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Correspondence Memorandum

Date: July 20, 2023

To: Group Insurance Board

From: Renee Walk, Programs & Policy Unit Director
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Office of Strategic Health Policy

Subject: Group Health Insurance Program Alignment

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

Background

The State of Wisconsin Group Health Insurance Program (GHIP) has evolved over time in response to Group Insurance Board (Board) direction, market trends, and ever-increasing costs of healthcare. As described in a summary of programs presented to the Board in November 2019 (Ref. GIB | 11.13.19 | 5C), the Board began to break off programs in the early 2000s in an effort to consolidate purchasing power and lower costs. The Board first carved out the pharmacy benefit, then created a uniform dental benefit, and, most recently, contracted with a wellness and disease management (DM) vendor (currently WebMD).

Each of these carve-outs has helped the Board manage costs and ensure uniform quality and access in the programs offered by these vendors. However, some changes were predicated on other program adjustments that ultimately did not occur, such as the carve-out of DM, which was intended to happen at the same time as self-insuring the medical benefits. This resulted in the Department of Employee Trust Funds (ETF) and the Board pivoting strategies to adjust. In addition, each carved-out service requires more active management and collaboration by vendors and ETF to ensure that the benefits coordinate to maximize their impact.

While pharmacy and wellness/DM benefits have been carved out, the combination of these, along with medical insurance, make up the GHIP. Members who enroll in the GHIP have access to medical, pharmacy, and wellness/DM benefits. Members have the option to enroll in dental benefits separately. For purposes of this memo, staff will focus on the core three benefits included in the GHIP.

Eileen K Mallow

Reviewed and approved by Eileen Mallow, Director, Office of Strategic Health Policy
Electronically Signed 07/27/2023

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The approach the Board has taken to carve out benefits leverages flexibilities allowed under program structure and/or state law to best meet member needs. After the passage of the Affordable Care Act, the Board took advantage of flexibilities allowed to carve out adult dental coverage and vision benefits in order to manage medical insurance costs while still ensuring access to basic levels of care. Statutes limit the Board from signing contracts that increase costs. As discussed in February 2023, however, the same limitation does not apply to wellness or DM programming. Rather, the Board is limited based on its fiduciary duties, such as acting in the best interest of plan participants, ensuring the costs of the program are reasonable, and demonstrating a reasonable return on investments (Ref. GIB | 02.22.23 | 4). The Board and ETF have interpreted this to mean that the Board is allowed to add programming through the wellness/DM program, such as weight management or lifestyle programming. Adding these services under the medical benefit would require reductions in other benefits to remain cost neutral.

Healthcare Triple Aim

In November 2019, the Board approved using the Healthcare Triple Aim (Triple Aim) as the guiding principle for approving changes to the programs it oversees (Ref. GIB | 11.13.19 | 5D). Instead of focusing solely on reducing cost, the Triple Aim requires consideration of the health outcomes of members and the quality of the services they receive. To support the monitoring of health and quality of services received by the Board's members, GHIP vendors are required to submit data to Data Analytics and Insights (DAISI), the Board's data warehouse. ETF analyzes this data and presents it to the Board to allow for data-informed decisions and action and has often used the Triple Aim to analyze program changes and outcomes. ETF and its data warehouse vendor are working together to establish high-level Triple Aim dashboards to help with overall evaluation and trending over time.

Figure 1. Healthcare Triple Aim

Data Sharing and Integration
To help with the overall coordination of care and benefits ETF requires that GHIP vendors share data with one another. The Pharmacy Benefit Manager (PBM) shares pharmacy claims with the health plans and WebMD. Some plans use this data to identify members with certain medical conditions for outreach, but others do not integrate the data at all. WebMD uses pharmacy claims to identify members for targeted outreach and to assist nurses and coaches during health coaching or condition management calls. The PBM incorporates data from the health plans to manage deductible accumulators for the High Deductible Health Plan (HDHP).

Additionally, WebMD shares health assessment, screening, and coaching data with the health plans. Some plans use this information to help identify members for targeted outreach. WebMD also shares data with Navitus for the administration of the It's Your Health: Diabetes program.

As mentioned previously, each vendor also submits data to the DAISI data warehouse. When the data warehouse was initially implemented, ETF explored whether some level of access could be provided to plans for the purposes of condition management. However, there were limitations in the level of granularity in the data that ETF could share with plans, so this access was not pursued.

