to further develop the Board's HDHP product strategy.

Legislative & Regulatory Review

Wis. Stats. §40.515 requires that the Board offer an HDHP and Health Savings Account (HSA) option to state employees, following the passage of 2013 Wisconsin Act 20. The law requires state employers to make contributions to an employee's HSA and for the Board to ensure the design of the HDHP can be paired with an HSA. This means that the HDHP must meet the federally defined minimum deductible amount, which is updated annually, and for the majority of services to be subject to deductible before coverage begins.

Currently, the only automatic exceptions are for services that are defined as preventive by the United States Preventive Services Task Force (USPSTF). The Internal Revenue

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy Electronically Signed 01/28/2022

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Service (IRS) issued guidance in 2019 allowing plans to reimburse for services related to chronic conditions before the deductible is met without any impact to HSA qualification (IRS Notice 2019-45). According to Segal, the Board's actuary, the adoption of this change by employer plans has been slow. Making this change within the Board's programs is likely to increase the cost of the program, which would violate Wis. Stats. § 40.03(6)(c) that limits changes that increase the cost of the GHIP.

The IRS sets deductible minimums each year. The minimum deductible set for plan year 2022 is $1,400 for an individual and $2,800 for a family (IRS Rev. Proc. 2021-25). In order for a person to be able to contribute to an HSA on a pre-tax basis, IRS rules prohibit them from having any other coverage that pays for services before their HDHP deductible is met (IRS Publication 969). Additional examples of disqualifying coverage include another group or individual health insurance plan, Medicare, and TRICARE.

When the Board's HDHP began in 2015, the Board interpreted the requirements of the statute to require that any state employee who elects the HDHP must also elect the HSA. This is often referred to by the Department of Employee Trust Funds (ETF) and employers as the "dual enrollment requirement". It also became policy in 2015 that the employee must elect the HSA offered by the state. This specific requirement was intended to reduce the administrative complexity and costs of sending the employer contribution to multiple banks, which may have differing administrative fees or abilities to intake direct deposits from employers. It was also intended to maintain the large group bargaining leverage of the state to reduce account fees for HDHP/HSA members.

Local employers that offer Program Option 7/17, which was designed to mirror the state employee HDHP, are not required to offer an HSA, and are not currently allowed to offer an HSA through the Board's HSA program.

The dual enrollment requirement has ensured that state members have at least some savings dedicated to health care needs, and that State of Wisconsin (State), University of Wisconsin System (UW), and UW Hospital and Clinics (UWHC) employers contribute money as well. However, it has also limited the number of individuals who can enroll in the HDHP and HSA programs. Employees with other spousal coverage or retirees who are Medicare-eligible are not eligible for an HSA and therefore cannot enroll in the HDHP.

Employer HDHPs in Other States

ETF compared its HDHP with five states: California, Illinois, Minnesota, Michigan, and North Carolina. A comparison of deductibles and out-of-pocket limits (OOPL) is summarized in Table 1.

- California offers only the basic HMO and PPO coverage for employees. California does not offer an HDHP or HSA.[1]
- Illinois markets its HDHP as a Consumer Driven Health Plan (CDHP). The plan provides the same annual medical deductibles as Wisconsin, but has a $500 to $1,000 higher OOPL. Illinois contributes $500 to an HSA for an individual plan and $1,000 for a family plan.[2]
- Minnesota calls its HDHP an Advantage HDHP. The plan provides the same annual medical deductibles as Wisconsin, but has a higher OOPL than Wisconsin and Illinois. Minnesota contributes $500 to an HSA for an individual and $1,000 for a family plan.[3]
- Michigan began offering an HDHP with an HSA in 2021 and has adopted a similar HSA employer contribution to Wisconsin. Deductibles and OOPLs are much higher for out-of-network services.[4]
- North Carolina offers the highest deductibles and OOPLs of the states compared. The state does not require HSA enrollment with an HDHP and it does not contribute toward an employee HSA. Employees must find an HSA provider on their own.[5]

Table 1. Deductibles and Out-of-Pocket Limit Comparison

State	Offers HDHP / Naming Convention	Annual Medical Deductibles Individual /Family	Annual Medical Out-of-Pocket Limit (OOPL)	HSA Employer Contributions Individual /Family
Wisconsin	Yes	$1,500 / $3,000	$2,500 / $5,000	$750 / $1,500
California	No	Not Applicable	Not Applicable	Not Applicable
Illinois	Yes / Consumer Driven Health Plan (CDHP)	$1,500 / $3,000	$3,000 / $6,000	$500 / $1,000

[1] California Public Employees' Retirement System. (2022). State Health Benefits Guide. https://www.calpers.ca.gov/docs/forms-publications/state-health-guide.pdf

[2] State of Illinois. (2022). Consumer Driven Health Plan (CDHP) Benefits. https://www2.illinois.gov/cms/benefits/StateEmployee/Documents/FY2022/CDHP22_SEGIP_ADA.pdf