Vendor Coordination
The Council for Health Program Improvement (CHPI) began in 2017 as a means of bringing all vendors for the Board's programs together. The mission is "to develop cooperative strategies that positively impact member health." The vision is "optimization of overall health and high-quality service delivery for all members." There were some early successes, but overall challenges to true collaboration and open discussion remain, since many of the CHPI members (health plans) are in direct competition with one another in the general insurance marketplace. ETF continues to attempt to engage CHPI members, review meeting outcomes, and solicit feedback for improvements. A current area of focus with some CHPI members includes a cross-vendor collaboration on advanced care planning education and resources.

One health plan and the dental benefits administrator worked together for member referrals into the Evidence-Based Integrated Care Plan, which provides additional dental cleanings for those with certain conditions. Originally, ETF deemed this a pilot program. However, after further review, ETF determined this was not a pilot since it did not impact overall Uniform Benefits. The referrals, however, were an example of cross-vendor collaboration that ETF will continue to promote. ETF encourages GHIP vendors to help with member referrals as appropriate, but vendors do not have direct financial incentives. In some cases, vendors may feel that they manage risk better by trying to push members to their own programming versus to another vendor. In other cases, some may be giving member referrals, but they do not have a tracking mechanism in place to monitor and report them. Most other pilot programs have not required the vendors to work together, as most are implementing programs that they administer on

their own. Furthermore, there is no financial incentive to offer a pilot program or work with other GHIP vendors to implement one.

WebMD includes links to a member's health plan, Navitus, Delta Dental, Optum, and the relevant employee assistance program (if the employer has one) in its portal. WebMD also collects information on additional programming available at each health plan and updates this information annually so health coaches and nurses can assist with referrals as necessary. Other GHIP vendors are asked to include links and referrals to one another, but due to monitoring requirements and ETF staff capacity, this has not been strictly enforced.

Opportunities to Improve

The overall experience of vendor carve-outs has been positive, but ETF recognizes that there are now opportunities to better synchronize the vendors to create a more holistic member experience.

Some possibilities for improvement include:

- Adding health plan performance standards for quality in addition to the quality credit. Currently, the quality credit is awarded for an aggregate set of measures to the top five health plans in the Board's programs. This provides incentives to plans who know they can be competitive in this area, but it tends to be the same plans who are in the top five, leaving limited incentive for the remaining plans to maintain quality. Adding more incremental performance standards related to quality could encourage all plans to reach a certain base level of service.
- Increase monitoring and potentially add requirements for data integration and use by health plans. If there are specific areas where ETF and the Board see opportunities for plans to leverage data already shared with them, the Board could add contract standards. ETF would expect to collaborate with plans to develop requirements for use that are reasonable and would result in improved member outcomes. ETF would also undertake a foundational analysis to ensure that data sharing amongst vendors is compliant with state and federal law.
- Adding Well Wisconsin participation as a measure in the overall quality credit analysis to encourage health plans to assist with communication and member referrals into the wellness/DM program. As discussed earlier, there are already performance guarantees in the WebMD contract.
- Increase consistency in DM reporting. DM reporting from WebMD and the health plans has changed over the years, and ETF is working with vendors to develop and implement reporting standards. ETF would also like to collect information from other GHIP vendors on population health-related programs and initiatives to comprehensively evaluate program and vendor impact on member health, quality, and costs instead of relying solely on WebMD to accomplish these aims. Long-term strategy can include financial incentives to GHIP vendors who can prove they are positively supporting health, quality, and costs.
- Adding a performance standard related to return on investment for the wellness program.

Other Considerations
While there are many opportunities to increase contract requirements, a key limitation is the availability of ETF resources to monitor and enforce requirements. Even beyond the current demands of the Insurance Administration System, staff are typically at capacity in monitoring existing programs and contract requirements.

Other key considerations include limits to collecting and sharing information in federal law and state law, and cybersecurity risks. For example, with respect to federal law, the Health Insurance Portability and Accountability Act (HIPAA) and the Genetic Information Nondiscrimination Act (GINA) limit what information may be collected and shared. Regarding state law, while Wisconsin does not have comprehensive data privacy protections, the landscape of data privacy laws in other states continues to evolve at a rapid pace. Even though those laws do not directly apply to ETF, they may impact GHIP vendors who have a nationwide footprint, limiting what vendors are able to share.

Additionally, ETF's current contracts include strong cybersecurity protections related to the health information and individual personal information of our members. At the same time, there are inherent challenges and risks whenever data is shared.

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