[3] State of Minnesota. (2022). 2022 Minnesota Advantage Health Plan Schedule of Benefits. https://mn.gov/mmb-stat/segip/open-enrollment/advantage-schedule-of-benefits.pdf

[4] State of Michigan. (2022). State High Deductible Health Plan with HSA. https://www.bcbsm.com/content/dam/microsites/som/high-deductible-benefits.pdf

[5] State of North Carolina. (2022). North Carolina State Health Plan. https://www.shpnc.org/media/2579/open

State	Offers HDHP / Naming Convention	Annual Medical Deductibles Individual /Family	Annual Medical Out-of-Pocket Limit (OOPL)	HSA Employer Contributions Individual /Family
Minnesota	Yes / Advantage HDHP	$1,500 / $3,000	$3,600 / $7,200	$500 / $1,000
Michigan	Yes	$1,500 in-network and $3,000 out-of-network for individual / $3,000 (in-network and $6,000 out-of-network for family	$4,000 in-network and $8,000 out-of-network for individual / 8,000 in-network and $16,000 out-of-network for family	$750 / $1,500
North Carolina	Yes	$5,000 in-network and $10,000 out-of-network for individual / $10,000 (in-network and $20,000 out-of-network for family	$6,540 in-network and $12,900 out-of-network for individual / $12,900 (in-network and $25,800 out-of-network for family	Not Applicable / HSA is not required with the HDHP

HSA Use in the Market

A survey of the top 100 providers in the HSA market was completed in July 2021 by Devenir, an investment company that works with Optum Financial, the Board's HSA vendor. For the 2021 plan year, the average employer HSA contribution was $658 and the average employee HSA contribution was $1,184.

The survey also showed that partnerships and relations with an employee play a key role in driving employees to enroll in new HSA accounts. In Table 2, health plan and employer referrals accounted for 78% of new HSA accounts opened in the first half of 2021. Employees are likely to consider making a shift in their health benefit coverage with an HSA when the referral is from a person they know, such as their employer. ETF will continue to partner with health plan vendors and employers in providing members with the appropriate resources to make informed benefit decisions.

Table 2. Partnerships Role in Growth

New Accounts Attributed to Various Partnerships in 2021 YTD	Percentage (%)
Health Plan Referrals	41%
Direct Employer Referrals	37%
Insurance Agent Referrals	8%
Administrator / TPA Referral	5%
Other	1%

Current Board HDHP Enrollment and Cost Trends

The HDHP offered by the Board represents a relatively small portion of the membership of the Group Health Insurance Program (GHIP). In 2021 12.7% of employees selected the HDHP, a slight increase from 11.9% in 2020. In 2021 employees with the HDHP were more likely to choose an individual plan than a family plan. HDHP members also tend to be younger, on average, than their non-HDHP plan counterparts: 30.9 years of age versus 33.6, respectively.

Despite the small enrollment gains experienced by the HDHP between 2020 and 2021, the overall migration of members between plan designs is minimal. Only 2% of employees changed plan designs between 2020 and 2021. 99.3% of people who enrolled in the $250/$500 deductible IYC Health Plan in 2021 continued that enrollment from 2020. Only 8.7% (820 people) moved from the IYC Health Plan in 2020 to the IYC HDHP in 2021. However, the healthcare use habits of some people in the IYC Health Plan indicates that a greater proportion could potentially benefit financially from changing plans, without suffering any loss in health or quality of care received.

ETF asked IBM Watson Health (IBM), the Board's data warehouse and analytics vendor, to examine the utilization behaviors of members enrolled in the HDHP and non-HDHP program options. IBM found that overall, HDHP members were more likely to receive annual preventive visits than their non-HDHP counterparts. HDHP members also had generally comparable rates of preventive health screenings, such as colon, cervical, and breast cancer screenings to those members in the non-HDHP programs. HDHP members made fewer visits to the emergency room (130 visits per 1,000) than their non-HDHP counterparts (196 visits per 1,000); made fewer overall visits to a doctor's office (4.7 versus 6.1 visits per member per year); and had a much lower rate of prescription drug use (220 versus 385 days' supply per member per year).

IBM also analyzed the overall costs incurred by members to determine if they are selecting the most cost-effective plan design for their utilization patterns. Prior utilization is one of the most accurate predictions of future health care needs. Approximately 36% of the members who enrolled in the IYC Health Plan for plan year 2021 may have been over-insured, due to incurring $500 or less in out-of-pocket costs during plan year 2020. Members with lower out-of-pocket costs typically make the most of HDHP and HSA benefits, including a monthly premium more in keeping with their actual rate of

utilization, and accruing interest on their HSA funds. These members would generally benefit from learning more about the HDHP options available to them, particularly if they are in the state program and eligible for employer HSA contributions.

Stakeholder Input Strategy
The first phase of ETF's stakeholder input approach was a survey of ETF staff. Survey responses included numerous suggestions on how to improve the HDHP/HSA program option, such as:

- Provide more comprehensive employer education on advanced topics, including disqualifying other coverage.
- Offer more education in general for employees about the differences between HSAs and other pre-tax savings accounts, such as Health Care Flexible Spending Account (FSA).
- Develop additional HDHP education and resources, including but not limited to how the plan works, a comparison of costs with other plan designs, optimizing the HDHP/HSA benefit option, and advanced financial effects.
- Publish additional handouts and references for employees.
- Provide advanced member education, specifically regarding the dual reenrollment requirement and how it is impacted by HSA eligibility requirements and disqualifying other coverage
- Fund the total employer HSA contribution amount at the start of the plan year, rather than throughout the year, to reduce financial uncertainty for members enrolling in the HDHP/HSA plan option for the first time.
- Administer an HSA program for local employers, mirroring the state offering managed by ETF and Optum Financial.

ETF will also solicit HDHP/HSA feedback from external stakeholders. External stakeholders include state and local government employers and Optum Financial. Feedback from external stakeholders will be provided to the Board in May.

Options to Consider
Several options are outlined in this memo for Board consideration and discussion. Based on Board feedback and further discussion with external stakeholders, ETF will present final proposed changes to the Board in May.

<u>Change the Dual Enrollment Requirement</u>
While the dual enrollment requirement reinforces the value of funding the HSA, it may inadvertently limit certain members from enrolling in the program. Members with other health insurance—for example, through a spouse, Medicare, or military service—cannot enroll in the HDHP because of the required enrollment in the HSA. Sometimes enrollment in other coverage is not discovered by ETF or employers for months at a time, but when discovered, ETF must retroactively adjust coverage, claims, and HSA contributions to the date that the other coverage was effective. If the dual enrollment requirement were not in place, only the HSA would need to be adjusted. Changing this may require legislative action. ETF will continue to research this issue.

Local Employer-Specific Improvements Offer Multiple Program Options
The "Board Strategic Initiative Update: Wisconsin Public Employers" memo to the Board (Ref. GIB | 05.12.21 | 7B) on the local employer health insurance program raised the issue of the local employers currently being unable to offer both the HDHP and another program option. Local government employers feel by offering a HDHP and non-HDHP option, they will offer a more appealing health insurance choice for employees. ETF will continue to research the possibilities and any limitations in facilitating these opportunities for local employers.

Local Employer-Specific Improvements Participation in the State Sponsored HSA
A second issue raised in the "Board Strategic Initiative Update: Wisconsin Public Employers" memo (Ref. GIB | 05.12.21 | 7B) was the ability of local employers to participate in the Board's HSA. Local government employers also feel that, by participating in the state sponsored HSA, the HDHP product would be more appealing to employees while limiting administrative burden for local employers. ETF will continue to research the possibilities and any limitations in facilitating these opportunities for local employers.

Education Regarding HDHP/HSA
One common theme noted by both ETF staff and some external stakeholders is the limited understanding of the HDHP and HSA program option. For many employees who newly join the HDHP and HSA, the initial bills from providers can be a shock, and more risk-averse members may not be comfortable with how to properly fund their HSA to plan for medical expenses. There also appears to be limited understanding among employees about how the HSA can be used as another tool to plan for retirement. ETF could create educational resources designed to help both employers and members better understand the HDHP and HSA and ultimately, make more informed decisions.

Create an "Evergreen" HSA Enrollment Status
Under the state employee HDHP/HSA program, members must re-enroll in the HSA each year during open enrollment. This means that employees must log in to their respective HR portals, proactively select their plans and the HSA associated with it, and re-enter their annual elections—unlike members in the non-HDHP, whose coverage will continue if they don't make any changes. This is due, in part, to the requirement that members re-certify their intent to remain in the HSA. There are some employers who offer "evergreen" HSAs that do not require this same annual consent to continue. Removing this extra step could reduce some of the burden on employees who are in the HDHP, improving the member experience. ETF will review this option with Optum Financial to determine if it can be implemented in the Board's program.

Options Not Under Review
Certain challenges and opportunities highlighted during ETF's research are outside of the scope of this project.

HSA funding policy

The issue of when the HSA is funded (at the beginning of the year, periodically throughout the year, etc.) came up during both market information review and in discussion with ETF staff. The policy of how and when to fund the HSA is not within ETF's authority and therefore outside the scope of this project.

Chronic Condition Coverage Pre-Deductible

As noted above, the IRS released guidance in 2019 that allows HSA-qualified HDHPs to cover certain chronic condition care-related services before the deductible in the plan is met. This guidance is optional. Given that this change would increase the premiums for the plan, and that the change is not mandatory, ETF cannot recommend the Board pursue this further under its current HDHP option.

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